Our Values

PERSONAL
SAFE
EFFECTIVE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton University Hospital
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2018/19

Incorporating hospital and community health services, teaching and research

Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2018/19

Presented to Parliament pursuant to Schedule 7,
paragraph 25(4) (a) of the National Service Act 2006

Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2018/19

ANNUAL REPORT

QUALITY ACCOUNT

demonstrating our commitment to providing quality care for all patients and reporting back on our performance against priorities for quality improvement agreed by the Board of Directors, and identifying our priorities for 2019/20.

ANNUAL ACCOUNTS

including the consolidated Annual Accounts for the financial year 2018/19.

ANNUAL REPORT


Our Values
PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

1 Performance report

1.1 Overview of performance

The purpose of the Performance Report is to provide an overview of our organisation, its purpose, the key risks to achieving our objectives, and our performance during the year.

Chairman's and Chief Executive's overview

Introduction

Welcome to our 2018/19 Annual Report

The high level of public interest in the challenges affecting the NHS referred to in our report last year continued unabated in 2018/2019. The familiar concerns over inadequate funding and the need to deliver high quality care to increasing numbers of patients with progressively more complex needs were further complicated by the political and organisational challenges associated with the ongoing upheaval created by Brexit.

Notwithstanding these challenges the Trust continued to make good progress, the credit for which must as always go to our incredibly talented, hard-working and committed staff. They in turn have been well supported by our Clinical Commissioning Group, other health care organisations and GPs, the London Borough of Hackney and the City of London Corporation, our patients, and the wider community. Much is said about the need for health care to become better integrated to be more effective and patient centred, and this is only possible through these various groups working closely together.

Quality and Patient Care

It is our key responsibility to ensure that the quality of the clinical and other services we provide to our patients, coupled with their overall experience while they are in our care, is as good as it can be.

The quality of our care is substantially dependent on the quality, relevance and coverage of the information generated within the Trust and elsewhere. A particular example over the past year is in the considerable improvement made in the reporting of serious incidents, and the timeliness of their evaluation. It is important that we should be a continuously learning organisation.

The success of the Trust in this all-important area has been underlined in the recent past by a series of "Good" CQC reports, culminating in the CQC's overall evaluation of the acute site and the Trust as a whole in the current financial year. Not only is the whole Trust rated "Good", but our A&E Department continues to be rated as "Outstanding", and our Medical Services are now also rated at this highest level.

Financial Performance

Within the context of the continuing financial constraints imposed on the NHS as part of the Government's austerity programme, and despite in year pressures, the Trust has continued to perform well financially. After achieving our control total last year, resulting in additional funding from the Government, we are pleased to have achieved the same this year, 2018/2019.

The consequence of this, coupled with a determined and successful effort by the Finance Team over the past year to recover overdue debt, is a significant improvement in the Trust's cash position. This is vital to the future successful development of the Trust as it puts us in a stronger position to invest in capital developments, aimed at improving both the quality and reach of the services we provide to our patients.

Strategic Development

The strategic development of the Trust can be considered at two levels, borough (both Hackney and the City) and the local geographical area of east London.

As far as Hackney and the City are concerned, good progress has been made in partnership with our Clinical Commissioning Group in developing more integrated care. The foundation for this is a series of workstreams based on eight "neighbourhoods", where action is being taken to develop more integrated care pathways across our own acute and community services, GPs, the local authorities, and other health and care agencies.

There have been a number of developments in the East London Health and Care Partnership (ECHLP and previously the Sustainability and Transformation Partnership) involving greater integration of some of the CCGs in the area, and other activity relevant to the Trust.

The Trust not only works as part of ELCHP but also with the inner ELCHP providers and commissioners, between whom there is more pathway flows of patients. The inner area includes the two acute trusts, Barts and Homerton. There is some sense in this given the plans that we are already developing in partnership with Barts. The first of these plans is a possible pathology partnership, which continues to be the subject of complex negotiations between the two trusts.

People

None of what we have achieved would have been possible without the excellent performance of all our staff and the support of the organisations with which we work. We are both very conscious of and grateful for this.

Turning to the Board, Sheila Adam, our Chief Nurse, retired during the year; our Finance Director Jonathan Wilson left to take up the same position at Moorfields Eye Hospital NHS Foundation Trust; and Daniel Waldron, our Director of Organisational Transformation, left the Trust to take up a senior position at the Guy's and St. Thomas' NHS Foundation Trust. We are very grateful for the work they did whilst at the Trust.

We are delighted that Dr Deblina Dasgupta, as Medical Director; Catherine Pelley as Chief Nurse and Director of Governance; Phill Wells as Finance Director; and additionally Frances O'Callaghan as Director of Strategic Implementation and Partnerships; have all joined the team of executive directors, and all are already making excellent contributions to our progress.

We would also like to acknowledge the excellent work done by Susan Osborne and Polly Weitzman during their time as non-executive directors on the Board and thank them for their services. We are delighted that Dr Shree Datta and Cherron Inko-Tariah have recently joined the Board in a similar capacity.

Finally we want to thank our outgoing Chair Sir Tim Melville-Ross for his excellent leadership over the last six years. He has been a hugely popular and respected individual within the Trust and local community. In particular, he kept the Board focussed on the key objective of doing what was best for patients and the Trust as a whole. We wish him well for the future.

Sir John Gieve

Chair

24 May 2019

Tracey Fletcher

Chief Executive

24 May 2019

A post script from Sir Tim

I would like to add my own personal note this year as it has been the last in which I have chaired the Trust. My own view is that our patients and our community are very well-served by an excellent acute hospital and community services, and I wish my successor Sir John Gieve as much enjoyment and fulfillment in the role as I have had. And thank you to everyone with whom I have come into contact over the last six years for your support, encouragement and commitment.

Sir Tim Melville-Ross

About Homerton

Homerton University Hospital NHS Foundation Trust is an integrated care trust which provides hospital and community health services for Hackney, the City and surrounding communities. The Trust provides a full range of adult, older people's and children's services across medical and surgical specialties.

The Trust operates acute services from a single site: Homerton University Hospital, which has almost 500 beds spread across 11 wards, a nine bed intensive care unit and maternity, paediatric and neonatal wards. There are three day surgery theatres and six main operating theatres and the types of surgery performed include general surgery, trauma, orthopaedics, gynaecology, maxillofacial, urology and ear nose and throat (ENT).

Community services operate from over 60 partner sites in Hackney and the City of London, and include sexual health, locomotor services, school nursing and diabetes eye screening. The Trust also provides continuing health care at the Mary Seacole Nursing Home which in Hoxton, east London.

A range of specialist care is offered in obstetrics and neonatology, foetal medicine, fertility, HIV and sexual health, asthma and allergies, bariatric surgery and neuro-rehabilitation across east London and beyond.

The clinical services are led and operated by three divisions within the Trust: surgery, women's and sexual health services (SWSH); children's services, diagnostics and outpatients (CSDO); and integrated medical and rehabilitation services (IMRS). The corporate directorates which operate in support of these include finance, estates and facilities, governance, information technology and workforce.

The Trust's strategic vision in 2018/19

Homerton was one of the first trusts to gain foundation status in 2004. Since this time, The Trust has maintained its reputation as a high performing NHS provider, delivering quality patient and service user care, whilst maintaining compliance with all key performance and regulatory requirements.

The Trust's strategy 'Achieving Together' was established in 2014 and is the blueprint for developing Homerton's services over five years. It sets out the Trust's ambitions and priorities for building on our current high standards and establishing the Trust as one of the country's foremost health providers, with a reputation for quality, innovation and leading the way on service integration.

In consultation with a wide range of Trust staff and key stakeholders, three strategic priorities were identified: Quality, Integration, and Growth; each supported by clear aims and objectives to realise our mission:

'Safe, caring, effective health and social care provided to our communities with a transparent, open approach.'

We recognise that successful delivery depends as much on the approach we take, as on the priorities themselves. We have developed a set of organisational values which describe the approach we will take in delivering the services and the standards we will uphold and set out in the document 'Living our Values'.

‘Achieving Together’ outlines the priorities for the next stage of our development and the values of the Trust. These values provide a framework for how we make our decisions and engage with patients, staff, carers, governors, and the Trust’s membership.

We are proud of the services we offer at Homerton and the reputation the Trust has developed for providing high quality care. ‘Achieving Together’ ensures we continue to build on this reputation both locally and nationally.

We have a number of initiatives supporting our strategic direction to ensure we maintain high standards of operational performance. These include a continued focus on organisational development and workforce engagement; a productivity and efficiency strategy; and a quality agenda designed to further embed high-quality provision and a positive patient experience.

In 2018/19 the Trust continued to support the work of the East London Health and Care Partnership which brings together the area’s eight councils and 12 NHS organisations, who are combining their expertise and resources to ensure health and care services meet the needs of local people, now and in the future. The Trust has also been a core partner and leader within City and Hackney in developing integrated working with commissioners and providers of health and social care at a local level. This programme aims to deliver an integrated, effective and financially sustainable local system which listens to and meets local people’s needs and works as part of the wider north east London footprint.

The Trust’s strategic objectives in 2018/19

The Trust’s mission – ‘Safe, caring, effective health and social care provided to our communities with a transparent, open approach’ – will continue in the coming year and also our commitment to ‘Achieving Together’.

The Quality, Integration, and Growth strategic priorities established within the context of the five year strategic plan, 2014 – 2020, continue to be supported by the following objectives:

Quality

- Safe – Continuously strive to improve patient safety and provide harm free care.
- Effective – Provide services based on the latest evidence and clinical research.
- Positive patient experience – Ensure all patients have an excellent experience of our services through providing person-centred care that takes into account each patient’s or service user’s needs, concerns and preferences.

Integration

- Pathways – Ensure care pathways, across the health system, are designed around the needs of the individual.
- Prevention – Focus on early intervention to improve health and wellbeing and reduce the cost of health care provision.
- Partnership – Create seamless services in which organisational boundaries are not evident to the patient or service user.

Growth

- Scale – Ensure core services are of a sufficient scale for long term sustainability and effectiveness.
- Reputation – Develop a national reputation and profile for leading the way in the provision of high quality and innovative health care services.
- Turnover – Establish an ability to respond to the financial and quality challenges facing health care providers by increasing turnover to £400m by 2020.

Key risks to delivering our strategic objectives

The key risks that could impede us from achieving our strategic objectives are:

- failure to develop an engaged and motivated workforce may undermine the Trust's ability to deliver its services in accordance with its values and desired staff behaviours, resulting in a poor experience for the patient;
- a patient receives avoidable harm from poor practice as a result of a failure to comply with required Trust safety policies and lessons learned;
- if the culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust falling short in the quality of care delivered to patients;
- a lack of adherence to latest research, or practice which is not compliant with the best evidence could lead to a less effective service provision;
- failure to achieve financial targets may result in difficulties in funding future investment plans and threaten the organisation's financial autonomy;
- poor reviews or reports on performance outcomes by regulators, other bodies, the press and public may result in a damaged reputation that diminishes the Trust's ability to grow;
- failure to expand and retain sufficient activity through a failure to adapt and engage in local collaborative healthcare arrangements may limit the Trust's ability to increase turnover and maintain clinically sustainable services.

The risks that threaten achievement of the strategic objectives are identified within the Board Assurance Framework, which is reviewed regularly by the Board of Directors and Risk Committee. The Trust's risk management processes are designed to assess the impact of all risks identified on the Trust's Risk Register, and ensure that they are appropriately mitigated and managed.

Throughout the year the Board of Directors reviewed the risks that may prevent the Trust from achieving its objectives, complying with its NHSI Licence Conditions and fulfilling the requirements of the operating and financial plan. The Board also assesses outcomes through regular review of performance reports.

During the year the Trust also made appropriate preparations for the impact of the UK's departure from the European Union. All trusts were provided with guidance by the Department for Health and Social Care to support their preparations for the possibility of a no-deal departure from the EU on 29th March 2019. The Trust complied with this guidance in full and was an active participant in discussions across the region. Internally a Brexit Board, chaired by the Chief Executive Officer, was established to oversee this activity and the Trust Board was updated regularly. The Government has now agreed a new date for the UK's departure from the EU which is expected to be no later than 31st October 2019.

Going concern disclosure

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.

Performance against strategic priorities 2018/19

We have recorded a number of achievements during the year:

- Overall, CQC inspectors rated Homerton University Hospital as 'Good' following their inspection of four core inpatient services in April 2018. Urgent and emergency services and medical care (including care of the older person) were rated as Outstanding.
- We remain one of the best performers for A&E services in London and nationally; consistently delivering over 90% for the 4-hour wait target and achieving 94.34% overall against the 95% target in 2018/19
- We continue to achieve good compliance against the key operational and quality requirements with a strong performance against the 18 week referral to treatment standard (best performing England and Wales) and improving access to psychological therapies
- We met our financial control total and successfully implemented a new financial transactions process in partnership with NHS Shared Business Services
- We retained the Planet Mark accreditation for a second year by showing good practice in sustainability including achieving a 9.6% total carbon footprint reduction in 12 months and decreasing carbon emissions from buildings by 9.7%.
- We exceeded the midwifery continuity of carer target, ensuring the delivery of a more holistic care model for expectant mothers
- An overseas recruitment campaign led to the employment of 49 new nurses last year
- We launched the Lighthouse Programme to help nurses achieve the NMC clinical examination qualification and also to provide welfare support to overseas nurses
- The inpatient cardiac arrest rate of 0.5% is well below the national average of 1.6%
- The Acute Pain Team was recognised as the Team of the Year by the National Acute Pain Symposium
- Throughout the year some of our clinicians were also shortlisted for a number of awards, including Nurse Leader of the Year
- We successfully implemented a new voice recognition system to facilitate the information entry in electronic notes and letter production.
- Our doctors are using new technology to access cardiology, endoscopy and radiology images and a new phone app allows clinician to safely take clinical photographs.
- A significant improvement for us in the 2018 staff survey was the staff recommendation of the organisation as a place to work or receive treatment
- We delivered harm free care to 96.4% of Homerton patients

1.2 Performance analysis

Review of financial performance

The Trust had an Income & Expenditure (I&E) surplus of £16.8m for the financial year 2018/19, compared to the planned surplus of £11.4m. The main source of income for the Trust is contracts with commissioners in respect of health care services, the Trust's main commissioner being City and Hackney Clinical Commissioning Group.

A comparison of planned and actual performance (excluding impairments) is shown in the table below.

	Plan	Actual	Variance
2018/19	**£m**	**£m**	**£m**
Income			
Clinical contracts	**291.2**	**293.8**	**2.6**
Other income	**23.9**	**25.3**	**1.4**
STF Funding	**11.0**	**16.4**	**5.4**
Total income	**326.1**	**335.5**	**9.4**
Expenses			
Pay	**-206.2**	**-213.3**	**-7.1**
Non pay	**-96.3**	**-93.0**	**3.3**
Total expenses	**-302.5**	**-306.4**	**-3.8**
EBITDA*	**23.6**	**29.1**	**5.6**
Depreciation and amortisation	**-7.7**	**-8.1**	**-0.4**
PDC dividends	**-4.3**	**-4.3**	**0.1**
Net interest	**-0.2**	**0.1**	**0.2**
Sub-total	**-12.2**	**-12.3**	**-0.1**
Net Surplus/(Deficit)	**11.4**	**16.8**	**5.4**

*Earnings Before Interest, Tax, Depreciation and Amortisation

Income was £4.0m (1.3%) above plan and was driven by increases in activity above plan in accident and emergency, daycase, outpatient and non-elective activity. Sustainability and Transformation Funding (STF) income totalled £16.4m for the year and was higher than plan by £5.4m.

The Trust achieved £10.3m of savings during the year as part of its Quality, Innovation, Productivity and Prevention (QIPP) agenda. Projects included staffing and skill mix reviews, reduction in premium rates for additional clinical workload, service reconfiguration, negotiation with suppliers and more efficient use of our capacity.

Capital expenditure

Capital expenditure for the year totalled £11m, of which £4.9m related to new and replacement medical equipment including endoscopy stacks and x-ray machines, £2.2m related to IT projects and £3.9m related to Estates projects, the most significant of which was the refurbishment of Lloyd Ward.

The Trust's liquidity position improved in-year due to the income and expenditure surplus of £16.8m and improved performance on the collection of aged debt. The Trust ended the year with debtors £2.9m lower than at the last year-end and the closing cash balance £21.4m higher.

The Trust strives to pay all suppliers in line with the agreed terms for each supplier but in any event no later than 30 days from receipt of goods or services or the invoice date if later.

The Trust's treasury management strategy is routinely reviewed by the Audit Committee, a committee of the Board. The Committee has not identified any immediate liquidity concerns. The Trust is confident that it has sufficient funds to remain as a going concern.

Operational performance

The Trust delivered against the majority of its key performance indicators in year; however, there were some significant challenges in relation to the delivery of some of the regulatory national standards.

The following table sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all trusts, were required to report to NHS on a range of measures quarterly.

Key Performance Indicators	2018/19 Target	2018/19 Performance
A&E patients discharged < 4hrs	95%	94.34%
Cancer		
2 Week Wait	93%	95.9%
31 Day Target	96%	99.4%
62 Day Target	85%	87.2%
Infection Control		
MRSA	0	2
Clostridium difficile (*C.diff*)	6	3
18 Week RTT Indicator		
Incomplete Pathways	92%	96.71%
IAPT Indicators		
6 week target	75%	96.50%
18 week target	95%	99.52%

With regard to the delivery of key operational milestones, the Trust has performed strongly throughout the year in relation to the Incomplete RTT standard (for patients who have been referred on to consultant-led referral to treatment pathways), and strong performance is expected to continue in to 2019/20, although increasing demand for the Trust's services is anticipated to present a new set of challenges for the Trust to overcome.

In 2018/19, the Trust has again performed comparatively strongly against the 4-hour Accident and Emergency standard but, as in 2016/17 and 2017/18, has found maintaining compliance throughout all four quarters challenging and, as a result, did not deliver the annual 95% performance standard, although the Trust did successfully meet its target to achieve additional PSF funding. As in previous years the following variables in particular prove challenging: available staffing particularly, although not exclusively, associated with medical posts, increasing patient acuity and rising activity volumes – particularly in relation to surges within ED attendances. It should also be noted that the Trust did not open its escalation ward throughout 2018/19, thus being able to manage its emergency demand through its core bed base. In 2018/19, the Trust has also seen increases in its level of activity driven by ambulance arrivals. The challenge in relation to meeting this standard has again been flagged as a risk in the Trust's 2019/20 Operating Plan.

Similarly, the Trust generally performs well against the suite of cancer standards. Nevertheless, and in line with historical trends, Trust performance with regard to the 62-day standard oscillated in the early part of the year; however, the Trust successfully met the standard for six consecutive months from September 2018 to March 2019. As stated in previous reports, it should be noted that the Trust only delivers a limited number of treatments on-site and is therefore disproportionately reliant on partner organisations to achieve compliance with the standard, although with the expected introduction of the new performance standards in 2019/20, it is anticipated that performance in general will be much more within the Trust's ability to control. Despite the strong performance in the second half of the year, the challenge with regard to meeting this standard has been highlighted as a risk in the Trust's 2018/19 Operating Plan.

As in previous years, the Trust was set challenging targets for MRSA and *Clostridium difficile* (*C.diff*) infection. Further details regarding the actions being taken to minimise hospital acquired infections are detailed in the Quality Account.

The Trust has continued to perform strongly against both the 6 week and 18 week Improving Access to Psychological Therapies (IAPT) indicators, whilst also performing strongly against the access and recovery standards.

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month. Details of performance against key quality indicators that were prioritised throughout 2018/19 are presented in the Quality Account.

Environmental matters and sustainability

The NHS Sustainable Development Unit, via its Carbon Reduction Strategy, requires NHS organisations to reduce carbon emissions by 34% by 2020. The latest report published in January 2016, shows that the NHS carbon footprint in England is 22.8 million tonnes of carbon dioxide equivalents (MtCO2e) and the carbon footprint reduced by 11% between 2007 and 2015.

The NHS carbon footprint comprises three key areas: travel, building energy use and procurement. Homerton along with other NHS organisations supports the agenda for driving down carbon emissions in these areas. The Trust is working towards its carbon reduction target via a number of strategic energy efficiency infrastructure improvements in the estate, and through increased activity to support wider sustainable outcomes over the next year.

The Board approved the Sustainable Development Management Plan (SDMP) in 2017/18 which includes climate change adaptation planning. The SDMP details carbon reduction through energy efficiency, as well as looking at other environmental aspects such as waste, water, community engagement and travel. It will also seek to integrate and embed sustainability through governance, workforce and procurement functions.

Homerton became the first NHS Trust in the country to be accredited with a Planet Mark™ sustainability certificate in recognition of its ongoing environmental commitment in 2017 and was reaccredited in 2018 for its ongoing commitment to year-on-year progress in carbon footprint reduction.

Holders of the certificate have a minimum requirement to reduce their carbon emissions by 2.5 per cent every year. The Trust met these requirements by April 2018, reporting a carbon footprint of 2.04 tonnes carbon dioxide equivalent (tCO2e) per employee, totalling in 7,074 tCO2e overall. This equates to a 9.6% reduction on the previous year against a target of 5%.

The Trust's assessment also included emissions from energy use in the building, with electricity accounting for nearly three quarters and natural gas a quarter of the total emissions.

Trust Resource Usage

Resource	**2016-17**	**2017-18**	**2018-19***
Electricity (kWh)	10,373,536	10,012,291	10,807,633
Gas (kWh)	17,936,638	17,744,378	18,275,104
Water (m3)	92,264	99,758	102,513

* Estimated usage

In addition, to the Planet Mark™ award, the Trust also received the Acre of Rainforest Certificate which ensures through continuous sustainability efforts that an acre of rainforest is protected from deforestation. Our acre is located in Ashaninka, Northern Peru. This award protects 240 trees, 245 animal shelters, 22 endangered species and supplies 76,000 litres of water to the community.

The Trust has introduced a new green travel plan which supports sustainable travel modes by staff, patients and visitors to support the reduction of car parking, renewable travel options and reusable energy sources such as a decrease in the use of petrol cars in favour of electric bicycles and cars. A new parking policy was implemented in April 2018 and the Trust actively promotes how staff, visitors and patients can better access the Homerton sites via public transport in partnership with Hackney Council.

To achieve our sustainability goals, the Trust relies on the support of all staff to ensure the best possible environmental working practices at Homerton. Simple interventions like switching off lights and equipment when not in use, and closing doors and windows helps to improve resource efficiency, reduce waste, achieve cost savings, and reduce the Trust's carbon footprint.

Social community and human rights issues

The Trust is committed to ensuring that services meet the needs of people with protected characteristics under the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

This is also in accordance with our public sector equality duties under the NHS Constitution. The Trust recognises the importance of respecting and protecting the human rights of patients, staff and members, in line with Equality and Human Rights Commission guidance.

The Trust's equality objectives and Equalities Report which sets out how we meet specific employment duties are available on the website at www.homerton.nhs.uk

The Trust is committed to safeguarding all patients and works with partners through local multi-agency Safeguarding Boards to safeguard vulnerable adults and children. Safeguarding child and adult leads are in place to ensure that policies and procedures are applied in response to safeguarding issues. All staff receive safeguarding training as part of their mandatory training requirements.

To meet the needs of a diverse population, a telephone interpreting service is available and key information leaflets are provided in other languages and in a user friendly format. A multi-faith spiritual care team which reflects the different faiths and beliefs of the local population is also available to support patients and relatives.

The Trust's Policy Group has oversight of the development of new policies and updates to existing policies. It ensures that equality impact assessments have been carried out to confirm that policies, functions and services are not discriminatory.

Important events since the end of the financial year

Between 1 April 2019 and the date of this report, the Trust has no important events to declare.

Overseas operations

There were no overseas operations in 2018/19.

Tracey Fletcher

Chief Executive

24 May 2019

2. Accountability report

2.1 Directors' report

Trust Board

The Board, led by the Chairman, sets the strategic direction of the Trust and is responsible for the organisation's decision-making and performance to ensure the Trust delivers high quality, safe and efficient services.

The Board meets 11 times a year in public and can also, when necessary, convene special meetings. The Board comprises seven non-executive directors and six executive directors. The Chairman leads the Board and ensures its effectiveness. The Board monitors the delivery of objectives and targets and provides leadership with regard to operational performance, risk, quality assurance and governance.

The Chairman and non-executive directors are held to account by the Council of Governors. Board members are invited to attend Council of Governors meetings and joint Board and Council of Governors meetings are also held twice a year. The Chief Executive is accountable to the Board for the management of the Trust's operational business.

The Board held five seminars during the year to discuss strategic issues and to hear about service developments.

Board members

Directors' details, together with their committee membership, are confirmed below. Board members declare their interests at the time of their appointment and on an annual basis. The register of directors' interests is published annually. It can be found on our website on the Board of Directors' pages or a copy may be obtained from the Company Secretary; email address: huh-tr.Enquiries@nhs.net and telephone number: 020 8510 5555.

Directors are also required to confirm they meet the "fit and proper person" condition set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. All directors have met the requirements of the "fit and proper person" test.

Non-executive directors

The term of office for non-executive directors is three years. Thereafter, and subject to satisfactory appraisal, a non-executive director is eligible for consideration by the Council of Governors for a further uncontested term of three years. The Chairman and Non-Executive Directors can also be removed by the Council of Governors.

Sir Tim Melville-Ross, Chairman

Sir Tim Melville-Ross joined the Board in April 2013 and has had a long and distinguished career in commerce. After working for British Petroleum and a short period in the City of London, he joined Nationwide Building Society, where he worked for 20 years, including 10 years as Chief Executive. He was then Head of the Institute of Directors for five years and until 31 March 2018 was the Chair of the Higher Education Funding Council for England. Sir Tim chairs the Nomination and Remuneration Committee and is a member of the Risk Committee and the Trust's Charitable Funds Committee.

Sir John Gieve

Sir John Gieve joined the Board in November 2011. He was a career civil servant, which included appointments as Managing Director of the Treasury for three years and Permanent Secretary to the Home Office between 2001 and 2005. Sir John was Deputy Governor of the Bank of England from 2006 to 2009. He is also Chair of Nesta, the innovation charity, and of Vocalink, the payments company. Sir John is a member of the Audit Committee and is the Trust's Senior Independent Director and Deputy Chair. In December 2018, the Council of Governors approved Sir John's appointment as the Trust's Chairman with effect from 1 April 2019.

Vanni Treves CBE

Vanni Treves joined the Board in September 2012. He was for many years Senior Partner of Macfarlanes, a leading firm of solicitors, and also has a broad experience of industry and education. He is a former chairman of London Business School, the National College for School Leadership and Channel Four Television. Vanni was awarded the CBE in 2012. He chairs the Risk Committee.

Jude Williams

Jude Williams was formerly Lead Governor on the Council of Governors prior to her appointment as a non-executive director in May 2014. She has a career in public health strategy and policy development, with a particular focus on health inequalities, staff wellbeing and public and patient involvement. She worked in east London as a director within the Health Authority followed by national level work in the Department of Health and as Head of Public Health in the Healthcare Commission. She currently undertakes executive level coaching and some anti-gang violence work with the Home Office. She is a member of the Audit Committee.

Martin Smith

Martin Smith joined the Board in November 2014. He was a London Borough Chief Executive for a decade, for Ealing until 2016, and before that Tower Hamlets. Martin led Ealing through a period of rapid change accelerated by the unprecedented financial challenge of the austerity agenda. He also led on the health agenda on behalf of the chief executives of all 33 London Councils. Martin is a qualified Chartered Public Finance Accountant, was statutory chief financial officer in two organisations and currently chair's the Trust's Audit Committee.

Dr Shree Datta

Shree Datta joined the Board as a non-executive director from 1 November 2018. Shree is a Consultant Obstetrician and Gynaecologist at King's College Hospital and Associate Clinical Dean for King's College Medical School. She specialises in menstrual and pain problems, Colposcopy and high risk Obstetrics. Shree was appointed to the General Medical Council's ruling body in 2013 and is a former Chair of the BMA's Junior Doctors Committee. She is also secretary to the Obstetrics and Gynaecology section of the Royal Society of Medicine. Shree is a member of the Risk Committee

Cherron Inko-Tariah MBE

Cherron Inko-Tariah joined the Board as a non-executive director from 1November 2018. Cherron is a former civil servant and has undertaken leadership roles in various policy and strategic positions across Whitehall, working with ministers and permanent secretaries. She has a master's degree in Employment Studies and Human Resource Management. In 2012, Cherron left the Civil Service to follow her passion; staff networks and the positive impact they can have on the individual and organisation. She now works as a consultant, facilitator and coach.

In 2011, Cherron was awarded an MBE for her services to Government and for her work in the faith community with young people. She is a member of the Audit Committee.

Executive Directors

Tracey Fletcher, Chief Executive

Tracey became Chief Executive in January 2013. She re-joined the Trust in 2010 as Chief Operating Officer, having previously been with Homerton for many years. She has extensive experience in health care management, having begun her career in a mental health trust followed by a community trust prior to joining Homerton. Tracey is a member of the Charitable Funds Committee and Risk Committee.

Dylan Jones, Chief Operating Officer

Dylan Jones was appointed Chief Operating Officer in January 2013. Previous roles at the Trust include Divisional Director of the Integrated Medical and Rehabilitation Services Division (2011 to 2013) and General Manager for the General and Emergency Medicine Division (2008-11). Before that Dylan worked at the former Barts and the London NHS Trust, and NHS trusts in South Wales.

Dr Deblina Dasgupta, Medical Director

Deblina was appointed as Medical Director from July 2019 and has worked at Homerton Hospital for the past 13 years as a Consultant Physician in Geriatric and General Medicine. She was an Associate Medical Director from 2016 and since 2012 the Clinical Lead for Elderly Care, Stroke and Intermediate Care.

Deblina trained in a number of London hospitals including the Whittington, University College London and Newham before joining Homerton. She has been a leader in developing simulation training in geriatric and general internal medicine in London and an innovator in establishing the pioneering Integrated Independence Team for City and Hackney. Deblina is a member of the Risk Committee

Catherine Pelley, Chief Nurse and Director of Governance

Catherine joined the Trust in June 2018 on an interim basis and was appointed substantively in January 2019. Catherine has over 33 years NHS experience including care of older people, health visiting, working as part of a neighbourhood nursing team and working with families affected by drug and alcohol issues. She has also served as a service commissioner in Brent and Harrow and later as a director of commissioning in Hertfordshire.

She has worked at NHS England focusing on patient experience and safeguarding children, and also with NHS Improvement as a nurse fellow developing resources to support ward sisters and team leaders. Catherine has been awarded the honour of becoming a Queen's Nurse. She is a member of the Risk Committee.

Phill Wells, Director of Finance

Phill was appointed Director of Finance in October 2018. He joined the Trust after 16 years as a Civil Servant where he had worked at both the Cabinet Office and the Department for Work and Pensions where he latterly held the position of Finance Director. Phill is chair of the Charitable Funds Committee, a member of the Audit committee and is a qualified Chartered Public Finance Accountant.

Director of Organisational Transformation

This post is currently vacant.

Other directors who attend the Board:

Iain Patterson, interim Director of Workforce

Iain has been providing interim cover for the Director of Organisational Transformation position since January 2019 having previously been the Trust's Associate Workforce Director. He initially worked at the Trust in 2004 before joining UCLH and then Barts Health before returning in 2013. Professionally Iain is a Fellow of the Chartered Institute of Personnel and Development.

Frances O' Callaghan, Director of Strategic Implementation and Partnership

Frances joined the Trust in October 2018 and has a broad range of experience in different settings. As well as working in the NHS for over 20 years in clinical and strategic roles, she has also been responsible for estates, communications and other board level corporate services roles. In addition she has undertaken director roles within an Academic Health Sciences Centre and has returned to the NHS after three years as a director within the Corporate Finance Team at PricewaterhouseCoopers.

Board members who stood down during the year:

Susan Osborne, CBE

Susan Osborne was a non-executive director from May 2014 until 31 October 2018.

Polly Weitzman

Polly Weitzman was a non-executive director from May 2014 until 31 October 2018.

Sheila Adam

Sheila Adam was Chief Nurse and Director of Governance from July 2013 until 31 May 2018.

Daniel Waldron

Daniel Waldron was Director of Organisational Transformation from May 2013 until 21 December 2018.

Jonathan Wilson

Jonathan Wilson was Director of Finance from August 2016 until 31 October 2018.

Further details of the expertise and knowledge of Board members who stood down this year can be found in our 2017/18 Annual Report.

Directors' Board attendance

The directors' record of attendance at Board meetings during 2018/19 is confirmed below.

Non-executive director	Board attendance	Executive director	Board attendance
Sir Tim Melville Ross	10/11	Tracey Fletcher	11/11
Dr Shree Datta	4/5	Sheila Adam	1/2
Sir John Gieve	10/11	Deblina Dasgupta**	7/8
Cherron Inko-Tariah	5/5	Dylan Jones	10/11
Susan Osborne	4/6	Frances O'Callaghan*	5/6
Martin Smith	10/11	Iain Patterson*	3/3
Vanni Treves	7/11	Catherine Pelley	9/9
Polly Weitzman	4/6	Daniel Waldron	7/8
Jude Williams	10/11	Phillip Wells	6/6
		Jonathan Wilson	6/6

* The Director of Strategic Implementation and Partnership and interim Director of Workforce attend Board meetings in a non-voting capacity.

** Dr Michael Gill attended the Board as an interim Medical Director from April 2018 to July 2018.

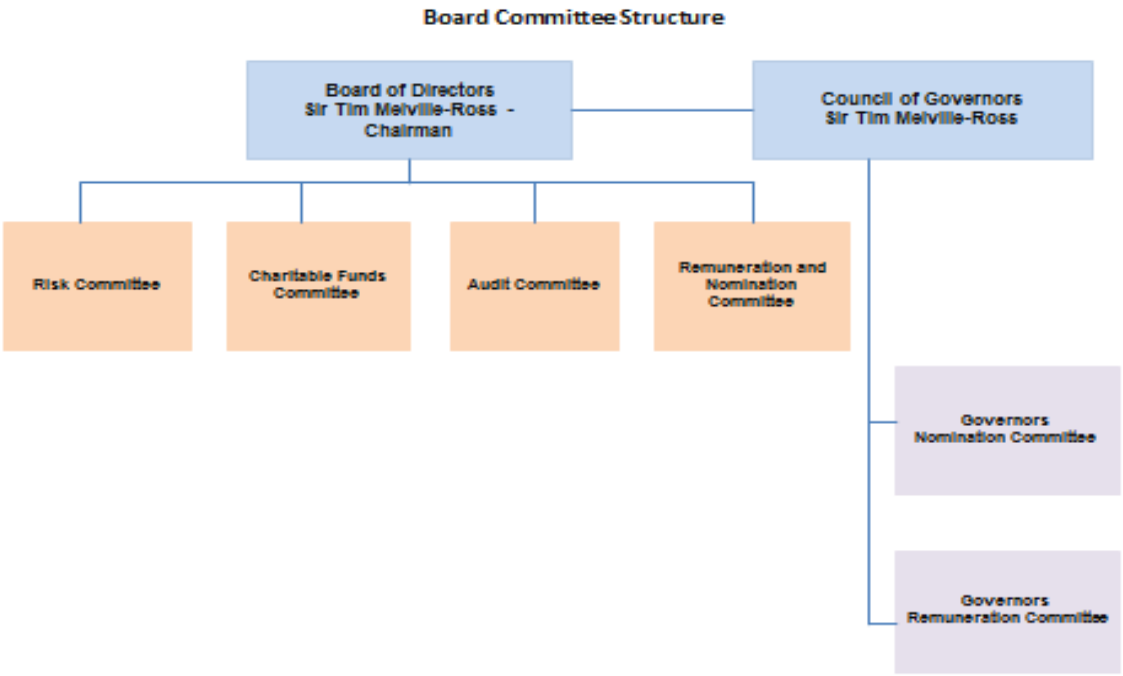
Board committees

The Board committee structure is set out below. Terms of reference set out the responsibilities of each committee and this structure monitors and provides assurance to the Board on the delivery of the Trust's objectives and other key priorities.

Contacting the Board

Board members may be contacted via the Trust s Company Secretary as follows:

Telephone: 020 8510 5555 or Email: huh-tr.Enquiries@nhs.net



Audit Committee

Membership and attendance

The Audit Committee is chaired by Martin Smith, a non-executive director, and includes three other non-executive directors. Sir John Gieve and Jude Williams were non-executive members of the Audit Committee throughout 2018/19, and Polly Weitzman was a member until the 31 October 2018 when she stood down from the Board. From 1 November 2018 she was replaced by Cherron Inko-Tariah. The Audit Committee met six times in 2018/19.

Name	Attendance
Martin Smith (chair)	6/6
Sir John Gieve	5/6
Polly Weitzman	0/3
Jude Williams	6/6
Cherron Inko-Tariah	2/3

How the Audit Committee discharges its responsibilities

The Audit Committee's primary purpose is to provide assurance on the adequacy and effective operation of the Trust's overall system of control. It is directly accountable to the Board. The Committee assures the Board of Directors that probity and professional judgment is exercised in all financial matters. It advises the Board on the adequacy of the Trust's systems of internal control and its processes for securing economy, efficiency and effectiveness.

Significant issues considered

During the year the Committee considered 13 reports from the Internal Auditors that sought to provide assurance to the Trust on the overall adequacy and effectiveness of the risk management, control and governance processes.

Overall, the internal auditors concluded that the organisation had an adequate and effective framework for risk management, governance and internal control. Their work identified further enhancements to ensure that it remained adequate and effective. During the year, the internal auditors provided one substantial assurance (green), four reasonable assurance (amber green) opinions, and seven partial assurance (amber red) opinions. The remaining report was advisory and therefore did not result in a formal opinion.

For all reports, management provides an action plan to address any issues identified. Progress against these action plans is reviewed at each Audit Committee and further testing is undertaken by Internal Audit to ensure their recommendations are embedded in the organisation. The Committee has also reviewed key policy documents and discharged its duties by reviewing the schedule of tender waivers to ensure any such waivers are in line with the Trust's policy. Other areas of the Committee's work include: reviewing the Trust's progress on budget setting and business planning; considering the Trust's medium term financial strategy; reviewing arrangements for Clinical Audit; considering the Trust's compliance with the Overseas Visitors Mandatory Up Front Charging legislation; and reviewing the Trust's proposals for implementing NHS Improvement's Costing Transformation Programme.

The Audit Committee has also considered significant financial matters as part of its ongoing work, including consideration of debtor balances and their recoverability (note 11 to the accounts), and the valuation and accounting treatment of the Trust's property estate (note 9.1 to the accounts).

Auditors

The Trust's internal auditors are RSM, appointed by the Trust in December 2012. Their role is to provide the Trust with an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives and to provide independent support to help management improve the organisation's risk management, control and governance arrangements.

The external auditors for Homerton are KPMG LLP, appointed by the Council of Governors in December 2016. Their fees for audit services undertaken in 2018/19 were £73,825. KPMG's accompanying report on the Trust's financial statements is based on their audit conducted in accordance with International Financial Reporting Standards and the Financial Reporting Manual issued by NHS Improvement. Their work includes a review of the Trust's system of internal control which is used to inform the nature and scope of their audit procedures.

The external auditors confirmed in their Audit Plan, which was approved by the Audit Committee, that the significant audit risks being reviewed are: valuation of land and buildings, management override of control, operating income from patient care activities and fraudulent expenditure recognition.

The external auditors may also perform non-audit work where the work is clearly audit related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered.

The processes in place ensure auditor objectivity and independence is safeguarded. There was no non-audit work carried out during 2018/19.

Remuneration and Nomination Committee

The Remuneration and Nomination Committee determines the pay and employment policy for the executive directors and other staff designated by the Board. Remuneration is reviewed with due regard to benchmarking information and survey data of other comparative senior posts within the NHS. The committee also considers the performance of the executive directors.

The Committee has been chaired by Sir Tim Melville-Ross, Chairman of the Board and all of the non-executive directors are members. The Committee met on one occasion in 2018/19. Details of salary and pension entitlements for Board members are set out in the Remuneration Report on page 32.

Risk Committee

The Risk Committee was established by the Board to support the development of the Trust's risk management systems and processes. It ensures that the Trust Risk Register is fit for purpose and that risks are subject to robust scrutiny to achieve the Trust's principal objectives and deliver its core business. The Committee receives annual compliance reports from key areas of the business to provide assurance to the Board that quality and risk management arrangements are appropriate and robust.

The Risk Committee is chaired by Vanni Treves and met four times in 2018/19.

Homerton Hope – the Trust's Charitable Fund

The Trust's Charitable Fund (known as Homerton Hope) is an NHS Charity as defined within the NHS Charities guidance and was established in March 1997.

The Trust is the charity's Corporate Trustee, which means that the executive and non-executive directors share the responsibility for ensuring that the Trust fulfils its responsibilities in managing the charitable fund. The Trust Board has delegated this responsibility to the Charitable Funds Committee, which comprises the Director of Finance (chair), the Trust Chair, the Medical Director and the Chief Executive.

The Director of Finance is responsible for the day-to-day management and administration of the charitable fund, and in particular, for ensuring that expenditure is in accordance with the objectives and priorities agreed by the Charitable Funds Committee and the Trust Board.

Charity objectives

The charity is funded by donations and legacies received from patients, their relatives, the general public, and other organisations. The charity's objective is "to provide support for any charitable purpose or purposes relating to the National Health Services provided by Homerton University Hospital NHS Foundation Trust including services provided to the community"

This objective is met by ensuring that all expenditure by the charity relates to one of the following three areas:

- Patient expenditure – Purchase of items of equipment, provision of services, and the provision of facilities not normally provided by, or in addition to, normal NHS provision;

- Staff expenditure – Purchase of educational material and conference/course fees in addition to those provided from the Trust's training and development budgets. Enhanced staff facilities and services that improve staff wellbeing; and

- Capital equipment - Purchase of equipment in addition to that provided by NHS funds through the Trust's Capital Programme.

Review of achievements

During 2018/19, the charity continued to support a wide range of charitable and health related activities, benefiting patients and staff in a variety of areas. Generally, funds are used to provide specialist staff, goods and services which would not have been possible using NHS funding. Some of the activities which continued over the past year are described below.

Peer navigators project

With the help of another donation from the MAC Aids Fund the Charity has been able to support the running of a peer navigators' programme. This project helps patients build confidence to seek employment, navigate the complex and ever changing social care system, and also provide support in living well with HIV.

Art programme

The therapeutic value of art in health and in speeding recovery is well documented. The Trust has always displayed art work in its wards, corridors and courtyards. Based in the heart of Hackney, the hospital provides an excellent blank canvas for artists to display their work to patients, staff and visitors. Thanks to a grant from the Postcode Lottery we have been able to continue our art therapy sessions in the Elderly Care Unit, the Graham Ward Stroke Unit and the Regional Neurological Rehabilitation Unit (RNRU).

Christmas presents for inpatients

The charity continued its annual tradition of providing small gifts to patients who were staying in hospital during Christmas 2018.

Staff welfare

The charity provided funding for a number of courses, conferences and award ceremonies attended by staff including food and entertainment for the summer staff barbeque. Contributions were also made to support the work of the Healthy Homerton Project.

Equipment purchased for patients

Over the last year charitable funds were used to purchase a number of items of equipment and to provide additional services to benefit patients, for example:

- Asthma awareness kits for Starlight unit

- Cancer awareness kits for families

- NHS 70 anniversary staff celebrations

- Hackney Ark roof garden improvements
- Memorial garden improvements
- Diabetes volunteer group garden

Donations

The charity mainly receives donations from organisations such as the Justgiving and Virgingiving websites and members of the public. Total funds received were in excess of £30,000 (excluding fees). The charity also received £30,000 from MAC Aids for the peer navigator role.

We also received:

- £6000 from Tesco Groundworks which helped fund the memorial garden redevelopment, and the purchase of large toys for the children's ward and children's A&E
- £18,000 from the Postcode Lottery funding to provide art classes for RNRU, the stroke unit and the elderly care unit
- £765 from the John Lewis Stratford, Barbican and Highbury & Islington community matters programme for children's services
- £2500 from London Catalyst to help us provide grants for patients with HIV and cancer

The charity continues to actively fund raise through a variety of activities, for example, in September 2018 a group of celebrities hosted an event to raise awareness about hair loss. This event raised over £8500.

Board, committee and directors' evaluation

The Board of Directors is satisfied that its balance of knowledge, skills, and expertise is appropriate to fulfil its function in accordance with the requirements of the NHS Foundation Code of Governance and the Trust's Terms of Authorisation.

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Lead Governor of the Council of Governors to seek the views of directors and governors. The performance of non-executive directors is evaluated annually by the Chairman.

The Chief Executive reviews the performance of the executive directors during their annual appraisal.

Governors and members

The Trust is accountable to the communities it serves and members of the public are able to become members and if elected, governors of the Trust. Being a member provides people with the opportunity to find out more about the Trust and to get involved.

We have two membership constituencies as set out in the Trust constitution:

- Public
- Staff

Membership is open to any member of the public over the age of 16 who lives in the London Borough of Hackney, the City of London or the outer area. The outer constituency includes Tower Hamlets, Waltham Forest, Newham, Redbridge, Barking, Havering, Camden, Islington, Haringey, Enfield, Lambeth, Southwark, Westminster and Epping Forest District. There is no separate patient constituency.

The staff constituency is divided into clinical and other staff categories. Any staff on permanent employment contracts or those who have worked at the Trust for at least 12 months, including contractual staff or those holding honorary contracts, will be welcomed as members unless they choose to opt out.

The Trust is committed to recruiting a diverse membership which is reflective of the community that it serves. There is no set limit on the number of people who can register as members within the eligibility criteria. The public membership continues to be broadly representative of the local population in terms of ethnicity and gender but is under represented in the 16-39 age category.

The Trust ended the year with 4,781 public members and 3,743 staff members which represents a relatively stable position.

Membership engagement and strategy

The Trust's Membership Strategy (2017-2020) sets out the engagement and communication priorities to engage with members and to increase Homerton's membership, with particular emphasis on recruiting younger people. The Trust has established a Membership Engagement and Communication Committee, which has oversight of membership activities and is chaired by a public governor.

During the year, membership recruitment sessions, supported by governors, were held at the hospital and other venues across the borough. 'Memberlink' newsletters were sent to all public members providing information, election details and news about the Trust's services. Governors also include updates about their work in '*Homertonlife*', the Trust's magazine.

A member is able to vote for, or stand for election as a candidate to become a governor. There is an opportunity for interested members to ask questions about the role at the Annual Members' Meeting or at membership engagement events which are hosted by governors.

Council of Governors

The Council of Governors represents the views of patients, public members and staff and it comprises elected public and staff members, together with representatives of partner organisations, local authorities and commissioners.

The Council has 25 Governors including:

- 14 Public Governors (elected)
- 6 Staff Governors (elected)
- 5 Appointed Governors nominated from partnership organisations.

On 31 March 2019, 21 of the 25 governor seats were occupied.

Governors normally hold office for three years and are eligible for re-election or re-appointment at the end of their first term. Governors may not hold office for more than nine consecutive years.

The Council also elects one of its members to be the lead governor. John Bootes has held the position since July 2014.

The following table confirms the names of our governors, their terms in office and attendance at Council meetings during 2018/19.

Name	Constituency	Current Term	End of Term	Meetings Attended
Elected Governors				
Paul Ashton	Public (Hackney)	second	Sept 2019	3/5
Neil Burgess	Public (Hackney)	first	Sept 2021	3/3
Julia Bennett	Public (Hackney)	third	Sept 2021	4/5
Eric Cato (deceased)	Public (Hackney)	first	Sept 2020	2/4
Steve Cummaford	Public (Hackney)	first	Sept 2020	2/3
Dr Coral Jones	Public (Hackney)	first	Sept 2019	5/5
Stuart Maxwell	Public (Hackney)	third	Sept 2021	5/5
Sally Mulready	Public (Hackney)	first	Sept 2021	1/3
Saleem Siddiqui	Public (Hackney)	first	Sept 2019	5/5
Christopher Sills	Public (Hackney)	first	Sept 2019	3/3
John Bootes	Public (City)	third	Sept 2019	5/5
Nagaraja Akkisetty	Public (Outer)	first	Sept 2021	2/3
Mary Rose Thomson	Public (Outer)	first	Sept 2020	4/5
Hilda Walsh	Staff (Clinical)	second	Sept 2019	5/5
Helen Cognoni	Staff (Clinical)	second	Sept 2021	4/5
Suzanne Levy	Staff (Clinical)	second	Sept 2020	4/5
Vijay Venkateshappa	Staff (Clinical)	first	Sept 2019	2/3
Ibrahim Hafeji	Staff (Non Clinical)	first	Sept 2020	2/5
Chris Mullett	Staff (Non Clinical)	first	Sept 2019	4/5
Appointed Governors				
Jeremy Mayhew	City of London	first	May 2021	2/4
Dr Paul Kelland	City and Hackney CCG	first	June 2021	2/4
Yvonne Maxwell	Hackney Council	first	October 2021	1/2

Governors who stood down in 2018/19

The following governors stepped down during the year, either through resignation or their terms of office expiring:

Name	Constituency	Current Term	End of Term	Meetings Attended
Ayse Ahmet	Public (Hackney)	first	Sept 2018	1/2
Ruth Martin	Public (Hackney)	first	Sept 2019	2/2
Hazel McKenzie	Public (Outer)	first	Sept 2018	1/2
Shuja Shaikh	Public (Hackney)	first	Sept 2018	2/2
Danny Turton	Public (Hackney)	second	Sept 2020	1/2
Judith Sunderland	City University (Appointed)	first	Feb 2021	1/2

Role of the Council

The Council has a number of statutory responsibilities including:

- Holding the non-executive directors to account for the performance of the Board
- Appointing or removing the Chairman and non-executive directors
- Appointing or removing the Trust's auditors

The Chairman of the Board of Directors is also Chairman of the Council. This establishes an important link between the two bodies and helps governors to fulfil their statutory duties. The Chairman ensures that governor views on key strategic issues are considered at the Board of Directors meeting as part of the decision-making process.

The Council of Governors and the Board of Directors hold regular joint meetings during the year. Executive directors and non-executive directors regularly attend Council meetings to gain an understanding of governor views and the membership constituencies they represent. In turn governors have the opportunity to ask Board members questions about areas of concern or wish to receive further information.

The Lead Governor holds regular meetings with governors to keep in touch with opinion, to seek views about future agendas and to enhance communication between the Council and the Board.

The governors held five meetings in 2018/19 including two joint meetings of the Council and the Board.

Director Attendance

The directors' record of attendance at Council of Governors meetings is shown below.

Non-executive director	Council attendance	Executive director	Council attendance
Sir Tim Melville Ross	5/5	Tracey Fletcher	5/5
Dr Shree Datta	1/2	Sheila Adam	1/1
Sir John Gieve	5/5	Deblina Dasgupta	0/3
Cherron Inko-Tariah	0/2	Dylan Jones	1/5
Susan Osborne	0/3	Frances O'Callaghan	0/3
Martin Smith	5/5	Iain Patterson	0/1
Vanni Treves	2/5	Catherine Pelley	3/4
Polly Weitzman	0/3	Daniel Waldron	3/4
Jude Williams	3/5	Phillip Wells	1/3
		Jonathan Wilson	3/3

The Council receives regular reports from the Board on clinical and financial performance, quality standards and reports from the Chair of the Audit Committee. The Chief Executive updates the governors on service developments and collaborative work within the East London Health and Care Partnership.

Register of interests

Governors sign a code of conduct and declare any interests that are relevant once elected or at the time of appointment. A copy of the register may be obtained from the Company Secretary; email address: huh-tr.Enquiries@nhs.net and telephone number: 020 8510 5555.

Committees of the Council

The Council of Governors has responsibility for approving the reappointment or appointment of non-executive directors as recommended by the nomination committee or by a non-executive or chair appointment panel.

Non-executive directors are appointed by the Council for an initial period of three years and subject to satisfactory appraisal appointments may be extended for a further three years. In exceptional circumstances a non-executive director can serve for a further year. The Council may also remove the Chairman or another non-executive director in accordance with the provisions set out in the constitution.

Nomination Committee

The Nomination Committee of the Council of Governors comprises public and staff governors and is chaired by the Trust Chairman. Its purpose is to select non-executive directors and approve non-executive reappointment.

In 2018/19 the committee met on four occasions and during the year the terms of reference and membership were reviewed.

In April 2018 the committee met to discuss the composition of the Board due to the imminent expiry of three terms of office in respect of:

Sir John Gieve	31 October 2018
Sir Tim Melville-Ross	31 March 2019
Vanni Treves	31 August 2018

In addition, Susan Osborne and Polly Weitzman had signalled their intention to step down from the Board owing to other commitments.

Given the prospect of five non-executive director (NED) vacancies in the coming year the Nomination Committee agreed to the recruitment of two new NEDs and mindful of Board stability and continuity the committee also recommended that Sir John Gieve's and Vanni Treves' term of office was extended for a further year.

In July 2018 a recruitment panel comprising the Chairman and four governors interviewed five candidates for the NED roles. The process was supported by Odgers Berndston, external search advisors.

On 19 July 2018 the Council approved the appointment of Dr Shree Datta and Cherron Inko-Tariah MBE to the Board and agreed the recommended reappointment of Sir John Gieve and Vanni Treves.

Appointment of Chair

In September 2018, the Nomination Committee established a chair appointment panel to oversee the appointment of Sir Tim Melville-Ross' successor. The panel was chaired by John Bootes, Lead Governor and other members were:

- Jude Williams, non-executive director
- Dr Helen Cugnoni, staff governor
- Paul Ashton, Julia Bennett and Stuart Maxwell, public governors

Odgers Berndston, external search advisors and Steve Hitchins, Chairman of Whittington Health NHS Trust provided professional and independent recruitment support.

In December 2018 the Council unanimously approved the appointment of Sir John Gieve as Trust Chairman with effect from 1 April 2019.

Remuneration Committee of the Council of Governors

The Remuneration Committee of the Council of Governors comprises public and staff governors and is chaired by the Lead Governor. Its purpose is to recommend salary and related conditions of the non-executive directors and the Chairman. The committee met on one occasion during 2018/19 to consider non-executive performance and remuneration.

Contacting the governors

If a member of the public or patient wishes to contact a governor they can do so by email:

huh-tr.members@nhs.net or by telephone: 020 8510 5302.

Cost allocation and charging guidance

The Trust has complied with HM Treasury cost allocation and charging guidance, including incorporating action plans and feedback from previous audit recommendations.

Political and charitable donations

The Trust has not made any political or charitable donations this year.

Better payment practice code

During the financial year to 31 March 2019, the Trust paid 91.7% by volume and 89.0% by value of all non- NHS suppliers within 30 days.

NHS Improvement (NHSI) well-led framework

In 2017/18 the Board commissioned an external well-led governance review which was carried out by Grant Thornton UK LLP[1]. The review was based on the NHSI well-led framework and the details were reported in last year's Annual Governance Statement.

In this reporting year the Board has taken assurance from the CQC's well-led inspection in May 2018 that there are robust arrangements in place to ensure that services are well-led. Further details may be found in the Annual Governance Statement on page xx.

Before his departure, Sir Tim Melville Ross completed an evaluation report which concluded that the Board was performing well.

Patient care activities

The Quality Account at part 3 describes what the Trust is doing to develop its services and improve patient care.

Stakeholder relations

The Trust continues to maintain and develop relationships within the NHS, the local authority and education partners and community and patient representative groups. The Trust works jointly with local commissioners and providers within the City and Hackney Transformation Board which oversees the strategy for integrating health and social care services across the boroughs. The Trust maintains good representation at each of the four associated workstreams, including the Unplanned Care Board which is chaired by the Trust's Chief Executive. The Trust continues to work with NHS and local authority partners as part of the East London Health and Care Partnership.

The Trust is an executive partner of University College London Partners and a member of NHS Quest, a network of high performing NHS Foundation Trusts.

The Trust has a statutory duty to collaborate with partners in health and social care. We have representation at Hackney HealthWatch meetings and we also attend Health Scrutiny Commission meetings which are held in public. The Trust is also actively engaged in the Health and Wellbeing Board for Hackney and is represented within its formal sub-structures.

[1] Grant Thornton produced an independent report and has no other connections with the Trust

Some of our key stakeholders have nominated representatives on the Council of Governors which enables them to receive regular service and performance updates along with elected representatives of members of the public living in local boroughs.

Income disclosures

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust complies with this requirement as can be seen in the following table:

	£'000
Health care income	331,016
Non-health care income	4,493
Total income	**335,509**

The Trust has included within "health care income": all income from contracts for patient services, Sustainability & Transformation Fund income, and income for the use of the Trust's buildings and facilities where it is from another NHS body engaged in the provision of health care. During the year the Trust received a total of £16.4m funding in relation to Sustainability & Transformation funding.

The Trust has included within "non-health care income": income from private patients; rental income from non-healthcare bodies; income from overseas visitors, and other miscellaneous non-healthcare related income. This income makes an additional contribution towards the cost of providing NHS health care and improving the services that the Trust can provide to its patients.

Disclosure to auditors

As far as the directors are aware, there is no information relevant to the audit which has not been disclosed to the auditors. The directors have taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Remuneration report

For the purposes of this report the disclosure of remuneration to senior managers is limited to executive and non-executive directors of the Trust.

In accordance with the constitution, executive director remuneration is determined by the Nomination and Remuneration Committee of the Board, comprising the Chairman and all non-executive directors. The remuneration of the Chairman and non-executive directors is determined by the Remuneration Committee of the Council of Governors.

Both committees work to common principles and procedures. Remuneration levels are set taking into account the requirements of the role, market rates, the performance of the Trust, benchmarking information (NHS and public sector) and affordability. The committees are authorised to obtain external or other professional advice on any matters within their terms of reference, with due regard to probity and cost. No individual is involved in any decision that affects his or her own remuneration.

The Nomination and Remuneration Committee is responsible for determining and agreeing, on behalf of the Board, the broad policy for the remuneration of very senior managers. It is also responsible for considering the performance of the Chief Executive and executive directors. The Trust does not award performance bonuses.

The committee meets at least annually to review the Board structure, size and composition, to consider succession planning and to identify the required board level skills and knowledge. The committee must also meet as part of the process of appointment for executive directors and decide on their remuneration. During 2018/19 Dr Deblina Dasgupta, Frances O'Callaghan, Catherine Pelley and Philip Wells were appointed as executive directors.

Executive directors are required to give six months' notice to terminate their employment contracts. Non- executive directors are required to provide three months' notice. All directors have permanent contracts. Non-executive directors are appointed for a period of three years in accordance with the Constitution.

The Trust currently carries a provision of £0.325m for early retirements relating to ex-members of staff.

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce. The remuneration of the highest paid director in the Trust in 2018/19 was £195,604 (2017/18 £167,407). This was 5.8 times (2017/18 5.3 times) the median remuneration of the workforce, which was £34,027 (2017/18 £31,754). The remuneration of the highest paid director increased in 2018/19 due to the receipt of a clinical excellence award by the incoming medical director.

The remuneration of two Executive Directors is greater than £150,000.[2] In consideration of benchmarking information compared with peer trusts, the scope of the job roles and their responsibilities and the continued probity of the Remuneration Committee the Trust is satisfied that the remuneration is fair and reasonable. A further 18 employees received a salary which exceeded £150,000 when pro-rated.

[2] £150,000 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury as set out in guidance issued by the Cabinet Office. Although the Cabinet Office approvals process does not apply to NHS Foundation Trusts the threshold is used as a benchmark for disclosure.

Audited Analysis of Staff Costs 2018/19				
			2018/19	2017/18
	Permanently Employed	**Other**	**Total**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	161,898	817	162,715	155,643
Apprenticeship Levy	795		795	755
Social Security costs	17,457		17,457	15,679
Employer contributions to NHS Pensions Agency	18,787		18,787	17,960
Pension Cost - Other	14		14	5
Termination Benefits	41		41	255
Agency staff		13,527	13,527	12,187
	198,992	**14,344**	**213,336**	202,484

The following table provides information on the remuneration of senior managers in the Trust in 2018/19.

Audited Remuneration of Senior Managers 2018/19						
	Salary	**Taxable Benefits**	**Annual Performance related Bonus**	**Long Term Performance Related Bonus**	**Pension-related Benefits**	**Total**
	(bands of £5,000)	**(to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £2,500)**
Executive Director	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Fletcher T – Chief Executive	180-185	-	-	-	77.5-80.0	**260-265**
Jones D - Chief Operating Officer	130-135	-	-	-	65.0-67.5	**195-200**
Wells P – Director of Finance [1]	60-65	-	-	-	-	**60-65**
Wilson J – Director of Finance [1]	75-80	-	-	-	-	**75-80**
Pelley C – Chief Nurse and Director of Governance [2]	95-100	-	-	-	-	**95-100**

Adam S - Chief Nurse and Director of Governance [2]	15-20	-	-	-	-	**15-20**
Dasgupta D – Medical Director [3]	145-150	-	-	-	-	**145-150**
Gill M – Interim Medical Director [3]	40-45	-	-	-	-	**40-45**
Kuper M – Medical Director [3]	0-5	-	-	-	-	**0-5**
Waldron D - Director of Organisation Transformation [4]	80-85	-	-	-	25.0-27.5	**105-110**
Patterson I – Interim Director of Organisation Transformation [4]	20-25					**20-25**
Melville-Ross T - Chairman	40-45	-	-	-	-	**40-45**
Gieve Sir J – Non-executive Director	10-15	-	-	-	-	**10-15**
Treves V – Non-executive Director	10-15	-	-	-	-	**10-15**
Williams J – Non-executive Director	10-15	-	-	-	-	**10-15**
Weitzman P – Non-executive Director [5]	5-10	-	-	-	-	**5-10**
Osborne S – Non-executive Director [5]	5-10	-	-	-	-	**5-10**
Smith M – Non-executive Director	10-15	-	-	-	-	**10-15**
Datta S – Non-exective Director [6]	5-10	-	-	-	-	**5-10**
Inko – Tariah C – Non executive Director [6]	5-10	-	-	-	-	**5-10**

[1] Jonathan Wilson held the post of Director of Finance until 31st October 2018 when he left the Trust. Phill Wells took up office as Director of Finance from 8th October 2018.

[2] Sheila Adam held the post of Chief Nurse and Director of Governance until she retired on the 1st June 2018. Catherine Pelley covered the role of Chief Nurse and Director of Governance on an interim basis from the 25th June 2018 until she was appointed into the role substantively with effect from 1st January 2019.

[3] Martin Kuper held the post of Medical Director until he left the Trust on the 5th April 2018. The role was covered on an interim basis by Mike Gill between April and July 2018 when Deblina Dasgupta was appointed substantively to the role.

[4] Daniel Waldron held the post of Director of Organisation Transformation until he left the Trust on the 21st December 2018. The role was covered on an interim basis by Iain Patterson from 1st January 2019 onwards.

[5] Polly Weitzman and Susan Osborne held non-executive director roles until they left the Trust on the 31October 2018.

[6] Cherron Inko-Tariah and Shree Datta joined the Trust as non-executive directors on the 1 November 2018.

In 2018/19 the Trust paid £96 as expenses to one of its executive directors (2017/18 - £433) and there were no payments made to Governors (2017/18 – nil). The Trust is well served by its Governors and volunteers who are not paid for their services.

The element of the Medical Director's salary that related to their clinical role in 2018/19 was approximately £38k.

The following table provides information on the remuneration of senior managers in the Trust in 2017/18.

Audited Remuneration of Senior Managers 2017/18						
	Salary	**Taxable Benefits**	**Annual Performance related Bonus**	**Long Term Performance Related Bonus**	**Pension-related Benefits**	**Total**
	(bands of £5,000)	**(to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £2,500)**
Executive Director	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Fletcher T – Chief Executive	165-170	-	-	-	50.0-52.5	**215-220**
Jones D – Chief Operating Officer	120-125	-	-	-	30.0-32.5	**150-155**
Wilson J – Director of Finance	135-140	-	-	-	-	**135-140**
Adam S - Chief Nurse and Director of Governance	110-115	-	-	-	15.0-17.5	**130-135**
Kuper M - Medical Director	150-155	-	-	-	120.0-122.5	**275-280**
Waldron D - Director of Organisation Transformation	100-105	4,400	-	-	25.0-27.5	**130-135**
Melville-Ross T - Chairman	40-45	-	-	-	-	**40-45**
Gieve Sir J – Non-Executive Director	10-15	-	-	-	-	**10-15**
Treves V – Non-Executive Director	10-15	-	-	-	-	**10-15**
Williams J – Non-Executive Director	10-15	-	-	-	-	**10-15**
Weitzman P – Non-Executive Director	10-15	-	-	-	-	**10-15**

Osborne S – Non-Executive Director	10-15	-	-	-	-	**10-15**
Smith M – Non-Executive Director	10-15	-	-	-	-	**10-15**

Pensions

Normal Retirement age is dependent upon NHS Pension scheme, for the 1995 scheme normal retirement age is 60, for the 2008 scheme normal retirement age is 65. One of the Trust's directors during 2018/19 is a member of the 1995 scheme and their normal retirement age is 60. The outgoing Director of Finance opted out of the NHS Pension scheme on commencing employment with the Trust in August 2016. There are no additional benefits receivable in the event of early retirement and no rights under more than one pension scheme arising for the Directors.

There were no payments in the year in respect of "golden hellos", compensation for loss of office, or benefits in kind for any of the senior managers. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

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 below relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV amounts, and from 2004/05 the other pension amounts, 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 pensionable 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 and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The CETV at 31March 2018 is discounted by the HM treasury discount rate. A common market valuation factor is then applied to the difference between this and the CETV as at 31 March 2019 to calculate the real increase in CETV. If a director or senior manager started during the year, the opening pension or cash equivalent transfer value (CETV) values will not normally be available and therefore the opening value or increase in year will be set to nil. Jonathan Wilson, Director of Finance, left the NHS Pension scheme on commencing employment with the Trust in August 2016 therefore the pension figures in the table below have been set to nil.

Audited Pension Benefits of Senior Managers

Name and title	Real increase in pension at Pension Age	Real increase in pension lump sum at Pension Age	Total accrued pension at pension age at 31 March 2019	Lump Sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500)	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**£000**	**£000**	**£000**
Fletcher T - Chief Executive	2.5-5.0	5.0-7.5	55-60	130-135	997	811	177
Jones D - Chief Operating Officer	2.5-5.0	2.5-5.0	25-30	55-60	382	279	101
Wells P – Director of Finance	-	-	0-5	-	11	-	-
Adam S - Chief Nurse and Director of Governance	-	-	50-55	155-160	-	-	-
Pelley C- Chief Nurse and Director of Governance	-	-	30-35	100-105	612	-	-
Dasgupta D – Medical Director	-	-	40-45	110-115	811	-	-
Wilson J – Director of Finance	-	-	-	-	-	-	-
Kuper M - Medical Director	-	-	55-60	135-140	1,043	953	80
Waldron D - Director of Organisation Transformation	0.0-2.5	-	15-20	-	227	173	52

Nomination and Remuneration Committee – Chairman's report

The Nomination and Remuneration Committee met in October 2018 to consider executive director performance and remuneration. The meeting was chaired by Sir Tim Melville-Ross and also present were Sir John Gieve, Martin Smith, Susan Osborne, Vanni Treves and Polly Weitzman and Jude Williams. The meeting was also part attended by the Chief Executive and fully attended by the Company Secretary.

The Committee considered the external context and wider salary and workforce situation at the Trust as well as current director salaries and benchmarking information. Following discussion, the Committee agreed to increase executive director salaries taking into account individual performance, national pay awards and comparative benchmarking salary data. The components of senior management remuneration are confirmed in the table below.

The Committee also met in May 2018 to consider executive director vacancies and approve the recruitment process for the Chief Nurse, Finance Director and Director of Strategic Implementation and Partnership.

Components of Senior Management Remuneration

Component	Purpose	Operation	Opportunity	Performance measures	Recovery
Salary	The Trust has 3 strategic priorities Quality Integration Growth Executive directors are set annual performance objectives aligned to these priorities and lead on the delivery of divisional business plans structured around the same priorities.	Executive directors are on spot salaries, which are agreed upon appointment. Salaries are reviewed annually by the remuneration committee who consider both the market rate for the position, any alterations to scope and the performance of the individual as assessed in their PDR. A remuneration benchmarking report, based on a basket of similar trusts, is prepared for the Remuneration Committee.	Executive directors are paid a flat salary that is not linked to performance outcomes. Based on performance and benchmarking decisions are made by members of the Remuneration Committee in respect of the potential for pay awards.	Executive directors along with all staff are assessed against both what they achieve (objectives) and how they achieve it (values and behaviours) as part of their annual PDR.	There are no provisions for withholding payments.

Pension	Executive directors are eligible to join the NHS pension scheme which is linked to the director's salary and therefore the above applies.	NHS pension rules and contribution rates apply.	As above	N/A	Where dismissals are made due to misrepresentation in relation to obtaining office there are general provisions for recovering employer pension contributions .

Executive directors are not on Agenda for Change terms and conditions. The Trust's approach to remuneration for executive directors is set out in the terms of reference of the Trust's Remuneration Committee.

Medical staff within the Trust are on standard medical terms and conditions. Non-medical staff are employed on Agenda for Change terms and conditions and pay increments are based on performance in line with the framework described above.

Employees were not consulted as part of the preparation of the current Nomination and Remuneration Committee Terms of Reference which cover executive directors' remuneration.

Policy on payment for loss of office

Payments for loss of office are made in line with the Trust's change management policy.

Tracey Fletcher

Chief Executive

24 May 2019

Staff report

The number of staff directly employed by the Trust increased by 76.46 full-time equivalent (FTE) from 3535.49 FTE in 2017/18 to 3611.95 FTE in 2018/19. Excluded from these figures are pre and postgraduate health care practitioners who were placed with us for training, bank and agency employees, staff holding honorary contracts and catering and domestic personnel.

In respect of the staff groups the Trust employs, this is presented below:

Average number of whole time equivalent (WTE) employees	**2017/18**	**2018/19**
Medical and dental	**519**	**525**
Ambulance staff	**0**	**0**
Administration and estates	**804**	**701**
Healthcare assistants and other support staff	**740**	**756**
Nursing, midwifery and health visiting staff	**1,357**	**1,372**
Nursing, midwifery and health visiting learners	**0**	**0**
Scientific, therapeutic and technical staff	**552**	**651**
Other	**98**	**88**
Total average numbers	**4,070**	**4,093**

Of these staff, 69% work primarily in an acute setting, 22% primarily in a community setting and 9% in corporate functions.

Gender and Disability Analysis

Gender	2017/18	%	2018/19	%
Male	846	22%	832	21%
Female	2995	78%	3105	79%
Total	**3,841**		**3,937**	
Recorded Disability	140	3%	152	4%

In total, 79% of our staff are female which is typical of NHS organisations. This proportion has increased by 1% since last year. At the end of the year there were seven male and six female members of the Board of Directors.

Homerton published its gender pay gap report during the year and this is accessible via the Trust's website. The pay gap has narrowed since reporting began in 2017/18 and we aim to build on this progress. In the recent staff survey, 12% of staff declared they had a long-standing illness, health problem or disability. This represents a higher number than the recoded disability data. Supporting staff with their health and well-being is a key priority for the Trust.

Staff performance indicators

Performance against workforce indicators overall remains consistent, with the Board and the service managers receiving monthly performance information.

Vacancy rates have steadily decreased over the last financial year from 8.89% at March 2018 to 7.50% at March 2019. The staff turnover rate has decreased over the last financial year by 0.08 percentage points. The highest increase in the turnover rate has been within the staff groups Add Prof Scientific and Professional and Allied Health Professionals.

Staff support and wellbeing

Employee health and wellbeing is a commitment that organisations must make throughout the employment lifecycle. This starts with health clearance at the pre-employment stage, ensuring staff are fit to undertake their appointed role and they will not be putting themselves or others at risk. This is followed by an on-going commitment from the organisation to ensure that the employee's health and wellbeing is not negatively impacted by the work or work environment. These are essential components for good employee relations and the provision of safe patient care.

The Trust's occupational health (OH) service team has worked closely against a targeted action plan and has delivered some significant improvements. Firstly, close working with our recruitment team has led to an improved turnaround time for pre-employment health screening checks. Secondly, OH has performed well against key performance indicators (KPIs) for management referrals. In March alone, 77% of referrals resulted in staff being able to remain at work, with appropriate support. Similarly, early indications in relation to the Trust's Employee Assistance Programme (EAP), implemented in January 2018, show that its therapy service has begun to have a positive impact on employees. Following therapy intervention 38% of employees returned to work.

The Trust's sickness absence rate averaged 3.18% for the 2018/19 financial year. This is above our 3% target and is largely attributable to a number of long-term absences. In 2018/19 the average working days lost to sickness per WTE based on a calendar year is shown below:

Total Days Lost	25,289
Total Staff years	3,517
Average working days lost (per WTE)	7

The sickness management policy is widely used to ensure appropriate support is provided and attendance is managed in the interests of service delivery. The OH team regularly reviews core employee health metrics, including reasons for referral and referrals by staff group and division. Mental health and musculo-skeletal concerns have been identified as the most common reasons for referrals. Further work is ongoing in these areas, including plans to deliver stress awareness workshops and an enhanced physiotherapy service. The OH service was recently re-audited and remains SEQOHS accredited.

Influenza Vaccinations

During 2018/19 NHS England set a Commissioning for Quality and Innovation (CQUIN) scheme to improve the uptake of frontline healthcare workers receiving the influenza vaccine to above 75%. This year's campaign saw a total of 2,391 (70.2%) frontline healthcare workers at Homerton receiving the vaccine; a slight decrease of 0.5% in comparison with the 2017/19 campaign.

The Trust achieved a significant year-on-year improvement in the vaccinations for clinical staff where the uptake increased from 34% in 2016/17 to 68% in 2017/18 and 79% in 2018/19. Planning for the 2019/20 influenza campaign has already begun, to ensure appropriate resources are in place to provide as many vaccinations as possible.

Staff involvement and engagement

The Trust has a range of mechanisms to support the involvement of staff and staff representatives in the planning and development of services. The monthly 'Team Brief' system, involving presentations from the Chief Executive and other senior leaders is used to cascade key messages across the Trust on a monthly basis. This is complemented with a printed quarterly staff newsletter (HomertonLife), an electronic weekly newsletter (HomertonLite) and weekly managers' briefing. In addition, quality improvement and learning opportunities are shared with staff through a monthly electronic bulletin (QTC).

The Trust intranet continues to act as the primary information source for staff and it is kept up to date with news items and feature articles on developments across the Trust. This is supplemented by regular updates on the Trust Twitter feed and Facebook account.

The Trust intranet continues to act as the primary information source for staff and it is kept up to date with news items and feature articles on developments across the Trust. This is supplemented by daily updates on the Trust Twitter feed and Facebook account. The Trust's website and intranet have been subject to review during the year to ensure they are informative, relevant and easy to use.

The Trust's staff engagement group oversees the development and delivery of the annual staff engagement improvement plan. The plan is informed by the annual staff survey, the quarterly staff friends and family survey, exit interview data and other local research. Building on the ICE creates work, which commenced in 2017/18; a range of tools has been launched to help embed our values in everything that we do. The tools include:

- the story of Homerton – statement of the Trust's purpose
- our values – a refreshed set of values, designed to better engage staff across the organisation
- the Homerton way – an articulation of what leadership means across the organisation and at all levels, so that it means something to everyone
- four functions of successful teams – a map for team success and how each member of staff can identify with where and how they fit.

The Joint Staff Consultative Committee and the Local Negotiating Committee (for doctors) are well established and meet regularly throughout the year. At year end, all elected staff governor positions were filled and their participation in Council of Governors' meetings supported.

Staff survey

In broad terms our 2018 staff survey tells us that our staff are proud of the care that they provide to our patients and they positively rate the safety culture, managers and engagement. However, ratings for morale, health and well-being, bullying and harassment as well as diversity and inclusion, do not score as highly and these are areas we are seeking improvement.

The 2018 Staff Survey ran between September and November 2018 and was based on a whole Trust sample of 3,668 eligible staff. The Trust achieved a 52.4% response rate with 1,921 colleagues completing the survey which asked 90 core questions. This is an increase on last year's 50.4%; the average response rate for similar trusts was 40% and the best 53.8%.

For the purposes of benchmarking, Homerton is categorised as a combined acute and community trust, of which there are 43 in total.

In terms of our benchmarked group the Trust was above the average for the following themes:

- Immediate managers
- Quality of appraisals (= best)
- Quality of care
- Safe environment – violence
- Safety culture
- Staff engagement

Our top five scores were:

2018	Top 5 scores (compared to average)	2017 Score	Average Score
50%	Q19e. Appraisal/performance review: organisational values definitely discussed	49%	35%
71%	Q22c. Feedback from patients/service users is used to make informed decisions within directorate/department	70%	56%
50%	Q9b. Communication between senior management and staff is effective	50%	40%
42%	Q9d. Senior managers act on staff feedback	44%	32%
70%	Q22b. Receive regular updates on patient/service user feedback in my directorate/department	70%	61%

The Trust was below the average for the following themes:

- Equality, diversity and inclusion
- Health and wellbeing
- Morale
- Safe environment – bullying and harassment

Our bottom five scores were:

2018	Bottom 5 scores (compared to average)	2017 Score	Average Score
82%	Q19a. Had appraisal/KSF review in last 12 months	78%	88%
88%	Q15a. Not experienced discrimination from patients/service users, their relatives or other members of the public	89%	93%
86%	Q15b. Not experienced discrimination from manager/team leader or other colleagues	88%	91%
77%	Q14. Organisation acts fairly: career progression	79%	82%
68%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	69%	72%

Homerton's overall results when benchmarked against other trusts are:

	2018/19		2017/18		2016/17	
	Trust	Benchmark Average	Trust	Benchmark Average	Trust	Benchmark Average
Equality, Diversity and Inclusion	8.4	9.2	8.5	9.2	8.6	9.3
Health and Well Being	5.7	5.9	5.9	6.0	6.0	6.1
Immediate Managers	6.9	6.8	6.9	6.8	7.0	6.8
Morale	6.0	6.2				
Quality of Appraisals	6.2	5.4	6.3	5.3	6.3	5.4
Quality of Care	7.8	7.4	7.8	7.5	7.9	7.5
Safe Environment – Bullying & Harassment	7.8	8.1	7.9	8.1	8.1	8.2
Safe Environment – Bullying Culture	9.5	9.5	9.5	9.5	9.5	9.5
Safety Culture	6.9	6.7	6.9	6.7	6.9	6.7
Staff Engagement	7.2	7.0	7.2	7.0	7.2	7.0

Staff Engagement

A multi-disciplinary staff engagement group has been established to assess staff survey results, along with other sources of information about staff experience. An action plan has been developed by the group's membership to ensure the Trust can positively respond to the findings and act on the feedback provided.

The action plan is built around a number of key themes and the actions are informed by feedback from a range of sources including an engagement project delivered in partnership with ICE Creates. Our focus has been on targeting support in the areas where poor staff experience has been reported. For example, the trust's employee assistance programme has been in place for a full year and is already starting to show benefits to those who have used it.

The delivery of the action plan is overseen by the Workforce Committee. The table below summarises they key actions against each theme.

Improvement Themes	Key Actions	
Theme 1: Career Progression, Development and Retention	1.1	Establish a regular programme of career development training open to all staff
	1.2	Establish a nursing Transfer Process
	1.3	Set up Career clinics for nursing staff
	1.4	Develop career ladder work for nursing and admin staff
	1.5	Programme of support and development for preceptorship nurses to be established
	1.6	Develop band 5.5 role to attract and retain experienced band 5 nurses
	1.7	Develop rotational programme for experienced band 5 nurses
	1.8	Deliver Post Grad training programme for band 5 nurses
	1.9	Provide additional advanced clinical skills programmes for specialist nursing areas
	1.10	Carry out a review and improvement of on boarding process
	1.11	Pilot settling in conversations for new staff
	1.12	Establish an admin development programme
	1.13	PDR process to be transferred on to ESR
	1.14	Develop Talent Management Strategy
Theme 2: Leadership Strategy	2.1	Develop a managers induction programme
	2.2	Establish leadership competency framework and tools
	2.3	Review leadership development programmes to ensure consistent approach, quality and access
Theme 3: Staff Health and Wellbeing	3.1	Develop MSK strategy and action plan
	3.2	Develop stress and mental health strategy and action plan
	3.3	Roll out of new Employee Assistance Programme
	3.4	Establish a violence and aggression sub group of the Health and Safety Committee
	3.5	Develop and implement improvement plan for violence and aggression
	3.6	Develop programme of work for the Health Ambassadors
Theme 4: Reward and Recognition	4.1	Review staff benefit offer
	4.2	Develop a Staff Recognition Strategy
Theme 5: Diversity, Inclusion and Opportunity	5.1	Review process for managing performance and conduct to include Director level review of cases prior to decision to take formal action
	5.2	Carry out a yearly audit of all ER cases to identify potential bias or inconsistency
	5.3	Develop best practice guidance on recruitment and selection of managers including use of various assessment tools and interview panel composition

	5.4	All staff managers involved in recruitment to attend Unconscious bias training
	5.5	Inclusion Lab project run in partnership with BRAP
	5.6	Targeted development programme(s) for BAME Staff
	5.7	Deliver programme of event for Black History month
	5.8	Disability related action in line with Workforce Disability Scheme Commitments
Theme 6: Division and service level interventions	Wide dissemination of local level results with resources to support improvement.	
	To be agreed divisionally and fed into performance review process.	
Theme 7: Communications	Ensure interventions are widely publicised and accessed.	

Trade Union Facility Time

In accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to disclose it meets the criteria of having at least one trade union representative and at least 49 full time equivalent employees during any seven of the 12 month period of the annual report.

The following disclosure is provided under Schedule 2 of the above Regulations and follows the guidance provided by the Cabinet Office.

Number of employees who were relevant TU officials during the relevant period	FTE Equivalent
35	33.73 WTE
Percentage of time spent on Facility Time	
Percentage Time	Number of Employees
0%	0
1 – 50%	35
51 – 99%	0
100%	0
Percentage of Pay Bill Spent on Facility Time	
Total cost of facility time	£101,246
Total pay bill	£180,435,096
Percentage of the total pay bill spent on facility time (total cost of facility time / total pay bill x 100)	0.056%
Paid Trade Union Activities	
Time spent on Trade Union Activities as percentage of total paid facility time hours calculated as: Total hours spend on paid trade union activities by relevant union officials / total facility time hours	59%

Education and related activities

The Trust ended the year with an overall compliance rate of 88% against all core mandatory training requirements. There was a particular focus on Information Governance which reached 85%, its highest percentage since 2015. The compliance rate with regard to Adult Basic Life Support and Moving and Handling People remained above 80% in spite of staffing shortfalls. With the recent permanent appointments to both roles, we anticipate an improvement over the coming year.

WRAP training (Workshop to Raise Awareness about PREVENT), part of the government's approach to tackling radicalisation was introduced during the year. In the first year it has been completed by 1883 people, 70% of the workforce. Work will continue over the next 12 months to raise staff awareness of this subject area and to improve compliance to a minimum of 90%.

Leadership development

The Trust ran successful leadership programmes in 2018-19. A total of 45 staff took advantage of these opportunities and have provided positive feedback.

The quality improvement (QI) element was strengthened within some programmes, and staff created impressive poster presentations of their work-based QI projects.

In response to the staff survey which indicated that BAME staff are disproportionately represented in lower bands, the leadership programmes aimed specifically at Black, Asian and Ethnic Minority (BAME) staff (REACH) were oversubscribed and positively received.

An analysis of the impact of these programmes on staff mobility and career development is being undertaken to understand the broad impact of these interventions. Through our work with our organisational development partner, ‘ICE creates’, we will be further refining and refreshing the content of our leadership programmes to ensure that Trust values and behaviours are integrated into the taught elements.

In addition, we are developing a team leadership skills programme which will be made available to all staff with management responsibilities. We continue to offer a range of stand-alone leadership workshops to provide staff with key business and personal-effectiveness skills to succeed in their roles.

The organisation continues to expand the Trust mentoring service to provide ongoing support and development for aspiring leaders and talented staff within the organisation.

Apprenticeships

The apprenticeship programme at Homerton has seen an increased number of apprenticeships in comparison to previous years. We have also seen staff progress with their development through higher level apprenticeships.

There were a number of posts where it was not possible to fill with an apprentice due to a lack of suitable candidates. Nevertheless, there has been a creation of career development apprenticeship opportunities for existing staff in all pay bands. For instance, staff have been placed on the Assistant Project Manager Level 4 and Nursing Associate Level 5 apprenticeship courses. The Trust is continuing to offer apprenticeship courses in business administration, health care support, team leading and management. In addition to this, the Trust has procured the following apprenticeship courses:

- Business Administration
- Human Resource Management (CIPD)
- Nursing Associate
- Service Improvement Technician

The Trust aims to continue procuring and expanding the training opportunities for staff as new apprenticeship standards are approved and mapped to career pathways. We are working in partnership with NHS Trusts across London to procure allied health professions apprenticeship degree courses, including physiotherapy and occupational therapy apprenticeship degrees, and continue to work with the North-East London Implementation Group for the Nursing Associate Apprenticeship.

We have seen growth in our work experience programme in partnership with local schools and colleges. We have offered 35 administrative and clinical (non-medical) placements for work experience students between April 2018 and March 2019. We also hosted a number of career awareness sessions for students from local schools to introduce them to the variety of NHS health care roles. These were extremely popular and we will continue to support school careers fairs in 2019-20.

Workforce education and development

The Trust continues to provide programmes of workforce education and training to support all staff in the delivery of safe, effective care and a positive patient experience.

As part of our focus on increasing educational opportunities for front-line staff we have developed and commissioned new courses, such as *Effective Receptionist*, *Professional Telephone Techniques* and *Effective Customer Care in Challenging Situations*.

We have developed a career pathway tool for non-clinical staff in pay bands 1-7 and we are currently developing a similar model for staff in clinical support worker roles.

Our mental health training for staff working in physical settings, delivered by our mental health colleagues, has been very popular and has increased staff awareness and resourcefulness in this area.

The Trust is also continuing to use simulation and e-learning as part of a blended approach to education and development. We have commissioned training with service user organisations to promote increased awareness of the experience of patients and their carers, particularly those with sight or hearing disabilities, when using our services.

Our preceptorship programmes for newly qualified nurses have expanded with taught modules and support provided for 12 months following recruitment into post. Our Band 5 nurse post graduate programme continues to attract a full cohort of 12 staff each year.

The Trust has taken advantage of the targeted funding from Health Education England (HEE) with regard to advanced clinical practice education programmes, for both allied health professionals and nursing staff.

We continue to review and refresh a number of programmes in response to feedback from staff and managers for both acute and community staff; we have provided Care Certificate training for a further 120 support staff, and have put in place assessment and Care Certificate training for a further 250 support staff.

We continue to fully utilise our budget allocation from HEE to respond to workforce and education priorities and to take advantage of new low-cost initiatives, such as the shared learning approach to integrated urgent care pathways and the development of sector-side work-based learning for neonatal specialist training.

Medical education

In 2018/19 the Trust continued to demonstrate its commitment to the delivery of undergraduate and postgraduate medical education. The results from the national GMC survey of doctors in training were positive. Feedback from the Barts and the London School of Medicine and Dentistry Quality Visit was also very positive. The Trust has increased the numbers of medical students on placements and continued to accommodate physicians' associate students on placements. Initial feedback from students is good. Homerton has delivered regional teaching days for several specialties. Three Grand Rounds also took place during the course of the year and were well received.

During the summer the trust accommodated 21 City and Hackney sixth form students for medical work experience. The simulation team also ran an 'Inspiring Future Doctors' day.

The simulation centre was again successful in securing bids and delivering numerous courses, many in collaboration with other centres across the region and pan London. Among these were Return to Practice simulation for returning staff, a Transfer course delivered by the NE/NC London Adult Critical Care Network and Mental Capacity Assessment. The simulation team developed and delivered an innovative new programme in 2018, Resuscitative and Interventional Procedures in Simulation (RIPS). This was multi-professional for emergency medicine trainees and senior Emergency Department and Resuscitation nurses. HEE are funding RIPS in 2019 and additional funding has been requesting to support the demand. In situ simulation is now embedded across the Trust as are regular courses. During the year, the eighth Homerton Simulation Conference 'Advances in Simulation and Virtual Reality for training: Even better than the real thing?' was held and received good feedback.

The Newcomb Library continues to offer a much appreciated service to Trust staff and students on placement. The team is supporting quality improvement (QI), pathway development and patient care by providing literature searches; 75 searches have been completed since April 2018. These are followed up with a questionnaire to determine current and future impact of the search. The Newcomb Library team were awarded third prize in the 2018 Health Education England Sally Hernando Innovation Awards that celebrate innovation in NHS libraries. The library team submitted an entry under the title, "Understanding the Person: Insights into the Patient Experience", outlining the impact of the library's collection of medically-themed graphic novels, cartoon books, memoirs and novels. The books in this collection enable health care professionals to gain an insight into medical conditions from a patient perspective and can also be used in conjunction with other patient information to assist patients in the understanding of their conditions.

Equality and diversity

Given the diversity of the population of Hackney well as the profile of staff employed by Homerton, the Trust is committed to do all it can to ensure it operates as an employer in the most inclusive manner possible. In doing this the Trust will be able to enhance its ability to deliver high quality health outcomes for patients and provide a positive employment experience for staff.

The Trust's lead for equality and diversity is the Director of Organisational Transformation. The latest Equalities Report, performance against the Workforce Race Equality Standard (WRES) and our equality objectives are available on the Trust's website. All publication duties have been met.

Diversity data

The below table confirms the Trust's diversity data. In total 52% of staff at the Trust identify as from black and minority ethnic (BME) backgrounds. This is more diverse than the local population (45%).

Representation of BME staff at a senior level remains a priority for the Trust and in the last year our Board has become more reflective of the wider organisation.

Ethnicity	2017/18	%	2018/19	%
White	1737	45.2%	1743	44.3%
Mixed	142	3.7%	139	3.5%
Black or Black British	1110	28.9%	1113	28.3%
Asian or Asian British	594	15.5%	619	15.7%
Other Specified	164	4.3%	189	4.8%
Not Stated	78	2.0%	64	1.6%
Undefined	16	0.4%	70	1.8%
Total	3,841		3,937	

To meet our equality objectives a Diversity, Equality and Inclusion Strategy is being developed and will outline what the Trust will do to support the cultural transformation set out in the NHS England Long Term Plan and the Trust's diversity aspirations.

Staff Policies

Raising Concerns (Whistleblowing)

We encourage staff to raise concerns with senior managers about patient safety, criminal offences, breaches of legal obligations, miscarriages of justice, or the deliberate concealment of information. Our Raising Concerns at Work policy guides this process. Our Freedom to Speak Up Guardians offer confidential advice to support staff to raise issues with senior management. We continue to raise the profile of this service so that staff are aware of its benefits.

Counter fraud, anti-bribery and corruption

The Trust has counter fraud, corruption and bribery policies for dealing with suspected fraud, bribery and other illegal acts involving dishonesty or damage to property. Staff can contact nominated officers in confidence if they suspect a fraudulent act. The nominated officers are the Director of Finance and the local counter fraud specialist, provided by Grant Thornton.

Consultancy Expenditure

The 2018/19 expenditure on consultancy was £1.2m (2017/18 £1m) and this included the cost of consultancy work around organisational development and support, advice on the development of the clinical services surgical review and additional specialist procurement support.

Exit Packages

Exit Packages awarded in 2018/19 were as follows:

	Reason	Redundancy	PILON	Other	A/L	Total
1	Agreed Termination	£0	£7,015	£0	£0	£7,015
2	Agreed Termination	£0	£0	£44,500	£0	£44,500
3	Agreed Termination	£0	£0	£2,800	£0	£2,800
4	Agreed Termination	£0	£9,175	£0	£0	£9,175
5	Agreed Termination	£0	£17,103	£0	£0	£17,103
6	Compulsory Redundancy	£40,244	£0	£0	£0	£40,244
Totals		**£40,244**	**£33,293**	**£43,044**	**£0**	**£120,837**

Salary and pension entitlements of senior managers

Tax arrangements of public sector appointees

The tables below summarise the Trust's appointees who fall within the definition of PES (2017)11 published by HM Treasury.

- All off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2019	1

Of which:

Number that have existed for less than one year at time of reporting.	-
Number that have existed for between one and two years at time of reporting.	1
Number that have existed for between two and three years at time of reporting.	-

Number that have existed for between three and four years at time of reporting.	-
Number that have existed for four or more years at time of reporting.	-

For the one existing engagement the Trust has undertaken 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.

- For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
Of which:	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency / assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

- For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number 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.	10

Disclosures set out in the NHS Foundation Trust Code of Governance

Homerton University Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

For the year ending 31 March 2019 the Trust complied with all the provisions of the Code as set out in NHSI's Annual Reporting Manual 2018/19.

Throughout this Annual Report the Trust describes how it has met the Code's requirements. The table below provides a summary of where information can be found on the issues the Trust is required to disclose.

Code Reference	Annual Report Section	Page
A.1.1	Board of Directors and Council of Governors	15
A.1.2	Directors Report and Board Committees	15
A.5.3	Council of Governors	25
Additional requirement	Council of Governors	26 and 28
B.1.1	Board Composition	15
B.1.4	Board Composition and Directors' Evaluation	15
Additional requirement	Board Composition	15
B.2.10	Nomination Committee	28
Additional requirement	Governor Nomination Committee	29
B.3.1	Sir Tim Melville-Ross' biography	15
B.5.6	Foundation Trust Membership	24
Additional requirement	Not applicable	-
B.6.1/B.6.2	Directors' Evaluation and Well-led Framework	24 and 61
C.1.1	Statement of Accounting Officer's Responsibilities	55
C.2.1	Annual Governance Statement	56
C.2.2	Audit Committee	20
C.3.5	Not applicable – Accepted by the Council	-
C.3.9	Audit Committee	20
D.1.3	Remuneration Report	32
E.1.4	Contacting the Board/Contacting the Governors	19 and 29
E.1.5	Council of Governors	25
E.1.6	Foundation Trust Membership	24
Additional requirement	Membership Strategy	25
Additional requirement	Register of Directors'/Governors' Interests	15 and 28

NHS Improvement's Single Oversight Framework

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

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

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

Homerton is currently in segment 1, with no support needs identified across the five themes. Current segmentation information for NHs trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	**Metric**	**2018/19 Q4 score**	**2017/18 Q4 Score**
Financial sustainability	Capital Service Cover	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	3	2
Overall scoring		**1**	**1**

There were no formal interventions introduced by NHSI under the legal authority as Monitor.

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Homerton University Hospital NHS Foundation Trust.

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Homerton University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Homerton University Hospital 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 NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 the NHS Foundation Trust Accounting Officer Memorandum.

Tracey Fletcher
Chief Executive
24 May 2019

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Homerton University Hospital 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 Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

The Audit Committee reports on the adequacy and effective operation of the Trust's overall control system. In particular it reviews, monitors and evaluates all aspects of financial risk management and oversees the policies and procedures for counter fraud, bribery and corruption activity, as well as oversight for the internal audit programme.

Capacity to handle risk

Throughout the reporting year the Trust has ensured that its risk management system receives the appropriate leadership and management. The Chief Nurse and Director of Governance is the executive lead for risk management and the Director of Finance has lead responsibility for managing financial risk.

The Board of Directors has established a Risk Committee to provide assurance to the Board that the Trust has effective risk management processes. The Risk Committee has been in operation since 2005 and is chaired by a non-executive director (NED). Meetings are held on a quarterly basis.

The Risk Committee:

a) ensures that the Trust Risk Register is fit for purpose and has an appropriate structure is in place for the regular scrutiny and monitoring of risks;

b) is kept informed about all aspects of risk management through a variety of reports from sub-committees and working groups on clinical and other organisational risks;

c) receives scrutiny reports from both internal and external sources including the Care Quality Commission;

d) receives annual compliance reports from the Improving Patient Safety Committee, Information Governance Committee, Improving Clinical Effectiveness Committee, Improving Patient Experience Committee and the Resilience Committee (for emergency planning and business continuity) ;

e) supports the development of risk management systems and helps to promote a culture in which risk management is seen as an integral component of all aspects of healthcare delivery.

The Board Assurance Framework (BAF) is the mechanism which is used to record the Trust's strategic objectives and manage the associated risks that threaten their achievement. The BAF is reviewed on a monthly basis by the Executive Directors and is formally reviewed by the Risk Committee and Board of Directors to ensure that appropriate controls are in place and mitigating action is being taken against the key risks.

All Executive Directors take responsibility for risk identification, management and mitigation within their designated areas of work. Operational and other corporate risks are reviewed by the Board as part of its regular monitoring of performance through reports received, or in the context of specific issues that arise.

There are internal processes to ensure that incidents which fit the national criteria for serious incidents are reported on the Department of Health and Social Care's Strategic Executive Information System (STEIS). The Trust's Improving Patient Safety Committee has oversight of serious incidents and receives a monthly report on serious incidents declared and reports completed that month. The Board is provided with a monthly report on serious incidents.

The corporate induction programme ensures that all new staff receive information on the Trust's risk management systems and processes. This includes the comprehensive induction of all junior doctors with regard to key policies, standards and practice prior to commencement in clinical areas. The mandatory training programme ensures that essential training is delivered to staff members, which includes risk management processes such as health and safety, manual handling, resuscitation, infection control, safeguarding patients, blood transfusion and information governance.

In addition, specialist risk training is identified by managers for individual job roles and agreed with staff through personal development plans. Board members receive training in risk management awareness and an overview of the risk systems.

The Trust is committed to continuous improvement and learning; from incidents and complaints, outcomes from audits and the experiences of patients, other service users and staff.

The divisional Quality and Patient Safety Managers report regularly via the Head of Quality and Patient Safety to the Chief Nurse and Director of Governance.

Best practice is highlighted and shared across divisions through the divisional leads, the Improving Patient Safety Committee and Improving Clinical Effectiveness Committee and their respective sub-committees. We seek to learn from both internal and external sources of good practice.

During the reporting year a new serious incident process was implemented which has strengthened the handling of clinical incidents within the divisions. In addition we have reviewed our risk management software system (Datix) with the aim of simplifying the reporting of incidents and maximising the system's functionality to identify themes and trends.

The risk and control framework

The Risk Management Policy was reviewed by the Risk Committee in November 2018 and approved by the Board of Directors in December 2018. It describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process and the Trust's risk appetite.

The policy was revised to include a greater level of detail on the processes for risk assessment, risk approval, risk review and on identifying actions to mitigate risk with the intention of providing a comprehensive guide to staff on how risks are escalated from the front line to the board. The updated policy is available to all staff via the Trust's intranet.

As set out in the Risk Management Policy, associate medical directors, divisional operations directors, senior nurses, and other relevant senior managers are responsible for the management of risk within the workplace. Together they foster a culture of risk awareness throughout their divisions and ensure that risk assessments for all work-based activity are conducted. The revised policy includes guidance on the risk assessment matrix used to evaluate risks for inclusion in the Trust's risk registers. The Head of Quality and Patient Safety is responsible for the maintenance of the Trust's risk register. Risk registers are also held within the divisions and they are subject to regular scrutiny.

The Risk Management Policy confirms which risks need to be escalated to the next management level and describes the risk escalation route. Risks are classified as low, moderate, major and catastrophic, based on a consequence and likelihood matrix approved by the Board. While the Board recognises that risk is inherent in the provision of healthcare and its services, the Trust has an extremely low risk appetite for risks that could affect patient safety.

Incident reporting is openly encouraged through staff training and the Trust's positive risk management. Risks identified from serious incidents that impact on public stakeholders are managed by involving the relevant patient and/or their family.

During the year the Trust's risk management culture was subject to internal audit. The review report advised that the Board could take reasonable assurance that controls were in place to manage risk that were suitably designed and consistently applied.

Quality governance arrangements

The quality governance arrangements within the Trust are organised through the divisional structure with each division headed by an operational and clinical lead, and with a governance structure in place that supports the achievement of all quality priorities. The divisions review quality governance and performance information on a regular basis, including incidents and serious incidents; patient experience feedback including Friends and Family Test; survey reports; complaints; Patient Advice and Liaison Service (PALS) enquiries; litigation; clinical audit data and NICE compliance. Divisional performance is also monitored and reviewed each month against a range of performance measures including quality and safety at divisional performance review meetings.

The Trust Management Board (Quality and Operational Assurance), chaired by the Chief Executive, meets monthly and reviews and monitors quality issues for the whole Trust. The Risk Committee, the Improving Quality Board, Improving Patient Safety Committee and the Clinical Effectiveness Committee also have an important governance role in the oversight of quality.

The above committees and their supporting sub groups are used as conduits to disseminate information from the wards, departments and divisions to the Board and vice versa. This approach supports the process for enabling that improvement action is delivered at the point of care and it also provides a route for escalation of concerns and monitoring of mitigating actions to the Trust Board.

Performance assessment

The Board is provided with an integrated monthly performance report to evaluate the Trust's performance. The report is designed around the CQC's five key lines of enquiry and provides metrics and commentary to update the Board on progress against the Trust's key performance indicators.

The Board of Directors receives performance information each month in relation to:

- performance against national targets, including infection control, A&E waiting times, cancer access and referral to treatment (RTT) standards, which are accompanied by improvement plans if there are concerns in relation to any particular targets
- key performance indicators related to patient safety and clinical effectiveness, such as patient safety thermometer results, numbers of falls and pressure ulcers, delayed transfers of care and standardised hospital mortality ratios
- exception report from the maternity services dashboard
- patient experience data, including Friends and Family Test, PALs and complaints data
- key workforce metrics, such as agency spend, vacancy rates, turnover and sickness absence
- key financial performance data, including income and expenditure and a summary of Cost Improvement Programme (CIP) performance
- progress reports on the Trust's financial plan

The Council of Governors holds the Board of Directors to account on its performance, including quality and risk. The meetings are held on a regular basis throughout the year and members of the public are able to raise issues directly at these meetings and at the annual members meeting.

The year-end key performance indicators are confirmed on page 10 of the annual report. The Trust did not achieve the A&E 4-hour wait target during 2018/19 and the 62 day cancer wait target in quarters one and two.

CQC Registration

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

In April 2018, the CQC inspected four core inpatient services at the main hospital site which included; emergency and urgent care, medical care (including older peoples care), surgery

and maternity services. Overall, the CQC rated Homerton University Hospital as ‘good’. Urgent and emergency services and medical care (including care of the older person) were rated as ‘outstanding’ overall.

In May 2018 the CQC conducted a well-led inspection which resulted in an overall rating of ‘good’ for this domain.

The CQC inspected the Trust’s community health services and the Mary Seacole Nursing Home in 2017. A ‘good’ rating was received across all domains.

The Risk Committee receives regular CQC updates and reviews the CQC Insight reports to identify areas of deteriorating performance.

Major risks

A Board Assurance Framework (BAF) detailing the principal risks to the achievement of the Trust’s strategic objectives was in place for the financial year.

The key risks to the achievement of the strategic objectives include:

- failure to develop an engaged and motivated workforce may undermine the Trust's ability to deliver its services in accordance with its values and desired staff behaviours, resulting in a poor experience for the patient;
- the patient receives avoidable harm from poor practice as a result of a failure to comply with required Trust safety policies and lessons learned;
- if the culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust falling short in the quality of care delivered to patients;
- a lack of adherence to latest research, or practice which is not compliant with the best evidence could lead to a less effective service provision;
- failure to achieve financial targets may result in difficulties in funding future investment plans and threaten the organisation’s financial autonomy;
- poor reviews and performance outcomes by regulators, other bodies, the press and public may result in a damaged reputation that diminishes the Trust's ability to grow;
- failure to expand and retain sufficient activity through a failure to adapt and engage in local collaborative healthcare arrangements may limit the Trust’s ability to increase turnover and maintain clinically sustainable services.

The most significant clinical risk for the Trust is the ability to recruit and retain medical and nursing staff to ensure the delivery of safe, harm free care for patients. The Trust continues to monitor the number of clinical post vacancies and it will remain a major focus in 2019/20.

The financial pressures within the health economy and the risks associated with the delivery of cost improvement efficiencies will continue to challenge the Trust in the coming year and may impact on the Trust's achievement of its control total and other financial targets.

The Trust has comprehensive plans in place to mitigate the above risks which are assessed regularly by the executive team and reviewed by the Trust Board on a monthly basis and quarterly by the Risk Committee. The Trust recognises its risk management approach will not totally eliminate risk, but it will provide the organisation with a means to identify, prioritise and manage the risks.

Workforce

The Board receives twice yearly reports on the Trust's staffing levels. The reports include information to demonstrate how the Trust complies with the '*Developing Workforce Safeguards'* recommendations. The Trust has a 2017-2020 Workforce Strategy in place which is overseen by the Workforce Committee.

The Board receives an assessment of staffing levels based on agreed tools and quality metrics in accordance with National Quality Board guidance on a monthly basis.

The Trust uses care hours per patient day (CHPPD) information to assess the number of care hours provided on the wards. This assessment is benchmarked against all trusts to review the Trust's performance.

During the year the Board has reviewed the impact of recruitment and retention actions on the overall nursing and midwifery staffing levels. Positive action has resulted in a reduction in the overall nursing and midwifery vacancy rate. The Trust continues to work to ensure safe staffing in all clinical areas.

Foundation trust governance requirements

The Board sets the vision, values and strategic direction of the Trust and is collectively responsible for its performance. The Council of Governors receives regular updates on clinical and financial performance and service delivery. The Governors meet jointly with the non-executive directors (NEDs) twice a year and the NEDs are available to answer questions in formal and informal settings to enable the Governors to discharge their duties.

The Board is supported by our four committees and two executive led committees with a remit to monitor the effectiveness of risk management, quality, performance, financial sustainability, internal control and assurance arrangements. The Board of Directors receives regular assurance reports from its sub committees.

The Board made a self-declaration in June 2018 that it was compliant with the conditions of the NHS provider licence and with no significant risks identified in relation to the corporate governance statement.

Well led framework

As mentioned above the Trust received a 'good' rating following the CQC's well-led inspection in May 2018. The CQC reported that:

- The trust leadership team had the experience, capability and integrity to ensure that the strategy could be delivered and risks to performance were addressed.
- Executive and non-executive directors were visible and approachable across the trust.
- The trust leadership team were knowledgeable about issues and priorities for the quality and sustainability of services and largely understood what the challenges were to address these.
- The trust had a clear vision and set of values that prioritised the delivery of safe and effective patient care.
- The trust strategy was aligned to local plans in the wider health and social care economy and services were planned to meet the needs of a diverse local population.

- The trust had effective governance processes to support the delivery of its strategy and ensure quality and performance information was reviewed and escalated appropriately.

The Board considered the results of the CQC inspection in September 2018 and paid close attention to the report's findings. The Board approved an action plan which had been developed to address the issues raised.

There were no significant issues raised with regard to the governance of quality. The clinical governance arrangements within the divisions have been reviewed in response to comments received from the CQC inspection in April 2018. The Trust's governance structure will be reviewed in 2019/20 to further improve the reporting lines between the divisions and committees.

Together with the 'good' rating achieved from the NHS Improvement assessment of the Trust's use of resources in May 2018, the Board received assurance on the organisation's well-led capability.

Other control measures

The Standards of Business Conduct Policy was revised during the reporting year to reflect the '*Managing Conflicts of Interest in the NHS*' guidance and the Trust has published an up-to-date register of interests for decision-making staff.

Control measures are in place to ensure that the Trust is compliant with equality, diversity and human rights legislation. An equality impact assessment is completed for all new and revised policies, which is considered by the relevant committee and the Trust's Policy Group. The Workforce Committee is responsible for progressing actions to advance equality in the Trust and meet the standards set out in the NHS Equality Delivery Systems (EDS2).

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.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has established processes in place to ensure that resources are used economically, efficiently and effectively. In addition to the financial review of resources and the quarterly monitoring returns to NHS Improvement (NHSI), all budget holders are provided with monthly financial information for the purposes of monitoring and control. The Board also receives financial performance reports on a monthly basis.

Internal audit reports consider value for money and KPMG is required as part of their annual audit to satisfy themselves that 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 it has not.

The Trust has an internal performance management review process which provides evidence of divisional performance and the actions being taken to ensure resources are being used effectively and efficiently. In addition productivity and efficiency opportunities are identified as part of the annual business planning process.

The Trust has a comprehensive Quality, Innovation, Productivity and Prevention (QIPP) Programme Board in place to identify and deliver efficiencies against the Trust target for savings which is chaired by the Director of Finance.

The Board of Directors and Council of Governors receive regular updates on progress and the risks associated with the Trust's cost improvement plans.

The Trust received a 'good' rating from NHS Improvement's use of resources assessment in May 2018.

Information governance

The Trust's information governance (IG) work is led by the Medical Director, as the Caldicott Guardian and the Chief Operating Officer in his role as Senior Information Risk Officer. The IG Manager is the Trust's designated Data Protection Officer. The Information Governance Committee is responsible for monitoring and controlling risks relating to data security and has oversight of the IG risk register. The Information Governance Committee reports to the Risk Committee on a quarterly basis, which in turn reports to the Board.

All Information Governance security related incidents were reported to NHS Digital during 2018/19 and there were no level two incidents reported during this period. Also no breaches were reported to the Information Commissioner in the last 12 months.

The Trust submitted evidence in support of all the 100 mandatory elements of the new Data Security and Protection Toolkit in March 2019. The Trust did not meet the 95% mandatory IG training compliance standard and an improvement plan has been agreed with NHS Digital.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Annual Quality Account 2018/19 has been developed in accordance with relevant national guidance and legislative requirements. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements.

There are a number of assurances and controls in place to ensure the quality of data within the Quality Account, which includes:

- The Chief Nurse and Director of Governance leads on the production of the Quality Account at Board level. The Head of Quality and Patient Safety is responsible for drafting the Quality Account, managing the consultation processes for planning priorities and feedback, and managing the process of regular reporting to the Trust Management Board.

- Plans for the achievement of the main quality priorities are developed, reviewed and assured by the Trust Management Board.

- Consultation is carried out with internal and external stakeholders, including the Council of Governors, and fed back to the Trust Management Board before the quality priorities are set for the coming year. The content of the draft report is reviewed by the Board and the Council of Governors. The Trust Management Board approves the final content of the report before it is presented to the Trust Board.

- The Trust has a range of policies and procedures in place to support the achievement of the quality priorities and the management and use of its data and the information derived from it.

- The data used within the Quality Accounts is a combination of Trust and Health and Social Care Information Centre (HSCIC) generated information, which is subject to inherent limitations and these are referred to in the Chief Executive's statement.

- Data quality is audited internally and externally

- Data quality is scrutinised routinely by commissioners

- External assurance statements on the quality report are provided by local commissioners, the Overview and Scrutiny committee (OSC), Healthwatch and our Governors as required by Quality Account Regulations.

The Trust's Information Services Team produces information which is used in the Quality Account and for operational performance management, including the management of elective waiting lists. All of the information which is generated is subject to approval by senior managers before internal distribution or national return submission. The HSCIC indicator portal is also used in the preparation of accounts to ensure that nationally reported figures align with those being reported internally. The Trust also has a dedicated data quality team and an established corporate data quality framework for managing data quality.

The Board has regularly reviewed the Trust's elective waiting time performance and other national performance standards. The Trust's auditors are actively engaged in the validation of the data used in the preparation of the Quality Account and any data quality issues are reported to the Audit Committee. Further details of the Trust's data quality processes can be found in the Quality Account.

Review of effectiveness

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

In addition, I gain assurance from the following third party sources:

- reports from the internal and external auditors and the local counter fraud specialist
- patient and staff surveys
- Care Quality Commission review reports

The Trust's regular reporting to NHS Improvement provides additional assurance with regard to compliance with our licence conditions.

The key considerations of my review of the effectiveness of the system of internal control can be summarised as follows:

- The Board has been actively involved in reviewing the Trust's risk management processes and the Board Assurance Framework. The Board has played a key role in reviewing risks to the delivery of performance objectives through monitoring and discussion of the Integrated Board Report.
- The Risk Committee has overseen the effectiveness of all the Trust's risk management arrangements including review and endorsement of the Risk Management Policy, the on-going development of the risk register and all key clinical and non- clinical risks highlighted by other committees.
- The Audit Committee has overseen the system of internal control, especially with regard to corporate risk and counter fraud, and it has actively engaged in the oversight of the Trust's key financial challenges.
- Internal Audit has reviewed and reported on financial controls and financial reporting, cost improvement plans, clinical audit and risk management culture, based on an audit plan approved by the Audit Committee. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

- Internal Audit provided consistent support and advice with regard to the system of internal control. The head of internal audit opinion did not, based on the work they undertook during the year, highlight any significant control issues. The opinion was the Trust had an adequate and effective framework for risk management, governance and internal control. Some weaknesses were identified in the application of some internal controls and management actions to address these weaknesses were agreed and are progressing.

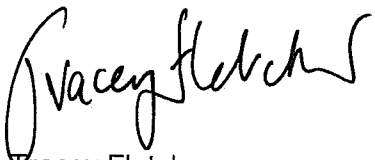
Conclusion

The Trust has a robust system of internal control that supports its aims and objectives, while safeguarding patients and the public funds. We have taken steps to mitigate and resolve issues in-year and we continue to work towards successful assurance outcomes. No significant internal control issues have been identified.

Tracey Fletcher

Chief Executive Date: 24 May 2019

Signature to the accountability report:



Tracey Fletcher

Chief Executive

24 May 2019

QUALITY ACCOUNT


Martin Galligan
Lead Nurse
Acute Pain Service
Our Values
PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

2018-19 Quality Account

CONTENTS

PART 1: STATEMENT ON QUALITY

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to present our Quality Account for 2018-19, which detail the Homerton University Hospital NHS Foundation Trust's position on quality over the last year, and which provides assurance that we continue to strive to provide the highest quality clinical care. We are proud to continue to perform well against our key performance and regulatory requirements while delivering high quality care for our patients and service users. The ongoing focus given to the quality improvement work is key to these achievements.

Our Improving Quality programme has continued to lead and support improvement projects throughout the year. This approach has increasingly been applied to improvement work within the Trust and it also influences the approach to change across the wider system, particularly within Hackney and The City. The Trust continues to be key partner in the work associated with the establishment and development of Neighbourhoods, enhancing the opportunity for multi-disciplinary working. The strong partnership approach also positively impacts on the management of urgent and emergency patients within the system, with all partners contributing to the success seen in the performance management of these pathways.

The internal quality transformation work has once again explored the benefits of technological and system advancements and considered how these could improve the way we are able to offer care and share information effectively. This has resulted in a shift to a paperless outpatients service with pathways managed entirely through the use of digital technology and enhancements to health systems, from referral to communication back to the GP. Our next area of focus now needs to result in ensuring such opportunities are available to patients.

The Trust also remains high performing in key areas of quality measures:

- A&E 4 hr waits – one of the best performing Trusts nationally
- Standardised Hospital Mortality Index (SHMI) –.one of the lowest in the country
- Referral to treatment (waiting times) – 96.7% of patients wait <18 weeks
- Diagnostic waiting times - 99.8% of patients wait < 6 weeks for diagnostic procedures
- Improving Access to Psychological Therapies (IAPT) -– 99.5% of patients wait <18 weeks to begin treatment
- Homerton attributable C Diff levels significantly below the national threshold set for the trust – 3 cases against a threshold of 10

We have also welcomed the Care Quality Commission during the past year when they carried out inspection visits to the acute services based on the hospital site. Four service areas were reviewed as part of this inspection and three of the four ratings were improved. Urgent & Emergency Services retained the Outstanding rating. Medical Care, including older people's care also received an Outstanding rating. Maternity and Surgery both improved and were rated Good. Overall the Acute services were rated as Good, combined with the previous inspections for Community services and Mary Seacole Nursing Home, the Trust overall was rated as Good. This is a significant achievement and recognition for all staff across the Trust, reflecting the quality of service they provide to patients and their families on a daily basis.

There are many examples of innovative and quality improvement examples that were successfully implemented in 2018/19 and these include:

- The Acute Pain Team was recognised as the Team of the Year by the National Acute Pain Symposium. The award is just the beginning for the service with further developments planned for the future including the development of pain link nurse roles, developing nurse led telephone clinics and growing and expanding the team further with the addition of two new trainee clinical nurse specialists.
- A range of new technological innovations have been introduced in outpatients aimed at improving quality, safety and efficiency. A new voice recognition system using Dragon, aids the information entry in electronic notes and letter production. Doctors now also able to access cardiology, endoscopy and radiology images directly from EPR via a new image archive, whilst a new app allows clinicians to safely take a clinical photograph with a smart phone. After scanning the QR code, the photo is directly uploaded into the appropriate record and then automatically deleted thus maintaining patient confidentiality.
- A newest part of the Trust's network of sexual health clinics opened at 80 Leadenhall in the heart of the City of London. The centre provides a range of services including testing for sexually transmitted diseases (STIs) and administering post-exposure prophylaxis preventing HIV infection (PEP). The clinic welcomed over 4,000 client visits in the first four months of opening.
- An innovative team of advisers from Redthread Youth Violence intervention Programme were introduced into the emergency department to offer support and counselling to young people who have or might be victims of violence.
- The Trust retained its Planet Mark accreditation for a second year by showing good practice in sustainability including achieving a 9.6% total carbon footprint reduction in 12 months and decreasing carbon emissions from buildings by 9.7%.
- The Trust dismantled its remaining smoking shelters and replaced them with additional bike racks.
- The Elderly Care Unit welcomed animal friends to patients. The "Pets As Therapy" scheme increases a person's level of interaction and can reduce agitation, something that can be particularly helpful for people with dementia who can show symptoms of distress and agitation when in hospital.
- The Care Certificate programme was expanded over the year with 104 members of staff completing the programme.
- The Trust introduced a scheme to provide employment experience opportunities to people with learning disabilities.
- The Trust has signed a commitment to supporting members of the armed forces as they seek new employment opportunities on leaving the services. The Armed Services Covenant ensures that Homerton pledges to recognise the value serving personnel, reservists, veterans and military families bring to the organisation as well as ensuring that no member of the Armed Services Community should face disadvantage.
- Homerton has joined other local public service leaders in signing a No Smoking pledge. The pledge has been designed by the Smokefree Action Coalition and is endorsed by NMHs England, Public Health England and Health Ministers.
- Talking Mats have been introduced by the speech therapy team. The mats are a tool which is used as a visual communication tool that is used with children and adults with a wide range of communication difficulties.
- New developments have improved the environment of Mary Seacole Nursing Home. The gardens were completely refurbished and new door pictures for wards were installed with old photographs reflecting local landmarks in Hackney.
- Lloyd Ward has been completely refurbished complete with a new reception area for visitors.

- We continue to actively participate as a member of NHS QUEST. This is a network of trusts and foundation trusts, working collaboratively to reduce avoidable harms in hospital, to stimulate innovation and to improve staff satisfaction.

We continue to share our examples of good practice both within Homerton at our Quality Sharing Days, Simulation Training Day and the annual Research & Development Day, all with attendance from local stakeholders and partner organisations. Additionally, a range of individuals, services and innovations have been recognised by reaching the final shortlists of several national awards.

Sharing learning in this way is not only a vital part of maintaining and improving our quality standards, but helps to inform our future aspirations. Our Quality Priorities set out areas of focus for the coming year, drawing on both local experience and requirements agreed with our commissioners, and national programmes of work.

Whilst every effort has been made to reflect accurately the position of the Trust against the measures reported on, there are a number of inherent limitations in doing this which may affect the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgment about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Board of Directors have sought to take all reasonable steps and to exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

As always, the Trust's key strategic quality priorities remain the focus of our goals and ambitions for the quality of care we deliver.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Tracey Fletcher
Chief Executive
Homerton University Hospital NHS Foundation Trust

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT DURING 2019/20

We have agreed our annual priorities for 2019/20 which support our Organisational Strategy and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, City and Hackney Clinical Commissioning Group and Healthwatch. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by 31 March 2020 and progress to achieve them is to be monitored by our Trust Management Board.

Patient Safety (Safe)

Priority 1	To reduce the number of community and hospital attributed pressure ulcers – carried forward from 2018/19
Rationale	The Trust is unlikely to have achieved this priority in 2018/19 therefore has agreed to continue with this priority in 2019/20. The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures. There is continued national focus on the need to reduce the number of pressure ulcers. Work to reduce the rate of community acquired pressure ulcers link to the wider development of neighbourhoods in City and Hackney.
Monitoring	Improving Patient Safety Committee
Reporting	Total number of avoidable community and hospital acquired pressure ulcers at grade 2 and grade 3+ Numbers of pressure ulcer free days.

Priority 2	Appropriate identification and management of deteriorating patients - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the deteriorating patient group to build upon the work established in 2018/19. This priority will also include the timely identification and treatment of patients with sepsis.
Monitoring	Critical Care Committee, Improving Clinical Effectiveness Committee
Reporting	Implementation and measures established through the deteriorating patient group. Sepsis measures to mirror sepsis CQUIN.

Priority 3	Reducing physical violence and aggression towards patients and staff – New priority
Rationale	The most recent national staff survey shows that more than 15% of NHS employees have experienced violence from patients, their relatives or the public. Implementation of the NHS Violence Reduction Strategy is to be a priority for the Trust to reduce the impact on staff and patients through improved training and prompt mental health support for staff.
Monitoring	Health and Safety Committee
Reporting	Local implementation of the national strategy.

Clinical Effectiveness (Effective)

Priority 4	Improving management of end of life patients for adults - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the End of Life Board to build upon the work established in 2018/19 and the implementation of the End of Life Strategy 2018-21. The key elements of the strategy being personalised end of life care, supporting our staff, improving environment and communication & information. This will include the wider partnerships the trust has with community organisations including the local hospice.
Monitoring	End of Life Board
Reporting	Implementation and measures of strategy to be established through the end of life board.

Priority 5	Making Every Contact Count – New priority
Rationale	Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Implementing MECC means providing their staff with the leadership, environment, training and information so that staff have the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them. Initially being implemented in maternity then the wider Trust. The delivery of MECC in the trust will contribute the wider prevention work stream priority across City and Hackney
Monitoring	Improving Quality Board
Reporting	Metrics based upon implementation programme.

Priority 6	Learning from complaints, incidents, claims and compliments – New priority
Rationale	It is fundamental that we listen to our patients and learn from their experiences. We will carry out an in depth review of complaints, incidents, claims and compliments to better develop actions to ensure learning is captured and fedback to staff and shared across the organisation and practice is changed to prevent recurrence.
Monitoring	Patient Safety Committee
Reporting	Metrics to be established.

Patient Experience

Priority 7	Improving the first impression and experience of the Trust for all patients and visitors - carried forward from 2018/19
Rationale	Creating positive first impressions of the Trust for patients and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients and visitors and therefore play a pivotal role in this. We will continue to develop a range of measures to support receptionists and their managers create a positive first impression for every service user and visitor to the Trust at every visit.
Monitoring	Patient Experience Committee
Reporting	Metrics based upon results of 2018/19 priority outcome - to include training and compliance with first impression standards.

Priority 8	Getting Patients Moving – New Priority
Rationale	Move, groove and improve – Trust wide implementation of the 2018 national *EndPJParalysis* campaign. The campaign focuses on encouraging patients in hospitals, where possible, to stop wearing their pyjamas or hospital gown when they don't need to. This is because wearing pyjamas for many patients reinforces the 'sick role' and can prevent a speedier recovery. Obviously the patient and their condition need to be taken into consideration and this principle cannot apply to every single in-patient, however for many, it's a matter of enabling them to get up, get dressed and get moving.
Monitoring	Patient Experience Committee
Reporting	Metrics to be established.

Priority 9	Improvements in staff health and wellbeing – New priority
Rationale	Aiming to create a working environment which is beneficial to the health and wellbeing of our staff. All staff will be supported to maintain and improve their health and wellbeing and are encouraged to take reasonable steps to improve their own health and wellbeing. The goal is to inspire our staff to take a greater interest in their own health and wellbeing.
Monitoring	Workforce Committee
Reporting	Metrics to be established.

2.2 Statements of Assurance from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

2.2.1 Review of Services

During 2018/19 Homerton Hospital NHS Foundation Trust (HUHFT) provided and/or sub-contracted 68 relevant health services.

Homerton Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2018/19.

2.2.2 Participation in clinical audit

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

The Trust participates in relevant national audits and confidential enquiries programmes as listed through the HQIP. All the programmes listed were assessed for relevance in 2018/19.

During 2018/19, 37 national clinical audits and five national confidential enquiries covered relevant health services that Homerton provides.

During that period HUHFT participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that the Homerton was eligible to participate in during 2018/19 are listed in **Appendix A.**

The national clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2018/19, are listed in appendix A 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.

The reports of 15 National Clinical Audits were reviewed by us in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 1: Examples of changes from a national audit

Audit	Trust Actions
National Joint Registry (NJR)	Low consent rates documented for NJR data collection. Consent for NJR data collection now routinely collected at time of consent for surgery and consent rates audited locally. A British Orthopaedic Association review of arthroplasty during the last year was supportive of the department's current clinical practice.
National Lung Cancer Audit (NLCA)	All relevant clinicians contacted to ensure completion of spirometry and Eastern Cooperative Oncology Group (ECOG) performance score (using voice recognition template provided when possible). Continue to refer patients urgently to the relevant clinical teams for chemotherapy and radiotherapy. Ensuring regular presence of Thoracic Surgeon at Homerton "Diagnostic MDT" Discussions under way to obtain cover for Diagnostic MDT in the absence of the Chest specialist Radiologist
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Homerton neonatal unit overall performance is comparable or above national average in most areas investigated. Homerton performance is below national average in two areas measured: Lower admission temperature of babies born very preterm (less than 32 weeks gestation). Action taken - Education and awareness of maintaining normal temperature at induction and regular teaching. Monthly admission temperature tracking and discussion at clinical governance Follow-up at two years of age: around 45% of eligible babies were reviewed at two years of age (National average is 61%). Action taken - Business case to be submitted for a dedicated follow-up co-ordinator to ensure babies attend clinic follow-up at correct age.
Falls and Fragility Fractures Audit programme (FFFAP)	2018 Best Practice Tariff achievement is 58.3% - a significant increase from 2017 which was 46.5%. Key actions being taken are: • Ensuring completion of Abbreviated Mental Test Score in the Emergency Department before surgery. • Ensuring completion of the rapid assessment test for delirium in 7 days post-op with translators being used if there is a language barrier. • Reducing time to get to surgery. • Ensuring physiotherapy reviews for patients admitted on the weekend. • Reducing inpatient falls and improving after care, including prompt X-rays and diagnosis. • Reducing incidence of pressure ulcers.
MBRRACE-UK Saving Lives, Improving Mothers' Care	Action being taken includes the Venous Thrombo-Embolism audit being added to the 2019-20 audit plan for maternity services

Major Trauma Audit (TARN)	The following actions are being taken as result of the major trauma audit: Review and improvements in the Trust governance around major Trauma through the Trauma Operational Group Training and education including online competencies for nurses, Trauma Intermediate Life Support (TILs) training, Trauma Team Leaders education and Resuscitative Interventions Procedure training.
National Audit of Dementia	The following actions are being taken as result of the National Audit of Dementia: • Creation of 'delirium champions' on surgical wards with the wider hospital in phase II • Care plan to be made available electronically. • Offer multiple Dementia awareness training sessions – including the dementia and delirium study day – several sessions arranged for 2018 • Monthly audits to assess completion of the Disability Assessment for Dementia and fed back to the governance meeting. • Discussions with Ward Sisters and Heads of Nursing, Lead Therapists for advice around dementia and delirium care bundles being available in on the Electronic Patient Record. • Patient and carer information to be incorporated into dementia care support worker role. • Visual Identifier to be incorporated into 'care bundle' proposal for patients to have access to food throughout the day and night offered regularly. • Ongoing work with transport regarding delays to ensure that patients are discharged in the early part of the day.
NCEPOD Acute Heart Failure	The following actions are being taken as a result of the audit: • Provision of heart failure rehabilitation is provided where appropriate and when available • The aim is for information relating to correct diagnosis, cause of heart failure, current medications and need for monitoring is on the discharge summary. • The inpatient heart failure nurse gives the patient additional information regarding self-management, and liaises with the medical staff and community heart failure staff with regards to discharge planning • This criteria is met for all heart failure patients ascertained by the inpatient surveillance mechanism and in whom heart failure team advice is followed • The cardiology department aims to provide an echocardiogram on all inpatients within 48 hours of the request being made during weekdays

Local clinical audit

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe, evidence based and meets agreed standards. All staff are encouraged to complete clinical audits or other similar projects to monitor and then improve services.

The reports of 158 local clinical audits were reviewed by us in 2018/19. A selection of these audits is outlined in the following table and the Trust intends to take the following actions to improve the quality of health care provided.

Table 2: Examples of actions that the Trust intends to take or has taken following local clinical audit recommendations

Audit title	Key actions following the audit
Maternity booking summaries – are they present in all antenatal notes?	Continue 100% compliance with booking summaries in antenatal notes. Ensure all booking summaries are placed behind the Antenatal Care tab in antenatal notes. Report printer issues as soon as possible to ensure summaries can be printed. If printing not possible, gain consent from woman to post summary to her home address (checking address details are correct) for her to add to her antenatal notes.
Audit of Referrals to Bariatric Assessment Clinic	Ensure vetting referral pathway is clear with all members of the team (bookings and bariatrics). Continue ongoing work of encouraging electronic referrals to the bariatric service.
An audit of *Molluscum contagiosum* against the UK BASHH guidance	Add *Molluscum contagiosum* guideline in to the HSHS guideline booklet
Audit of C&H wheelchairs currently in use in local nursing homes	Nursing Home managers to be informed regarding wheelchair service criteria for future reference. An Information sheet has been provided to Nursing Home managers.
Audit of GP Ultrasound referrals	Encourage addressing of clinical query on conclusion/summary. To develop an information sheet for GP's to ensure that referrals are improved with specific queries.
An Audit of VTE prophylaxis	Introduce a VTE score as part of standard 26 week midwife appointment. Update of midwifery guidelines
Postnatal readmission for hypertension audit	Send reminder to all GPs regarding community treatment of hypertension. Information to be added to CCG newsletter update
Review of the powered wheelchair assessment pathway	Wheelchair Service team agreement regarding the Powered Pathway. Implementation of the Powered Pathway
Perinatal mental health audit	Formalise discussion of medication in mental health with women of childbearing age. Incorporate a tick box into the mental health review template indicating discussion about medication with women of childbearing age.
Audit of nutrition screening in adult medical admissions 2016-2018: Re-audit after initial intervention and subsequent Quality Improvement Project Plan	Formalise training for nursing staff. Rewrite compulsory nursing training e-learning module on nutrition to emphasise the importance of getting an accurate weight for all patients
Women's Health Physiotherapy Documentation Audit	Gestation and expected date of delivery (EDD) documentation. Changed new paperwork to "Gestation/Post-Partum" and "EDD/Baby DOB" to accommodate post-natal patients too.

Speech and language therapy stammering Pathway for under 8 year olds in mainstream primary schools in Hackney	Raising awareness about stammering; its potential impact and the importance of referring a child to SLT early. Stammering advice leaflet and poster developed and distributed in team
Diabetic foot amputations	Education of A&E staff. Review of standard operating procedure for diabetic foot complications
Evaluating incidence of pain in Post Anaesthetic Care Unit (PACU)	Establish working group with anaesthetic department and PACU. Develop standardised recovery documentation
Audit of clinical practice at Homerton postnatal echo technician clinics	Parents' information leaflet. Design a leaflet with information on the procedure, discussion on results and medical follow up. Modify the neonatal clinic referral to highlight babies scheduled for outpatient echo.

2.2.3 Research

Clinical research remains high on the Government agenda with continued funding to Clinical Research Networks (CRN) ring-fenced for the promotion of research within the NHS. Research is written into the NHS Constitution and this has recently been reinforced through the CQC inspection process. In September 2018 the Care Quality Commission (CQC) signed off the incorporation of clinical research into its Well Led Framework (NHS Trusts)[1]. This formally recognises clinical research activity in the NHS as a key component of best patient care. Thus, clinical research is no longer perceived as just a 'nice to do' exercise in the NHS - it is now a key part of improving patient care. Furthermore, the government reflect this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England, stated that 'Research is central to the NHS… We need evidence from research to deliver better care. Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence. We can only correct that with research.'[2] Homerton is committed to this path growing research capacity year on year. During 2018 between 130 and 150 studies were recruiting at any given time, with a total of 222 studies recruiting patients during 2018.

We aim to open studies that are particularly relevant to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that studies are in line with local clinical practice. During the lifecycle of each study the R&D team ensure that all governance and regulatory processes are approved and adhered to; recruit patients who are eligible for the trial; collect and maintain necessary data and accurately record the data; and finally confirm secure archiving of all necessary trial related documentation at the end of the study.

Participation in research remains important to patients with over 94% of a national consumer poll indicating that it is important for the NHS to carry out clinical research, with a similar number saying it was important so that new treatments could be offered by healthcare professionals[3].

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 3078.

This increase in recruitment has led to a consequential increase in the number of personnel in the research team. In 2018 we were fortunate to be able to support an apprentice as well as research nurses, research practitioners and administrative staff.

[1] Well Led Research in NHS Trusts: A Briefing for Clinical Research Network Staff about outputs from the work to establish research markers in CQC inspection

[2] Excerpt from video Enhancing patient care through research

[3] Results of Censuswide consumer poll of people in England in September 2014

The team provide both an excellent and efficient service and Homerton performs consistently well and once again is top for value for money when compared to other mid-sized acute trusts in North Thames.

R&D department is committed to growing research both locally and nationally and the department supports novice researchers setting out on an academic pathway. Currently there are three researchers, all in allied health professions, who are being funded through NIHR grants to achieve ether an MSc or PhD. Additionally four members of staff are being funded for PhD studies through research income. We also offer support and advice for those seeking funding for projects. Successful grants in 2018 include £500k for a fertility study under Dr Priya Bhide, and £1m for a study in neonatology under Dr Narendra Aladangady.

We further promote, develop and support researchers at the annual conference offering the opportunity to share research findings and hear the experiences of veteran researchers. The 2018 conference covered many topics and introduced us to our keynote speaker: Dr Chris Turner, University Hospitals Coventry & Warwickshire; who spoke about "Why Civility Counts in a Complex World" a salient and important discussion.

Patient involvement in research

Both nationally and locally we seek to gain opinions and views of patients involved in all aspects of research. We encourage researchers to involve patients/lay members of the public in the design of their research thus enhancing the acceptability of the research to service users. We also host a stall in the reception area of the Trust to engage and inform members of the public in the research being undertaken locally. Nevertheless, in our 2018 survey only 26% of our respondents were aware that Homerton were involved in research activity prior to being recruited to a study.

A taste of research activity at Homerton

STOPPIT 2 - Prematurity is thought to account for over 70% of twin neonatal deaths and adversely affects fetal survivors, with increased risks of future respiratory problems, motor and sensory impairment, learning difficulties and social and behavioural difficulties. Twins alone account for over 20% of neonatal unit cot stays, a significant excess given they comprise only 2% of all births. Together, the complications of preterm birth result in an estimated annual cost of £2.9 billion to the public purse in England and Wales (2006 prices).

There is a clear expressed need for innovative interventions to reduce preterm birth in both high-income and low-income countries. The 2011 National Institute for Health and Care Excellence (NICE) Multiple Pregnancy Guideline Group noted that bed rest at home or in hospital, progesterone, cervical cerclage and oral tocolytics are all ineffective at preventing preterm birth in twins, concluding that alternative effective interventions are urgently required.

STOPPIT-2 is a multicentre open-label randomised controlled trial of the Arabin pessary (CE marked device) versus standard treatment in women with twin pregnancy recruited from NHS antenatal clinics. The study is in two phases: a screening phase, in which women with a short cervix (cervical length of 35 mm) are identified, and a treatment phase, in which women with a short cervix will be randomised to either treatment with Arabin pessary or standard treatment.

The primary objective of this study is to test the hypothesis that the Arabin cervical pessary reduces spontaneous preterm birth in women with a twin pregnancy and a short cervix (35 mm).

The study, which commenced in January 2016, has consented 72 patients and has randomised 26 patients at Homerton. Homerton is the sixth recruiting site out of 56 participating Trusts nationwide and has played a key role in the achievement of the national target of 500 randomised patients.

Microbial Colonisation and Immune Responses in Preterm Babies - Necrotising Enterocolitis (NEC) and septicaemia disproportionately affect infants with extreme prematurity or low birthweight. Both carry high rates of mortality and morbidity and can impact significantly on neurodevelopmental outcomes in survivors. A number of previous studies have shown that the preterm microbiome is different from the microbiome of term babies with typically more potentially pathogenic bacteria seen. There have been some studies that suggest these abnormal pathogenic bacteria are associated with an increased risk of NEC and septicaemia. Little is known about how the immune system develops in preterm babies and what factors alter immune responses. This local study looked at the relationship between the developing immune system and the preterm intestinal microbiome.

Babies admitted to the Homerton NICU and born between 23+0 to 31+6 weeks gestation were recruited with written informed consent. Stool samples were collected every day and weekly gastric aspirates were collected and stored to evaluate intestinal colonisation. Blood samples were also taken weekly and when babies were being evaluated for suspected infection to assess the immune responses. 143 babies and more than 6000 biological samples were collected during the study. To date, outputs from this study have been presented at: The European Federation of Microbiology (Valencia Spain); The Neonatal Society (Dublin, Ireland); The London Microbiome Meeting (GSST, London); The Pediatric Academic Society Meeting (Toronto, Canada) and the British Society of Immunology (London).

Discover Study - The DISCOVER study is a clinical trial of PrEP to test whether a combination of emtricitabine and tenofovir alafenamide (F/TAF) is as safe and effective as Truvada® (emtricitabine and tenofovir disoproxil fumarate, F/TDF) at reducing the risk of HIV infection when used as PrEP. F/TAF was recently approved for HIV treatment, but it is not yet known whether it is effective as PrEP

This international multi-site study is a double blind randomised controlled trial where participants in the study are randomly allocated to get either active Truvada® and placebo F/TAF or active F/TAF and placebo Truvada®. Neither the participants nor the study clinicians will know which drug the participant is taking until the end of the study. Participants are followed up three monthly for two years and are told which drug they were getting at the end of study follow up.

The eligible population for this study is men who have sex with men and transgender women who have sex with men. This study is funded by Gilead Sciences and enrolled 5000 patients at 92 study sites across the United States, Canada and Western Europe. Homerton recruited 49 patients in to this study and currently everyone in follow up.

APPIPRA - Rheumatoid arthritis (RA) is a chronic autoimmune disease and can affect any racial group with a higher rate in women. It causes painful, stiff and swollen joints that if left untreated can lead to deformity of synovial joints and significant disability.

There is no cure for RA but Professor Andrew P Cope and his team at Kings College London are trying to determine if it can be prevented with their trial 'Arthritis Prevention in the Pre-Clinical Phase of RA with Abatacept' (APIPPRA).

APIPPRA is one of 11 studies that Homerton is currently running within the Rheumatology Department. It is a randomised, multicentre, placebo controlled, double-blind clinical trial of abatacept. APIPPRA closed to recruitment earlier this year having met the target of 206 subjects, five of whom who were recruited here at Homerton.

Abatacept is a new drug in the class of 'selective costimulation modulators' and is already licenced for the treatment of RA. Participants were eligible if they have the presence of arthralgia and are positive for rheumatoid antibodies but do not yet have joint swelling. They were given a year's course of either a placebo or abatacept.

We are now in the follow-up phase of this trial and meet with each participant every three months for a further year. We are collecting data including DNA samples, routine bloods, x-rays, joint ultrasounds, Disease Activity Scores, clinical assessments and quality of life questionnaires.

Patients benefit from being seen by their clinicians at three monthly intervals and from the potential to receive a medication that is not routinely available to those with pre-clinical RA. Their participation will help to determine the feasibility, efficacy and acceptability of abatacept for RA prevention for future patients in a similar position to themselves.

2.2.4 Goals agreed with Commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by the Trust.

During 2018/19 the Trust continued to work with the Commissioning for Quality and Innovation (CQUIN) scheme to drive quality improvements across the organisation.

A proportion of the Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the 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 payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/

The monetary total for income in 2018/19 conditional on achieving quality improvement and innovation goals was £6.146m and the monetary total for the associated payment in 2017/18 was £5.464m.

In 2018/19, the Trust continued to hold three major contracts that encompassed a number of CQUIN schemes; the acute services contract, the community health services contract and the NHSE contract (which encompasses specialised services, public health services and acute dental services). However in 2017/18 last year, there was a significant change to the way CQUINS were delivered. For the first time, NHSE published a programme of two year CQUIN schemes. The purpose was to provide more certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives. The current CQUIN programme runs from 2017-2019.

Appendix B provides details of the Trust's 2018/19 CQUINs.

2.2.5 What others say about Homerton

Care Quality Commission (CQC)

Homerton University Hospital NHS Foundation Trust is required to register with the Care Quality Commission. Its current registration status is 'registered with the CQC' with no conditions attached to registration.'

The Care Quality Commission has not taken any enforcement actions against Homerton University Hospital NHS Foundation Trust during the reporting period 2018/19.

There were no special CQC reviews or investigations during the reporting period for the Trust to participate in.

CQC Inspection of acute services.

An inspection of Homerton acute services was carried out by the CQC during April 2018, followed by a 'well-led' inspection in May 2018. The four core services inspected were Urgent and Emergency Care; Medical Care; Surgery; and Maternity care. The CQC took into account the current ratings of the other four services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the Trust achieving an overall rating of 'Good'. The core services of Urgent and Emergency Care and Medical Care, including older people's care each received the highest rating of 'Outstanding' overall.

	Safe	Effective	Caring	Responsive	Well led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Requires improvement	Good
Medical care (including older people's care)	Good	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆
Urgent and emergency services (A&E)	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good

The CQC found areas of 'Outstanding' practice across all the core services inspected which are highlighted in the inspection report. Examples of this include

Urgent and Emergency Care

- There was an active quality improvement programme in place which was monitored by two consultants
- The service performed consistently better than the England average for patients admitted, transferred or discharged within four hours between February 2017 and March 2018
- 95% of patients between March 2017 and February 2018 would recommend the service to friends and family
- There were good protocols in place for the recognition and management of sepsis

Medical Care

- The division that managed medical services also included the delivery of local community services which facilitated the integrated delivery of care for patients on their transfer from inpatient to community teams

- Flow through the medical wards was excellent, facilitated by effective streaming of patients through the assessment unit and on to the speciality wards. Despite a busy winter period, patient flow was well managed enough to not need to use the hospital escalation ward
- The Trust had one of the highest rates of referral for patients with sickle cell anaemia and thalassaemia in the UK. The Medical Day Unit provided specialised and targeted health promotion, diagnosis, treatment and follow up (as well as crisis support) for patients
- Medical wards had access to a number of clinical nurse specialists to meet the needs of local patients. This included access to a dementia support team, mental health liaison, critical care outreach and various oncology nurse specialists

The CQC highlighted a number of areas for improvement. These included:

- The need to improve the capacity and sustainability of the adult safeguarding team to ensure timely completion of safeguarding referrals and Deprivation of Liberty Safeguards (DoLS) assessments, monitor incidents, provide engagement with other agencies, and ensure the consistent delivery of training for staff
- Increase the mandatory training completion rates for medical staff in Surgery and Maternity to meet the Trust target of 90% and for nursing staff in Surgery who did not meet Trust targets for most mandatory training modules
- Eliminate the inconsistent hand hygiene practices carried out by doctors and midwives in maternity services
- Reduce the varying understanding and gaps in the compliance of the WHO surgical safety checklist and its use among staff in maternity services

An action plan has been developed to address the CQC's recommendations. Good progress is being made against the actions which are monitored and reported on, through divisional and Trust-wide committees.

2.2.6 NHS number and General Medical Practice Code Validity

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

Homerton submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data for **April 18 – Mar19**:

- which included the patient's valid NHS number was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.0%	98.3%	99.5%		
Outpatients	99.7%	98.5%	99.6%		
A&E	94.7%	94.8%	97.6%		

- which included the patient's valid General Medical Practice Code was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	100.0%	99.9%	99.9%		
Outpatients	100.0%	99.9%	99.8%		
A&E	99.9%	99.2%	99.3%		

The Trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

2.2.7 Information Governance (IG)

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and presents them in one place as a set of Information Governance requirements.

The Trust submitted evidence in support of all the mandatory elements of the new Data Security and Protection Toolkit in March 2019. The Trust did not meet the 95% mandatory IG training compliance standard and an improvement plan has been agreed with NHS Digital.

2.2.8 Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

Clinical coders collect, collate and code clinical information, relating to the diagnosis and operations for the patients admitted to the hospital. This data is essential for the effective management of the Trust, and also forms the basis for clinical audit, clinical governance reporting and payment.

Homerton was not subject to the Payment by Results (PbR) clinical coding audit during 2018/19 by the Audit Commission. The Audit Commission has closed.

The Clinical Coding department supports patients' care by providing ICD-10 DIAGNOSTIC codes and OPCS procedure codes that are used for a variety of purposes, including payment and Hospital Standardised Mortality Ratios. The department codes around 70,000 admitted spells (approx. 93,000 FCEs) a year across a wide range of specialities.

The Trust has an internal Clinical Coding Audit post that is responsible for auditing the accuracy of the Trust's clinical coding on a monthly basis. This is further supported through specific external audits undertaken by independent coding auditors to ensure that the accuracy of the Trust's coding is of a sufficient standard. In 2018/19, an external audit was undertaken in Trauma & Orthopaedics the results of which are set out below. The aims of these audits were to focus on improving the quality of our data and focus on providing a high quality, accurate coding service.

- Primary diagnosis correct 95.2%
- Secondary diagnosis correct 80.2%
- Primary procedures correct 85.1%
- Secondary procedures correct 83.9%

*The results should not be extrapolated further than the actual sample audited. 167 FCEs were sampled.

2.2.9 Actions to improve data quality

Accurate and timely data is essential to provide robust intelligence and allow sound clinical and strategic decisions to be made. The Trust continues to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

A Data Quality Committee chaired by the Chief Operating Officer met four times last year. Through the use of data quality indicators for both acute and community services the committee is a vehicle for data quality improvement and awareness within the Trust. The committee promotes and maintains robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality.

The Trust will be taking the following additional actions to improve data quality in 2019/20.

- Engage in relevant national conferences and workshops in relation to clinical coding standards.
- Develop further new data quality indicators.
- Provide staff with any additional training and developmental support required or identified to maintain skills, knowledge and data management.
- Implement a formal internal rolling programme of audit.
- Maintain close working relationships with clinical services.
- Continue to use benchmarking data to enable the Trust to identify areas of opportunity i.e. where the Trust is benchmarked as being a negative outlier.
- Develop internal programme of quality improvement to ensure the availability of clinical information is enhanced, thus ensuring clinical coders have easy and quick access to all relevant clinical information.
- Engage an external auditor to undertake a comprehensive independent review of the Trust's clinical coding.

2.2.10 Learning from deaths

This is section of the Quality Report that NHS Trusts are required to include was introduced in 2017/18. In March 2017 the National Quality Board published a document called 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

All deaths are reviewed by the primary clinical team and also discussed at a multi-professional forum to learn from every death.

During 2018/19, 387 patients died at Homerton Hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 91 in the first quarter
- 79 in the second quarter
- 112 in the third quarter
- 105 in the fourth quarter

By 31 March 2019, 296 case record reviews and 10 investigations have been carried out in relation to 387 of the deaths during 2018/19

In 11 cases a death was subjected to both a case record review and an investigation.

The total number of deaths reviewed was 296. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 75 in the first quarter
- 64 in the second quarter
- 98 in the third quarter
- 59 in the fourth quarter (as of 30th April 2019)

7 of the 387 (1.8%) of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 3 of the 75 deaths (4%) reviewed for the first quarter
- 1 of the 64 deaths (1.6%) reviewed for the second quarter
- 1 of the 98 deaths (1%) for the third quarter
- 2 of the 105 deaths (1.9%) for the fourth quarter (as of 30th April 2019)

2 representing 1.3% of the patient deaths during quarter 4 of 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been achieved using the CESDI score methodology supported by the learning from deaths guidance.

Please see below a summary of some of the learning identified following case record reviews and investigations for 2018/19:

- Lack of focus on advanced care planning in oncology patients
- Delayed transfers of care.
- Difficulty starting individualised end of life care plan when family may not agree
- Good palliative care input.
- Delays in transfers to Nursing Homes may add to risk of decline.
- Difficulty establishing preferred place of death/appropriate discharge location
- Death certification information/discharge letters not on EPR.
- Appropriateness of ITU interventions.
- Delays in discharge preventing meeting Preferred Place of Death (PPD).
- Communication with family as well as with professional teams.
- Delay in appropriately focused diagnosis and/or treatment.

Please see below a summary of the actions which the Trust has taken in 2018/19 and actions it proposes to take following the reporting period as a result of the learning.

- Implementation of an online mortality review tool.
- Developed a formal checklist for blood gases to ensure entire sample is reviewed in a systematic manner.
- Audit of NEWS scores
- Developed a Poster detailing all the vascular access mid lines and long lines utilised in the trust to be displayed in the CT control room.
- Review by Thrombosis Committee of the two thrombolytic agents in use in the Trust.
- Staff to receive training on pain in delirium.
- Review of written consent process in gynaecology
- Raised awareness about aortic dissection.

Please see below a summary of the impact of actions taken in 2018/19

Deteriorating Patients

It was recognised that there were a number of issues with the management of deteriorating patients, including delays in escalation to ITU, lack of or slow escalation, tolerance of abnormal physiology and poor handover. As a result, the Deteriorating Patients task and finish group was relaunched at the request of the Medical Director in September 2018, with a remit to look at education, NEWS 2 implementation, to review the hospital at night model and to develop guidelines for escalation and referral to critical care.

There have been a number of key achievements:

- Improved nursing escalation – from August to December 2018, the number of patients with a NEWS score of 5 or over who were escalated appropriately increased from 53% to 73%. The documentation is significantly better, and the changed assessment in EPR has also helped.
- There has been a reduction in delayed ITU referrals, reduction in inadequate medical team response and delayed nursing response, and fewer incidents recorded of staff tolerating patients with high oxygen requirements.
- Reduced number of bleeps going to the wrong place at night time.

The Group is led by the Medical Director, Chief Nurse and Clinical Lead for the Acute Care Unit, with support and input from the Chief Registrars, ITU, ED, IT, surgery, the Critical Care Outreach Team, the Simulation Lead, Education and Training and the Patient Safety Team.

Online Mortality Review Tool

The Trust ability to track and report on mortality reviews has improved since the introduction of the mortality review tool and additionally the number of reviews is increasing and all deaths are being reviewed in a multidisciplinary forum to facilitate learning.

Over the last year, the Trust has been developing an online Mortality Review Tool. The tool has been developed under the guidance and leadership of the Medical Director and the Specialty Mortality leads, who have played a crucial role in ensuring the tool is fit for purpose. The tool is a live web-based system, linked to EPR, which is designed to help clinicians review deaths in a systematic and consistent way. It is based on the existing paper-based tool, and is accessible to all staff involved in the mortality review process.

There are a number of advantages over the existing paper based system, including:

- Ability to identify and track themes and areas of good practice.
- Ability to record family concerns so that they can be linked to the review process
- Automatic link to EPR, so that teams can more easily identify the patient deaths requiring a mortality review
- Area to record details of SI investigations to better link up learning.
- Improved reporting so that data, themes and learning can be more easily identified, and so that reminders can be sent where reviews are overdue.

Following implementation of our online mortality review tool in October 2018 we have been better able to draw together more comprehensive learning and aim to strengthen the way we share learning. This will have the net effect of providing clarity around themes which may not have been joined up across the organisation previously.

The impact of the implementation of the online tool will in time allow identification of high impact communication streams and projects as a consequence of thematic learning as well as consolidating the existing newsletter process.

Coordinate My Care

The Trust collaborates actively with City and Hackney primary care colleagues to allow system wide participation in Coordinate My Care (CMC). CMC is used as the shared urgent care plan to improve patient care. A CMC care plan supports a patient if they have an urgent care need. Health care professionals should be more informed about the patient they are attending to and better able to provide care in accordance with the patient's needs and wishes. A CMC care plan should help to avoid unnecessary hospital admissions as well as improving coordination of care for patients at the end of life by giving professionals the information they need at the first point of contact with a patient in an urgent care situation.

CMC has been adopted in City and Hackney for the following groups of patients:

- End of Life Care Register
- Proactive Care Practice Based Register (including High Intensity Users)
- Proactive Care Home Visiting Register
- C&H Nursing Home Patients
- Patients with Dementia under the Diagnostic Memory Service (ELFT)

The first phase has achieved the creation of care plans and work is continuing to ensure there is access to those care plans by the wider urgent care system and that the care plans are of sufficient quality to be fit for purpose.

2.2.11 Seven day services

NHS trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven day hospital services. Ten clinical standards for seven day services in hospitals were developed in 2013. These standards define what seven day services should achieve, no matter when or where patients are admitted. Four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Homerton made good progress with implementation of the four standards and has met both standards five and six.

Two main challenges exist with regard to standard two. Firstly given the relatively low numbers of patients developing appropriate consultant rotas across surgical specialities has been a challenge. Following recent work undertaken the Trust would expect performance to improve in future. Secondly the challenge exists with regards to overnight admissions in terms of prioritising the review of acutely unwell patients against chronological review of all admissions on the morning post take ward round. It is important to stress that those patients not reviewed within 14 hours missed the expected timely review by a short margin.

With regard to standard eight the Trust's current model is to have 12 hour consultant presence on the Acute Care Unit seven days a week. This means all admissions during this period are reviewed in real time and critically unwell patients are reviewed as regularly as necessary.

This model ensures the daily review of over 90% of emergency admissions, however it doesn't cater for two structured ward rounds as stated in the standard. There is no current evidence that this leads to any detriment in patient care or missed opportunities for early recognition of deteriorating patients.

2.2.12 Speak up Safely

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising concerns. The Trust Board of Directors receives a six monthly Raising Concerns at Work report which includes content from the Freedom to Speak Up Guardians as well as additional information on live/closed formal cases that have occurred in the reporting period.

In addition there are two Freedom to Speak up Guardians in the Trust to promote the need for staff to speak up where issues of concern arise as well as support them in doing so. In addition there are two designated Board Leads one Executive Director and one Non-Executive Director.

2.2.13 Rota gaps

Homerton has had a Guardian of Safe Working in place since the implementation of the new junior doctors' contract in 2016. Their role is to monitor the exception reports that come in and ensure any issues are addressed in a timely manner. Currently we have a 92% fill rate across medical and dental. Any vacancies in rota's are filled on a temporary basis by bank or agency doctors, whilst the post is advertised and a substantive/fixed term doctor is appointed. In the last six months we have advertised on 50 occasions for junior or senior clinical fellow posts. The Trust Board of Directors receives reports from the Guardian of Safe Working which includes details on fill rate and actions taken across the trust to support junior doctors.

2.3 Reporting against core indicators

All NHS foundation trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. Where the required data is made available by NHS Digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS Digital website and may not reflect the Trust's current position (please note that the data period refers to the full financial year unless indicated). All data provided is governed by standard national definitions.

All Trusts are also required to include formal narrative outlining the reasons why the data is as described and any actions to improve.

1. Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care

The SHMI reports on mortality at trust level across the NHS in England. SHMI is the ratio between the number of patients that die following hospitalisation and the number of patients expected to die based on the national average and on the particular characteristics such as comorbidities of our patients.

It reports on all deaths of patients who were admitted to hospital and either died whilst in hospital or within 30 days of discharge. The Standardised Hospital Mortality Indicator is unaffected by palliative care coding.

SHMI has three bandings: higher than expected, as expected as and lower than expected. If the number of deaths falls outside the 'as expected' range, then the Trust will be considered to have either a higher or lower SHMI than expected. A 'higher than expected' SHMI should not automatically be viewed as bad performance, but rather should be viewed as a 'smoke alarm', which requires further investigation. Conversely, a 'lower than expected' SHMI does not necessarily indicate good performance.

If you would like to know more about how these ranges are calculated, then please refer to the NHS Digital website at: https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Table 3: Summary Hospital Level Mortality Indicator data

Indicator	Reporting Period	Homerton Performance	National Average	Highest Performing Trust	Lowest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct 2016 – Sept 2017	Value: 0.87 Banding: 3	Value: 1.01	Value: 1.25 Banding: 1	Value: 0.73 Banding: 3
	Oct 2017 – Sept 2018	Value: 0.69 Banding: 3	Value: 1.00	Value: 1.27 Banding: 1	Value: 0.69 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Oct 2016 – Sept 2017	45.4%	31.6%	11.5%	59.8%
	Oct 2017 – Sept 2018	43.6%	33.8%	14.3%	59.5%
	Jan 2018 – Dec 2018	46%	34%	15%	60%

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

The data is produced using a recognised national agency and adheres to a documented and consistent methodology. The Trust recognises and is assured by its benchmarked position as having one of the lowest SHMI in the country.

The Trust intends to take the following actions to sustain and improve the SHMI, and so the quality of its services:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths.
- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

2. Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMS) is a tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. It covers four clinical procedures:

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)
- Groin hernia
- Varicose vein (Homerton Hospital does not participate in this PROM as we do not provide this type of operation)

A patient will complete two questionnaires: one prior to surgery and one six months after surgery. These questionnaires ask patients about their health and quality of life (as well as the effectiveness of the operation) before and after surgery.

Completion of these questionnaires is voluntary and the patient's consent to participate must be granted in order for the data to be used.

Table 4: Average adjusted health gain for hip replacement, knee replacement and groin hernia surgery.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Hip Replacement Surgery	Apr 2016 – Mar 2017	**0.467**	0.437	0.329	0.533
	Apr 2017 – Mar 2018	**0.476**	0.458	0.357	0.550
Total Knee Replacement Surgery	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.391
	Apr 2017 – Mar 2018	**0.332**	0.337	0.254	0.406
Groin Hernia Surgery	Apr 2016 – Mar 2017	**0.048**	0.086	0.006	0.135
	Apr 2017 – Mar 2018	**No data***			

Data source: Latest figures available on NHS Digital

*PROMs data was collected on groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for groin hernia procedures up until September 2017 has been published. Submission figures of less than 30 do not allow calculation of the adjusted health gain. HUHFT submitted 25 groin hernia records between April and Sept 2017.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre and postoperative questionnaires.
- There has been sustained improvement in outcomes for total hip and total knee replacements. This is consistent with data collected by the trust for improvement projects, such as the opening of the ring fenced elective orthopaedic ward, and patient feedback questionnaires.

The Trust intends to take the following actions to sustain and improve the PROMS, and so the quality of its services.

- Review of how we collect PROMS data. We are currently trialling an electronic system to collect PROMS. It is anticipated this will allow for a fuller dataset, i.e. increased six month PROMS completion and allow the service to be more responsive to patient feedback.
- Review of Enhanced Recovery Protocol to improve the patient's immediate post op recovery.
- Reviewing PROMs data and findings and discussing these within relevant departments.
- Reviewing PROMS data on a bimonthly basis through the Improving Clinical Effectiveness Committee.

3. 28 day emergency readmission rate

This indicator on the NHS Digital portal was last updated in December 2013 for the 2011/12 reporting period. Due to their 'statistical method' in continuous inpatient spell (CIP) construction, we are unable to replicate the data produced by NHS digital (the national standardisation process involves external data sources that we do not have access to). However, the information provided below is based on our internal dataset and NHS digital methodology without the standardisation applied.

Table 5: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over.

Indicator	Reporting Period	Homerton Performance
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	2016/17	3.63%
	2017/18	4.66%
	2018/19	4.36%
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	2016/17	12.7%
	2017/18	11.95%
	2018/19	12.60%

Data source: Latest figures available on NHS Digital

The Trust is unable to provide national comparative data for this measure due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust has a robust clinical coding and data quality assurance process, and readmission data is monitored through the Trust Management Board on a monthly basis.

The Trust intends to take the following actions to sustain and improve the 28 day readmission rate, and so the quality of its services.

- Working together with partners across Hackney to develop the concept of 'neighbourhoods' which will allow better coordination and integration of geographically based community services. A key metric for neighbourhoods will be to readmissions, as the aspiration is that better coordinated and integrated services should allow patients to be discharged more safely and cared for at home to prevent the requirement for readmission.
- We will work with the new Head of Information to develop our information capacity and systems, so that local services can drill down seamlessly from Trust wide through divisional to local level in order to permit more real time tracking and interventions to reduce readmissions.

4. Responsiveness to personal needs of patients.

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Table 6: responsiveness to the personal needs of patients

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The Trusts responsiveness to the personal needs of its patients during the reporting period.	2016/17	**66.3**	68.1	60.0	85.2
	2017/18	**68.1**	68.6	60.5	85.0

Data source: National Inpatient Survey

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust uses an approved contractor, Picker Institute to collect the required data which follows the methodology set out by the CQC.

Whilst we have improved since 2016/17 we have performed just below the national average for our responsiveness to the personal needs of our patients in 2017/18.

The Trust intends to take the following actions to sustain and improve the responsiveness to personal needs of patients, and so the quality of its services by:

- Improving communications between ward and community services to improve discharge planning
- Implementing improvements in the care of patients with dementia
- Implementing Learning Disability awareness training for staff
- Implementing actions in relation to nutrition and hydration overseen by the Nutrition Steering Group
- Implementing the 'Hearing the voice of the child' project on Starlight Ward
- Launching the trust End of Life care strategy

5. Staff recommending the Trust as a place to work or receive treatment to Family and Friends.

The National NHS Staff Survey provides the opportunity for organisations to survey their staff in a consistent and systematic way on an annual basis and benchmark their results against each other. Obtaining feedback from staff, and taking into account their views and priorities is vital for driving real service improvements across the NHS.

Table 7: Staff recommending the Trust to family and friends

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	2017	**73.4**	70.2	48.0	89.3
	2018	**75.1**	69.9	49.2	90.3

Data source: National Staff Survey

Assurance Statements

The Trust considers that this data is as described for the following reasons:

- The Picker Institute conducted the survey on behalf of the Trust and all full and part time staff employed by the organisation on the 1st September 2018 (with certain specific exclusions) had the opportunity to complete the survey electronically between September to December 2018. The Trust achieved a return rate of 52.4%, which represented a 2.4% point increase from 2017 (50%).
- We have performed above the national average for staff recommending friends and family as a place to be treated with the score improving by more than one percent since 2017.

The Trust intends to take the following actions to sustain and improve the percentage of staff recommending the Trust to their friends and family, and so the quality of its services.

We will act on this information responsively to drive further improvements in engagement levels by:

- Ensuring the organisation acts fairly: career progression.
- Reviewing the Staff Engagement Action Plan in light of the 2018 Staff Survey results (key features of the plan including those areas where results were not so positive when benchmarked against comparator).
- Responding to our latest staff survey under the themes of equality and diversity; career progression and recognition; leadership strategy; staff health and wellbeing; reward and recognition; and Trust values.

6. Patients recommending the Trust to Family and Friends

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is considered vital in transforming NHS services and supporting patient choice.

Table 8: Patients recommending the Trust to family and friends.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Percentage of patients who would recommend the Trust to their family and friends. (inpatient)	2017/18	94.5%	95.6%	54.5%	100%
	2018/19	93.7%			
Percentage of patients who would recommend the Trust to their family and friends. (A&E)	2017/18	93.0%	86.4%	59.2%	98.3%
	2018/19	92.7%			

The Trust is unable to provide national comparative data for this measure in 2018/19 due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust follows the guidance and methodology as set out by the Department of Health in the provision of data to Optimum Healthcare.
- A process is in place to ensure that data is quality assured prior to being uploaded onto the national reporting system UNIFY.

The Trust intends to take the following actions to sustain and improve the percentage of patients recommending the Trust to their friends and family, and so the quality of its services.

- Review of how data on Friends and Family is collected and utilised. This will be overseen by the Improving Patient Experience Committee.
- Use Perfect Ward and Chief Nurse Rounding to ensure that feedback is provided in clinical areas to patients on actions taken as a result of feedback.
- Triangulate FFT date with wider patient experience data to agree areas for further improvement.

7. Rate of admissions assessed for VTE

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill-health problems – many of which are avoidable. 1 in 20 people will have a VTE at some time in their life and the risk increases with age. It is estimated that as many as half of all cases of VTE are associated with hospitalisation for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognised as a clinical priority for the NHS in England.

Table 9: Rate of admissions assessed for VTE

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2016/17 (full year)	**96.2**	95.6	79.1	100
	April-June 2017/18	**97.0**	95.2	51.4	100
	July-Sept 2017/18	**96.7**	95.3	71.9	100
	Oct-Dec 2017/18	**97.4**	95.4	76.1	100
	Jan-Mar 2017/18	**96.6**	95.2	67	100

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton has consistently met or exceeded the national average for patients admitted who received a documented risk assessment for VTE. This is through an on-going programme for education, training and user prompts on the hospital-wide electronic medical record under the regular review of the Trust Thrombosis Committee.

The Trust intends to take the following actions to sustain and improve the percentage of patients risk assessed for VTE, and so the quality of its services.

- All hospital acquired VTEs are recorded on Datix and investigated through the incident review process.
- Trust Thrombosis Committee (TTC) reviews serious incidents and hospital acquired thrombosis to look for any systematic issues.
- Working with the GP Confederation that has been commissioned to provide a community anticoagulation service for Hackney to ensure patients receive an integrated service.

8. *Clostridium difficile* rate (*C. difficile*)

Acute hospitals in England are required to report all *C.difficile* toxin positive stool samples in those patients over two years of age. During the 2018/19 reporting period we have had three Homerton Hospital attributable cases against our national threshold of no more than 10 cases. This is significantly less than the 10 Homerton Hospital attributable cases in 2017/18. In addition the hospital has admitted patients who acquired *C.difficile* prior to admission. The Trust continues to report low number of cases when compared to other trusts across England. Review of these cases is still in progress by the Trust's clinical commissioning group. Patient management issues arising from the Root Cause investigations included the time from start of symptoms to taking a stool specimen & thus commencement of appropriate precautions. The *C.difficile* rate per 100,000 days as shown is sourced from the DH website and is up to end July 2018. It represents the latest published comparable data available. It shows a slight increase in our rates from the previous year. However we compared favourably to other London trusts and we are significantly below the national average.

Table 10: The rate per 100,000 bed days of cases of *C.difficile* infection.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2016/17	**3.3**	14.9	66.0	0.0
	2017/18	**8.9**	13.7	82.7	0.0

Data source: Latest figures available from Public Health England data collection

Table 11: The total number of cases of *C.difficile* infection.

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Number of Clostridium Difficile (C-diff) cases.	10	3	10	4

Data source: Latest figures available from Public Health England data collection

Assurance Statements

The Trust considers that this data is as described for the following reasons:

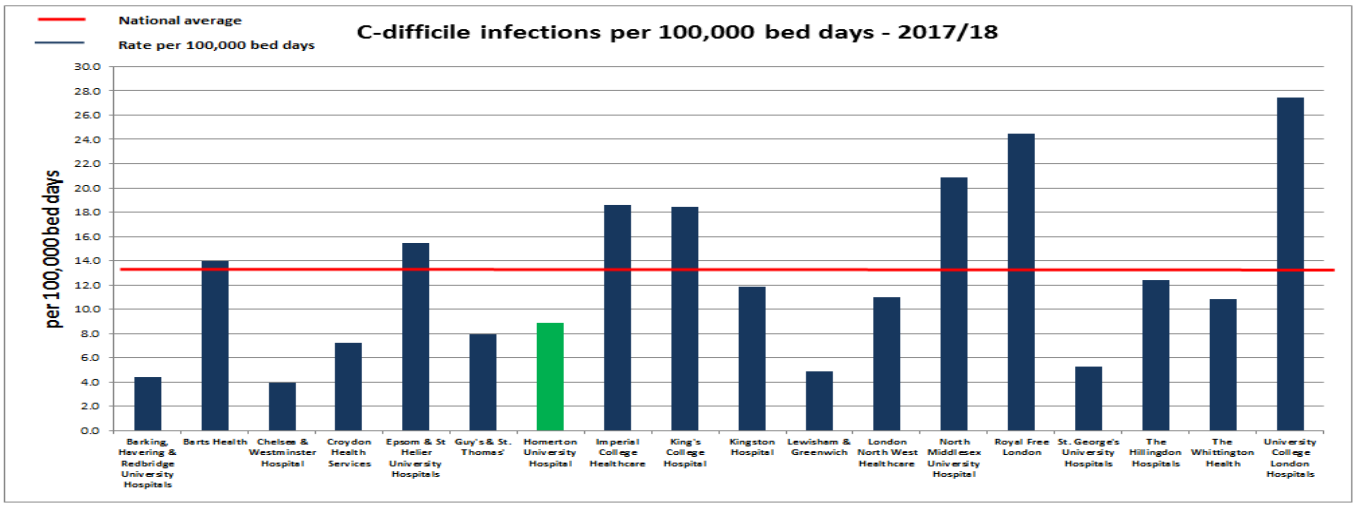
The data has been sourced from the Department of Health website and validated against the Trust's internal data derived from the pathology laboratory and inputted onto the Public Health England mandatory surveillance system. There is a defined process for checking data at a number of levels which include daily reports from the laboratory, reporting of cases as incidents with a post infection review and monthly sign off by the Director of Infection Prevention and Control.

The Trust continues to work hard at reducing the risk of C-difficile infection to our patients including continuously improving our already embedded processes for risk reduction by antimicrobial stewardship, prompt identification of possible cases and laboratory testing processes.

The Trust intends to take the following actions to sustain and improve the rate of *C-difficile* infection, and so the quality of its services.

- Raised profile of *C.difficile* mandatory induction & update training.
- Focus on timely isolation of all ward patients with diarrhoea whilst awaiting results.
- Focus on timely sample testing of all diarrhoeal stools enabling prompt identification of *C-difficile* positive cases.
- Environmental decontamination by deep cleaning and going forward hydrogen peroxide vapourisation (HPV).
- Focus on clutter reduction in ward environments to enable high standards of cleaning.
- Regular audits to ensure compliance with national and local guidelines.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.
- Root Cause Analysis investigation of every case to identify lessons to be learnt and feedback to the multidisciplinary teams and into the governance structure to ensure learning across the Trust.

Figure 1: *C.difficile* rate in London NHS Trusts 2017/18



9. Patient safety incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe. Patients should be treated in a safe environment and protected from avoidable harm.

Homerton actively encourages its staff to report all adverse incidents that have either caused harm or have the potential to cause harm during their care at the Trust. This is to ensure an open and transparent culture and promote organisational learning from safety incidents with the intention of preventing similar incidents from reoccurring in the future. Like NHS England, the Trust considers its high reporting culture as a 'positive indicator of its healthy safety culture, giving organisations the chance to learn and improve'.

Table 12: Reported Patient Safety Incidents

Indicator	Reporting Period	Homerton Performance	National Average*	Lowest Performing Trust*	Highest Performing Trust*
Number of patient safety incidents	Apr – Sept 2017	**2951**	5226	1133	15228
Rate of patient safety incidents (per 1000 bed days)		**52.9**	42.8	23.5	111.7
Number (%) of patient safety incidents resulting in severe harm or death		**11 (0.37)**	18	0 (0)	121 (1.97)
Number of patient safety incidents	Oct 2017 – March 2018	**3151**	5449	1311	19897
Rate of patient safety incidents (per 1000 bed days)		**56.9**	42.6	24.2	124.0
Number (%) of patient safety incidents resulting in severe harm or death		**4 (0.13)**	19	0 (0)	99 (1.56)

Data source: Latest figures available on NHS Digital
*based upon all the Acute (non-specialist) Trusts

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust has reported more incidents in the second reporting period above in comparison with the first reporting period.
- The Trust has a much higher rate of incidents reported per 1000 bed days than the national average.
- The Trust has a lower rate of serious harm and death incidents than the national average.
- The Trust aims to promote a just culture to ensure that staff feel confident to report incidents and this is reflected in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

In addition:

- The Trust has a robust process to ensure rigorous incident management. All incidents are reviewed at weekly divisional or corporate CLIP (Complaints, Litigation, Incidents and PALS) meetings and themes and trends reviewed at monthly divisional governance meetings. Trust Management Board receives quarterly updates from the Divisions.
- During 2018/19, the Trust has worked to improve the electronic incident reporting system (Datix) so that staff can report and investigate incidents more effectively. This has included training and engagement sessions with teams and individuals across the Trust.
- The Trust has strengthened its processes around Serious Incident (SI) and internal root cause analysis investigations, to ensure that reports are completed by appropriately trained investigators within agreed timescales.
- An Assurance Panel has been established to quality assure and approve all SI and RCA investigation reports. This is chaired by the Chief Nurse and attended by the Divisional Leads to ensure a robust approval process.

The Trust intends to take the following actions to sustain and improve this indicator further, and so the quality of its services.

- We continue to consider ways to improve our incident reporting processes through induction training and raising staff awareness to ensure staff feel confident and able to report incidents.
- Undertaking a full review of the incident reporting system (Datix) to identify areas for improvement across all the modules.
- In addition to induction training for new starters on incident reporting, the Quality and Patient Safety team will be delivering training on Datix and incident reporting to staff in both the acute and community settings. The aim is to further develop staff capacity and capability as well as confidence in reporting patient safety-related incidents.
- Further work to provide feedback to staff who report incidents, so that they can realise the benefits or improvements to patient safety and care that have resulted from the incident(s) they reported.
- Improving the ways in which learning from investigations is shared across the organisation, using better and more consistent use of existing channels including divisional and team meetings. The aim is to also look at other ways of sharing learning and promoting change, including closer working with the Quality Improvement team and the Training and Development teams.
- Continuing to build closer links with the legal, complaints and PALS teams to ensure that information is shared in a more useful and timely fashion, and so that themes that cut across complaints / incidents / claims etc can be identified.
- Ensuring that actions and lessons learned from investigations are followed up in a consistent and systematic way so that there is assurance across the Trust that actions have been completed.

PART 3: OTHER INFORMATION

This section of the Quality Account provides information on our quality performance during 2018/19. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Risk Assessment Framework and Single Oversight Framework are outlined. We are also proud of a number of initiatives which contribute to strengthening quality improvement systems. An update on progress to embed these initiatives is also included in this section.

3.1. REVIEW OF QUALITY PERFORMANCE

Performance against priorities identified for improvement in 2018/19

We agreed a number of priorities for improvement in 2018/19 published in last year's Quality Account. These were selected in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1 - To prevent the number of community and hospital attributed pressure ulcers. – Partially Achieved

Background

The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures.

Our target was to reduce the number of avoidable grade 3 and 4 pressure ulcers in both the hospital and community by 10% and to reduce the number of avoidable grade 2 pressure ulcers in both the hospital and community by 5%

Our success measures have been

For the full year there has been a quarter on quarter reduction in the number of grade 3/4 community and hospital acquired pressure ulcers. However the reported numbers remain high and the target of a 10% reduction in ulcers was met for hospital acquired but not community acquired.

For grade 2 attributable pressure ulcers there has also a reduction quarter on quarter however the target of a 5% reduction has been met for community acquired ulcers but not for hospital acquired.

What did we achieve to date?

The format of the Pressure Ulcer Scrutiny Committee (PUSC) has been revised and relaunched in January 2019 with the aim being to provide a more structured opportunity for shared learning, identification of contributing factors and how these can be addressed to aid reduction.

The Trusts processes for the identification and management of pressure ulcers has been reviewed and updated in line with the publication of the NHSI – Pressure ulcers: revised definition and measurement framework.

We can evidence progress through

- Revised terms of reference for PUSC
- Minutes of meetings held

- Revised guidance.

What will we do in 2019/20 to continue improvements?

- Continue with this important priority in 2019/20.
- Review of the effectiveness of the revised PUSC
- Development of a pressure ulcer dashboard on Datix
- Provision of information at ward and team level to support the strategic information currently provided
- Quarterly thematic review of contributing factors identified in PUSC to ascertain what worked and any further action required.

Priority 2 - Improve patients by appropriate management of their nutritional needs. – Partially Achieved

Background

Nutrition and hydration are key factors influencing the health and well-being of patients across all healthcare settings and the Trust's policy for the treatment of malnutrition in adults is based upon the NICE clinical guideline 32: nutritional support in adults; which states that "All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients and when there is clinical concern for outpatients".

Our target was to ensure that patients have MUST score assessed and appropriate nutritional management based on the result of the MUST score.

Our success measures have been

The MUST audit completed on the Acute Care Unit in May 2018 indicated 55% of patients were screened within 24hrs of admission against a target of 95). This is a decrease from results of a large audit completed in February 2018 which indicated a 70% uptake and 82% uptake in November 2017.

A subsequent MUST audit undertaken in August 2018 across 8 wards (80 patients) indicated a 73% record of MUST. MUST score is therefore not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately.

The most recent MUST audit undertaken in April 2019 across 10 wards (219 patients) indicated a 75% recording of MUST.

Whilst improvements have been achieved since May 2018 MUST score is not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately and acted upon appropriately.

What did we achieve to date?

A number of actions have been achieved such as:

- A standardised audit tool was produced in collaboration with nursing staff across 8 wards.
- Liaison has taken place with Practice Development Nurse's and training provision enhanced to include:
  - HCA (care certificate) training and essential skills training,
  - Mandatory Nutrition training for nurses increased to 60mins from 30mins
  - New MUST training for Band 5 & 6 nurses lasting 1 hour
  - Mandatory Nutrition training for nurses training length increased to 60mins

    - Online Elsiver training has been established but low uptake as staff prefer face to face training
- The Nutrition Steering Group (NSG) has been re-established - this provides a forum for discussing and recording adherence to quality standards, such as MUST Electronic Recording of MUST - Change request submitted to EPR to indicate if weight recorded is estimated/self-reported or accurate.

We can evidence progress through

- Six monthly audits
- Nutrition steering group bi monthly Meetings

What will we do in 2019/20 to continue improvements?

- MUST 'snapshot' audits to be undertaken twice yearly, including Mary Seacole.
- Nutrition Steering Group to meet bimonthly
- Development of automated MUST Audit reporting per ward via EPR.
- MUST Quality Improvement (QI) projects to be undertaken with support from the QI Team to identifying the barriers and potential solutions to facilitate the improvement of MUST screening and recording.

Priority 3 - To improve identification and response to acutely deteriorating patients Partially Achieved

Background

Severe sepsis and septic shock have a mortality of 25-35% with approximately 44000 deaths per year in UK (2014/2015 data). Improvement in outcomes of patients suffering from severe sepsis and septic shock can be attributed to timely early management, namely prompt assessment and senior review, initial treatment (sepsis 6) and source search and control.

We need to ensure we have robust systems in place to ensure that we consistently identify deterioration in inpatients in a timely way no matter the cause and ensure an appropriate rapid response. We strive to ensure we are continually reviewing our progress in this area and are committed to continuous quality improvement.

Our targets were:

- To establish a deteriorating patient task and finish group
- Ensure timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Timely treatment of sepsis in emergency departments and acute inpatient settings
- Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
- Reduction in antibiotic consumption per 1,000 admissions.

Our success measures have been

A multi-professional deteriorating patient task and finish group has been established reviewing the models and resources available to enhance the detection of, and response to, deterioration in adult medical and surgical inpatients out of hours.

Sepsis screening - The results April 18 to January 19 for both acute and emergency demonstrate that 98% of all patients that met the criteria for sepsis screening were screened for sepsis showing continuous improvement from last year. Year end results confirm the target was met.

Timely treatment – Whilst not achieved throughout the year there have been improvements in Q4 and the target was met with a performance of 92%. The likely reason for the drop in performance in Q2 and Q3 was a change in staff, both with new doctors starting in August and also the departure of the sepsis nurse. A new sepsis nurse has now been in post since December 2018.

Assessment of clinical antibiotic review - There has been a steady improvement in compliance with antibiotic review criteria over the financial year. Targets for the year have all been met.

Reduction in antibiotic consumption - Total consumption increased in Quarter 3 of this financial year, in comparison to Quarter 1 and 2, as is to be expected over the winter period. Overall however we met the target to achieve our 1% reduction in total antibiotic consumption in 2018/19 in comparison to 2017/18 total consumption.

What did we achieve to date?

The Deteriorating Patient Group has multi-professional representation from across all services involved in the detection and response to deterioration including Critical care, Surgery and Medicine. So far the group has:

- Completed a review of clinical incidents related to deterioration
- Completed regular audit of the escalation and response to abnormal National Early warning scores in adult inpatients
- Completed two detailed thematic analyses of case reviews of patients admitted as an emergency to critical care from adult inpatient wards.
- Used this data to inform an updated education plan around deterioration including in-situ simulation, seminars with all clinical departments and updated nurse study days
- Review of the workload and competences of all members of staff involved in providing care to inpatients in the hospital at night
- Options appraisal for different suggested staffing and models of care overnight
- Completed roll-out of the NEWS 2 system of physiological monitoring in January 2019 Completion and roll-out of new guidelines for escalation of deterioration and for referral to critical care

There has been continuous work and training around sepsis recognition and treatment.

A new sepsis nurse has now been in post since December 2018 and the effect of that is evident in the improvement in performance in the last quarter. There are a number of interventions undertaken to improve sepsis awareness including teaching on mandatory training for nurses and doctors, training sessions on wards, close work with PDNs and resus officer to facilitate sepsis training.

The microbiology team continues to monitor use of all antibiotics where indicated and works with pharmacy to provide an education and awareness raising programme, support the Antimicrobial Stewardship Virtual Ward Round, as well as providing feedback to clinical teams regarding progress. There has been a steady improvement in compliance with antibiotic review criteria over the financial year.

We can evidence progress through:

Progress for the deteriorating patient group can be evidenced by the rollout of new teaching sessions, minutes of the meeting of the group and the rollout of the new escalation pathways

What will we do in 2019/20 to continue improvements?

The Trust intends to continue with this important priority in 2019/20.

The deteriorating patient Group will continue to focus on regular data collection looking at escalation and response to deterioration.

Once a new model for hospital at night cover for adult inpatients has been agreed the team will focus on its rollout and reviewing its efficacy

The sepsis nurse role has shown to be invaluable as evidenced by the drop in our performance when the post was vacant. For 2019/20 we will continue with a number of interventions currently in place to increase sepsis awareness. Other future plans include, continuing to provide regular training to both doctors and nurses in ED; in ward SIM training; and raising awareness throughout the hospital with posters on all wards.

We will continue to provide educational initiatives and develop our Trust strategy via antimicrobial management group regarding antimicrobial stewardship, including daily antimicrobial stewardship ward rounds and use of carbapenem-sparing agents where appropriate. We will focus on the promotion of electronic tools (e.g. Medicine Powerplans for Sepsis) to improve antimicrobial stewardship and adherence to guidelines with incorporation of such tools for example into simulation training sessions on acutely deteriorating patients where relevant.

Clinical Effectiveness (Effective)

Priority 4 - To achieve the Quest best employer accreditation - Not Achieved

Background

NHS Quest, of which Homerton is a member, has decided to add to its core role as a quality improvement network by developing an Employment Brand.

NHS Quest were initially attempting to support the 'Best Employer Brand' by developing an accreditation regime designed to assure employers they were focussing on the right things that would ensure they featured in the top 20% NHS trusts to work by 2020 as measured by the NHS staff survey.

Our success measures have been

This work has not progressed as envisaged and subsequently QUEST is currently reflecting on next steps in respect of how to effect quality improvements in this key area for member organisations. Homerton continues to be involved where appropriate.

What did we achieve to date?

2018 Staff Survey feedback indicates that Homerton broadly managed to continue with its previous ratings which indicate that it remains in the top 20% of NHS Trust to work for.

Specifically the 2018 Staff Survey indicates that 70% of staff would recommend the organisation as a place to work and 76% would be happy with the standard of care if a friend or relative needed treatment.

We can evidence progress through

- Staff Engagement Meetings and Action Plan.

- Equality & Diversity Meetings and Action Plan.
- Healthy Homerton Meetings.
- Staff survey completion and results

What will we do in 2019/20 to continue improvements?

The Trust is currently formulating an action plan to generate improvement at corporate and local levels with the aim of achieving an overall improvement in Trust ratings across a range of areas. Significantly priorities at corporate level have been identified as follows:

- Harassment and Bullying of Staff by Patients and Carers
- Equality, Diversity and Inclusion in employment
- Staff Health and Well Being
- Trust Values and Culture
- Appraisal rates consistently high across the organisation.

The Trust plans to include a priority related to staff health and wellbeing in 2019/20.

Priority 5 - Improving services for people with mental health needs who present to A&E – Achieved

Background

It is widely recognised and accepted that people with mental health problems are up to three times more likely to present to an ED than the general population; and are also up to five times more likely to be admitted to an acute hospital. 'Frequent Attenders' to an ED continue to be a 'growing health concern' with research suggesting that each of these ED attendances are not always beneficial for the patient, yet are resource-intense both in terms of clinical time and financially. As such, clinicians in acute settings need to be adequately equipped to recognise urgent mental health needs as well as identifying underlying mental health conditions.

Our aim was to maintain a 20% reduction in attendances to ED for patients within a selected cohort of frequent attenders in 2017/18 and identify a new cohort of frequent attenders to ED during 2017/18 that could benefit from interventions to reduce by 20% their attendances to ED in 2018/19.

Our success measures have been

Maintain 20% reduction in attendances to A&E for patients within the selected cohort of frequent attenders identified in Year 1 (2017/18) – the Trust achieved an 80% reduction.

Identify a new cohort of frequent attenders to A&E during 2017/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19 – the Trust achieved a 60% reduction.

What did we achieve to date?

A summary of the achievements to date is set out below:

- Identify subsets of patients who would benefit from assessment, review and care planning with specialist mental health staff
- Produce care plans for each patient in the cohort, engaging with local partner agencies
- Establish joint governance arrangements
- Establish local data collections to support the evaluation of the CQUIN project
- Provide assurance on EPR recording/coding for patients presenting with MH complaints
- Ensure a system is in place to identify new FA

- Continue to develop and embed service development plans to support sustained reduction in attendances for people with MH needs
- Identify whether the presentations of the patient cohort were recorded/coded correctly on the electronic patient record system
- Agree service development plan to support sustained reduction in attendances for people with MH needs

We can evidence progress through

- CQUIN updates
- Operational Meetings
- Steering Group meetings (HUH and ELFT)
- Urgent Care Quality Meeting
- ED attendance data

What will we do in 2019/20 to continue improvements?

- To continue to monitor, review and analyse frequent attenders and adopt a multi-disciplinary approach to managing this patient cohort.
- To continue developing our understanding on this cohort of patients and their health needs.
- To improve individualised care planning for identified frequent attenders.
- To ensure robust governance systems between acute and community settings and maintain information sharing mechanisms.
- To learn and share experiences on individual case management.

Priority 6 - Improving the management of end of life care for adults. - Achieved

Background

This priority relates to the need that when a patient is dying that they and their family receive the best possible care. This involves ensuring they do not receive unnecessary medical interventions and that care is delivered in line with the 5 priorities of care identified by The Leadership Alliance for The Care of Dying People (One Chance to Get it Right June 2014).

Our targets were to ensure our patients who die within the hospital have an end of life care plan and a treatment escalation plan.

Our success measures have been.

Completion of an individualised end of life care plan ensures individualised needs are identified, regularly reviewed and any nursing interventions evaluated in a timely way. It ensures that the needs of the family are considered and met. This has been achieved in over 70% of cases over 2018/19.

Completing a Treatment Escalation Plan enables the documentation of communication with patients and families around recognition of dying, appropriate treatment options at this time, identification of preferred place of care and death and other priorities for the dying person and their family. With the TEP there is an End of Life Review completed, again ensuring psychological, spiritual and social needs have been considered. This has been achieved in over 70% of cases over 2018/19.

What did we achieve to date?

- In 2018 the Trust launched a revised end of life care strategy for 2018-2021.

- The Trust applied and was granted funding from Macmillan for a two year end of life facilitator post to take forward the strands of the strategy.
- The end of life care plan has been revised to better reflect the needs of the dying patient and their family. The Trust will be introducing a programme of teaching in relation to the new care plan. This went live on EPR in 2019.
- Following consultation with the ward staff, a two hour communication training programme for ward nurses and health care assistants has been delivered to staff on ECU and Edith Cavell.
- An End of Life Care Facilitator started in 2018 and has been establishing and promoting this new post and the Strategy throughout the Trust (inpatient and community).
- In December 2018 we started giving out a bereavement feedback survey to the next of kin of all adult patients that have died in the hospital.

We can evidence progress through

- Maintaining records of training done, attendance numbers and evaluations including doctors training, nurse's band study days, annual update training, ward based training and Simulation training.
- Audits demonstrating a continued increase each quarter in the number of patients at end of life with a TEP (and EOL Review) and nursing end of life care plan.
- Feedback received in the bereavement surveys.

What will we do in 2019/20 to continue improvements?

The Trust is taking forward the aims of the End of Life Strategy 2018-21. These are:

- Personalised End of Life Care
- Supporting our staff
- Improving environment
- Communication and Information.

We will deliver ward teaching re changes to the End of Life Care plan.

Conversations with patients and families about dying have been included in simulation training for nurses and health care assistants and this will continue and be developed for medical staff too.

Patient Experience

Priority 7 - Ensuring staff are actively hearing the Voice of the Child and this is integral to care. – Achieved.

Background

Two key drivers for ensuring that the voice of children and young people is heard, listened to and shape the way in in which Homerton provides services for them are:

In 2015 the CQC published a report which reviewed 50 inspection reports and concluded that the 'voice of the child' was deafeningly silent.

One of the guiding principles that the Trust has signed up to as member of the City and Hackney Safeguarding Children Board is developing a culture which ensures that children and young people are heard through professionals taking the time to listen to what children and young people are saying, putting themselves in the child or young person's shoes and thinking deeply about what their life might truly be like.

Our targets were to ensure; that the voice of the child is included in health visitors safeguarding supervision; children feel involved in decisions about their care; children feel safe as in-patients and staff attend me first training.

Our success measures have been

- 100% Health Visitors have the voice of the child documented on RIO as part of their supervision.
- Over 90% of children sampled felt involved in their care.
- A how safe do you feel pilot questionnaire has been developed.
- Over 30% of relevant staff have attended Me first training

What did we achieve to date?

- Standard Operating Procedure developed for documenting safeguarding supervision on RIO which includes guidance on documenting the voice of the child.
- 24 Safeguarding children supervision records were audited in Q's 3 & 4.
- HV participated in a Voice of the child audit. Report completed and findings have been used to form the basis of a workshop scheduled for 12th April 2019.
- Parents and children on Starlight Ward continue to be asked to complete the patient satisfaction survey using Optimum Technology.
- How safe do you feel questionnaire has been developed and piloted with 36 children aged 8-15 years (the denominator was not established), who were in patients on Starlight ward. The momentum for this work slipped in quarter 3 when the trust quality improvement lead left the organisation.
- Staff (nursing and medical) attended Me first Masterclass

We can evidence progress through

- Dip sample audits of supervision records
- In patient satisfaction feedback report
- 'How safe do you feel' questionnaire developed and piloted.

What will we do in 2019/20 to continue improvements?

Continue work on embedding the voice of the child in clinical practice as an objective in the Safeguarding Children 2019/20 work plan which will be monitored by the Safeguarding Children Operational Forum.

Priority 8 - Improving the first impression and experience of the Trust for all patients and visitors – Not Achieved.

Background

Creating positive first impressions of the Trust for patients, service users and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients, service users and visitors and therefore play a pivotal role in this. We will develop a range of measures to support receptionists and their managers create a positive first impression for every patient, service user and visitor to the Trust at every visit.

Our targets were to initiate a quality improvement project with non-clinical outpatient staff, increase the numbers of staff attending the effective receptionist course and developing first impressions standards.

Our success measures have been

A Quality Improvement project has been established looking at measuring ourselves against best practice, identifying expected behaviours and barriers and enablers to delivering this and measures to support delivery.

There is an action plan for the First Impressions project and it included the need for 50% of the receptionist staff to undertake the Effective Receptionist training. The uptake of training was not fully taken up.

A draft set of first impression standards has been produced aiming to create a positive first impression which will help to provide consistency across the Trust.

What did we achieve to date?

First Impressions Workshop Sept 2018 attended by 20 receptionists from a range of teams including reception managers, Head of Learning and Head of Patient Experience. The session explored three questions to help inform an action plan.

- What does the Trust need to put in place to ensure that 'first impression' standards can flourish?
- What are the things that currently get in the way and prevent us from delivering a positive first impression?
- What are the factors that will help you deliver a positive first impression?

A draft First Impressions Standard was proposed and a number of areas agreed to support its delivery including recruiting staff with the right attitude, competencies and training, supporting staff to consistently exhibit behaviours.

We can evidence progress through

A draft set of First impression Standards has been developed including code of behaviours. An action plan has been created which will form the basis of the work plan for the first impression steering group to deliver. Additional Effective Receptionist courses have been commissioned for 2018/19.

What will we do in 2019/20 to continue improvements?

Refresh the action plan, meeting membership and key priorities. Review the Effective Receptionist training to ensure it is tailored to the new standards. The initiative will be project managed in line with the QI principles. A new OPD Manager has been appointed and will give the initiative a refreshed launch.

Priority 9 - For patients who on discharge are receiving one or more community services for their discharge to be seamless and communication between all services enhanced. – Achieved.

Background

Improving discharge from hospital is a key priority for the trust. This has previously been shown to be an area that could be improved on and that affects both patients and the effective operational performance of the hospital. While considerable work was done in 2017/18 with hospital services including wards and multi-disciplinary teams to better facilitate discharge, greater focus has now turned to enhancing the community-facing services involved in supporting discharge.

Our targets were to develop a patient information leaflet in relation to discharge services offered; implement a discharge to assess pilot; ensure continuing care assessments are completed in the community and ensure continuing care assessments are completed within 28 days.

Our success measures have been

A discharge patient information leaflet has been developed and is awaiting approval.

What did we achieve to date?

A patient information leaflet has been produced describing the range of the discharge related services.

The discharge to assess pilot has been implemented and assessed.

We have achieved our target of 85% continuing healthcare (CHC) assessments complete in the community, unless exempt by agreement.

We have achieved our target of 95% CHC assessments to be completed within 28 days.

We can evidence progress through

Minutes or action logs of meetings including Medical Productivity Group, CQUIN Board, Integrated Discharge Steering Group and Unplanned Care Board

What will we do in 2019/20 to continue improvements?

- To ratify patient information leaflet
- To seek data for other D2A services as a comparator
- To maintain delivery of local CHC CQUIN
- To ensure on-going attendance and effective functioning of various groups identified above.

Priority 10 - To implement a complete electronic postnatal discharge process with a failsafe element to ensure timely and appropriate delivery of postnatal care to mothers and babies once transferred from hospital into the community setting. - Achieved.

Background

Datix incident reports identified a trend in 'missed' postnatal discharges from inpatient areas to community care to Homerton and out of areas (16 missed discharges in January 2018). This resulted in mothers and babies having delayed home visits and therefore the schedule of postnatal care in the community not being followed. This was of serious patient safety concern as mothers and babies were having essential care and screening tests delayed, which in turn has the potential for harm.

Following review it was identified that the missed discharges were occurring in both the transfers of care to Homerton's community services and out of Homerton area community services. It was also identified that the missed discharges were coming from all inpatient areas that process Incorrect Homerton community zone/out of area hospital identified by midwife to be notified of discharge.

There were a number of reasons why discharges were not reaching appropriate community teams, it was decided that a new process was to be implemented to cut out the manual process of paper notification and minimise the number of individuals involved in the process to reduce the risk of errors being made.

Our targets were to ensure postnatal discharges are sent electronically, daily failsafe checks were being made and missed discharges were reported on Datix – with the aim of having 0 missed discharges by March 2019.

Our success measures have been

As part of the new process, sending of the discharges electronically is mandatory as there is now no provision for paper copies to be collected. This has been successful with 100% compliance.

The daily failsafe check is completed by two different teams; Community complete the failsafe to check they have received all of the Homerton community discharges, and Delivery Suite complete the failsafe to check all of the out of Homerton community area have been sent. There was a decline in the compliance with this in Quarter 2, which was identified when missed discharge incidents were being reported. Both the Delivery Suite and Community leads have identified the issues which lead to not achieving 100% compliance with the daily failsafe.

Although the target of 0 missed was achieved in March 2019, prior to this there were low levels of incidents monthly. It is however evident that there has been a clear reduction since the implementation of the new process and failsafe.

The main reasons for discharges being missed were;

- Discharge not sent on day of discharge, and failsafe not done therefore missed discharge not identified
- Discharge sent to incorrect out of area hospital – no notification from other hospital or notification not acted upon due to the failsafe not being done

The missed discharges are generally identified by families calling the maternity helpline to inform them that they have not had their expected visit, or the health visitor informing us. All missed discharges would be identified at the latest by the national Northgate Newborn Blood Spot (NBBS) failsafe system which would identify a delayed NBBS sample. All are logged via Datix and reviewed and actioned by the line manager of the area that the client was discharged from.

What did we achieve to date?

- Standard Operating Procedure implemented for new discharge process
- Datix reporting and investigation of any missed discharges
- Staff support in implementing the new process including training, discussion at team meetings, written feedback
- Monitoring of incident trends via the maternity trends report with feedback to staff
- Updates at team meetings
- Focus on ensuring failsafe completed daily, including further training
- Putting processes into place to ensure failsafe is completed when core members of the administration team are not working

In late Quarter 4, implementing the London-wide map to support ensuring discharges are sent to the correct hospital.

We can evidence progress through

Gradual reduction in missed discharges and maintenance of lower level of incidents. There is a continued focus on discharge incidents. In March 2019, we achieved the aim of 0 missed discharges.

What will we do in 2019/20 to continue improvements?

- Further work with administration teams to work towards the aim of 100% compliance with the daily failsafe, including further training and audit.
- Continued reporting via Datix of any missed discharge to identify any training or system issues.
- Continue to embed the use of the London-wide electronic map to support the staff to select the correct hospital for discharge.

3.2. Review National Performance Indicators

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016. Please note Summary Hospital-level Mortality Indicator (SHMI) Clostridium difficile and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Homerton endeavours to meet all national targets and priorities. Below is a summary of the national targets and indicators.

Cancer Waits

Table 13: 62 day cancer waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Cancer: 62 day wait for first treatment (from urgent GP referral for suspected cancer)	85%	87.70%	81.70%	83.90%
Cancer: 62-day wait for first treatment (from NHS Cancer Screening Service referral)	90%	66.67%	100.00%	100.00%

Data source: Somerset Cancer database

The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and is a significant improvement against last year's performance. The Trust continues to place significant focus on the delivery of this standard via its fortnightly Cancer Access Board. It should be noted that the improved performance has coincided with the appointment of a new Head of Access. With regard to the screening target, it should be noted that although the performance is below the 90% standard, this relates to a total of three treatments, of which one treatment was recorded as a breach.

Referral to Treatment Time

Table 14: Referral to treatment time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Referral to treatment time (incomplete pathway) - within 18 weeks	92%	96.71%	96.18%	95.30%

Data source: Homerton EPR/RIO

The Trust has continued to perform strongly against the 92% standard and has met the standard for every month of 2018/19, despite increase demand for its outpatient services. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Accident and Emergency (A&E)

Table 15: A&E waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
A&E - total time in A&E under 4 hours (from arrival to admission/transfer/discharge)	95%	94.34%	94.73%	94.10%

Data source: Homerton EPR

The Trust has seen an improvement in its overall performance against the total time in A&E standard in 2018/19, although overall the Trust has not delivered the 95% standard. However, it is of note that the standard has been delivered in five months over the course of the year.

Diagnostic procedures

Table 16: Diagnostic procedure waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Maximum 6 week wait for diagnostic procedures	99%	99.77%	99.97%	N/A

Data source: Homerton EPR

The Trust has consistently performed strongly against the six week wait standard for diagnostic tests despite on-going increases in demand. Whilst performance has been compliant overall on a monthly basis, there have been some instances where the standard has not been met within individual modalities. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Improved Access to Psychological Therapy (IAPT)

Table 17: IAPT waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Proportion of people completing treatment who move to recovery (from IAPT* database)	50%	60.45%	56.65%	N/A
Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	75%	96.50%	93.87%	84.4%
Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	95%	99.52%	99.42%	99.1%

Data source: Patient Case Management Information System

The Trust has continued to deliver its core IAPT targets throughout 2018/19 and performance has improved compared to 2017/18 across the three core standards.

3.3. QUALITY IMPROVEMENT AT HOMERTON

'Quality Improvement' (QI) can be defined as an approach to improving service quality, efficiency and morale simultaneously, using improvement science. It is part of a broad range of activities known collectively as 'improving quality'. QI uses systematic methods to involve those closest to the quality issues in developing solutions to a complex problem. The systematic method used at the Trust is the Institute for Healthcare Improvement (IHI) Model for Improvement.

Building and fostering QI knowledge and skills

During 2018/19 the QI team priority has been building QI knowledge and skills in staff (clinical and non-clinical) whatever the service they deliver or the role they play. QI has been incorporated into the organisational development activities aimed at fostering an 'improvement mindset'. We have introduced a QI session into the induction of staff that have managerial or supervisory duties because we want every team to be empowered and supported to use QI to improve the care provided.

The Trust Leadership Level 2 programme 2018 for the first time included QI tools and approaches with bespoke teaching from the QI team as well as one to one coaching for each of the participants. The nurse preceptors also benefitted from QI teaching and support. Staff in both of these programmes completed high quality QI projects, produced posters and presentations sharing their findings widely through the QI Forum, audit days and Research and Development conferences. These projects delivered improvements in the efficiency of systems and processes reducing the time patients wait for care, decreasing the time taken to administer or dispense medication, improve patient and staff confidence and levels of feedback as well as safety through better reviews and assessments of patients.

The QI Forum was launched in June 2018 as a place for staff to share QI project activities with colleagues from across the Trust. Presentations and discussion highlight issues, findings and solutions that are transferable. As a regular participant fedback 'I like the learning – there's always something to take away'. The Improving Quality Board, co-chaired by the Medical Director and the Director for Organisational Transformation, is responsible for a strategic overview of the broad range of improvement activities from mortality reviews to themes from patient feedback and patient safety and effectiveness which shape QI project priorities.

Lessons from the QI team's work with preceptor nurses, as well as the 'Improving Trust and Confidence in Nurses' workstream, is being used to develop a Chief Nurse QI Fellow programme, specifically for Band 5 nurses. This will run from April 2019. Staff groups such as Allied Health Professionals and doctors in training are already in the forefront of putting QI into practice. The team provide teaching and advice to these groups as part of their induction, learning and development programmes. All staff undertaking QI projects are encouraged to align their projects with Trust and service priorities and to include patients/clients and service users as key partners.

Working in partnership

Partnerships are crucial to the Trust's QI approach. Homerton is part of UCLPartners (Academic Health Science Network) and shares QI projects using the LIFE collaboration and data analysis platform. The Trust subscription to the IHI also provides staff with access to e-learning and to international QI cases studies and resources.

Homerton is also an active participant in the QUEST network of 16 NHS organisations which are committed to focussing on improving quality and patient safety. The Trust contributes to the QUEST 'Best Employer Brand' initiative because we recognise that high levels of staff engagement improve the quality of patient care.

Homerton QI in the City and Hackney health economy and beyond

The QI team ethos is to bring QI support to wherever teams are based. For example, we have built on the 'lunch and learn' QI sessions for Adult Community Nursing teams and practice nurses in the south west of City and Hackney to improve communication between practitioners to provide seamless care to clients. The QI team is part of a project using Experience Based Co-Design principles and methods to develop and deliver better services and solutions with and for patients. This is an exciting opportunity to use QI principles in 'Neighbourhoods' or place based models of care.

One of three 'transformation' projects ongoing during 2018/19 related to mobile working in community service teams. This project took a holistic approach to examining how the benefits of mobile working could be realised in three services which included different care models e.g. adults and children's services and therapy and nursing teams. 'Time in motion' studies were conducted using validated tools together with assessing staff and patient/client experience and attitudes to the use of technology. Recommendations for action are informing the development of IT systems and place based 'Neighbourhood' care models. This work aligns with the North East London Sustainability and Transformation Plan: investment in and development of technology and delivering paper-free care at the point of use.

Homerton has a track record of developing technology enabled healthcare, such as electronic patient records and sharing information efficiently and securely across health organisations via the Health Information Exchange (HIE). In July 2018, Homerton organised and hosted an event for NHS partners in the Quest network focussing on this theme. Homerton Experience Day included immersive sessions for participants to see the HIE in action in the hospital and try out Voice Recognition software to produce clinic letters. We showcased the latest thinking from Homerton staff harnessing the power of wearable technologies to help patients manage long-term conditions and the proposed use of Artificial Intelligence to screen and triage referrals. The event included insights from Dr Simon Eccles, Chief Clinical Information Officer for Health and Care, the Northern Care Alliance (a Global Digital Exemplar) as well as an opportunity to explore the positives and pitfalls of technology in healthcare through a lively debate.

The Surgical Transformation Programme aims to increase efficiency and productivity in surgical services. Staff used skills developed in the Quest Improvement Science for Leaders (IS4L) to improve the percentage of patients undergoing gallbladder removal to go home safely on the day of the procedure. Theatres team members also took part in the 'Improving Theatre Safety Collaborative' which used a clinical communities model to drive and sustain improvements in outcomes.

Homerton has again been successful in winning a place on the IS4L programme in 2018/19. The team project is called 'Mind the Gap' and is focussed on decreasing the late diagnoses of speech, language and communication needs in children and young people living in Hackney.

QI Futures 2019/2020

Homerton's QI activities in 2019/2020 aim to support the Trust's ambition to be a provider of 'Outstanding' care. The QI approach is in line with the Care Quality Commission (CQC) guidance on trusts with a maturing QI function. Key priorities will be to develop and embed better use of data and qualitative information, improve how we work in partnership with patients and service users, sustain and spread successful QI projects and communicate and raise awareness of QI in innovative and compelling ways.

APPENDIX A. LIST OF NATIONAL AUDITS AND CONFIDENTIAL ENQUIRIES 2018/19

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
Adult Community Acquired Pneumonia (BTS)	✓	✓	-	73	-
Case Mix Programme (CMP)	✓	✓	578	578	100%
NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults	✓	✓	-	4	-
Elective Surgery (National PROMs Programme)	✓	✓	294	375	78%
Falls and Fragility Fractures Audit programme (FFFAP)*	✓	✓	96	96	100%
Feverish Children (care in emergency department)	✓	✓	120	120	100%
Inflammatory Bowel Disease (IBD) programme	✓	✓	982	982	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	3	3	100%
Major Trauma Audit	✓	✓	136	-	-
Mandatory Surveillance of bloodstream infections and *Clostridium difficile* infection	✓	✓	54	54	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme(MBRRACE)	✓	✓	53	53	100%
NCEPOD - Medical and surgical clinical outcome review programme - Perioperative diabetes	✓	✓	3	4	75%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism	✓	✓	-	-	100%
NCEPOD - Medical and Surgical Clinical Outcome review programme - Acute Bowel Obstruction	✓	✓	7	7	100%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Acute Heart Failure	✓	✓	3	5	60%
Myocardial ischaemia National Audit Project (MINAP) *National Cardiac Audit Programme (NCAP)*	✓	✓	278	278	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)* *Secondary care*	✓	✓	90	90	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	x	-	-	-
National Audit of Cardiac Rehabilitation	✓	✓	224	420	53%
National Audit of Care at the End of Life (NACEL)	✓	✓	28	28	100%
National Audit of Dementia (in General Hospitals)	✓	✓	56	50	100%
National Audit of Intermediate Care (NAIC)	✓	✓	73	73	100%
National Audit of Seizures and Epilepsies in Children and Young People	✓	✓	36	49	73%
National Bariatric Surgery Registry (NBSR)	✓	✓	193	193	100%
National Bowel Cancer (NBOCA)	✓	✓	90	90	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	17	17	100%
National Clinical Audit for Rhematoid and Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	16	29	55%
National Comparative Audit of Blood Transfusion programme*	✓	✓	11	30	36%

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
National Diabetes Audit*	✓	✓	13958	13958	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	63	63	100%
National Heart Failure Audit (NCAP)	✓	✓	301	301	100%
National Joint Registry (NJR)	✓	✓	198	198	100%
National Lung Cancer Audit (NLCA)	✓	✓	144	144	100%
National Neonatal Audit Programme (NNAP)	✓	✓	1395	1466	95%
National Oesophago-gastric Cancer (NAOGC)	✓	✓	47	47	100%
Non- invasive ventilation Adults (NIV) (BTS)	✓	✓	-	3	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	✓	✓	6537	6537	100%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	152	153	99%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	✓	✓	7	7	100%
Surgical Site Infection Surveillance Service	✓	✓	1	1	100%
Vital Signs in Adults (care in emergency departments)	✓	✓	122	120	100%
VTE risk in lower limb immobilisation (care in emergency departments)	✓	✓	150	150	100%

*Multiple work streams

1. *Adult Community Acquired Pneumonia. We are submitting data with a deadline of 31/05/2019. 100% data submission is anticipated.*
2. *NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults- we are awaiting individual patient questionnaires. 100% data submission is anticipated.*
3. *Major Trauma: the expected number of cases is based on HES and EPR data and may not always reflect the true number of cases that are eligible for the audit. Therefore, it may appear that not enough cases were submitted for the audit. As we are a level 1 trauma centre, the majority of trauma cases would go elsewhere and would be captured through the Major Trauma data at tertiary centres. 100% data submission is anticipated for cases identified.*
4. *National Audit of Breast Cancer in Older People – The Trust did not submit the required data by the deadline.*
5. *NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism – Only organisation questionnaire required and was submitted.*
6. *Non- invasive ventilation Adults (NIV) We are submitting data with a deadline of 31/06/2019. 100% data submission is anticipated.*
7. *LeDeR audit became mandatory on the 1st of March 2017 and we have had no patients who met the criteria to date.*
8. *National Comparative Audit of Blood Transfusion programme. Despite the numbers of eligible patients not all patients will have received either FFP or massive transfusions and therefore will not have required an audit response. All patients who met the criteria in the period were audited.*

APPENDIX B. 2018/19 CQUINS

No.	National Indicator	Description of Indicator	Indicator weighting acute & community £
1a	**Improvement of health and wellbeing of NHS staff**	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.	127,754
1b	**Healthy food for NHS staff, visitors and patients**	Maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 and introducing 3 new changes	127,754
1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	Year 1 – Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2- Achieving an uptake of flu vaccinations by frontline clinical staff of 75%	127,754
2a	**Timely identification of patients with sepsis in emergency departments and acute inpatient settings**	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	75,935
2b	**Timely treatment of sepsis in emergency departments and acute inpatient settings**	The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.	75,935
2c	**Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours following the review criteria**	Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours following the review criteria	75,935
2d	**Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both in- patients and out-patients) within the Access AWaRe category.**	1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	75,935
4	**Improving services for people with mental health needs who present to A&E**	For 2018/19: 1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. 2. Identify a new cohort of frequent attenders to A&E during 17/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. In year 2, it is expected that the cohort will include groups who experience particular inequalities in access to mental health care (see below for further detail). Ensure that mental health attendances to A&E are recorded and submitted to the Emergency Care Dataset.	300,530
5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).	79,521
6	**Advice & Guidance**	The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	300,742
9a	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening**	Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	15,187

9b	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**	Percentage of unique patients who smoke AND are given very brief advice	60,748
9c	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication**	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	75,935
9d	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	75,935
9e	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral	75,935
10	**Improving the assessment of wounds**	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	106,028
11	**Personalised care and support planning**	Embedding personalised care and support planning for people with long-term conditions.	106,028
LO CAL	**Continuing Healthcare Assessments, reviews and best practice management**	This CQUIN aims to improve the care and support provided to people in receipt of continuing health care funded by City and Hackney CCG.	106,028

No.	NHSE Indicator	Description of Indicator	Indicator weighting - 2%
GE2	**GE2: Activation System for Patients with LTC**	To ensure patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition)	£42,875 0.31%
B13	**B13 – Automated Exchange Transfusion for Sickle Cell Care**	Patients with sickle cell disease require exchange transfusions to manage their condition. This can be done manually or using automated exchange. This CQUIN scheme aims to incentivise the use of automated exchange by specified specialist centres in order to improve patient experience and use of clinical resources.	£316,314.93 1.18%
B14	**B14 - Sickle Cell ODN**	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	£77,738.42 0.29%
	Neuro-Rehab	• Reduce unnecessary duplicate referrals and the time spent in waiting for assessment • Reduce the number of 'rejected' referrals rejected simply because the information is not complete. • Improve patient experience data at a unit level • Bring Level 1/2a neuro-rehabilitation services more fully into a 'system' of care in each STP in the London.	£58,973.97 0.22%

	CQUIN – DENTAL		Indicator weighting 2%
	Activity reporting by Referral to Treatment (RTT) for each dental specialty	Collection and submission of data for dental pathways using the CQUIN RTT dashboard.	£32,388

	Acute Dental Systems Resilience Group	Participate in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling.	£32,388
	Use of the acute dental portal	Develop a central storage system for all documents/ correspondence relating to acute dental activity and data	£32,388
			£97,164

No.	**Public Health Indicator**	**Description of Indicator**	**Indicator weighting DESP 2.5% , Bowel 2%**
DESP	**Improve outcomes and reduce risk of complications for patients with diabetes through implementation of Making Every Contact Count (MECC) project with patients attending for diabetic eye screening.**	London DES services to implement tailored MECC projects that will contribute to improved health and wellbeing of service users and support uptake of approved Diabetes Structured Education programmes, through facilitating referral of patients with diabetes. To include: • Development and implementation of CQUIN project plan in collaboration with and in alignment with STP Diabetes programme priorities. • Service protocol to include defined target patients • MECC training to support staff interventions with patients and evaluation. • Mechanisms to track MECC interventions and numbers of referrals • End of project evaluation	£76,792
	Bowel Scope Patient Experience Survey	Improve patient experience of Bowel Scope through conduct of Patient Feedback Survey and Focus group for all those who attend bowel scope at North East London screening site. Results from surveys will feed into local screening service improvement plans	£56,019

No.	**STP Indicator**	**Description of Indicator**	**Indicator weighting acute & community £**
STP	**STP CQUIN**	This CQUIN seeks to engage providers within the ELHCP in order to play a full part in the development and implementation of the productivity, efficiency and quality improvement schemes as well as supporting the development of the ELCHP and wider system management. A number of specific indicators have been set out with milestones for achievement, however, there are pre-conditions requirements that need to be met first	£1.8m

APPENDIX C: GLOSSARY OF TERMS AND ABBREVIATIONS

CCG	Clinical Commissioning Group
C-Diff	Clostridium Difficile
CEO	Chief Executive Officer
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy grading system
CLIP	Complains, litigations, Incidents Pals meeting
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission – The independent regulator of health and social care in England
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
DH	Department of Health
ED	Emergency Department
EoL	End of Life
EoLC	End of Life Care
EPR	Electric Patient Record
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement Partnership
HUHFT	Homerton University Hospital Foundation Trust
IAPT	Improving Access to Psychological Therapies
ICEC	Improving Clinical Effectiveness Committee
IG	Information Governance
IGT	Information Governance Toolkit
IHI	Institute for Healthcare Improvement
ITU	Intensive care unit
MDT	Multidisciplinary Team
MSK	Musculoskeletal
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Scores
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PbR	Payment by Results
PE	Pulmonary Embolism
PrEP	Pre-exposure Prophylaxis
PROMS	Patient Reported Outcome Measures
PUSC	Pressure Ulcer Scrutiny Committee
QI	Quality Improvement
R&D	Research & Development
RA	Rheumatoid arthritis

RCA	Root Cause Analysis
RiO	RiO (Community EPR*) - RiO is a secure, Electronic Patient Record (EPR) which is used by Homerton's Community Services in Hackney and the City as their primary clinical system
Sepsis	A life-threatening illness caused by the body's response to an infection. 'Red Flag Sepsis' is one or more criteria identified using the UK Sepsis Trust Sepsis Risk Stratification
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SLT	Speech and Language Therapy
SOP	Standardised Operating Procedure
TTC	The Trust Thrombosis Committee
VTE	Venous Thromboembolism

ANNEX 1: STATEMENTS FROM CLINICAL COMMISSIONERS, LOCAL HEALTHWATCH AND OVERVIEW AND SCRUTINY COMMITTEES

The Trust is grateful to all our scrutiny committees including our commissioners for their work in reviewing and responding to our quality account 2018/19 report. As part of 2019/20 quality improvement work, we will consider the points raised with the purpose of making continuous improvements to the care we provide to our patients.

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

8 May 2019

Ms. Catherine Pelley
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Trust Offices
Education Centre
Homerton Row, E9 6SR

Email to: c.pelley@nhs.net

Dear Catherine

Response to HUHFT's draft Quality Account for 2018/19

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2018-19. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The Commission Members take a great interest in the performance of our key local acute trust and were pleased to learn about some of your key achievements over the past year. Your overall '*Good*' rating in May 2018 from the CQC across all services and the '*Outstanding*' ratings for Medical Care and for Urgent and Emergency Services is to be commended. We note also the additional new Improvement Priorities you have set for 2019/20.

During the past year we have continued to enjoy a good working relationship with the Trust and we greatly appreciate the willingness of the Trust's representatives' to attend our Commission meetings and contribute to our work.

Your Chief Executive attended our June and September meetings where we discussed a range of issues including the proposals for reconfiguring the pathology service. Local residents and GPs continue to have concerns about the Path Lab consolidation and the proposed revised structure across the NEL area, therefore we will continue to pursue this with you over the coming year.

In September your CE also took part in a high level discussion item on the Estates Strategy for North East London with senior executives from the CCG, the Council and ELFT and she also contributed to the debates at the Inner North East London JHOSC on both the NEL Estates Strategy and the implications for east London of the NHS Long Term Plan. We will continue to

pursue these discussions with you this year as hopefully outline proposals will emerge in particular for the St Leonard's site. We hope to organise an engagement event on this later in the year.

In November your CE took part in a discussion on the implementation of the Overseas Visitor Charging Regulations after the impact of these on vulnerable migrants was raised with us by Hackney Migrant Centre and local GPs. We have since had a response to our letter to the Secretary of State. The Health Minister has made clear that these rules must be implemented sensitively and sensibly and we would ask therefore that, while there is no direction on you to monitor these impacts, that you do so, because of the level of local concern about their impact.

We are also grateful to your Director of IT and Systems who has also contributed to our own review on '*Digital first primary care'* in his capacity as the lead officer for City and Hackney Integrated Commissioning IT Enabler Group.

We wish to make the following specific comments on your draft Quality Account noting that it is an early draft:

a) Re p.15 again this year there is an absence of data relating to the new requirement to report on 'Learning from Deaths'. How is this being rectified?

b) Re p.16 on 'Seven Day Services' you say that because the numbers are low it has been a challenge to develop appropriate Consultant rotas across the surgical specialities. One presumes the numbers are low because this is just starting? You also say that having a 12 hr Consultant presence is sufficient yet this is not in compliance with this particular NHS priority clinical standard.

c) Re p.16 you describe the two new 'Freedom to Speak Up Guardians' to support whistleblowers, but give no evidence about how busy they have been? Is this policy working?

d) There has been a lot of media coverage this year nationally of junior doctors experiencing bullying and working for dangerously long periods. On p.16 you describe the 'Guardian of Safe Working' which you now have in place in response to the new junior doctors' contract. Can you give us examples of how often s/he might have intervened on issues regarding your rota gaps?

e) The Trust is to be commended for your significant progress in reducing the C-Difficile rates to just 3 in 2018/19 and for being one of the best performing Trusts nationally on this indicator.

f) You are to be commended for making steady progress on End of Life Care issues but, re p.32, why have only 70% of cases had 'End of Life

Care Plans' or 'Treatment Escalation Plans' during 2018/19. What are the barriers here and how are you addressing them?

a) Re p.35 on the "improving first impressions" indicator why has there been such poor uptake of training by receptionists and surely this should be mandatory?

b) Your reporting on Priority 9 on seamless discharge makes no reference to the 'Discharge to Assess' pilot which we've been informed about by the Integrated Commissioning Unplanned Care Workstream. Why is this?

c) Re p.36 the series of missed post-natal discharges was serious and resulted in mothers and babies having delayed home visits and follow up. You implemented a new failsafe system. Is there now 100% compliance on this?

d) The Trust's improvement on IAPT waiting time targets is to be commended.

We look forward to taking up these issues with you over the next year on the Scrutiny Commission.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Tracey Fletcher, Chief Executive, HUHFT
Cllr Feryal Demirci, Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks Dr Sue Milner, Interim Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

healthwatch Hackney

May 15th 2019

Dear Catherine,

Healthwatch Hackney contribution to the Homerton Hospital Quality Account 18-19

Thank you for sending us the draft Quality Account for review. Please find below our response to the Homerton University Hospital's Quality Account for 2018-19.

Co-production of Service Improvements for Patients

We would welcome a new approach to our engagement with your annual Quality Account. It seems under the current system we contribute each year to the Account, yet there is no clear feedback on how our proposals and recommendations are taken on board and influence service improvement for patients. As you know Healthwatch has the following statutory responsibilities, which require both submission of our proposals for service improvement and evidence that these have been acted on or reasons provided for not doing so:

a) promoting and supporting the involvement of local people in the provision and scrutiny of local care services;

b) enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;

c) obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;

d) making reports and recommendations about how local care services could or ought to be improved. These should be directed to providers of care services, and people responsible for managing or scrutinising local care services;

e) formulating views on the standard of provision and whether and how the local care services could and ought to be improved.

1) Presentation of the Quality Account

We would like to see a more accessible Quality Account, the Account from 16-17 was outstanding: interesting, an enjoyable read, well presented and accessible. This year's report and last year's has returned to previous style which is much less

The Adiaha Antigha Centre, 24-30 Dalston Lane, E8 3AZ
www.healthwatchhackney.co.uk Main Number: 020 7923 8188
Limited Company No: 08457463

comprehensible and would be difficult to understand for people in the community without a clinical background. It is too long, and segmented in a way that prevents the easy access to the many achievements that you record.

It is not clear who the report is intended for, but it is written as an internal technical document for staff and to satisfy the requirements of NHS Improvement. We strongly believe the report should be written in a way that is accessible to local people, celebrates your achievements and identifies areas for improvement and the means of achieving those aspirations.

Our key areas for service improvements are as follows:

1) **Pressure ulcers** – we recommend that in the community, any signs or symptoms of early development of ulcers identified by care workers, is placed in nursing notes kept in the patients' residence, or shared with health professionals using a process agreed between care worker agencies and the HUH or primary care. Information for families about the identification of early signs of pressure ulcers in the community would be valuable.

2) **Deteriorating patients** – this terminology may be very distressing to patients and their families/carers. We recommend that other terminology is used in any documentation visible to patients/family and that information about this condition is provided in a ways that is accessible, understandable and meaningful to patients, families and carers.

3) **Sepsis** – it would be useful if the QA could report on HUH's progress with implementation of NEWS 2 and how this has so far impacted on the incidence of sepsis, including reported deaths from sepsis on the past three years.

4) **End of Life Care** – the use of the term End of Life Board sound strange. Adults are mentioned but not children our young people. Supporting family is not mentioned. Access to minutes of the Board meeting for Healthwatch would be useful to give us greater insight into the developing work being carried out.

5) **Making Every Contact Count** – great idea, but implementation and developing appropriate metrics would seem to be a difficult aspiration to achieve.

6) **Learning from Complaints** – we are concerned about the effectiveness of PALS and impact of joining this service to complaints. A certain amount of independence is needed for PALS to be effective. We welcome a more effective process to demonstrate how complaints can result in enduring improvements in patient care and treatment. Feeding this information back to

1) patients is also very important. This need to know that their contribution has had a real impact on services. HWH will be testing the system using a mystery shopper exercise. We would welcome participation in the learning from complaints process.

Other issues:

a) The research section 2.2.3. is very interesting but not accessible to public. Improvements to the layout and language could be make this section much more accessible. There should be evidence that patients participating in trials are given feedback about the impact and outcomes of trials.
b) Section 2.2.4. is not about enhanced quality arising from the CQUINS, but about payments for achievement of CQUINS.
c) Patient safety incidents charts on pages 24/25 appear to have data presented in reverse.
d) Discharge planning – in relation to patients with dual diagnosis of mental and physical health problems does discharge planning start when the patient is admitted to a HUH ward and what is the process to ensure post discharge support in relation to both physical and mental health?
e) Dissemination of Complaints Charter and Poster to all clinical spaces, e.g. wards, OPD, front desk, waiting areas.
f) Accountability for ensuring prescription of appropriate medicines. Is it possible for a doctor to diagnose a patients condition, e.g. a VTE, record this in the patient's notes but not take action to ensure that appropriate medication is prescribed and provided to the patient. This accountability gap needs to be removed.

Additional Recommendations from HWH

1) **Access to Community Equipment.**
Problems with access to equipment for some people in the community who require equipment for mobility, access and to ensure their safety, is causing delays due to problems with the supplier (Millbrook). Delays in access to equipment can result in poor discharge arrangements and have resulted in patients developing pressure ulcers. In some cases the wrong equipment has been provided. The contract is held by Hackney Council and the City of London.

HWH recommends to joint approach between HUH and HWH to both Health and Wellbeing Board to get their support to ensure proper governance of the Millbrook contract and consequently the enhancement of service quality for patients.

2) **Clinical Follow-Up in the Care of Young People in the Fracture Clinic**
The system for following up young people who are referred to the fracture clinic needs to be reviewed. If a young person is referred to the fracture clinic and fails to attend, there is no certainty that the person will be followed up through the parents and GP causing potential harm.

HWH recommends that the non-attendance of a young person at a fracture clinic, should be subject to positive action to ensure that the person has either been treated elsewhere or that the parents and GP are aware of the importance of attending for the referral appointment.

3) **Mental Health – Delayed Transfers**
In the 2018 Quality Account, we asked for evidence of urgent plans to stop extended waits for patients requiring psychiatric care. This issue was raised because of unacceptable delays in the transfer of some patients, because the person's home CCG has not agreed to spot purchasing of an ELFT bed, or a failure of locate a bed in the person's home borough. Such delays are a clear breach of the duty of 'parity of esteem'. Unfortunately, this problem continues, e.g. a patient recently waited in Homerton A&E for at least 15 hours for transfer to a bed in Lewisham Hospital.

HWH recommends that HUH and ELFT jointly agree that no patient requiring an urgent mental health will be left to wait in A&E as this is a potential source of harm to a person in a mental health crisis.

4) **Ensuring Implementation of Ward Round Decisions**
During ward rounds the consultant may request the junior doctor to implement decisions regarding prescriptions for drugs and other forms of treatment. The junior doctor is expected to implement decisions 'on the run' and may not be able to do so because of the pressure of ward round or demands on the doctor's time immediately after the ward round.

HWH recommends that doctors have protected time after a ward round to ensure that patients get the medication and aids that they needs, and that doctors are provided with IPADs (or similar) to enable them to quickly requests prescribed medications.

We hope you find our contribution and comments helpful.

Yours sincerely

Jon Williams

Executive Director

CC: Malcolm Alexander (HWH Board member)

The Adiaha Antigha Centre, 24-30 Dalston Lane, E8 3AZ
www.healthwatchhackney.co.uk Main Number: 020 7923 8188
Limited Company No: 08457463

NHS
City and Hackney
Clinical Commissioning Group

Commissioners Statement for Homerton University Hospital NHS Foundation Trust 2018/19 Quality Account

NHS City and Hackney Clinical Commissioning Group (CCG) is the lead commissioner responsible for commissioning health services from Homerton University Hospital NHS Foundation Trust on behalf of the population of the City of London and the London Borough of Hackney.

Thank you for asking us to provide a statement on the Trust's 2018/19 draft Quality Account and priorities for 2019/20.

The Trust set itself ten challenging quality priorities for 2018/19. We note progress for the majority of these priorities and congratulate the Trust for aiming high. We support the Trust's work to develop metrics for the 2019/20 priorities to enable the Trust to celebrate success at the end of this year.

We congratulate the Trust on consulting with patients, staff and stakeholders on the 2019/20 priorities.

The Trust's recent CQC inspection illustrated the outstanding work taking place to improve quality of care with an overall rating of Good and improved ratings for maternity services and medical care, the latter now rated as Outstanding along with emergency care. We congratulate the Trust on their journey to move from Good to Outstanding and hope to support and contribute to this achievement going forward.

We are very pleased to see sustained improvement to patient experience scores as measured by the CQC National Inpatient survey linked to the work undertaken over the last few years to improve nurse communication skills and patient centered care. The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and there has been a significant improvement against last year's performance. The Trust has continued to deliver its core psychological therapies targets in 2018/19 and again performance has improved compared to 2017/18. We congratulate the Trust again for their performance in relation to the four hour A&E target. The Trust's approach to the new mortality review requirements is exemplary and a high percentage of unexpected deaths are investigated so that learning can take place.

The Trust has expanded research activity and increased the number of patients who are invited to take part and there is an impressive account of world class research activities taking place.

We commend the Trust on their focus on staff wellbeing and being responsive to staff feedback and once again the Trust has been very highly rated by staff on the care they provide and working at the Trust.

Last year we asked that the 2018/19 Quality Account provide greater emphasis on our City and Hackney plans for greater integration with our Local Authority partners and the development of our neighbourhood model. We are pleased to see references to wider system work throughout the document and are keen to see these developments progress further over 2019/20.

We are delighted to see further progress made by the Trust to embed quality improvement (QI) and the work of the QI team in the Trust, particularly the new QI programme for Band

NHS
City and Hackney
Clinical Commissioning Group

nurses and work being undertaken in surgical specialities. We encourage the Trust to make quality improvement everyone's business and to equip front line staff with the skills and capacity to develop this in 2019/20.

We confirm that we have reviewed the information contained within the Account, and checked this against and data sources where these are available to us, and it is accurate.

Overall we welcome the 2018/19 quality account and are excited at the prospect of another year working together to improve the quality of services for the population we serve.

Dr Mark Rickets

Chair, NHS City and Hackney Clinical Commissioning Group

Ms Jane Milligan

Accountable Officer, NHS City and Hackney Clinical Commissioning Group

Mr David Maher

Managing Director, NHS City and Hackney Clinical Commissioning Group

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES

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.

NHS Improvement 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 the 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 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- 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 2018 to [the date of this statement]
  - papers relating to quality reported to the board over the period April 2018 to 20/05/2019
  - feedback from commissioners received 17/05/2019
  - feedback from governors dated 30/04/2019
  - feedback from local Healthwatch organisations dated 15/05/2019
  - feedback from overview and scrutiny committee dated 08/05/2019
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/10/2018
  - the national patient survey 01/06/2018
  - the national staff survey 26/02/2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 24/5/2019
  - CQC inspection report dated 10/05/2018
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported 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 reported 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

24.5.19 Date ..... Chairman

24.5.19 Date ..... Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Homerton University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Homerton University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 17 May 2019;
- feedback from governors, dated 30 April 2019;
- feedback from local Healthwatch organisations, dated 15 May 2019;
- feedback from Overview and Scrutiny Committee, dated 8 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 1 June 2018;
- the latest national staff survey, dated 26 February 2019;

- Care Quality Commission Inspection, dated 10 April 2018 to 11 May 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the Trust's control environment, dated 24 May 2019; and
- any other information included in our review.

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 Homerton University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 Homerton University Hospital NHS Foundation Trust for our work or this report, except 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 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Homerton University Hospital 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 2019:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
London

28 May 2019

Annual Accounts

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

Homerton University Hospital NHS Foundation Trust Annual Accounts 2018/19

CONTENTS **Page**

Foreword to the Accounts

Homerton University Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2019 have been prepared by Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Signed.....

Tracey Fletcher
Chief Executive

24th May 2019

KPMG

Independent auditor's report

to the Council of Governors of Homerton University Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Homerton University Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018-19 and the Department of Health and Social Care Group Accounting Manual 2018-19.

Basis for opinion

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

Overview	
Materiality: financial statements as a whole	£6m (2018: £4.6m) 1.8% (2018: 1.5%) of operating income

Risks of material misstatement		vs 2018
Recurring risks	Valuation of land and buildings	◀▶
	Revenue recognition – NHS Income	◀▶
	New: Fraudulent expenditure recognition	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the three key audit matters (2017-18: 2), in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's members as a body may better understand the process by which we arrived at our audit opinion . These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows.

	The risk	Our response
Valuation of land and buildings (£122.7 million; 2018: £117.5m) *Refer to page 21 (Audit Committee Report), page 9 (accounting policy) and page 21 (financial disclosures)*	**Subjective valuation:** Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust may consider whether the asset would be realistically built to the same specification or in the same location. The Trust engaged a professional valuer to carry out a desktop valuation of its land and buildings as at 31 March 2019. The valuation figures included in the Trust's accounts are estimates. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to the valuer for consistency with the requirements of the Department of Health and Social Care Group Accounting Manual. We inspected the instructions provided to the valuer to verify that they are appropriate to produce a reliable valuation in line with the requirements of the RICS Red Book; — **Methodology choice:** We used our own valuation specialist to assess the methodology used in preparing the valuation, including the choice of indices used to determine the valuation; — **Test of detail:** We evaluated the accuracy of the floor area data submitted to the valuers for the preparation of the valuation by re-performing measurements of a sample of the Trust's properties; — **Our sector experience:** We challenged the Trust's assumptions used to prepare the valuation by comparing to our own expectations based on knowledge of the Trust and industry norms; — **Accounting analysis:** We assessed the accounting treatment of the adjustments made for the changes in valuation of the Trust's land and buildings following the valuation; and — **Accounting analysis:** We critically assessed the Trust's asset impairment review by inspecting the Trust's approach to assessing impairment. **Our findings** — We found the resulting estimate to be optimistic (2017/18: optimistic).

2. Key audit matters: our assessment of risks of material misstatement (cntd.)

	The risk	Our response
Operating income from patient care activities (£293m; 2018: £286m) *Refer to page 21 (Audit Committee Report), page 8 (accounting policy) and page 16 (financial disclosures)*	**2018/2019 income** Of the Trust's reported total income, £268.5 million (2017-18: £263.5m) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). CCGs and NHS England make up 80% (2017-18: 82%) of the Trust's income. Income is contracted based on expected levels of activity and standard tariff prices for procedures, however the actual income for the year is based on the actual levels of activity completed during the year. Other performance based income is received from NHS Improvement (via local CCGs). This results in estimates being required at the year end. Income from NHS England and CCGs is captured through the Agreement of Balances exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes. The Trust recognised £16.4 million of income from the Provider and Sustainability Fund. Receipt of this income is contingent on achievement of quarterly financial targets agreed with NHS Improvement.	Our procedures included: **Tests of detail:** — For the Trust's three largest commissioners we inspected documentation to confirm that contracts had been agreed for the delivery of services; — We inspected supporting documentation for variances over £300,000 arising from the Agreement of Balances exercise to critically assess the Trust's accounting for disputed income; — We tested that invoices had been issued in line with the contracts signed for the three largest commissioners; — We critically assessed the level of prudence applied in accruing for income at the end of the year where balances have not been agreed with commissioners, including the accrual made for partially completed spells; — We inspected a sample of items posted at the end of the financial year to assess whether they had been recorded within the correct period; and — We inspected the external confirmation received from NHS Improvement of the Trust's entitlement to Provider Sustainability Funding for 2018-19. **Our findings** — We found some errors, which were corrected, for which we have reported an audit difference. (2017/18: We found some errors, which were corrected, for which we reported an audit difference.)

2. Key audit matters: our assessment of risks of material misstatement (cntd.)

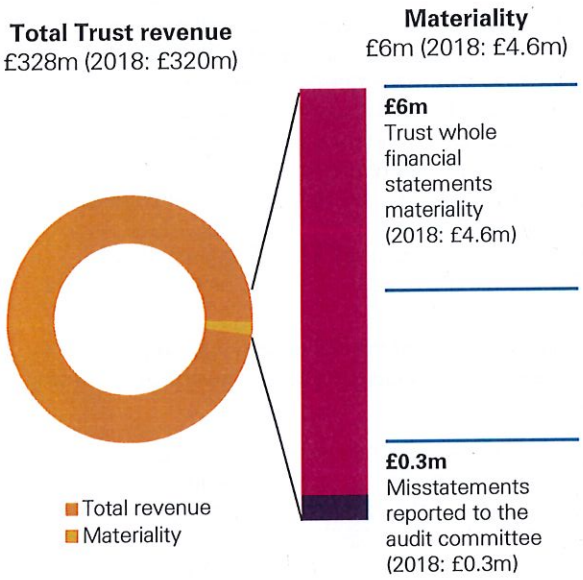
	The risk	Our response
Fraudulent expenditure recognition (£314.5 million; 2017-18: £304.3 million) *Refer to page 21(Audit Committee Report), page 8 (accounting policy) and page 17 (financial disclosures).*	**Effects of irregularities** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As the Foundation Trust fulfils some of the characteristics of a governmental body there is as much focus on the expenditure being incurred as the generation of revenue. The risk of material misstatement due to fraud related to expenditure recognition may therefore be as significant as the risk of material misstatements due to fraud related to revenue recognition and so we have had regard to this when planning and performing audit procedures. We consider this risk to relate to the completeness of the expenditure recorded as there may be an incentive to seek to defer expenditure in order to achieve financial targets. The Trust agreed a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: **Historic comparison:** We critically assessed whether there were significant accruals included in the prior year accounts that were not included as part of the 2018-19 accounts and the reason for this. **Tests of detail:** We undertook the following tests of detail: — We inspected transactions incurred around the end of the financial year to critically assess whether they had been included within the correct accounting period; and — We inspected a sample of accruals made at 31 March 2019 for expenditure but not yet invoiced to assess whether the valuation of the accrual was consistent with the value billed after the year end. **Our findings** — We found some errors, which were corrected, for which we have reported an audit difference.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £6 million (2017/18: £4.6 million), determined with reference to a benchmark of revenue (of which it represents approximately 1.8%). We considered operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2017/18:(£0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in London.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note [X] to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

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

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

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018-19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 55, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

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

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

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

We have nothing to report in this respect.

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

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

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

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks as during our risk assessment.

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

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Homerton University Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Richard Hewes
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
15 Canada Square
London
E14 5GL
28 May 2019

KPMG

Homerton University Hospital NHS Foundation Trust Annual Accounts 2018/19

Statement of Comprehensive Income for the year ended 31 March 2019

	NOTE	**2018/19 £000**	2017/18 £000
Revenue			
Operating income from Patient Care Activities	3	**292,948**	285,675
Other operating income	3	**42,561**	34,408
Operating expenses	4	**(314,559)**	(304,355)
Operating surplus from continuing operations		**20,950**	15,728
Finance costs:			
Finance income	7	**243**	77
Finance expenses	7	**(190)**	(203)
Public dividend capital dividends payable	17	**(4,205)**	(3,853)
Net finance costs		**(4,152)**	(3,979)
Other gains			16
Retained surplus / (deficit) for the year		**16,798**	11,765
Other comprehensive income			
Revaluations	SOCITE	**7,942**	5,060
Total comprehensive income / (expense) for the year		**24,740**	16,825

Surplus adjusted for Impairments		
Retained surplus for the year	**16,798**	11,765
Add back ; Impairment	**-**	447
Retained Surplus for the Year before Impairments	**16,798**	12,212

Statement of Financial Position as at 31 March 2019

	NOTE	For the year ending 31 March 2019 £000	For the year ending 31 March 2018 £000
Non-current assets			
Intangible assets	8	**6,085**	4,535
Property, plant and equipment	9	**143,889**	134,611
Trade and other receivables		**50**	50
Total non-current assets		**150,024**	139,196
Current assets			
Inventories	10	**2,986**	2,586
Trade and other receivables	11	**35,044**	42,119
Cash and cash equivalents	12	**47,641**	26,283
Total current assets		**85,671**	70,988
Total assets		**235,695**	210,184
Current liabilities			
Trade and other payables	13	**(30,059)**	(29,465)
Borrowings	13	**(374)**	(323)
Provisions	13	**(6,289)**	(6,689)
Tax payable	13	**(7,427)**	(6,914)
Other liabilities	13	**(6,180)**	(6,569)
Total current liabilities		**(50,329)**	(49,960)
Net current assets		**35,342**	21,028
Total assets less current liabilities		**185,366**	160,224
Non-current liabilities			
Borrowings	13	**(5,418)**	(5,635)
Provisions	13	**(898)**	(931)
Total non current liabilities		**(6,316)**	(6,566)
Total assets employed		**179,050**	153,658
Financed by taxpayers' equity			
Public dividend capital	17	**92,355**	91,703
Retained earnings	SOCITE	**41,527**	24,729
Revaluation reserve	SOCITE	**45,168**	37,226
Total taxpayers' equity		**179,050**	153,658

Statement of Changes in Taxpayers' Equity (SOCITE) can be found on page 5

The financial statements on pages 3 to 34 were approved by the Board and signed on its behalf by:

Signed: Tracey Fletcher .....(Chief Executive) **Date: 24th May 2019**

Tracey Fletcher

Statement of Changes in Taxpayers' Equity (SOCITE) 2018-19

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2018	**91,703**	**24,729**	**37,226**	**153,658**
Changes in taxpayers' equity for 2018-19				
Total comprehensive income for the year:				
Retained surplus for the year	-	16,798	-	16,798
Revaluations of Property, Plant and Equipment	-	-	7,942	7,942
Transfers between Reserves	-			-
New PDC received	652	-	-	652
Balance at 31 March 2019	**92,355**	**41,527**	**45,168**	**179,050**

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Changes in Taxpayers' Equity 2017-18				
Balance at 1 April 2017	**90,648**	**12,080**	**33,050**	**135,778**
Total comprehensive income for the year:				
Retained surplus for the year	-	11,765	-	11,765
Revaluations of Property, Plant and Equipment	-	-	5,060	5,060
Transfers between Reserves	-	884	(884)	
New PDC received	1,055	-	-	1,055
Balance at 31 March 2018	**91,703**	**24,729**	**37,226**	**153,658**

Statement of Cash Flows for the year ended 31 March 2019

	NOTE	**2018/19 £000**	2017/18 £000
Net cash inflow from operating activities	18	**38,024**	16,495
Cash flows from investing activities			
Interest received		**243**	77
Purchase of intangible assets		**(2,450)**	(401)
Purchase of property, plant and equipment		**(10,684)**	(6,814)
Proceeds from disposal of plant, property and equipment			16
Net cash outflow from investing activities		**(12,891)**	(7,122)
Net cash inflow before financing		**25,133**	9,373
Cash flows from financing activities			
Public dividend capital received	17	**652**	1,055
Loans repaid to the Department of Health		**(292)**	(292)
Movement in Other Loans		**87**	(31)
Interest paid		**(193)**	(203)
Public dividend capital dividends paid		**(4,029)**	(3,827)
Net cash outflow from financing		**(3,775)**	(3,298)
Net increase in cash and cash equivalents		**21,358**	6,075
Cash and cash equivalents brought forward as at 1st April		**26,283**	20,208
Cash and cash equivalents carried forward at 31 March		**47,641**	26,283

Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be the most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents

1.2 Accounting Convention

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

1.3 Basis of Consolidation

The Trust is the corporate trustee to Homerton University Hospital NHS Foundation Trust Charitable Fund, however the Charity's results have not been consolidated with those of the Trust in 2018/19 on the grounds of materiality. The Charity's accounts for 2018/19 will be published in September and can be found at www.homertonhope.org.

1.4 Critical accounting judgements and key sources of estimation of uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting policies

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

● Depreciation rates applied to property, plant and equipment and valuation methodologies and external indices applied to the valuation conducted by Gerald Eve LLP (note 9 to the accounts).

1.4.2 Sources of estimation uncertainty

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

● Income and expenditure accruals

Other sources of estimation uncertainty are the following:

● Provision for injury benefit claims, early retirements, impairments of receivables, and others (notes 11 & 15 to the accounts)
● Estimates for partially completed patient episodes.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies , the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transaction in the period which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income and is disclosed separately from operating costs.

1.6 Pooled budgets

The Trust has not entered into any pooled budget arrangements.

1.7 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Trust.

1. Accounting Policies (Continued)

1.8 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expendients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less;
- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate of all contracts modified before the date of initital application.

when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially completed spell is accrued and agreed with the commissioner.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

contract.

1.9 Employee Benefits

1.9.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. 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.

1.9.2 Pension costs

NHS Pensions

employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. These schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were defined contribution schemes: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Employers pension cost contributions are charged to operating expenses as and when they become due. The employer contribution payable in 2018/19 was £18.8m (2017/18 £17.9m).

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.10 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, the goods or services 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

1.10.2 Value added tax

Most of the activities of the Trust are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Corporation tax

The Trust is not liable to to pay corporation tax.

1. Accounting Policies (Continued)

1.12 Property, Plant and Equipment

1.12.1 Recognition

Property, Plant and Equipment is capitalised where:

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

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

1.12.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definition of investment properties or assets held for sale.

Revaluations of property, plant and equipment 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.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees, and where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

An increase arising on revaluation is taken the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of Other Comprehensive Income.

It is impracticable to disclose the extent of the possible effects of an assumption on another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of the Trust's land, property, plant and equipment could require a material adjustment to the carrying amount of the asset recorded in note 9.1.

1.12.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12.4 Depreciation

Items of property held at current value, are depreciated over their remaining Useful Economic Lives (UEL) as assessed by the NHS Foundation Trust's professional valuers in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have infinite life and is not depreciated. Leaseholds are depreciated over the primary lease term. Plant and Equipment initially held at current cost, is depreciated over the estimated UEL.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated. Assets in the course of construction are not depreciated until the asset is brought into use.

The following UELs apply to each individual asset category based on standard asset lives adjusted for local use and expected technology changes:

- Land - Land is not depreciated because it is considered to have an infinite life
- Buildings excluding dwellings - 15 to 75 years
- Plant and Machinery - 5 to 30 years
- Transport Equipment - 5 to 15 years
- Furniture and Fittings - 5 to 30 years
- Information Technology - 5 to 15 years

1. Accounting Policies (Continued)

1.13 Investment properties

Investment properties are measured at fair value, changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.14 Intangible Assets

1.14.1 Recognition

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

(i) Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• the way in which intangible assets will generate probable future economic or service delivery benefits e.g. the presence of a market for its output or, where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical or 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.

(ii) Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset. Costs associated with maintaining software are recognised as an expense when incurred.

Capitalised computer software is amortised over the expected useful economic life or 5 years, whichever is the shorter.

1.14.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in the development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.15 Depreciation

Freehold land, assets under construction or development, investment properties, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over the estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

1. Accounting Policies (Continued)

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

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.16 Donated Assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.17 Leases

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

1.17.1 The Trust as a lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 The Trust as a lessor

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

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

1. Accounting Policies (Continued)

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

1.19 Cash and equivalents

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

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

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 0.29% (2017-18: 0.10%) in real terms. All other provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of 0.76 % (2017-18: -2.42%) for expected cash flows up to and including 5 years.
- A medium term rate of 1.14% (2017-18: -1.85%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of 1.99% (2017-18: -1.56%) for expected cash flows over 10 years.
- A very long term rate of 1.99% (2017-18: -1.56%) for expected cash flows exceeding 40 years.

2018/19 percentages are at nominal rates, whereas 2017/18 percentages are in real terms.

1.21 Clinical Negligence

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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 as and when they become due.

1.23 Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1. Accounting Policies (Continued)

1.24 Contingent liabilites and contingent assets

A contingent liability is:

● a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or

● a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably;

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at amortised costs, financial assets at fair value through profit and loss, and financial assets at fair value through other comprehensive income. The classification is determined by the cash flow and business model characteristics of hte financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.25.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective it to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principle and interest. This includes most trade receivables, loans receivable and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial assset.

1.25.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assests and where the cash flows are solely payments of principal and interest.

1.25.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.25.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort agaisnt the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1. Accounting Policies (Continued)

1.26 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.26.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

● donated assets (including lottery funded assets)

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

● any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.]

1.28 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1. Accounting Policies (Continued)

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

1.30 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Gifts

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

1.32 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

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

●IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

●IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

4. Operating Expenses

4.1 Operating Expenses by type	**2018/19**	2017/18
	£000	£000
Purchase of healthcare from NHS bodies	**5,270**	6,133
Purchase of healthcare from non-NHS bodies	**1,406**	1,757
Directors' costs	**1,125**	1,261
Non executive directors' costs	**124**	126
Other Staff costs	**211,228**	201,223
Supplies and services - clinical (excluding drug costs)	**23,095**	21,780
Supplies and services - general	**8,683**	8,226
Establishment	**3,487**	3,554
Patient Transport	**1,718**	1,629
Premises	**17,620**	16,467
Increase in bad debt provision	**63**	509
Drugs costs	**16,119**	17,468
Depreciation on property, plant and equipment	**6,703**	6,136
Amortisation of intangible assets	**1,394**	1,351
Audit fees - statutory audit	**73**	65
Audit related assurance services	**16**	14
Audit fees - internal audit	**150**	117
Consultancy	**1,196**	1,002
NHSLA insurance premium	**11,734**	11,077
Other	**3,355**	4,013
Total (excluding impairment)	**314,559**	303,908
Impairments of property, plant and equipment		447
Total (including impairment)	**314,559**	304,355

In 2018/19 audit fees for statutory audit, and audit related assurance services (Quality Accounts), excluding VAT, were £60,825 and £13,000 respectively (2017/18 - £53,824 and £12,000). The limitation on auditors' liability is £2m.

4.2 Operating leases

4.2.1 Operating lease Rentals	**2018/19**	2017/18
	£000	£000
Rental of plant and machinery	**137**	1,186
Rental Hire of building	**-**	376
	137	1,562

4.2.2 Operating lease commitments

			2018/19	2017/18
	Land and buildings	**Plant and Machinery**	**Total**	Total
	£000	**£000**	**£000**	£000
Annual commitments on leases expiring:				
Within 1 year		220	**220**	531
Between 1 and 5 years		401	**401**	797
Greater than 5 years		-	**-**	234
Total	-	621	**621**	1,562

Leases in respect of plant and machinery relate to a CT scanner and other smaller items of medical equipment.

2. Segmental Analysis

All activities of the Trust are considered to be one segment, Healthcare. There are no individual reportable segments on which to make disclosures. Income and expenditure is not reported on a segmental basis to the Trust Board and as such the Trust is managed as a single segment.

3. Operating income from continuing operations

3.1 Income from activities	2018/19 £000	2017/18 £000
Elective income	**29,827**	27,505
Non-elective income	**40,699**	37,430
Outpatient income	**44,522**	47,984
A&E income	**15,181**	13,859
Non PbR activity income	**112,947**	101,220
Community income	**45,280**	42,225
Private and Overseas patient income	**917**	828
Other non-protected clinical income	**3,575**	14,624
	292,948	285,675
Other operating income		
Research and development	**1,024**	1,232
Education and training	**13,419**	12,825
Non-patient care services to other bodies	**8,131**	3,566
Sustainability and Transformation Fund (STF)	**16,411**	10,867
Other income	**3,576**	5,918
Total other operating income	**42,561**	34,408
Total operating income	**335,509**	320,083

Other income includes property rent and leasing income of £3.4m (2017/18 - £4.3m).

3.2 Overseas Patient Income

Income from Overseas Patients is £0.097m in 2018/19 (2017/18 - £0.23m). Cash payments received in year relating to Overseas Patients totalled £0.082m (2017/18 - £0.1m) and amounts added to the provision for impairment of receivables were £0m (2017/18 - £0.04m). Receivables relating to Overseas Patients of £0.217m were written off in the year (2017/18 - £0.4m)

3.3 Income by Source	2018/19 £000	2017/18 £000
NHS Foundation Trusts	**126**	4,669
NHS Trusts	**295**	985
CCGs and NHS England	**268,480**	263,453
Health Education - England	**13,419**	14,004
NHS Other	**-**	-
Local Authorities	**19,555**	20,409
Non NHS: Private Patients	**917**	828
Non NHS: Overseas Patients	**97**	234
NHS Injury Scheme	**788**	480
Sustainability and Transformation Fund (STF)	**16,411**	10,867
Other operating income	**15,421**	4,154
Total	**335,509**	320,083

NHS Injury Scheme income is subject to a nationally prescribed provision for doubtful debts of 21.89% (2017/18 22.84%) to reflect expected rates of collection.

3.4 Commissioner Requested Services

	2018/19 £000	2017/18 £000
Commissioner Requested Services	**288,456**	268,394
Non - Commissioner Requested Services	**47,053**	51,689
Operating income from continuing operations	**335,509**	320,083

As part of NHS Improvement's role under the Health and Social Care Act 2012 to licence providers of NHS services, it requires commissioners to designate Commissioner Requested Services (CRS). Prior to this designation occurring, all of the Trust's previous Mandatory Services have been designated as CRS.

5. Staff costs and staff numbers

5.1 Staff costs

	2018/19 Total	2017/18 Total
	£000	£000
Salaries and wages	**144,829**	139,891
Social Security costs	**17,457**	15,679
Employer contributions to NHS Pensions Agency	**18,787**	17,960
Pension Cost - Other	**14**	5
Termination Benefits	**41**	255
Bank Staff	**18,681**	16,507
Agency staff	**13,527**	12,187
	213,336	202,484

The staff costs above are shown in Operating Expenses (note 4.1) as Directors' costs and Other Staff Costs.

5.2 Average number of persons employed

	Permanently Employed Number	**Other Number**	**2018/19 Total Number**	2017/18 Total Number
Medical and dental	466	58	**525**	519
Ambulance staff			**-**	-
Healthcare assistants and other support staff	632	124	**756**	609
Nursing, midwifery and health visiting staff	1,187	185	**1,372**	1,355
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	620	31	**651**	707
Administration and estates	575	127	**701**	875
Other	72	17	**88**	-
Total	**3,552**	**541**	**4,093**	4,065

5.3 Employee benefits

There are nil individual employee benefit costs for 2018/19 (2017/18 Nil).

5.4 Retirements due to ill-health

	2018/19 Number	**2018/19 £000**	2017/18 Number	2017/18 £000
Early retirements agreed on the grounds of ill-health	**1**	**15**	-	-

The costs of early retirements due to ill-health are not included in Operating Expenses as the liability is met by the NHS Pensions Agency.

5.5 Staff exit packages

	Number of compulsory redundancies	**Cost of compulsory redundancies £s**	**Number of other departures agreed**	**Cost of other departures agreed £s**
<£10,000			3	18,990
£10,000 - £25,000			1	17,103
£25,001 - £50,000	1	40,244	1	44,500
Totals	**1**	**40,244**	**5**	**80,593**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note agreed in the year. Where Homerton University Hospital NHS Foundation Trust has agreed early retirements, the additional costs are met by t Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

5.6 Analysis of Other Departures

	Agreements Number	**Total Value of agreements £000's**
Contractual payments in lieu of notice	5	81
Total	**5**	**81**

6. The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within Other Interest Payable arising from claims made under this legislation.

7 Finance income	**2018/19**	2017/18
	£000	£000
Interest on loans and receivables and bank current accounts	**243**	77
Total	**243**	77

7.1 Finance expenses - finance liabilities	**2018/19**	2017/18
	£000	£000
Interest on Loans from the Independent Trust Financing Facility	**190**	201
	190	201

8. Intangible Assets

All Intangible fixed assets relate to software licences.

8.1 2018/19	Software	Assets Under Construction	Total
	£000	£000	£000
Gross cost at 1 April 2018	8,483	78	8,561
Additions - purchased		2,450	2,450
Reclassifications	1,988	(1,494)	494
Disposals		-	-
Gross cost at 31 March 2019	**10,471**	**1,034**	**11,505**
Amortisation at 1 April 2018	4,026	-	4,026
Provided during the year	1,394	-	1,394
Disposals	-	-	-
Amortisation at 31 March 2019	5,420	-	5,420
Net book value			
- Purchased at 31 March 2018	4,457	78	4,535
- Purchased at 31 March 2019	**5,051**	**1,034**	**6,085**

8.2 2017/18			
	£'000	£'000	£'000
Gross cost at 1 April 2017	7,998	164	8,162
Additions - purchased	401	0	401
Reclassifications	86	(86)	-
Disposals	(2)	-	(2)
Gross cost at 31 March 2018	**8,483**	**78**	**8,561**
Amortisation at 1 April 2017	2,675	-	2,675
Provided during the year	1,351	-	1,351
Disposals		-	-
Amortisation at 31 March 2018	**4,026**	**-**	**4,026**
Net book value			
- Purchased at 31 March 2017	5,323	164	5,487
- Purchased at 31 March 2018	**4,457**	**78**	**4,535**

9. Property, Plant and Equipment

9.1. As at 31 March 2019

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	22,340	123,476	2,414	31,510	118	7,999	1,840	**189,697**
Additions - purchased			8,533					**8,533**
Revaluations	4,210	3,732						**7,942**
Impairments - Charged to SOCIE								**-**
Reclassifications		4,072	(10,931)	5,624		741		**(494)**
Disposals								**-**
Cost or valuation at 31 March 2019	**26,550**	**131,280**	**16**	**37,134**	**118**	**8,740**	**1,840**	**205,677**
Depreciation at 1 April 2018	-	28,289	-	20,128	95	5,025	1,549	**55,086**
Provided during the year	-	2,872	-	2,756	5	1,019	51	**6,703**
Depreciation at 31 March 2019	**-**	**31,161**	**-**	**22,884**	**100**	**6,044**	**1,600**	**61,789**
Net book value								
- Purchased at 1 April 2018	22,340	94,308	2,414	11,202	7	2,974	291	**133,536**
- Donated at 1 April 2018	-	879	-	180	16	-	-	**1,075**
Total at 1 April 2018	**22,340**	**95,187**	**2,414**	**11,382**	**23**	**2,974**	**291**	**134,611**
Net book value								
- Purchased at 31 March 2019	26,550	100,119	16	14,250	18	2,696	240	**143,889**
- Donated at 31 March 2019	-		-			-	-	**-**
Total at 31 March 2019	**26,550**	**100,119**	**16**	**14,250**	**18**	**2,696**	**240**	**143,889**

9. Property, Plant and Equipment

9.2. As at 31 March 2018

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	21,500	115,907	1,886	28,432	118	7,035	1,799	**176,677**
Transfers by absorption								
Additions - purchased	-	2,318	2,474	2,856	-	722	37	**8,407**
Revaluations	840	4,220	-	-	-	-	-	**5,060**
Impairments - Charged to SOCIE	-	(129)	(318)	-	-	-	-	**(447)**
Reclassifications	-	1,160	(1,628)	222	-	242	4	**0**
Disposals	-	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2018	**22,340**	**123,476**	**2,414**	**31,510**	**118**	**7,999**	**1,840**	**189,697**
Depreciation at 1 April 2017	-	25,703	-	17,584	90	4,072	1,501	**48,950**
Provided during the year	-	2,586	-	2,544	5	953	48	**6,136**
Disposals	-	-	-	-	-	-	-	**-**
Depreciation at 31 March 2018	**-**	**28,289**	**-**	**20,128**	**95**	**5,025**	**1,549**	**55,086**
Net book value								
- Purchased at 1 April 2017	21,500	89,129	1,886	10,350	11	2,964	296	**126,136**
- Donated at 1 April 2017	-	1,075	-	497	17	-	2	**1,591**
Total at 1 April 2017	**21,500**	**90,204**	**1,886**	**10,847**	**28**	**2,964**	**298**	**127,727**
Net book value								
- Purchased at 31 March 2018	22,340	94,308	2,414	11,202	7	2,974	291	**133,536**
- Donated at 31 March 2018	-	879	-	180	16	-	-	**1,075**
Total at 31 March 2018	**22,340**	**95,187**	**2,414**	**11,382**	**23**	**2,974**	**291**	**134,611**

9.3 Assets held at market value

At 31 March 2019 the Trust held land assets at market value for existing use of £26,550,000 (31 March 2018, £22,340,000).

9.4 Valuation of land & buildings

The buildings have been valued as at 31 March 2019 using a Modern Equivalent Asset basis of valuation, as discounted for wear and tear.

Land has been revalued at 31 March 2019 at market value for existing use.

Both desktop valuations were carried out by Gerald Eve LLP whose address is 72 Welbeck Street, London. W1G 0AY.

Buildings have estimated useful economic lives ranging up to 73 years (2017/18 - 73 years).

9.5 Assets held under finance leases and hire purchase contracts at 31 March 2019

The Trust did not hold any finance leases or hire purchase contracts during 2018/19.

9.6 Fixed Asset Investments

There were nil fixed asset investments held at 31 March 2019 (31 March 2018 - Nil).

10. Inventories

10.1. Inventories	**2018/19**	2017/18
	£000	£000
Drugs	**1,342**	1,076
Consumables	**1,591**	1,466
Energy	**54**	45
Total	**2,986**	2,587

10.2 Inventories recognised in expenses	**2018/19**	2017/18
	£000	£000
Total Inventories recognised as an expense in the year	**15,182**	16,093

11. Trade and other receivables

	31 March 2019	31 March 2018
11.1 Amounts falling due within one year:	**£000**	£000
Contract Receivables *	**18,966**	-
Trade Receivables *	**-**	19,302
Allowance for impaired contract receivables	**(3,687)**	(3,883)
Prepayments	**1,831**	1,483
Accrued income	**15,386**	21,874
PDC Dividend Receivable	**140**	315
Other receivables	**2,408**	3,028
Total	**35,044**	42,119
Of which receivables from NHS and DHSC group bodies:	**12,870**	12,061

* Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

11.2 Allowances for credit losses -2018/19

	Contract receivables and contract assets
	£000
Allowances at 1 April 2018 - brought forward	**3,883**
New allowances arising	**-**
Utilisation of allowances (write offs)	**(259)**
Reversals of allowances	**63**
Allowances as at 31 March 2019	**3,687**

Allowances for Credit Losses by age - 2018/19	**31 March 2019 £000**
Up to three months old	**781**
In three to six months old	**254**
Over six months old	**2,652**
Total	**3,687**

11.2.1 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances at 1 April 2017 - as previously stated	**3,900**
Increase in provision	**509**
Amounts utilised	**(526)**
Unused amounts reversed	**-**
Allowances as at 31 March 2018	**3,883**

Allowances for Credit Losses by age - 2017/18	31 March 2018 £000
Up to three months old	292
In three to six months old	125
Over six months old	3,466
Total	**3,883**

11.3 Age analysis of unimpaired contract receivables:

	31 March 2019	31 March 2018
	£000	£000
Up to three months old	**10,064**	10,936
In three to six months old	**3,143**	1,399
Over six months old	**4,456**	8,248
Total	**17,663**	20,583

12 Cash and cash equivalents

	31 March 2019 £000	31 March 2018 £000
Balance as at 1 April	**26,283**	20,208
Net change in year	**21,358**	6,075
Balance at 31 March	**47,641**	26,283
Of which:		
Commercial banks and cash in hand	**76**	161
Cash with the Government Banking Service	**47,509**	26,059
Other current investments	**56**	63
Total cash and cash equivalents in the Statement of Cash Flows	**47,641**	26,283

13. Liabilities

13.1 (i) Current liabilities: Amounts falling due within one year	31 March 2019 £000	31 March 2018 £000
NHS payables	**5,067**	4,194
Non-NHS payables	**7,741**	5,747
Trade payables - Capital	**422**	2,573
Other payables	**350**	269
Accruals	**16,479**	16,640
Accrued interest on DHSC loans	**-**	42
Trade and other payables	**30,059**	29,465
Borrowings	**374**	323
Provisions	**6,289**	6,689
Tax payable	**7,427**	6,914
Deferred income	**6,180**	6,569
Total amounts falling due within one year	**50,329**	49,960

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 13.1. IFRS 9 is applied without restatement therefore comparatives have not been restated.

13.1 (ii) Non Current Liabilities: Payables due after more than one year	31 March 2019 £000	31 March 2018 £000
Provisions	**898**	931
Borrowings	**5,418**	5,635
	6,316	6,566
13.1 (iii) Total payables	**56,645**	56,526

14 Loans - payment of principal falling due:

	31 March 2019	31 March 2018
	£000	£000
Within one year	**374**	323
Between one and two years	**346**	323
Between two and five years	**1,039**	969
After five years	**4,033**	4,343
Total	**5,792**	5,958

Of which:

	31 March 2019	31 March 2018
	£000	£000
Wholly repayable within five years	**1,759**	1,615
Wholly or partially repayable after five years by instalments	**4,033**	4,343
Total	**5,792**	5,958

15. Provisions for liabilities and charges

	Pensions relating to former Directors	Pensions relating to former Staff	Clinical negligence	Redundancy	Other	**31 March 2019 Total**	31 March 2018 Total
	£000	£000	£000	£000	£000	**£000**	£000
At 1 April	88	895	77	194	6,366	**7,620**	7,510
Arising during the year	3	18			5,261	**5,282**	2,513
Change in discount rate	-	3				**3**	14
Utilised during the year	(7)	(48)		(138)	(3,987)	**(4,180)**	(2,286)
Reversed unutilised			(22)	(41)	(1,476)	**(1,539)**	(133)
Unwinding of discount	-		-	-	-	**-**	2
At 31 March	**85**	**868**	**55**	**15**	**6,164**	**7,187**	7,620
Within one year	7	48	55	15	6,164	**6,289**	6,689
Between one and five years	27	193				**220**	212
After five years	51	627				**678**	719
Total	**85**	**868**	**55**	**15**	**6,164**	**7,187**	7,620

Pension related provisions as at 31 March 2019 consist of £0.628m in relation to Injury Benefits and £0.325m relating to Early Retirement benefits payable to former employees of the Trust. These benefits are calculated and paid to the individuals concerned by the NHS Pensions Agency (NHSPA) and the provision represents the future liability of the Trust based on expected lifetime calculations discounted appropriately.

The Clinical Negligence provision totals £0.055m and is based on the estimated liability arising in the next year relating to claims that are being dealt with by the NHS Litigation Authority on behalf of the Trust. Redundancy provisions of £0.016m are based on the likely obligation of the Trust towards a small number of staff who are at risk of redundancy in the next year due to the outsoucing of certain back office administrative functions to an external provider.

The most significant elements of the other provisions figure are the following: £1.5m in respect of potential data challenges from commissioners relating to clinical contract income, £1.0m relating to the estimated value of untaken annual leave owed to Trust employees as at 31 March 2019, £0.245m in relation to a contractual issue with the Trust's facilities management provider, £0.24m in relation to potential employment tribunal claims and £2.965m in relation to provision for future credit notes.

16. Clinical Negligence Liability

The amount provided by the NHSLA in respect of clinical negligence liabilities of the trust as at 31 March 2019 is £207,791,496 (2017/18 - £182,305,000).

17. Movement in Public Dividend Capital

	2018/19	2017/18
	£000	£000
Public Dividend Capital as at 1 April	**91,703**	90,648
New PDC received	**652**	1,055
Public Dividend Capital as at 31 March	**92,355**	91,703

The dividend payment for the year was £4.2m (2017/18 £4.2m). Further details on how the dividend was calculated are set out in note 1.27.

18. Notes to the cash flow statement

18.1 Reconciliation of operating (deficit) / surplus to net cash inflow from operating activities:

	2018/19 £000	2017/18 £000
Total operating surplus	**20,950**	15,728
Depreciation and amortisation	**8,097**	7,487
Impairment	**-**	447
(Increase) in inventories	**(400)**	(63)
Decrease / (Increase) in receivables	**6,899**	(3,130)
Increase / (decrease) in payables	**3,300**	(4,910)
(Decrease) Increase in other liabilities	**(389)**	823
Other movements	**(434)**	113
Net cash inflow from operating activities	**38,024**	16,495

18.2 Reconciliation of net cash flow to movement in net funds

	2018/19 £000	2017/18 £000
Increase in cash in the year	**21,358**	6,075
Cash inflow from debt repaid and finance lease capital payments	**205**	322
Increase in net funds resulting from cash flows	**21,563**	6,397
Net funds at 1 April	**20,325**	13,928
Net funds at 31 March	**41,888**	20,325

18.3 Analysis of changes in net debt

	At 1 April 2018	Cash changes in year	At 31 March 2019	At 31 March 2018
	£000	£000	£000	£000
GBS cash at bank	26,059	21,450	**47,509**	26,059
Commercial cash at bank and in hand	161	(85)	**76**	161
Debt due after one year	(5,635)	217	**(5,418)**	(5,635)
Debt due within one year	(323)	(51)	**(374)**	(323)
Current investments	63	(7)	**56**	63
Total	**20,325**	**21,524**	**41,849**	20,325

19. Contractual Capital Commitments

There were £0.7m of commitments under capital expenditure contracts as at 31 March 2019 (31 March 2018 - £1.2m).

20. Contingent liabilities

	2018/19	2017/18
	£000	£000
Liabilities to Third Parties Scheme (LTPS) member's contribution	**35**	51
	35	51

21. Related Party Transactions

There were nil related party transactions with Executive and non-Executive Directors during the financial year (2017/18 nil).

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year Homerton University Hospital NHS Foundation Trust has had a significant number of material transactions with Government Departments and their agencies. The largest of these entities are listed below:

Name	Relationship
East London NHS Foundation Trust	NHS Foundation Trust
Barts Health	NHS Trust
Health Education England	Special Health Authority
NHS England - core	Commissioner
NHS England - London Regional Office	Commissioner
NHS England - London Specialised Commissioning Hub	Commissioner
NHS City And Hackney CCG	Commissioner
NHS Waltham Forest CCG	Commissioner
NHS Newham CCG	Commissioner
NHS Tower Hamlets CCG	Commissioner
NHS Islington CCG	Commissioner
NHS Redbridge CCG	Commissioner
NHS Barking And Dagenham CCG	Commissioner
NHS Enfield CCG	Commissioner
NHS Haringey CCG	Commissioner
NHS Resolution	Other NHS Whole of Government Accounts Body - Insurer
NHS Property Services	Other NHS Whole of Government Accounts Body
Department of Health and Social Care	Other NHS Whole of Government Accounts Body
HM Revenue & Customs - VAT	Central Government WGA Body
NHS Pension Scheme	Central Government WGA Body
HM Revenue & Customs - NI Fund & PAYE	Central Government WGA Body
London Borough of Hackney	Central Government WGA Body - Local Authority

The Trust has also received revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund. The Charity is registered with the Charity Commission (Charity Number 1061659) and has its own Trustees drawn from the NHS Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) and these documents are available on request from the Trust.

22. Private Finance Initiative Transactions

The Foundation Trust has no PFI schemes.

23. Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have played during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. In light of the continuing service provider relationship the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Audit Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures and their delegated authorities.

The Trust's financial instruments comprise loans, provisions, cash at bank and in hand and various items, such as trade receivables and trade payables, that arise directly from its operations. The main purpose of these financial instruments is to fund the Trust's operations.

23.1 Financial Instruments - Assets

	At 31 March 2019 £000	At 31 March 2018 £000
Floating rate	**47,641**	26,283
Non-interest bearing	**32,760**	39,224
Total	**80,401**	65,507

Financial assets consist of cash and cash equivalents and trade and other receivables excluding provisions less prepayments and PDC receivable.

23.2 Financial Instruments - Liabilities

	At 31 March 2019 £000	At 31 March 2018 £000
Fixed rate	**5,792**	5,958
Non-interest bearing	**37,136**	37,085
Total	**42,928**	43,043

Financial liabilities consist of current and non-current liabilities less deferred income, payments received on account, tax and PDC payable.

23.3 Analysis of Financial Instruments

	At 31 March 2019 £000	At 31 March 2018 £000
23.3 (i) Financial assets (Book and fair value)		
Cash	**47,585**	26,220
Receivables within one year	**32,760**	39,224
Other current investments	**56**	63
Total	**80,401**	65,507
23.3 (ii) Financial liabilities (Book and fair value)		
Payables within one year	**36,238**	36,154
Provisions over 1 year	**898**	931
Loans	**5,792**	5,958
Total	**42,928**	43,043

Notes

a) Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by HM Treasury's discount rate of 3.7% in real terms (2017/18 - 3.7%).

24. Third Party Assets

The Trust held £1,171 of patients' monies at 31 March 2019 (31 March 2018 - £5,700). This amount has been excluded from the cash at bank and in hand figure reported in the accounts.

25. Intra-Government and Other Balances

25.1 Receivable and Payable balances	Receivables: amounts falling due within one year At 31 March 2019 £000	Payables: amounts falling due within one year At 31 March 2019 £000
English NHS Foundation Trusts	1,968	3,037
English NHS Trusts	2,337	2,449
Department of Health	(13)	-
Public Health England	-	8
Health Education England	464	-
NHS England & Clinical Commissioning Groups	23,566	989
Other NHS Whole of Government Accounts bodies	79	2,181
Other Whole of Government Accounts bodies	4,732	7,436
Total	33,133	16,100

25.2 Income and expenditure values for the year	Income Year Ended 31 March 2019 £000	Expenditure Year Ended 31 March 2019 £000
English NHS Foundation Trusts	4,591	1,731
English NHS Trusts	295	4,779
Department of Health	2,690	-
Public Health England	-	35
Health Education England	13,419	-
NHS England & Clinical Commissioning Groups	284,891	433
Other NHS Whole of Government Accounts bodies	-	16,081
Other Whole of Government Accounts bodies	19,555	38,926
Total	325,441	61,985

26. Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases £000	Total number of cases	Total value of cases £000
LOSSES:				
1. Losses of cash due to:				
Other Losses - Pharmacy Expired / Damaged Stock	-	-	-	-
2. Fruitless payments and constructive losses	-	-	-	-
3. Bad debts and claims abandoned	85	259	715	618
4. Damage to buildings, property etc.(including stores losses)	-	-	-	-
TOTAL LOSSES *	**85**	**259**	**715**	**618**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	5	59	-	-
6. Extra contractual to contractors	-	-	-	-
7. Ex gratia payments in respect of:				
Loss of personal effects	3		11	2
Personal Injury with Advice	5	15	3	27
Other	8	2	12	4
8. Special Severance payments			1	5
9. Extra statutory and regulatory	-	-	-	-
TOTAL SPECIAL PAYMENTS *	**21**	**76**	**27**	**37**
TOTAL LOSSES AND SPECIAL PAYMENTS *	**106**	**335**	**742**	**655**

* Losses and Special Payments have been calculated on an accruals basis but exclude provisions for future losses.

27. Initial Application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking "expected loss" impairment model and a revised approach to hedge accounting. Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0.042m and trade payables reduced accordingly.

Reassessment of allowances for credit losses under the expected loss model resulted in nil decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1.8m.

27.1 Initial Application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

As directed by the GAM,t he Trust has applied the practical expendient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

NHS
Homerton
University Hospital
NHS Foundation Trust

Incorporating hospital and community health services, teaching and research

Homerton University Hospital, Homerton Row, London E9 6SR
Tel: 020 8510 5555
www.homerton.nhs.uk

Our Values
PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY