NHS
The Hillingdon Hospitals
NHS Foundation Trust

# ANNUAL REPORT 17|18

The Hillingdon Hospitals
NHS Foundation Trust

# The Hillingdon Hospitals NHS Foundation Trust Annual Report and Accounts 2017/18

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

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# **Performance** report

# 1.1 OVERVIEW OF PERFORMANCE

## Statement on overview of performance from the Chair and Chief Executive

Last year saw the Trust experience the busiest time in its entire history. This resulted in 526,680 patient contacts - up by 2% on the previous 12 months. The winter months were particularly demanding with more than 11,500 patients visiting Hillingdon's A&E department in November and December.

Our staff coped admirably with the increased pressures

With admission rates significantly higher than usual it was difficult to find beds for patients and the pressure on our staff both in A&E and across the organisation was immense. Our staff coped admirably with the increased pressures and we want to pay tribute to their considerable achievement in providing good quality, safe care throughout this most challenging period.

The increase in the demand for our services saw us unable to meet the A&E four-hour waiting time target more often than ever before although we performed well on this target in the Minor Injuries Unit at Mount Vernon Hospital . Despite this we largely continued to meet the target for our referral to treatment times and cancer treatment targets, although these also dipped during our busiest months.

On the financial front we successfully delivered £10 million of efficiency savings - more than double the year before - with no detrimental impact on quality. However, this fell short of the £12.5 million target we had set ourselves. Furthermore, NHS Improvement had set the Trust a Control Total target that would have required savings in excess of £20 million. The Trust Board took the difficult decision to not sign up to the Control Total set by NHSI as we sought to be realistic about what was achievable. This meant we were penalised and unable to access other funding sources.

Staff continued to work hard to improve services and the overall hospital experience for patients. This saw us successfully move to delivering 7-day services across the majority of our services. The Trust adopted a range of 'Home first' initiatives designed to support patients' recovery and get them back home earlier, with additional community support where needed. We re-organised some of our wards at Hillingdon Hospital to better align services as well as speed-up the time it takes clinicians to travel between wards to see patients. These changes and other initiatives are helping us to better manage the flow of patients through the hospital. To further support service improvement, the Trust Board stepped-up scrutiny of cross-cutting Serious Incident themes including Sepsis and NEWS.

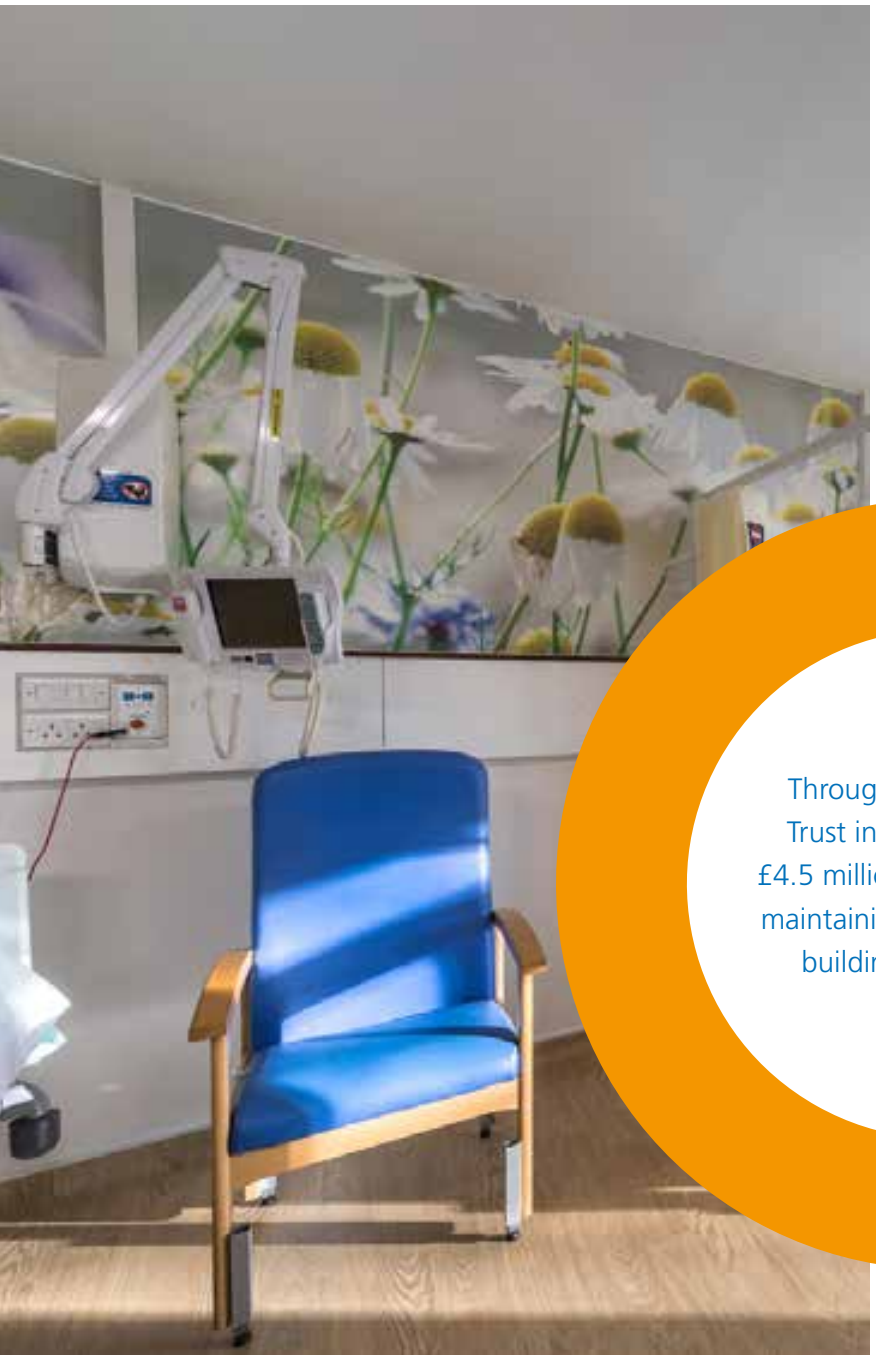
We continue to make good progress towards the government's target for the NHS to become paperless. We extended remote access to our digital Hillingdon Care Record meaning clinical staff can now view patient data anywhere. This enabled one Trust doctor to spot a life-threatening condition in a patient via his iPad

while at another hospital. All of our nursing handovers are now done electronically, reducing the potential for errors and enhancing patient safety. The newly implemented electronic referral system means local GP referrals are now made online, streamlining the process and making it easier to track. We implemented the new Care Information Exchange system, further joining-up patient care by enabling all relevant health and care providers to access and update a patient's records. A pilot scheme introduced towards the end of the year now enables patients to view their own medical records.

Throughout the year the Trust invested more than £4.5 million in improving and maintaining the fabric of our buildings and services. This included improvements to our electrics, heating and water supplies as well as carrying out essential roof repairs. Almost £500,000 was spent on improving our car parks at both hospitals, installing Automatic Number Plate Recognition (ANPR) systems, introducing pay-on-exit so that visitors only pay for time used, and segregating staff and public car-parking areas to make it easier for patients to park.

In addition, we made improvements to our Alderbourne Rehabilitation Ward, installing a much-needed new nurses' station, updating bathroom facilities and providing new secure storage. Thanks to a donation we were able to refurbish the specialist gym on our Stroke Unit and our Hospital Charity funded the upgrading of two Hillingdon wards.

We invested in a new CT scanner at Hillingdon to complement our existing scanner and enable us to carry out more patient scans, more efficiently.



Throughout the year the Trust invested more than £4.5 million in improving and maintaining the fabric of our buildings and services.

We also spent more than £100,000 to kick-start work on the £2.1 million A&E project we have planned to expand our department – currently one of the smallest in London for the number of patients we see. This much-needed expansion will be undertaken in the year ahead.

We continue to work collaboratively with the other key local health and care providers and Hillingdon Health and Care Partners (HHCP), our local Accountable Care Partner organisation, has made great strides in joining-up services in the last year. The Trust was an early adopter of the government's 'Home First' approach, which aims to avoid unnecessary hospital admissions and get people back home safely, with the correct support, as soon as possible. This aligns well with the overall HHCP ethos and is greatly supported by our own local initiatives - in particular Discharge to Assess, which focuses on the over 65s with complex needs. Patients discharged under this scheme are assessed in their own homes within two hours of arriving home. The assessment is undertaken in liaison with social services, community services and the voluntary sector to ensure that all patient needs are addressed. This approach has seen the length of stay in hospital being reduced by, on average, two days. In addition, our Frailty Unit at Hillingdon Hospital (introduced last year) is now well established and providing a quick turn-around service to largely older residents.

The big partnership news this year was the formal launch of a ground-breaking new partnership with Central and North West London NHS FT (CNWL) and Brunel University London to establish the Brunel Partners Academic Centre for Health Sciences. This new centre aims to revolutionise the way health and social care is delivered to meet the changing needs of society. It provides the perfect setting for cutting edge research that will transform the way health services are delivered in the future both here and beyond. And it will help us to attract the brightest and best employees through innovative training and development opportunities.

Externally the Trust has been recognised for its achievements winning a clutch of awards in the last year. These include our Catering Team winning a Health Business Award for improvements to food for patients, staff and visitors; our Procurement Team becoming the first London trust to attain level 2 of the NHS Standards for Procurement and our Ophthalmology Service scooping a Macular Society Award for Excellence.

This year we've boosted our green credentials by replacing four of our fleet of diesel vehicles with electric ones, which cost around 10% less to run. We also worked in close partnership with Brunel University London and Hillingdon Council to successfully secure a cycle-hire scheme for the borough with a station being installed at Hillingdon Hospital.

We continue to work hard to achieve the highest standards in patient care and this year we received over 37,500 responses to the Friends and Family test (FFT) with 96.2% of patients saying they were happy to recommend our services to their friends and family.

We once again, performed well in the national staff survey, with above average results in 13 out of 32 areas. We scored well in the fields of staff motivation at work and in the reduced incidence of physically violent incidents involving patients, their relatives or the public, down from 15% to 13%. Allied to that was the improved reporting rates of the most recent experience of violence, which was 71%, compared to 66% the year before. The biggest improvement was seen in staff appraisals, where the numbers of staff appraised was up from 86% to 93%. Areas where we need to do more is on the proportion of staff reporting errors or 'near-misses' witnessed which fell from 90% to 87%. The number of staff saying they experienced discrimination at work also rose from 12% to 17% as did staff experiencing harassment, bullying or abuse from patients, their relatives or the public, which was up from 28% to 30%. And the percentage of staff believing the Trust offers equal opportunities for career progression or promotion was down from 8% to 80%.

A comprehensive survey of all of our buildings and services mean we have been able to prioritise essential works

Our CARES Values continue to determine our approach to patient care. We maintained high standards of care as demonstrated by our good patient outcomes, and positive feedback from patients.

The most pressing issue for us continues to be the very poor condition of many of our buildings which require us to spend increasing sums on basic maintenance and repairs. A comprehensive survey of all of our buildings and services mean we have been able to prioritise essential works. And while we will not let this affect the quality of care we provide, we have made it clear to the regulator that continuing to undertake maintenance in this piecemeal fashion does not provide value for money and is unsustainable. We have invested time over the last year to ensure that senior health officials understand the severity of the situation.

Our partnership with Brunel and CNWL is proposing an ambitious plan to replace Hillingdon Hospital with a brand-new state-of-the-art health campus incorporating a new hospital on Brunel's site. It is still early days and we are in the process of looking at possible options to realise this ambitious plan. We continue to work with local MPs, NHS Improvement and the Department of Health and Social Care to explore ways to find an affordable solution to the increasing urgent problem of our estate.

We will continue to manage future challenges with the same optimistic attitude that has seen us through this past difficult year and we remain positive about the future.

We are grateful to our staff, governors, volunteers, and fellow Board members for their hard work and commitment to the Trust and the people who rely on us.

**Richard Sumray**
Chair
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018

# Purpose, Activities and History of the Trust

The Hillingdon Hospitals NHS Foundation Trust was established on 1st April 2011 when Monitor authorised the organisation as an NHS Foundation Trust. The Trust provides health services at two hospitals in North West London: Hillingdon and Mount Vernon. Hillingdon Hospital is the only acute hospital in the London Borough of Hillingdon and offers a wide range of services including accident and emergency, inpatient care, day surgery, outpatient clinics and maternity services. The Trust's services at Mount Vernon Hospital include routine day surgery at a modern treatment centre, a minor injuries unit, and outpatient clinics. The Trust also acts as a landlord to a number of other organisations that provide health services at Mount Vernon, including East & North Hertfordshire NHS Trust's Cancer Centre.

We provide clinical services to over half a million patients a year, including over 94,000 Emergency Department attendances.

As an NHS Foundation Trust, we have a 25-strong Council of Governors and over 6,000 public members. We employ over 3,500 staff making us one of Hillingdon's largest employers. The Board of Directors, led by Chairman Richard Sumray comprises of seven Non-Executive and six Executive Directors. We were rated overall as 'Requires improvement' by the Care Quality Commission (CQC) in 2015.

# Overview of the Trust's Strategy and business Model

## Vision

"To be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide best care where needed".

## Purpose

"To provide high quality, safe and compassionate care, improving the health and wellbeing of the people that we serve".

Our focus is to improve health outcomes, and we will adopt the most efficient approaches to deliver effective care – this means extending our reach beyond the footprint of our hospitals, and working with community-based partners in responding to local needs.

This statement of purpose is informed by the dual-nature of our role. We will continue treating people when they are ill, by providing the best available acute care – as has been our focus to date. Looking forward, we will be more forthright in helping people to stay healthy, so that they do not become ill in the first place – this will represent an increased focus on prevention.

During 2017/18, the Trust's strategy was refreshed in light of the North West London Sustainability and Transformation Plan (STP). The STP changes the landscape in which the Trust operates, and it's important that our longer term efforts are geared towards the new context with a particular focus on achieving shared objectives.

Although there is no regulatory obligation to produce a strategic plan, we consider it helpful to articulate our ambitions and collate our key strategies in one document. The Strategic Plan 2017-2021 permits us do this; and, it sets out how we intend to address the clinical and financial performance challenges which we face, in common with other acute trusts. Most notably:

- Demand for acute services is rising year on year as the population ages. The Trust is experiencing growth in both elective and non-elective activity
- Funding is growing at a slower rate than demand for services.

# CREATING A BETTER FUTURE

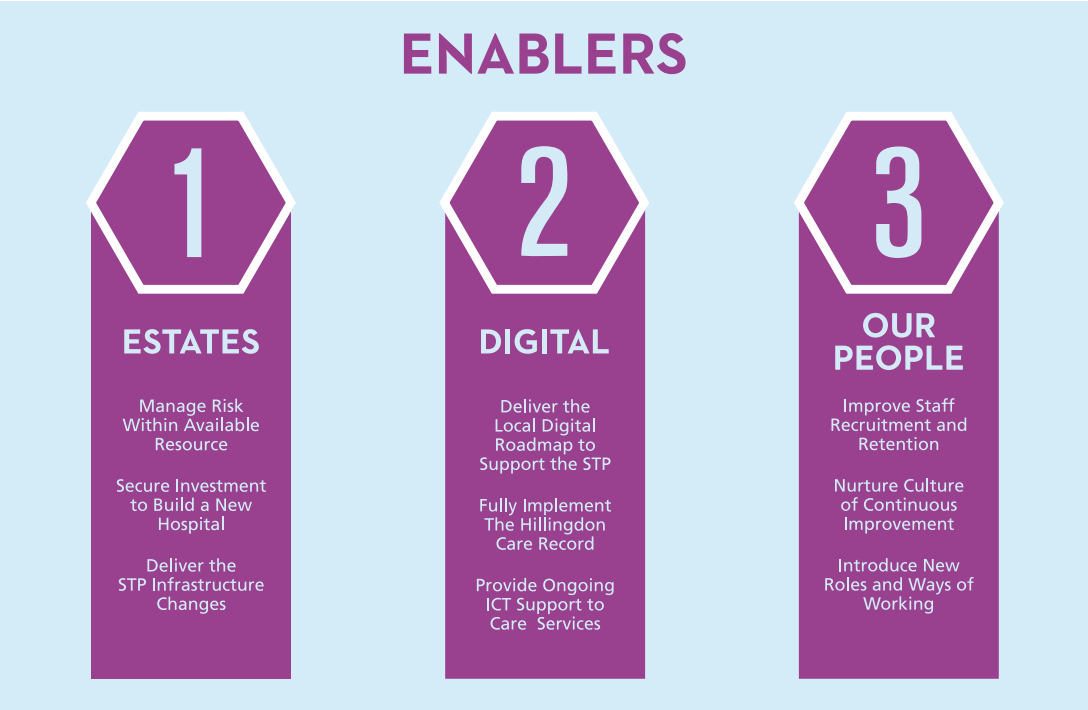
| | | | | | |
|---|---|---|---|---|---|
| **VISION** | **To be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide best care where needed.** | | | | |
| **PURPOSE** | **To provide high quality, safe and compassionate care, improving the health and wellbeing of the people we serve.** | | | | |
| **AREAS OF FOCUS** | Help people to stop smoking.<br>Improve the health of our workforce.<br>Promote better health in the community. | Engage people in their care.<br>Join-up services and integrate care.<br>Empower people to self-manage their long-term conditions | Improve end-of-life care.<br>Provide more care closer to home.<br>Better recognise, and support, the role of carers. | Strengthen crisis support services.<br>Ensure better access to mental health services in acute care. | Strengthen emergency care.<br>Improve clinical and financial productivity.<br>Implement core 7-day service standards.<br>Develop an academic health partnership with Brunel University London and CNWL. |
| **DELIVERY AREAS** | **Prevention and wellbeing** 1 | **Managing long-term conditions** 2 | **Transforming care for older people** 3 | **Improving mental health** 4 | **Sustainable, quality, safe, acute services** 5 |

cares
communication attitude
responsibility equity safety

# OPERATIONAL EXCELLENCE

| | | | |
|---|---|---|---|
| **TARGETS** | **Deliver the NHS Improvement indicators:<br>Treat people within 18 weeks of referral<br>Fulfil A&E performance standards<br>Achieve targets for cancer care** | **Comply with the requirements of The Care Quality Commission** | **Meet financial performance objectives** |
| **GOVERNANCE & MONITORING** | **Trust Board and committees: quality, finance and transformation, performance, risk, assurance** | | |
| | **Divisional performance reviews** | | |
| **PERFORMANCE** | **Balanced Scorecards and key performance indicators** | | |

# IMPROVING THE PRESENT




## Overview of the STP

The STP aims to transform the way that care will be experienced in 2020/21. It is a plan to implement system-wide changes which seek to improve population health & wellbeing, together with care and quality for patients. This ambition is clearly explained in the STP check-point submission, of June 2016. The shift in emphasis is illustrated below:

**Current System**

Reactive care, often responding to crises, under resourced and capacity pressures.

**Future System**

Pro-active care focusing on self-care, wellbeing and community interventions.

## Summary of our refreshed strategy and business model

The Strategic Plan 2017-21 provides a framework within which a number of supporting strategies and plans are referenced. It represents a high-level document, which avoids duplicating the more detailed information contained within Operational Plans. It articulates how we will deliver the quality, safe, acute services required by the STP, by implementing the following priority agendas over the medium term:

- Delivering more joined up, community based care to make best use of available resources. We are doing this by working in partnership with other organisations who deliver care, locally. These include Central and Northwest London NHS Foundation Trust (CNWL), the Hillingdon GP Federation, and 'H4all' (a consortium of voluntary sector providers). Together, we have formed 'Hillingdon Health and Care Partners' to be commissioned by Hillingdon Clinical Commissioning Group (CCG) as an Accountable Care Provider (ACP), and the launch of the Academic Centre for Health Sciences with Brunel University London and CNWL.
- Implementing transformation schemes to manage demand whilst also making best use of available financial and staffing resources. These include national initiatives like the 'The Model Hospital' and efficiency improvements recommended by Lord Carter's review; together with sub-regional schemes like the NWL productivity programme.
- Engaging with the population to begin to improve the prevention and wellbeing agenda.

The Strategic Plan 2017-21 provides a framework within which a number of supporting strategies and plans are referenced

# Key Issues for the Trust

## Increasing demand for services

The demand for services has continued to increase with us seeing an overall increase of 2%. Delays in the transfer of elderly patients has also had a detrimental impact on our ability to free up beds and improve the speed that we are able transfer patients from A&E.

## Increasing demands on staff

We had to rely far more heavily on agency staff that we wanted to. Our staff are working under greater pressure as the level of demand and activity continues to increase. There is also real competition for good staff in the region and a greater number of options open to them.

## Poor condition of our estate

Much of our estate would require significant investment to bring it up to modern-day standards

Many of our main buildings have been operational well beyond their expected life cycle and are continuing to deteriorate. Much of our estate would require significant investment to bring it up to modern-day standards. The Trust's modest capital investment programme means that we are unable to address the most substantial estates issues.

# Key Risks for the Trust

## 1 Achieving the 95% A&E target leading to a breach of its License.

During the year the number of emergency admissions into the hospital increased by 13%. Despite this there is evidence that the actions taken around integration and new models of care have had a positive impact on admissions for elderly patients. Admission rates for this group of patients increased at a lower rate of 10%. The biggest increase relates to patients aged between 18 and 64. The Trust will review capacity in ambulatory care to reduce admissions for patients in this age range that are admitted for 24 hours or less. Reduced admissions and a bigger ambulatory unit would improve flows through A&E and support better performance.

The Trust is working with Hillingdon Clinical Commissioning Group, Hillingdon Borough Council, Hillingdon Community Health and the third sector to integrate care and ensure that admissions to hospital are avoided where possible; and, that time spent in the A&E department is reduced. Action will be taken, following a recent independent review of patient flows, to and through the A&E department and into the Acute Medical Unit, to improve patients' waits in A&E.

## 2 Inadequate nursing levels due to a combination of vacancies, national shortages and additional capacity being opened to meet any surge in demand.

This risk is mitigated in real-time by proactive review of staffing by senior nurses and midwives to ensure each area is staffed in line with actual need. SafeCare, a real time electronic solution which supports acuity based daily staffing processes is being rolled out across inpatient wards; this will help unlock productivity and safeguard patient safety on a daily basis. Average shift-fill rates are also reviewed retrospectively alongside patient-centred outcome indicators. There has, and continues to be, ongoing and frequent recruitment, with each divisional team working in partnership with the recruitment manager to progress plans specific to the needs of their specialities. In addition to the international recruitment campaign to India in early 2018, more flexible working arrangements and recruiting overseas nurses already working in the UK, supporting them to achieve registration with the Nursing and Midwifery Council are some of the additional initiatives the Trust has employed to improve the recruitment of nurses. The Trust is actively progressing a robust nurse staffing retention action plan as part of the national improvement collaborative with NHS Improvement.

## 3 Delivering high quality patient care as a result of inadequate staffing provision and specifically inadequate staffing provision to meet the 7-day workforce initiative.

The Trust is reviewing its medical and support service workforce to improve frontline staff numbers and care at the bedside seven days a week. The Trust will continue to drive forward a robust recruitment and retention work programme to reduce the number of vacancies, develop new roles supporting the medical workforce and to support the increased activity that the Trust has seen during this past year.

A successful 'winter monies' bid enabled the implementation of additional frontline medical staff overnight and weekends in the division of medicine, and additional weekend therapy plus pharmacy staff. The impact of this is being reviewed along with the impact of ward relocations on clinical and quality indicators, which had already aided an improvement in the 7-day service Standards 2 and 8.

## 4 Complying with the expected standards set out by our regulators which could impact on the Trust achieving a 'good' rating with the CQC.

The Trust continues to strengthen its governance arrangements and its compliance with the Health and Social Care Act regulations through a programme of internal peer reviews and mock inspections to ensure there is evidence of improvement against a refreshed CQC action plan. Core services have been undertaking self-assessment against the inspection frameworks to support critical review of compliance against the CQC standards. There is increased scrutiny of operational performance and quality data and an accountability framework to ensure compliance with policy and delivery of statutory targets is being progressed. KPMG, the Trust's internal auditor has undertaken a review of the Trust's compliance against the key Lines of Enquiry and this has supported a refreshed and strengthened improvement plan to ensure key areas of focus are understood and improvement work progressed. The Trust is awaiting the outcome of a comprehensive core service inspection conducted in March/April 2018.

## 5 Effectiveness of the financial control system or inability to achieve the financial plan

The Trust has planned for a deficit of £14m in 2018/19 and having agreed a control total with NHSI is eligible for up to £6.2m of Provider Sustainability Funding to reduce the deficit further. However, the plan contains the following significant risks: a high level of savings (5%); no funding for activity growth above contracted levels, and no contingency. The 2018/19 financial plan has been developed and approved by the Board of Directors, and submitted to the regulator. There is robust monitoring in place via the Board, Audit and Risk Committee, Finance Committee and Transformation Committee. To give the Trust the very best opportunity of delivering its savings, a Project Management Office (PMO) is in place to support managers and clinicians to achieve identified savings plans.

Throughout the year weekly/ fortnightly risk assessment allows early sign of potential areas of non-delivery to be identified and ensure mitigating actions are put in place to prevent slippage or non-delivery

Throughout the year weekly/fortnightly risk assessment allows early sign of potential areas of non-delivery to be identified and ensure mitigating actions are put in place to prevent slippage or non-delivery. To further strengthen the PMO, the Trust is participating in a Financial Improvement Programme run by NHS Improvement. External consultants experienced in delivering financial improvements have been engaged to add capacity to the PMO and help strengthen the governance arrangements for QIPP delivery. To manage the service risk as robustly as possible all savings schemes have a project initiation document that requires risk assessment. Any significant risks identified need a comprehensive Quality Impact Assessment (QIA) that is reviewed by the Clinical Assurance Panel (CAP) led by the Medical Director. The CAP reviews, approves or rejects any schemes, thereby assuring the organisation that change and transformation programmes do not pose a material risk to the delivery of safe, high quality care. The CAP also reviews quality KPIs related to projects to track any changes alongside key changes to service delivery.

## 6 The scale of investment required to improve the Trust's fragile estate infrastructure

Failure to maintain the estate comes under Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises. The condition of key building systems is assessed by a five yearly survey, and is risk assessed and rated against available capital. The annual capital investment available for the estate is targeted at addressing specific extreme risks, and although the level of funding is insufficient to remove the risks it does enable a risk reduction. However, the available funds are insufficient to keep pace with the scale of backlog maintenance and the Trust continues to have high-risk estates issues on its Risk Register. The need for investment in our infrastructure has been highlighted through the Shaping a Healthier Future (SaHF) business case. The case identifies the need for investment, but also flags that though investment would help, it would not resolve all our issues with the current infrastructure. In addition, the Trust is working with partners to develop a longer term solution to the estates issues through the development of a new facility on a university health campus at Brunel University.

The Board formally escalated the condition the condition and risks associated with the Trust estate to NHS Improvement in February 2018

## 7 Modernising & reconfiguring the Estate & Facilities to meet the needs of our clinical services.

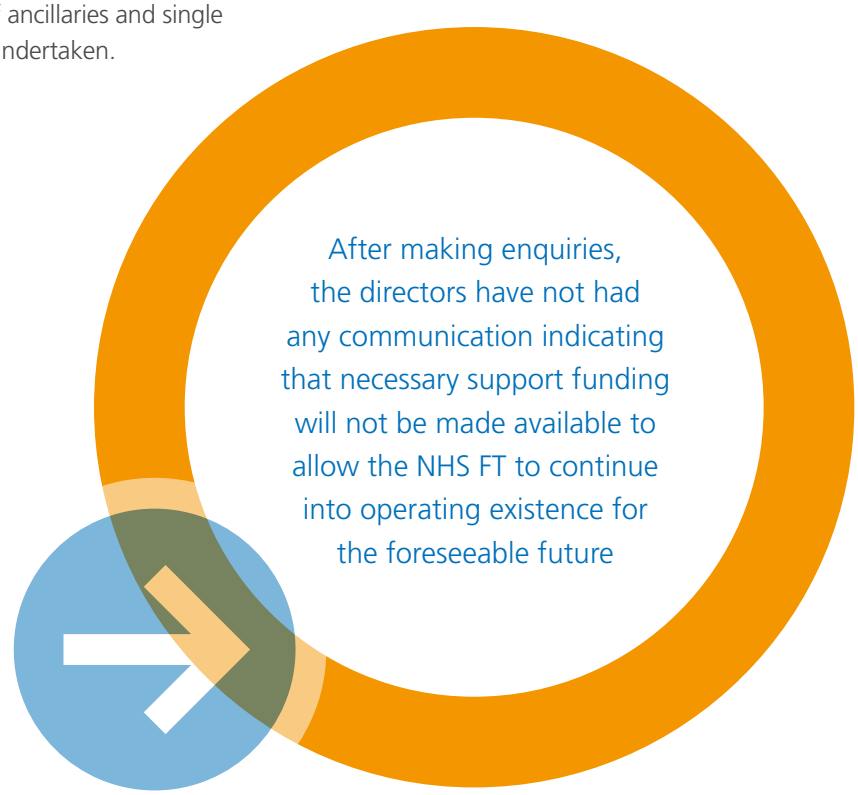
The estate has suffered from under-investment over an extended period and many building services have failed or are beyond their economic and design life cycle. Key facilities such as Theatres, Critical Care and many wards are of a design and condition that does not lend itself to the delivery of modern high quality healthcare.

A waste incinerator that provides the majority of heat to the Hillingdon acute site is operated by an external contractor. This contract can be extended to August 2019 with agreement of both parties. An operator will need to be found post August 2019 and the installation would need Investment to make attractive to potential operators. Options for an energy centre have been reviewed and whilst the future of the site is unknown, it is difficult to attract investors who would provide an Energy Performance Contract (EPC) programme. It is important that Hillingdon Hospital can generate sufficient steam to support the site without be dependent on steam from the incineration process. Therefore, a third boiler is being installed and a review of the condition of ancillaries and single point of failures is being undertaken.

Overall, the Trust will remain focused on the tension between quality, safety, financial efficiency and risk to ensure that patient care remains uncompromised. The Trust will do this by having regular Board and Executive reviews of progress and delivery of agreed, plans and check that all schemes are quality impact assessed.

# Going Concern disclosure

After making enquiries, the directors have not had any communication indicating that necessary support funding will not be made available to allow the NHS FT to continue into operating existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. Further Commentary can be found in the annual governance statement contained within this report.



# Summary of other performance 2017-2018

## Managing our resources well

During a very tough year we delivered in excess of £10 million of savings – more than double the previous year – without a detrimental impact on quality. We were also one of only eight trusts in the country to meet the Carter efficiency review recommendations.

## Achieving greater efficiencies

A number of changes improved our efficiency and saved money. These included: better utilisation of our Theatre lists by 3.9% (since July 17) reducing the need for extra weekend lists; a reduction in our outpatient 'do not attend' rate (DNA) from 9.8% to 8.5%; improved control and reporting of agency staffing, reducing staffing gaps and a resulting in 5% reduction in nursing agency spend and streamlining workforce processes through the TRAC recruitment system and 247 Time, leading to a reduction in our Medical and AHP agency costs by 17%.

## Improving our digital services

We significantly increased our digital capabilities. Improvements included: expanding remote access to patient records for clinical staff; enabling all nursing handovers to be undertaken electronically; implementing a new electronic referral system for GPs and introducing the new Care Information Exchange system, enabling all relevant health and care providers to access and update a patient's records.

## Securing external recognition

The Trust's work secured it a clutch of awards. These include: Our Catering Service winning a Health Business Award for improvements to food for patients, staff and visitors; Procurement becoming the first London trust to attain level 2 of the NHS Standards for Procurement and our Ophthalmology Service scooping a Macular Society Award for Excellence. Our Maternity Service was also praised in a local Healthwatch report.

## Maintaining and upgrading our buildings

The Trust invested more than £4.5 million in improving and maintaining our electrics, heating and water supplies as well as carrying out essential roof repairs. Improvements were also made to Alderbourne Rehabilitation Ward, and both Hayes and Grange wards at Hillingdon, while almost £500k was spent on improving our car parks at both hospital sites.

## Strengthening partnerships

In partnership with Central North West London NHS FT and Brunel University London we formally launched the ground-breaking new Brunel Partners Academic Centre for Health Sciences. This aims to revolutionise the way health and social care is delivered in the future. We also successfully we introduced a range of initiatives as part of Hillingdon's Accountable Care Partnership to better support elderly patients to stay in their own homes for longer.

## Improving patient facilities

We spent £480k on a new CT scanner at Hillingdon. This complements our existing scanner enabling us to carry out more patient scans, more efficiently. We also spent more than £100,000 to kick-start work on the £2.1 million project we have planned to expand our A&E department in the year ahead.

## Caring for our staff

In the annual NHS Staff Survey – 61% of our staff said they 'would recommend the Trust as a place to work' - 1% higher than the average for acute trusts. Overall, we scored above average in 13 areas with 4 of these being in the top 20% of all acute Trusts in England. We also launched a Leadership in Action Programme to support staff growth and develop our leaders of the future.

## Friends and Family Test

We received 37,518 responses to the FFT – 96.2% of patients would recommend our services to their friends and family.

**We spent £480k on a new CT scanner at Hillingdon**

# 1.2 PERFORMANCE ANALYSIS

## Approach to measuring performance

The Trust has in place an established integrated performance framework to monitor and track all the performance standards. The weekly meetings include detailed operational reviews of constitutional standards covering both emergency and planned care led by the Chief Operating Officer and the Director of Operational Performance. The monthly divisional reviews form a core part of the framework led by the executive team to ensure there is effective support and controls to deliver high quality services to patients. This element is a key part of the accountability framework.

The meetings report by exception to the respective sub committees of the board, where further scrutiny is applied to ensure continuous improvement of the Trust's delivery on quality and operational performance.

The Board receives these key performance indicators in a way that considers the risks associated with achieving performance standards within time defined targets in a "RAG" (red, amber, green) format with commentary on performance and the actions being undertaken or about to be undertaken to mitigate the risk of failing to achieve the target.

A 2 monthly integrated quality and performance report is presented to the board which covers the five key domains based on the Care Quality Commission (CQC) framework:

1. **Safe**, which includes infection Control, falls, maternity indicators, safety thermometer, Serious Incidents/never events, patient safety and mortality standards.
2. **Effective**, this covers readmissions and DNA's as well as monitoring performance on the use of Electronic Referral Service (ERS).
3. **Caring**, this domain monitors outputs and delivery of Friends and Family surveys, as well as complaints and feedback from the Trust's Patient Advisory and Liaison Service (PALS).
4. **Responsive**, focuses predominantly on the constitutional standards reporting on Emergency Care, Cancer and RTT.
5. **Well Led**, monitors recruitment and retention as well as sickness rates and PDR performance.

# Analysis of the Performance of the Trust

The overall Trust position remains stable in all the areas except for the 4 hour emergency care transit time standard of 95%. The Trust has worked closely with the regulators, system partners and the staff towards delivering sustained improvements in this key delivery area. Whilst the year end position for the 4 hour transit time standard was at 84.6%, the month of March ended with 77.6% of our patients being discharged, admitted or transferred within 4 hours. Quarter 4 2017/18 was particularly difficult with emergency patient flows at the Trust which was consistent with the national picture.

The performance for this standard is being monitored through the A&E Delivery Board which represents the whole care system leads, highlighting the dependency of achievement across all the agencies involved in providing emergency care for the residents of Hillingdon and the neighboring boroughs. The Performance table below provides a three year comparative for each of the performance standards.

| Attendance | 2016/2017 | 2017/2018 | variance |
|---|---|---|---|
| Attendances made to our Accident & Emergency Department | 64,421 | 66,462 | 3.2% |
| Attendances made to our Minor Injuries Unit | 28,098 | 27,885 | -0.8% |
| Attendances made to our Accident & Emergency Department and Minor Injuries Unit | 92,519 | 94,347 | 2.0% |
| Babies born in our maternity unit | 4,900 | 4,660 | -4.9% |
| Attendances made as out-patients | 369,229 | 375,580 | 1.7% |
| Admissions made for emergency treatment | 23,124 | 26,130 | 13.0% |
| Admissions made for planned operations and day-surgery | 26,834 | 25,963 | -3.2% |
| Total Contacts | 516,606 | 526,680 | 2.0% |

## Performance Table: 3 year comparator (2015/16 to 2017/18)

| Indicator | Performance In 2015/16 | Performance in 2016/2017 | Performance in 2017/18 | Target Achieved |
|---|---|---|---|---|
| Clostridium difficile (Total) | 12 | 12 | 19 | n/a |
| Clostridium difficile (Lapses of Care) | 1 | 2 | 2 | ✓ |
| All cancers: 31 days for second or subsequent treatment (surgery) | 100% | 100% | 98.7% | ✓ |
| All cancers: 31 days for second or subsequent treatment (anti-cancer drug treatments) | 100% | 100% | 100% | ✓ |
| All cancers: 62 days for first treatment from urgent GP referral for suspected cancer | 92.2% | 88.4% | 85.9% | ✓ |
| All cancers: 62 days for first treatment from NHS Cancer Screening Service referral | 98.4% | 95.0% | 96.5% | ✓ |
| All cancers: 31 days diagnosis to first treatment | 99.3% | 98.7% | 98.9% | ✓ |
| Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected) | 98.0% | 95.5% | 95.1% | ✓ |
| Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected) | 95.7% | 97.9% | 95.2% | ✓ |
| Maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway | 96.1% | 92.4% | 91.1% | ✗ |
| A&E: Total time in A&E less than 4 hours (Accident & Emergency, Minor Injuries Unit, Urgent Care Centre) | 92.0% | 84.0% | 84.6% | ✗ |
| Self-certification against compliance with requirements regards access to healthcare for people with a learning disability | Fully Compliant | Fully Compliant | Fully Compliant | ✓ |

## Clostridium difficile

The Trust reported 19 cases for 2017/18. There were 2 lapses in care during 2017/18 (at time of report as several cases remain under review with commissioners) against a threshold of 8 (lapses in care). This reflects an increase of 7 total cases when compared with 2016/17. Clostridium difficile infection rates remain however below the London and national average. An increase has been noted regionally and nationally.
A multidisciplinary Root Cause Analysis (RCA) investigation is undertaken for all cases of Trust attributed C. difficile, with the Consultant in charge of care, the Consultant Microbiologist, Lead Nurse Infection Prevention and Control, Ward Sister and responsible Matron forming a panel as part of the process. All RCAs are reviewed by the Director of Infection Prevention and Control and all reports are presented to the Clinical Commissioning Group for review for any lapses in care.

## Cancer Performance

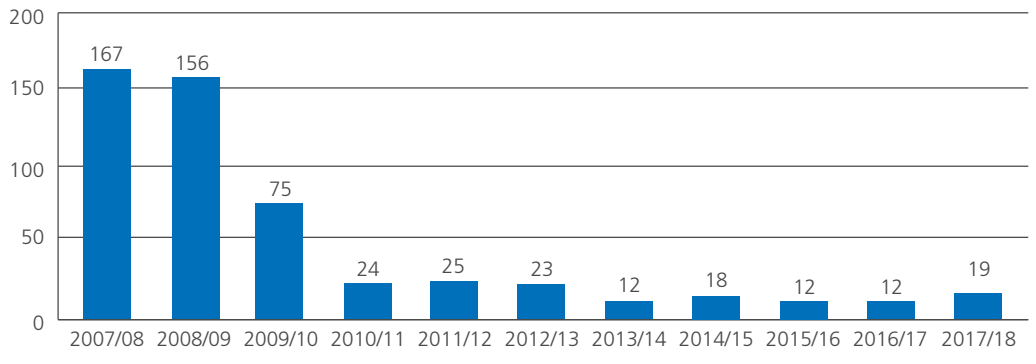
The Trust successfully achieved all of the cancer access targets for the fifth successive year. The close tracking of each patient at tumor site level with a strong multi-disciplinary approach has been a key enabler for this success. The Trust remains committed towards delivering a sustained performance for our patients in this area. However, key risks around diagnostic capacity and increased referrals remain. These are mitigated with tumor site review of demand and capacity.

## Referral to Treatment

The Trust ended the year with a performance of 91.1% against a target of 92%. This was particularly related to the emergency Care pressures experienced over Q3 and Q4 2017/18 resulting in cancellation of elective procedures to create inpatient capacity. The service teams continue to increase capacity at specialty level in response to demand based on clinical priority and chronological wait. The Trust RTT model is being developed further in light of the increasing levels of demand in 2017/18 to support the delivery of the standard.

***Clostridium difficile* Toxin Positive**

Source: PHE



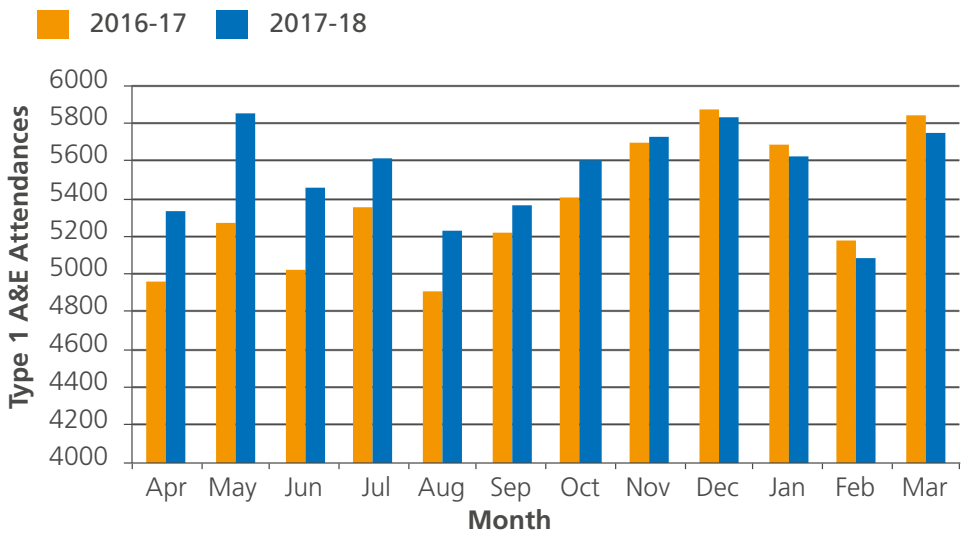
## A&E 4 Hour Standard

The Trust did not meet 95% performance for the 4 hour Emergency Care transit time standard achieving 84.6%. The month of March ended with 77.6% of our patients being discharged, admitted or transferred within 4 hours. Quarter 4 2017/18 was particularly difficult with emergency patient flows at the Trust which was consistent with the national picture. The Emergency care Improvement Plan continues to be monitored through the A&E Delivery Board which is represented by all the system leads across health and care ensuring a strong partnership approach.

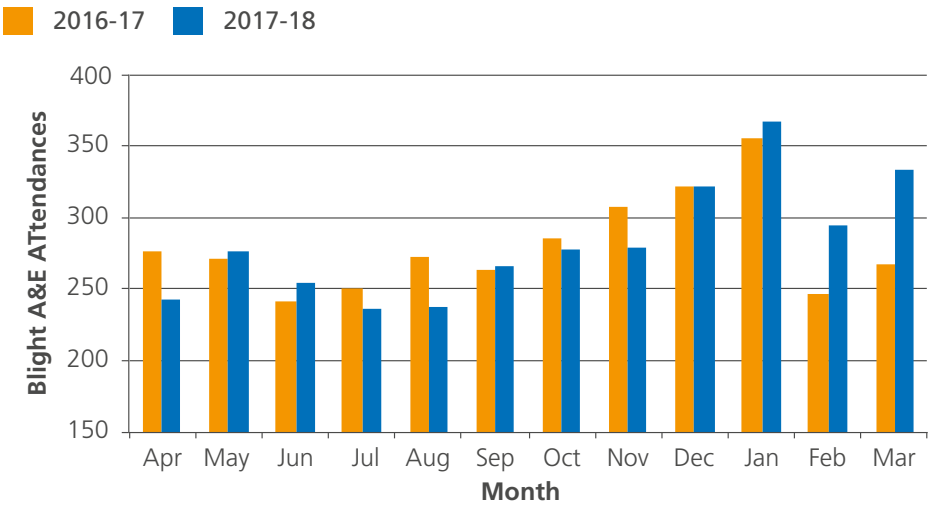
The A&E attendance (Type 1) increased by 3.2% compared to the previous year, Paediatrics went up by 2.8% and non-blue light ambulance conveyances was up by 4.3%. The Trust saw an increase of 13% in the number of emergency admissions during 2017/18. All these factors culminated in additional demands on the service and an increasing need for resources overall. The system wide Emergency Care Improvement Programme will remain a priority for the Trust into 2018/19. The work stream areas are System Demand Management, Emergency Department Process and Patient Flow, SAFER Care Bundle and Discharge Process. Some of the key improvement areas include:

- Ambulance handover time with ambulance streaming in place within a dedicated handover area
- The Clinical Decisions Unit is functioning well particularly with the improvement in bed flows within specialty wards enabling a quicker transfer of admitted patients
- The staff shift pattern leadership focus around the overall co-ordination of the department continues to improve incrementally and remains work in progress
- Early First Assessment and Management (EFAM) for self-presenters have strengthened ensuring timely clinical decision making in patient management
- Patient flows are improving with the Frailty Unit in place ensuring earlier and proactive management of patients within a 72 hour period
- The Trust has put in place a 24 hour clinical operating rhythm including 2 patient safety huddles a day throughout the week with ward managers. This has enabled the teams to focus on safe care whilst maximising discharges over a 24 hour period
- Ensuring the SAFER Care Bundle, including the visual patient management system 'red to green,' is maintained with further plans to strengthen the core elements, which will provide a consistent application at ward level
- Weekly review of patients on the wards with a length of stay of >6 days by the Director of Operations and the system leads
- Discharge to Assess is progressing well with partner organisations. The aim is to reduce medically optimised and "delayed transfer of care" patients in the hospital
- The daily conference calls for case managing medically optimised patients in hospital continues with partner agencies
- Further focus on hospital wide management of emergency care flows continues including the active management of the 4 hour breaches with the expectation of incremental improvements to achieve the set trajectory per month
- The Trust has introduced a clinician led model of "Best practice" support for SAFER on the wards
- Successful ward reconfiguration completed resulting in a co-located Medical and surgical assessment units supported by a dedicated frailty unit on Lister ward.

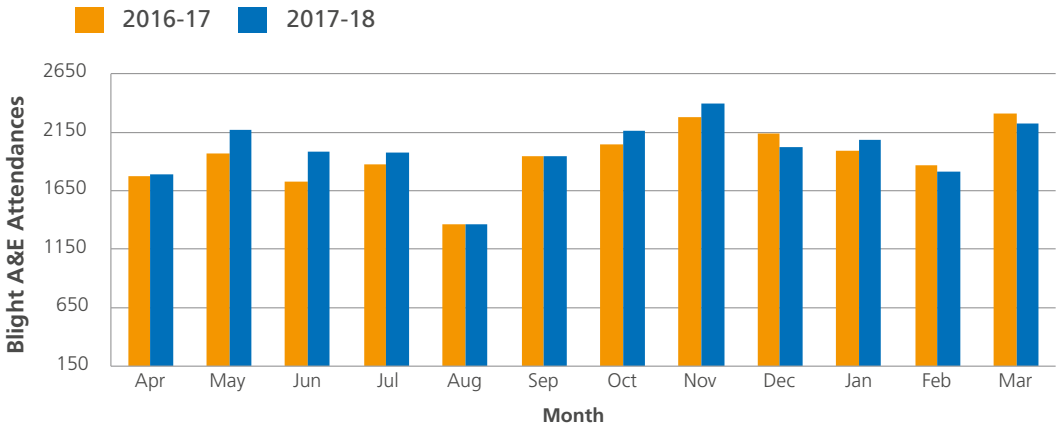
**Type 1 (Main A&E) Attendances by Month (Type 1 Attendances Increased by 3.2%)**




**Blue Light A&E Attendances by Month**
**(Blue Light Ambulance Attendances Increased by 0.9%)**




**A&E Attendances - Paediatric (excl UCC) (Paediatric Attendances Increased by 2.8%)**



# Financial performance

## Overall performance

The 2017/18 financial year proved to be as challenging as 2016/17 from a financial perspective. The Trust was unable to agree a "Control Total" with NHS Improvement as the Board was not prepared to agree to a savings target of 10%. As a consequence, the Trust was not eligible for £5.9m of Sustainability and Transformation Funding, leaving it with a planned deficit of £8.7m for the year. The Trust managed to improve on the plan delivering a £8.0m deficit following receipt of £0.6m of winter funding for costs that were already planned for. However, this result was again dependent on one-off accounting benefits derived from the Trust's property valuations. Delivery of savings in 2017/18 was more than double the achievement in 2016/17 due to the implementation of the Financial Improvement Programme.

## Trading for the year

The Trust ended the 2017/18 financial year with a financial deficit of £8m. This was significantly worse than the position in 2015/16 (£5.9m surplus) though better than the plan for the year (£8.7m deficit). However, this position was only delivered due to an unplanned accounting benefit of £10.670m relating to the revaluation of the Trust's investment properties.
The on-going increase in demand for the Trust's services led to a £11.1m increase in its clinical income when compared with the previous year. However, non-clinical income was down £9.9m, of which £7.5m related to the loss of Sustainability and Transformation Funding. Pay costs increased by £2.7m, which is less than the growth in clinical activity and reflects the benefit of the in-year Financial Improvement Programme. Non-pay costs increased by £11.4m, a greater rate than the growth in pay. This primarily reflected increases in clinical supply costs £6.8m, and contributions to the clinical negligence risk pool of £1.9m.

The Trust achieved £10m of savings in 2017/18. This fell short of the £12.5m target the Trust had set, thus contributing to the worsening financial position.

## Cash flow

The Trust's cash position deteriorated in year due to the deficit. This was financed by additional loans from the Department of Health (£19.444m). From the available cash, £4.6m was utilised to service outstanding debt and interest commitments from loans and leases, and to pay £4.3m Public Dividend Capital to the Department of Health. The remaining cash was used to finance the Trust's capital investment programme. The year-end retained cash balance of £1.1m was in line with last year's balance.

## Capital investment

During the financial year the Trust invested in a capital programme totaling £7.2m on the facilities, equipment and technology used by the Trust to deliver healthcare.

The Trust physical estate infrastructure again remained by far the largest area of investment. This was targeted toward prioritised risk-based investment to ensure operational buildings remained safe, fit for purpose, and compliant with statutory legislation.

The Trust received additional funding from the Department of Health to support improved flow through the A&E department. This work is due to complete in 2018/19. Further funding was also received to support improvements to Cyber Security.

Apart from the physical infrastructure, the Trust also continued to invest in updating its medical equipment impacting on a wide range of clinical services and on information technology infrastructure and capability.

## Looking ahead

Given the underlying deficit position, the Trust continues to face finance challenges moving forward. In addition to the national efficiency requirement of 2%, the Trust faces a number of other cost pressures in 2018/19. The target savings for the Financial Improvement Programme (FIP) are £12m. The FIP plan is supported by use of the 'Model Hospital' tool provided by NHS Improvement. This provides benchmarking information to support improvements in operational productivity.

The Trust's 'Control Total' has been adjusted by NHSI for 2018/19. As a consequence, the Trust has approved a budget consistent with achieving this target. This means the Trust will be eligible for £6.2m of Provider Sustainability Funding. This reduces the Trust's deficit for 2018/19 to £7.6m.

Over the medium term, the Trust still plans to achieve financial balance as the acute services reconfiguration in North West London is completed. However, the pace of these changes is not sufficient to deliver financial balance over the next three years. As a consequence of the challenging financial position the Trust is undertaking an analysis of the 'Drivers of the Deficit'. This work will be used to develop a financial strategy in conjunction with commissioners and the regulator.

Given its age and condition, managing the Trust's estate infrastructure is an ever increasingly difficult and expensive task. The cost of maintaining current facilities to meet compliance standards and service requirements remains high.

# Environmental Performance

## The Trust's Impact on the environment

The Trust recognises the need to operate as a financially and socially responsible organisation, minimising its impact on the environment in order to deliver the highest quality healthcare to the communities we serve, now and in future. In line with the Sustainable Development Management Plan work has been undertaken to continue to minimise the organisation's impact on the environment and reduce the Trust's energy use.

The Carbon Reduction Commitment Energy Efficiency Scheme (often referred to as 'the CRC') is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. The scheme features a range of reputational, behavioral and financial drivers, which aim to encourage organisations to develop energy management strategies that promote a better understanding of energy usage. The Trust has undertaken risk assessments and has Carbon Reduction Delivery Plans in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Extensive audits have been carried out on both sites to identify opportunities to reduce energy consumption and associated carbon emissions. Water surveys were also conducted on both sites to understand usage profiles and patterns better and to pinpoint areas where consumption can be optimised.

With increased electrical demand from rising clinical activity, the electricity consumption for the period 2017/18 increased to 16,586,786 kWh from 16,542,524 kWh in 2016/17, an increase of 0.27%. In addition, total gas consumption for the year rose by 1.97% against 2016/17 figures.

The Trust's contract with SRCL (Part of Stericycle Inc.) to operate the incinerator based on The Hillingdon Hospital site ensures our clinical waste travels a minimal distance before entering the incinerator process. It helps minimise the impact on the environment in that the steam created from burning clinical waste is used to provide 65% of the energy needed to heat the radiators and provide hot water at Hillingdon Hospital, therefore significantly reducing our need for energy sources such as gas and oil. The incinerator takes most of the waste from Hillingdon, and clinical waste from Mount Vernon Hospital.

The Trust's procurement contracts now require suppliers to demonstrate that they minimise any impact on the environment with the products and services they provide.

## Looking ahead

Investment in energy efficiency has been very low and in order to improve energy efficiency, investment is required in the energy generation and distribution infrastructure. Immediate investment is being made in an additional boiler for Hillingdon Hospital which will be more efficient in generating heat. Work has recently been undertaken to develop a medium term strategy to provide a resilient energy provision to the site until the long term future of the hospital location is known. Where possible, investment will be made (subject to budgetary constraints) to upgrade infrastructure to realise energy savings. Until the long term location of the hospital is known, it is unlikely that any significant investment in items such as an energy centre will be made.

The projects being considered include, but are not limited to:

- Lighting upgrades
- Electrical system enhancements
- Metering strategy and associated energy monitoring and targeting software

These initiatives will help the Trust become a more efficient user of energy and thereby lower its associated carbon emissions. In addition, the Trust will benefit from a reduction in both direct energy costs and non-energy charges in the form of lower carbon levies, operational, maintenance, and service costs.

## Waste reduction and minimisation

The Facilities waste & recycling service provides the safe collection, management and disposal of materials from our sites.

The Trust's Waste Group has met on a regular basis during the year. Part of its role is to ensure waste is segregated, managed, recycled and disposed of effectively in line with the Department of Health publication 'Safe Management of Healthcare Waste' and 'Waste Hierarchy' of the Department for Environment, Food & Rural Affairs.

Waste minimisation efforts have been focused on reducing reliability on plastic based packaging and replacing with either cardboard based or bio degradable alternatives. All takeaway food in the Trust restaurants is now served in compostable packaging.

There was a continuing decrease in the amount of waste sent to landfill in comparison to the previous year. During the year there has been considerable focus on improving waste segregation and processing and an increased drive to improve our recycling and reduce landfill working in partnership with the local authority.

## Green travel

The Trust has continued to promote green travel for staff and service users. The Trust Travel Plan Co-ordinator has been undertaking a range of initiatives to encourage green travel in liaison with the local authority including cycle to work schemes. The Trust worked on a joint bid with Brunel University to successfully secure a local Santander Cycle Scheme which will include the installation in 2018 of a 10 cycle docking station linked to further docking stations on the Brunel University Campus and Uxbridge town centre. The Trust introduced six electric car charging points for staff and the public to encourage carbon reduction and a greener environment. The Facilities Transport fleet also changed four of its Trust vehicles to electric cars and these are charged on site. The Trust was also successful in locating and leasing an increased number of local off-site parking spaces for staff.

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Total waste generated at Hillingdon and Mount Vernon Hospitals | 1,476 tonnes | 1,881 tonnes | 1,736 tonnes | 1,710 tonnes | 1,763 tonnes |
| Recycled materials recovered | 437 tonnes (30%) | 441 tonnes (23%) | 409 tonnes (24%) | 420 tonnes (25%) | 508 tonnes (29%) |
| Clinical waste incinerated to produce steam that generated heat and hot water at Hillingdon Hospital | 537 tonnes (36%) | 574 tonnes (31%) | 659 tonnes (38%) | 688 tonnes (40%) | 658 tonnes (37%) |
| Waste sent to landfill | 502 tonnes (34%) | 866 tonnes (46%) | 668 tonnes (38%) | 602 tonnes (35%) | 596 tonnes (34%) |

The Trust has continued to promote green travel for staff and service users.

# Community

The hospital is at the heart of the community and the Trust considers it essential to maintain and foster good relations with residents across the borough as well as local organisations.

The Trust hosts quarterly People in Partnership forums where Trust members and the general public can attend to discuss key local health issues. We regularly host service user groups to develop services, such as the Carers Strategy. Our Lay Strategic Forum comprises of members of the public who also contribute to service development and lay members sit on a number of our Committees such as the Quality & Safety Committee and Charitable Funds Committee. Hospital stalls take place at local community events.

At a strategic level representatives from the Trust attend the local Health and Wellbeing Board and the Chair and Chief Executive meet with the Local Authority. We have particularly close relationships with Hillingdon Healthwatch and regular meetings with our Director of Patient Experience and Nursing take place with them.

We continue to work collaboratively with the other key local health and care providers and Hillingdon Health and Care Partners (HHCP), our local Accountable Care Partner organisation and this year saw the formal launch of a ground-breaking new partnership with Central North West London NHS FT (CNWL) and Brunel University London to establish the Brunel Partners Academic Centre for Health Sciences.

# Equality, Diversity and Inclusion – Patients and Service Users

An update on progress with our 2017/18 objectives is:

- Discharge of older adults and ongoing care needs: Healthwatch Hillingdon conducted a hospital discharge project during 2016. As a result of this work a number of work streams were introduced to review aspects of the discharge process.

- Maternity services – Engagement with seldom heard groups: as part of our commitment to engage hard to reach groups we have established a new Maternity Voice Partnership (MVP) with a strong focus on user engagement from all backgrounds including hard to reach groups to improve the quality of the service we provide.

- Ensure effective access to interpreting services:

  – The Trust has a contract with an external provider to deliver face-to-face and telephone interpretation and translation to include British Sign Language for patients and carers across all services in the Trust
  – The Trust's Interpretation and Translation Policy ensures that patients, relatives and carers have access to the communication tools required to allow complete understanding of their diagnosis and proposed treatment, and to ensure that each patient's communication needs are met
  – During 2017 the Trust requested interpreting services on 3,817 occasions supporting patients with 51 languages compared to 3,782 occasions and 47 in 2016. These figures include requests for British Sign Language (BSL).

- Support for people with learning disabilities: In partnership with the Hillingdon Clinical Commissioning Group, the Trust has complied with the requirement to participate in the National Learning Disability Mortality Review Programme. A Learning Disability Awareness training programme has been developed and delivered in specific areas bespoke to the specialities i.e. maternity, phlebotomy and Churchill Ward. This training will continue into 2018/19. The Trust has established a referral process to the learning disability nurse/service across all wards. Activity is recorded by the learning disability nurse and reported to the Safeguarding Board on a quarterly basis.

- Dementia Care: There is a refreshed Trust Dementia Strategy in place, which was launched in March 2018. 94.4% of people aged 75 years of age and over, admitted as an emergency, have been screened for dementia (national target 90%).

- End of Life Care:- To increase number of patients who have completed advance care plan recorded on Co-ordinate My Care (CMC): During 2017/18, 23 key staff were trained to use CMC, thus improving seamless care as patients were transferred from the community to the hospital setting and back again.

- Patient and Carer experience: Friends and Family performance is reported monthly to the Trust Board and quarterly to the Experience and Engagement Group but does not include demographic data. Demographic information is collected and can be reported if required. Monthly ward level feedback highlights areas of good practice or concerns and will inform key areas of equality focus going forward. The Trust updated, ratified and launched a Carers Strategy during 2017. The carer's survey has been revised and is now distributed on the wards. The dementia nurses and ward staff are handing them out to carers, however the number of surveys returned remains low.

- Improving services for people with a sensory disability: Further work is still required to:

  – Introduce e-mail as a communication option
  – Appointment of a Braille service provider to generate outpatient letters in braille
  – Continued reinforcement of the process to all front line staff.

# Overseas operations

The Trust does not have any overseas operations.

# Bribery

The Trust contracts a specialist local counter fraud service which reports quarterly on fraud and bribery to the Audit and Risk Committee. Awareness training has taken place with our finance staff and this year an information stall for staff was set up where more details could be found.

# Modern Slavery

The Trust recognises the issue of Modern Slavery which may take a variety of different forms, the most recognised of which are:

- Sexual exploitation
- Labour exploitation
- Organ harvesting
- Forced criminality
- Domestic servitude

The Safeguarding Vulnerable Adults Policy recognises Modern Slavery. Additionally our Procurement Policy requires that suppliers are compliant with our modern Slavery code of practice.

# Developments since the end of the Financial Year

Care Quality Commission (CQC) Inspection of The Hillingdon Hospitals NHS Foundation Trust and the Use of Resources Framework

The first part of the Trust's CQC inspection took place between 6 and 8 March within the financial year 2017-18. Some initial high level feedback to the Trust was that the 'must dos' and 'should dos' from our last inspection had clearly been worked through, and that this had been demonstrated well in some of our core services.

This was followed by an unannounced visit and inspection of a small number of medical Wards with the 'Well Led' element of the inspection taking place between 24 and 26 April, focusing on eight themes across the Trust. They advised us that they observed many areas of good practice in relation to well led and, in particular, good team working at the different levels. They did however also advise that there are some areas that we need to work on.

As part of the CQC Well Led Inspection, the Trust was also assessed against the 'Use of Resources' (UoR) framework. This framework has been introduced to ensure the CQC rating takes a more holistic view of the Trust. The UoR assessment was undertaken by NHS Improvement on behalf of the CQC and included a full day visit on 2 May with the Executive and Senior Leaders. The rating for UoR will form part of the overall 'Well Led' rating, which in turn feeds into the Trusts overall CQC rating. Feedback from this part of the visit was generally positive.

The draft report will be sent to us to review in late June. There will then be two weeks for comments with a view to the report being published around mid-July.

# 1.3 ACCOUNTING OFFICER APPROVAL OF THE PERFORMANCE REPORT

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2017/18.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018


2

# Accountability report

# 2.1 DIRECTORS REPORT

## How we are organised

The Hillingdon Hospitals NHS Foundation Trust is run by a Board of Directors, comprising of a non-executive chairman and up to six other non-executive directors and up to seven executive directors. The Chief Executive leads the executive team and is accountable to the Board for the operational delivery of the Trust.

**The Board is collectively responsible for the performance of the Trust**

The non-executive directors scrutinise the performance of the executive management team in meeting agreed goals and objectives and monitor performance. However, the Board is collectively responsible for the performance of the Trust.

The Board meets two – monthly (commencing July 2017) and its role is to determine the overall corporate and strategic direction of the Trust and ensure the delivery of the Trust's goals and targets.

The Board of Directors has reserved powers to itself covering:

- Regulation and control
- The determination of board committees and their membership
- Strategy, plans and budgets
- Policy determination
- Audit
- Annual Report and Accounts
- Performance monitoring

The Board has an approved Scheme of Delegation which includes a schedule of items reserved to the Board. In turn the Board delegates some of its powers to its committees. The arrangements for delegation are set out in the Trust's Scheme of Delegation. The Trust's Constitution and terms of reference of these committees and their specific powers are approved by the Board of Directors. The Board approves the appointments to each of these committees which it has formally constituted. All Board committees have a non-executive chair. The Executive Group consists of directors of Clinical Operations and executive directors chaired by the Chief Executive. Its purpose is to ensure that the objectives agreed by the Board are delivered and to analyse the activity and performance of the Trust against the business plan to ensure that duties are appropriately delegated to the senior management team and actions monitored. It also ensures that the key information from external bodies is discussed, actions identified and messages disseminated appropriately across the organisation.

## Executive team

In compliance with NHS Improvement's Code of Governance, no Executive Director holds more than one Non-Executive directorship of an NHS Foundation Trust or other organisation of comparable size and complexity.

## Non- Executive directors

Non-Executive Directors are appointed for a period of three years and can be appointed for a further period of three years. Arrangements for the appointment and termination of appointment of non- executive directors are set out in the Trust's Constitution.

## Well Led Framework

The Trust Board declared compliance against Monitor's 'Well-Led Framework' in January 2017 and has been committed to continuing compliance with the quality governance requirements outlined in the framework during the past year. More detail can be found in the Annual Governance Statement

# 2017/18 Board of Directors

The Board was comprised of a Non-Executive Chair, six Non-Executive Directors, one Associate (non-voting) Non-Executive Director and seven Executive Director (one none voting). There were no Non-Executive vacancies that arose during the year. There was one Executive vacancy for the post of Director of the Patient Experience & Nursing which was recruited to. Following the reorganisation of the Executive Team the post of Director of Strategy & Business Development was removed and the Board operated from February 2018 with six Executive Directors.

## Richard Sumray: Trust Chair

Richard Sumray was appointed as Chair in November 2014. Richard has been involved for over 30 years as a Non-Executive Director in the NHS and is an experienced Chair. He chaired NHS Haringey (Primary Care Trust) for ten years from 2001 to 2011 and during that period also chaired the Joint Committee of London PCTs that supported Healthcare for London and the significant reforms to stroke and trauma services. He was also a member of the London Health Commission for eight years. Richard is a magistrate and has been chairing family and youth courts for 25 years in inner London. He was chair of the London 2012 Forum working with the London Organising Committee of the Olympic Games and was a leading figure in sport in London, starting the work on an Olympic bid in the early 1990s. In 2018 he stood down as Chair of Alcohol Concern and The National Centre for Circus Arts. He was also a member of the Metropolitan Police Authority for eight years. In addition to chairing the Board of The Hillingdon Hospitals, he chairs the Council of Governors, Council of Governors Nomination and Remuneration Committee Finance and Transformation Committee, Charitable Funds Committee and the Board of Directors' Nominations Committee. He is also a member of the Remuneration Committee and sits on the STP Transformation Board as well as

other health system Boards. His term of office expired on 31 October 2017 and the Council of Governors approved its extension for a further three years to 31 October 2020.

## Professor Soraya Dhillon MBE: Non-Executive Director and Deputy Chair

Soraya Dhillon was appointed in February 2014. Soraya retired from her full time role as Dean of the School of Life & Medical Sciences at the University of Hertfordshire at the end of October 2016. She was appointed Deputy Chair of the Board this year by the Council of Governors following the departure of Carol Bode as a Non-Executive Director from the Board.

Soraya has a PhD in clinical pharmacology and has held a number of key senior academic and clinical posts. Her research interests are in chronic disease management, prescribing, medicines optimisation and patient safety. Soraya is the former Non-Executive Chairman of Luton and Dunstable Hospital NHS Foundation Trust and a former member of the General Pharmaceutical Council. Soraya is a fellow of the Royal Pharmaceutical Society and was awarded an MBE for her contribution to health services in Bedfordshire. Soraya brings expertise in strategic leadership, academia and patient safety to the Board.

Her current appointments are Non-Executive Director NHS Digital and Academic Manager University of Hertfordshire. Soraya is the Chair of the Remuneration Committee and sits on the Finance and Transformation Committee, Audit and Risk Committee, and Nominations Committee. Additionally she is the Board's Digital Champion and Equalities Champion, as well as being the NED link for the Surgery division. Soraya's term of office expired on 31 January 2017 and has been further extended to 31 January 2020.

## Carol Bode: Non-Executive Director and Deputy Chair

Carol Bode was appointed in April 2012. Carol's professional background is in organisational development and governance and she has 35 years experience operating in the commercial sector, public sector and not for profit sector in retail, customer services, financial services, health housing and education. Previous Directorships have included Non-Executive Chair at Southern Health NHS FT, Trustee of Foundation Trust Network Board, Corporate Director with a General Motors Company and Director of The Costello School (an Academy Trust). Currently, Carol is Non-Executive Chair of Radian Housing Group, Independent Chair of Hampshire Safeguarding Adults Board, Associate Trainer with NHS Providers, Associate Director with The Rialto Consultancy and Senior Adviser to Newton Europe. Carol is also a serving magistrate in North Hampshire. Carol left the Board on 26 April 2017 and only attended the Board meeting on that day in terms of duties for the year 2017-18.

## Professor Elisabeth (Lis) Paice OBE: Non-Executive Director and Senior Independent Director

Lis Paice was appointed in February 2014. Lis qualified as a doctor at Trinity College Dublin and Westminster Medical School and trained at Stoke Mandeville and UCH before being appointed Consultant Rheumatologist at the Whittington Hospital and becoming a Fellow of the Royal College of Physicians. For 15 years Lis was Dean Director of London Deanery, overseeing the postgraduate training of doctors. Following this, she chaired the Inner and Outer North West London Integrated Care Programmes and led the patient engagement workstream of the North West London Integration Pioneer. Lis now co-chairs the Self Care workstream of North West London. Lis is an active coach and mentor, holds the ILM Diploma in Executive Coaching and Leadership Mentoring, and is the author of New Coach: reflections of a learning journey, McGraw Hill 2012. She was named NHS Mentor of the

Year 2010. In 2011 she received an OBE for services to Medicine. Lis chairs the Quality and Safety Committee and sits on the Governors Nomination and Remuneration Committee, the Nominations Committee and the Remuneration Committee. Additionally she chairs the Lay Strategic Forum and is the NED link for the Medical Division and Learning from Death, End of Life and Freedom to Speak Up. Lis' term of office expired on 31 January 2017 and has been further extended to 31 January 2020.

## Richard Whittington DL: Non-Executive Director

Richard Whittington was appointed on 1st October 2014. Richard is a chartered accountant (FCA) who was a Senior Partner at KPMG, where he was latterly in charge of the Infrastructure, Government and Healthcare Audit Group which provided services to the health and public sectors and building and construction companies.
Until May 2016 Richard was a Non-Executive Director and Chairman of the Audit Committee of ISG Plc, a £1.4 billion turnover international construction services group. He was also Chairman of the ISG Middle East businesses.
Richard is a Director, Trustee and Honorary Treasurer of the Community Foundation of Surrey, a Trustee of Surrey Care Trust and Chair of the Governors and Director of the Gordon's School Academy Trust Limited and a Trustee of the Gordon Foundation. He is also a Director of two small property management companies.
Richard was installed as High Sheriff of Surrey in April 2016 for twelve months and commissioned as a Deputy Lieutenant of Surrey in December 2017. Richard brings senior financial, audit and corporate governance experience to the Board, together with estates and capital investment expertise. Until early December 2016 Richard was Chair of the Capital Investment Committee (CIC). At that time he became Chair of the Audit and Risk Committee and remains in this position. He sits on the Quality and Safety Committee, the Nominations Committee and the Remuneration Committee. Richard is also the NED link for the Estates and Procurement Divisions. Richard's term of office expired on 30 September 2017 and the Council of Governors approved its extension for a further three years to 30 September 2020.

## Carl Powell: Non-Executive Director

Carl Powell was appointed on 1 May 2016. Carl is a Fellow of the Royal Institution of Chartered Surveyors, a Certified Valuation Appraiser and a Town Planner. He was formerly Chief Executive of Pell Frischmann Limited (PF) and Conseco International, consulting engineering firms providing financial and management services worldwide. He continues to work with PF and is a NED on several commercial infrastructure investment companies. Appointed in 2017, he is also a Lay-Chairperson at Kings College Hospital assisting with AAC Consultant appointments.
Previous positions include Managing Director of two financial services companies and Director of Planning and Transportation for Westminster City Council. He has also served as a Non-Executive Director at CNWL and East London and City Mental Health Foundation Trust. He sits on the Audit and Risk Committee, the Finance and Transformation Committee, the Charitable Funds Committee, the Nominations Committee and Remuneration Committee.
Carl is also the NED link for Cancer and Clinical Specialism Services as well as being the Boards Revalidation Champion. Carl's term of office expires on 30 April 2019 and could be considered for an extension of his appointment for a further three years from that date.

## Keith Edelman: Non-Executive Director

Keith Edelman was appointed on 1 May 2016. Keith is also currently Chairman of Revolution Bars Group Plc, Chairman of Bullion by Post Limited, Chairman of Pennpetro Plc a Non-Executive Director of Supergroup Plc, a Non-Executive Director of the London Legacy Development Corporation, and a Director of Stonebury Properties Ltd. In his executive career he was a Director of Ladbrokes, Managing Director of Carlton Communications Plc and Chief Executive of Storehouse Plc.
His most recent executive appointment was Managing Director of Arsenal Football Club where he was responsible for the development of Emirates Stadium and the attendant

regeneration of the area including Highbury Square. He sits on the Audit and Risk Committee, the Finance and Transformation Committee, the Nominations Committee and Remuneration Committee. Keith is also the NED link Finance. Keith's term of office expires on 30 April 2019 and could be considered for an extension of his appointment for a further three years from that date.

## Cheryl Coppell: Non-Executive Director

Cheryl Coppell joined the trust joined the Trust on 10 May 2017. Cheryl is an experienced public sector senior manager under whose leadership organisations and individuals flourish, transform and perform for local people. She was Chief Executive at both Slough Borough Council and then Havering until 2016, where she modernised and transformed a large London borough into a customer-facing authority able to predict and successfully navigate public sector financial constraints, delivered major regeneration programmes and reduced the council's operating costs by 20% through efficiencies rather than service reductions. She sits on the Quality and Safety Committee, the Finance and Transformation Committee, the Nominations Committee and Remuneration Committee. Cheryl is also the NED link for the Women and children Division. Cheryl's term of office expires on 9 May 2020 and could be considered for an extension of her appointment for a further three years from that date.

## Linda Burke: Associate Non-Executive Director

Linda Burke is presently the Director of Education and Quality at the Royal College of Obstetricians and Gynecologists. Previously she was Pro Vice-Chancellor of the faculty of Education and Health at the University of Greenwich. She is a nurse by background and was also Head of Strategy and Development at

NHS London. She sits on the Quality and Safety Committee, the Nominations Committee and Remuneration Committee. Linda is also the NED link for Human Resources and Learning and Development. Linda's term of office expires on 9 May 2020.

## Shane DeGaris: Chief Executive: Executive Director

Shane DeGaris was appointed Trust Chief Executive in March 2012 having previously been the Trust's Deputy Chief Executive and Chief Operating Officer. Shane is an experienced NHS Director having worked in a number of London Trusts in senior management roles including as Director of Operations at Barnet & Chase Farm Hospitals NHS Trust and as Deputy Chief Executive at Epsom & St Helier University Hospitals NHS Trust. Australian by birth, he began his healthcare career in 1990 after training as a Physiotherapist in Adelaide, South Australia. Shane is a Board Director of Imperial College Health Partners, a Board member of the London & South East LETB (a sub-committee of Health Education England) and Chair of a National Expert Reference Group for Evidence based treatment pathways for integrated Mental and Physical healthcare.

## Dr Abbas Khakoo: Medical Director: Executive Director

Abbas Khakoo was appointed as sole Medical Director in October 2014 having held the position on a job-share basis since in January 2013. Abbas is a Consultant in Paediatrics and the care of new born babies. Abbas also runs a children's allergy service at Hillingdon Hospital and at St Mary's Hospital, part of Imperial College Healthcare NHS Trust. Since July 2015, Abbas has been the Chair of the Paediatric Project Delivery Board and Joint Senior Responsible Officer for the Paediatric Transition, Shaping a Healthier Future. In 2016 he agreed to be a medical advisor to PA Consulting for a single overseas tender which was unsuccessful, and there is no ongoing relationship.

## Professor Theresa Murphy: Director of the Patient Experience & Nursing: Executive Director

Theresa Murphy joined the Trust in May 2013 having been the Director of Nursing at North Middlesex University Hospital NHS Trust. Theresa qualified in general nursing in 1987, before specialising in Neuroscience and Critical Care nursing. Theresa has also held a number of clinical and managerial posts in both teaching and general hospitals. Theresa was awarded the Florence Nightingale leadership scholarship for 2012, and is an Honorary Professor for the City of London University, and has an LLB. Theresa held Board level responsibility for nursing, governance and risk management, infection prevention and control, safeguarding people, patient experience and engagement between 1 April 2017 and 31 December 2017, resigning with effect from 1 January 2018.

## Jacqueline Walker; Director of the Patient Experience & Nursing: Executive Director

Jacqueline Walker was appointed as Executive Director of the Patient Experience and Nursing in January 2018. Jacqueline has over 30 years' experience of working within the NHS and has worked in many different specialties during her nursing career. She specialised in renal and urological nursing and then progressed her nursing management career in medical and surgical high dependency nursing and acute admissions. Jacqueline's previous experience includes her role as Deputy Director of Nursing and Integrated Governance within the Hillingdon Hospitals and Head of Acute Services and Nursing at Ealing Hospital.

Jacqueline holds a Masters' degree in Leadership and Management within Health and Social Care. Jacqueline has Board responsibility for Nursing and Midwifery practice and standards, Clinical and Corporate Governance, Infection Prevention and Control, Patient Experience, Safeguarding and Soft Facilities Management. Jacqueline is the Trust's Director of Infection Prevention and Control (DIPC) and the Security Management Director.

## Joe Smyth: Chief Operating Officer: Executive Director

Joe Smyth was appointed Chief Operating Officer in March 2015; having previously been the Trust's Director of Operational Performance. Joe has over 20 years senior managerial healthcare experience, including Deputy Chief Operating Officer at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Director of Service Improvement at Epsom and St Helier University Hospitals NHS Foundation Trust. Joe holds Board level responsibility for the management of the clinical divisions, emergency planning, Integration, strategy, business development and planning. One of Joe's key responsibilities is to ensure that the Trust meets and exceeds all national and local patient access standards.

## Matthew Tattersall: Director of Finance: Executive Director

Matthew Tattersall was appointed Director of Finance in April 2016. He has spent all his working life in NHS Finance joining as a graduate trainee in the North Thames Region and going on to qualify as a Chartered Public Finance Accountant. He also has an MSc in Healthcare Leadership and a NHS Leadership Academy Award in Senior Healthcare Leadership. His roles have included Director of Finance at Dacorum and Watford PCTs and Deputy Director of Finance at Homerton University Hospital. Matthew also holds Board level responsibility for Purchasing and Supplies, the Trust's Information Services and Information Technology functions, Health and Safety and is the Trust's Senior Information Risk Owner (SIRO).

## Terry Roberts: Director of People and Organisational Development: Executive Director

Terry Roberts joined the Trust in March 2016 as Director of People and Organisational

Development. Prior to this post he was the Director of Workforce at Kingston Hospital Foundation Trust and has held senior HR positions at Bart's Health, Ealing Hospital, St Mary's Hospital and North West London Hospital as well as working at the Department of Health as a National HR Advisor. Terry holds a Masters Degree in Human Resources Management and is a Fellow of the Chartered Institute of Personnel and Development (FCIPD). He has completed the Top Managers Programme with the Kings Fund and is a certified Coach and Mediator. Terry is also a Director of Transform Consulting Ltd.

Terry has Board level responsibility for communications, human resources (including recruitment, employee relations and temporary staffing), occupational health, nurse training, and workforce and organisational development. He became a voting member of the Board in January 2018.

## David Searle: Director of Strategy & Business Development: Executive Director

David Searle was appointed in 2007. David had a 20 year career in the Royal Navy as a Fleet Air Arm pilot, where senior roles included second in command of a major Air Defence warship and the Commanding Officer of a large front line Naval Air Squadron. David subsequently worked in the aerospace and defence industries where he held senior positions in procurement, commercial management, business development and marketing. He was latterly Director, Wider Markets in the Defence Aviation Repair Agency before joining the Trust. David had Board level responsibility for strategy, business planning, business development, estates and facilities and communications. Following a reorganisation of the Executive Team and its portfolios, David left the Trust in January 2018 and this post was disestablished with Executive responsibility for his areas of service passing to other Executives.

## Board member Register of Interests and Gifts and Hospitality

Company directorships and other declarations of interest or gifts and hospitality were declared by all Board members in year. The full register of declarations is available from the Trust Secretary.

## Statement on the balance, completeness and appropriateness of the membership of the Board

The Board of Directors Nominations Committee is responsible for reviewing the structure, size and composition of the Board and makes recommendations to the Council of Governors on the skills required for any upcoming Non-Executive Director appointments. As outlined in the biographies of Board members, the Board comprises of individuals with senior level experience in the public and private sectors, across a range of disciplines including clinical and patient care; health service leadership; commercial development; business transformation and change management; finance; governance; risk management; and human resources. The Board therefore confirms that the current composition is considered to be appropriate. Taking account of the NHS Foundation Trust Code of Governance published by Monitor, the Board considers the current Chairman and all of the Non-Executive Directors to be 'independent'.

## Performance evaluation of the Board its Committees

The Board had already reviewed its Committee structure in October 2015 and implemented revisions from that time. Consequently there were no revisions to its Committee structure in 2017/18.

# Meetings of the Board, its Committees and the Council of Governors 2017/18

## The Board

The Board met eight times during 2017/18, moving to two-monthly meetings with effect from July 2017.

In order to make Board meetings accessible to the public and Governors, two Board meetings were held at Mount Vernon Hospital and six at Hillingdon Hospital.

The Board set the strategic vision and direction of the Trust for the year 2017-8, agreeing the annual Operating Plan, the Budget and Capital Programme at an early point in the year.

The Board also acted as the body which was able to provide assurance that the Trust's statutory obligations, as well as its overall performance (including safety and quality) was of the standards expected or that appropriate action was being taken to ensure compliance with those standards, either directly or through its Committee structure.

## Committees of the Board

The Board had seven Committees, each chaired by a Non-Executive Director in 2017/18;

- Audit & Risk Committee
- Quality and Safety Committee
- Finance and Transformation Committee
- Board of Directors Nomination Committee
- Board of Directors Remuneration Committee
- Charitable Funds Committee

## Audit & Risk Committee

The Audit & Risk Committee met five times during 2017/18. As at 31 March 2017, the Trust's Audit & Risk Committee comprises of four Non-Executive Directors; the Committee Chair having recent and relevant financial experience. The Committee is usually attended by the internal and external auditors, the Local Counter Fraud Specialist, the Finance Director and the Director of Patient Experience & Nursing as the Executive Director responsible for clinical and corporate governance.

The Committee is responsible for providing an independent and objective review of the Trust's systems of internal control (both financial and non-financial) and the underlying assurance processes in place at the Trust. The Committee is also responsible for ensuring that the Trust has independent and effective internal and external audit functions and overall responsibility for organisation risk management.

### External audit

The Audit & Risk Committee is responsible for making recommendations to the Council of Governors on the appointment and removal of the external auditor. In October 2013 the Council of Governors appointed Deloitte as the Trust's external auditors for a three year period starting with the 2013/14 audit with an option for two one year extensions.

In line with the Code of Governance this reappointment is subject to annual review. This annual review involves the Audit & Risk Committee (ARC) members completing a structured review of external audit against the areas of work set out in Monitor's Audit Code:

- Financial statements
- Annual governance statement
- The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources; and
- The quality report.

Plus review of external audit against 46 criteria across the following domains:

- The audit partner
- The audit team
- The audit approach – planning and then execution
- Communications by the auditor to the ARC
- External audit's support to the work of the ARC
- Insights and adding value
- Formal reporting by the auditors.

The Chair of the ARC then presented a report to the July meeting of the Council of Governors on the outcomes of this review and whether external audit's appointment should be confirmed. The audit fees for 2017/18 were

- Internal Audit KPMG £119,000 inclusive of VAT
- External Audit Deloitte £68,400 for the financial statement audit and £15,340 for quality accounts work both net of VAT

In October 2013 the Council of Governors agreed an updated policy on the engagement of the external auditors to undertake additional services. Under this policy, any such work is reported to the Council of Governors. No such additional work was commissioned in 2017/18.

### Internal audit

The Trust's internal audit service is provided by KPMG.

Internal audit provides an independent and objective opinion on risk management, control and governance by measuring and evaluating the

effectiveness by which organisational objectives are achieved. Through detailed examination, evaluation and testing of the Trust's systems, internal audit play a key role in the Trust's assurance processes. The scope and work of the Trust's internal auditors, is set out in a charter approved by the Audit & Risk Committee.

The Audit & Risk Committee agree a work plan for internal audit at the start of each financial year, taking account of the risk assessment undertaken by internal audit. The Committee review the findings of internal audit's work against this plan at its quarterly meetings. Audits undertaken in 2017/18 included:

- Overide of SFIs
- Pharmacy
- Governance and Financial Management
- Capital Accounting
- Working with Regulators: CQC
- Absence Management
- Self-Certifications: Second Level
- Learning From Deaths
- Bank and Agency Staff
- Estates Procurement

The Head of Internal Audit reports to the Committee and is managed by the Director of Finance. The Head of Internal Audit has a right of direct access to Committee members.

Key issues considered by the Committee;

Key elements of the Committee's work include reviewing the Board Assurance Framework, the Risk Register and reviewing the findings of the Trust's internal and external auditors and Local Counter Fraud Specialist. The Committee is responsible for reviewing the annual financial statements, with particular focus given to major areas of judgement and changes in accounting policies, determining that the Trust remains a going concern, and reviewing the draft annual report including the annual governance statement. The Committee also reviewed the assurance in place in respect of data quality, information governance and health and safety.

In particular the Committee focused on compliance with internal audits review of the CQC's recommendations from 2015 and a growing portfolio of estates risks.

## Quality and Safety Committee

The Quality and Safety Committee met six times during 2017/18. As at 31 March 2018, the Trust's Quality & Safety Committee comprises of four Non-Executive Directors and four Executive Directors. The Committee's remit is to provide the Trust Board of Directors with assurance that quality and safety within the organisation is being delivered to the highest standards and that there are appropriate processes in place to identify gaps and manage them accordingly. The Committee combines the three themes that define quality;

- Effectiveness of the treatment and care provided to patients — measured by both clinical outcomes and patient-related outcome
- Safety of treatment and care provided to patients — safety is of paramount importance to patients and is the bottom line when it comes to what services must be delivering
- Experience that the patients have of the treatment and care they receive — how positive an experience people have on their journey through the organisation can be even more important to the individual than how clinically effective care has been

Key issues considered by the Committee;

The Committee has actively participated in the development of the Trusts five year Quality and Improvement Strategy to treat and care for people in a safe environment and protecting them from avoidable harm which is one of the five 'outcome' domains outlined in the NHS Outcomes Framework. The Committee also monitor's the Trust's compliance with Care Quality Commission registration requirements.

## Finance and Transformation Committee

The Finance and Transformation Committee met twelve times during 2017/18. As at 31 March 2018, the Finance and Transformation Committee comprises of five Non-Executive Directors and four Executive Directors. The Committee's remit is to provide the Trust with a finance and capital strategy and ensure that the right transformation programmes are in place, providing the the Board assurance that these workstreams are progressing appropriately or pointing out the key risks if not.

Key issues considered by the Committee;

In months one to nine, the Committee gave detailed attention to the position of the trust's finances and, in particular, its financial Improvement Programme. Throughout the year it ensured that the governance for the process for approval of new business cases was robust as well as monitoring the delivery of the capital programme. By December, the Committee recognised it was struggling to devote sufficient time to deal with transformation workstreams and moved to reviewing these on a quarterly basis, reducing the time it would spend on finance or capital at this meet.

## Nominations Committee

The Board of Directors Nomination Committee met three times during 2017/18. As at 31 March 2018, the Trust's Board of Directors Nomination Committee comprises of eight Non-Executive Directors and one Executive Director (Chief Executive) with the Director of People and Organisational Development in attendance. The Board of Directors Nominations Committee leads the process for Executive Board appointments, Non-Executive and Executive succession planning and evaluating that the Board has the right skills mix and training to lead the organisation.

Key issues considered by the Committee;

During 2017/18, the Committee's key issue was to consider the case for a restructure of the Executive which it recommended to the Board in autumn.

## Remuneration Committee

The Board of Directors Remuneration Committee met two times during 2017/18. As at 31 March 2018, the Trust's Board of Directors Remuneration Committee comprises of eight Non-Executive Directors with the Chief Executive and the Director of People and Organisational Development in attendance. The Committee sets Executive annual objectives, reviews performance and then sets pay based on a thorough appraisal of that performance.

Key issues considered by the Committee;

The Committee formally appraised the Chief Executive and all Executive Directors, agreed their pay and set targets for 2017/18.

## Charitable Funds Committee

The Charitable Funds Committee met three times during 2017/18. As at 31 March 2018, the Trust's Board of Directors Charitable Funds Committee comprises of three Non-Executive Directors and three Executive Directors. The Charitable Funds Committee assists the Trust in its role as corporate trustee for The Hillingdon Hospitals NHS Foundation Trust charity and has been established to make and monitor arrangements for the control and management of the Trust's charitable funds.

Key issues considered by the Committee;

The Committee actively reviewed income and expenditure within the fund and the performance of the fund managers. The Committee was keen to oversee the collapse of donations into a generic fund as opposed to having to money having to be spent on specific items. The appointment of a Charities Manager in the second half of the year meant it could consider a realistic three year strategy for raising the profile of the Trust charity.

An Annual Report and Accounts were produced, reviewed and lodged with the Charity Commission.

## Attendance at Board and Board Committee meetings 2017/18

The following table outlines Board members' attendance at Board and Committee meetings during 2017/18 against the total possible number of meetings for which an individual was a member. Committee attendance is shown in relation to those Committees of which a Director is a formal member or expected attendee as an Executive Director.

| | Board | ARC | QCS | FTC | NC | RC | CFC |
|---|---|---|---|---|---|---|---|
| Richard Sumray | 7 of 8 | | | 11 of 12 | 3 of 3 | 2 of 2 | 3 of 3 |
| Soraya Dhillon | 7of 8 | 5 of 5 | 2 of 2 | 10 of 12 | 3 of 3 | 2 of 2 | |
| Carol Bode | 1 of 1 | | | | | | |
| Linda Burke | 6 of 7 | | 4 of 4 | | 0 of 1 | 0 of 1 | |
| Cheryl Coppell | 7 of 7 | | 4 of 4 | 9 of 10 | 3 of 3 | 1 of 1 | 3 of 3 |
| Keith Edelman | 5 of 8 | 5 of 5 | | 9 of 12 | 0 of 3 | 0 of 2 | |
| Lis Paice | 8 of 8 | | 6 of 6 | | 3 of 3 | 2 of 2 | |
| Carl Powell | 5 of 8 | 3 of 5 | | 8 of 12 | 1 of 3 | 1 of 2 | 1 of 2 |
| Richard Whittington | 8 of 8 | 5 of 5 | 3 of 4 | | 2 of 3 | 1 of 2 | |
| Shane DeGaris | 8 of 8 | | 3 of 5 | 9 of 12 | 3 of 3 | 2 of 2 | |
| Abbas Khakoo | 8 of 8 | | 6 of 6 | | | | |
| Theresa Murphy | 2 of 4 | 0 of 2 | 8 of 8 | | | | 0 of 2 |
| Terry Roberts | 8 of 8 | | | | 2 of 2 | 2 of 2 | 0 of 1 |
| David Searle | 5 of 6 | | | | | | |
| Joe Smyth | 7 of 8 | | 2 of 5 | 9 of 9 | | | |
| Matthew Tattersall | 7 of 8 | 5 of 5 | | 12 of 12 | | | 2 of 3 |
| Jacqueline Walker | 2 of 2 | | 1 of 1 | | | | 0 of 1 |

# Governors Report

## Council of Governors

The role and powers of the Council of Governors statutory duties are set out in the Health and Social Care Acts of 2006 and 2012 and in summary are;

- To hold the non-executive directors to account for the performance of the Board
- Appoint the non-executive directors of the trust, including the chair and agree their remuneration
- Approve the appointment of the CEO as recommended to them
- Appoint the Trust's Auditor
- Approve changes to the Constitution
- Receive the Trust's Annual Report
- Approve "significant transactions" and may choose to set out the definition (s) in the trust's constitution

The composition of the Council of Governors is determined by the Trust's Constitution.

As at 31st March 2018 there were 25 positions on the Council of Governors: 13 elected to represent the public members, 7 elected to represent the staff members, and 5 appointed by partner organisations (Hillingdon Council, Hillingdon Clinical Commissioning Group, the London Ambulance Service, Hillingdon Healthwatch and the Trust's Joint Negotiating & Consultative Committee). Governors are normally appointed for a term of three years. By having publically elected governors and appointed governors representing the local area, the Trust ensures the public interests of patients and the community is represented.

The members of the Council of Governors who served during 2017/18 are:

| | Name | Date took office and method (see key below) | Term of office expires | Resigned |
|---|---|---|---|---|
| **Public Governors** | | | | |
| North (4) | Graham Bartram | 01/04/2014 (CE) | 31/03/2020 | |
| | Ian Bendall | 01/04/2014 (CE) | 31/03/2020 | |
| | Robin Launder | 01/04/2017 (CE) | 31/03/2020 | |
| | Tony Ellis | 01/04/2011 (CE) | 31/03/2020 | |
| Central (4) | Rosemary Jenkins | 01/04/2017 (CE) | 31/03/2020 | |
| | Mohan Sharma | 01/04/2017 (CE) | 31/03/2020 | |
| | Terry Thompson | 01/07/2015 (CE) | 31/03/2020 | |
| | Ian Burnell | 01/04/2017 (CE) | 31/03/2020 | |
| South (4) | Chris Commerford | 01/04/2017 (CE) | | (R) 10/01/2018 |
| | Keith Saunders | 01/04/2014 (CE) | | (R) 16/06/2017 |
| | Des Brown | 09/08/2017(UE) | 31/03/2020 | |
| | Doreen West | 01/04/2014 (CE) | 31/03/2020 | |
| | Rekha Wadhwani | 01/04/2014 (CE) | 31/03/2020 | |
| Rest of England (1) | Amanda O'Brien | 01/04/2017 (CE) | 31/03/2020 | |
| **Staff Governors** | | | | |
| Doctors & Dentists (1) | Dr Ari Basu | 01/04/2017 (UE) | 31/03/2020 | |
| Nurses, Midwives, Healthcare Assistants (3) | Sheila Bacon | 08/04/2014 (UE) | 31/03/2020 | |
| | Sheila Kehoe | 08/04/2014 (UE) | 31/03/2020 | |
| | Gillian Pearce | 01/04/2017 (UE) | 31/03/2020 | |
| Allied Health Professionals (1) | Lubna Hussain | 01/04/2017 (UE) | 31/03/2020 | |
| Support Staff (2) | Dee Fisher | 01/04/2017 (CE) | 31/03/2020 | |
| | Stephen Ihuanne | 01/04/2017 (CE) | 31/03/2020 | |
| **Appointed Governors** | | | | |
| Hillingdon Clinical Commissioning Group (1) | Dr Angela Joseph | 01/04/2017 (A) | 31/03/2020 | |
| London Borough of Hillingdon (1) | Mary O'Connor | 01/04/2014 (A) | 31/03/2020 | |
| Hillingdon Healthwatch (1) | Graham Hawkes | 01/04/2017 (A) | 31/03/2020 | |
| London Ambulance Service (1) | None | | | |
| Joint Negotiating & Consultative Committee (1) | Nicola Batley | 01/07/2015 (A) | | (R) 01/02/2018 |

Key: CE – contested election UE – uncontested election A – appointed by partner organisation R – resigned

In 2017/18 the Council of Governors formally met four times. Governor attendance at these meetings is stated below. Where a Governor was not in office for all four meetings, the maximum possible attendance is shown. The Chair of the Council of Governors is the Chair of the Board, Richard Sumray. He attended all four meetings.

| Governor | Meetings attended |
|---|---|
| Graham Bartram (Public) | 3 of 4 |
| Ian Bendall (Public) | 3 of 4 |
| Des Brown (Public) | 2 of 2 |
| Ian Burnell (Public) | 4 of 4 |
| Chis Commerford (Public) | 2 of 3 |
| Tony Ellis (Public) | 4 of 4 |
| Rosemary Jenkins (Public) | 2 of 4 |
| Robin Launder (Public) | 2 of 4 |
| Keith Saunders (Public) | 1 of 1 |
| Mohan Sharma (Public) | 4 of 4 |
| Terry Thompson (Public) | 4 of 4 |
| Rekha Wadhwani (Public) | 4 of 4 |
| Doreen West (Public) | 1 of 4 |
| Amanda O'Brien (Rest of England) | 3 of 4 |
| Sheila Bacon (Staff) | 4 of 4 |
| Dr Ari Basu (Staff) | 3 of 4 |
| Dee Fisher (Staff) | 4 of 4 |
| Lubna Hussain (Staff) | 4 of 4 |
| Stephen Ihuanne (Staff) | 1 of 4 |
| Sheila Kehoe (Staff) | 3 of 4 |
| Nicola Batley (Appointed) | 3 of 3 |
| Graham Hawkes (Appointed) | 4 of 4 |
| Dr Angela Joseph (Appointed) | 3 of 4 |
| Mary O'Connor (Appointed) | 4 of 4 |

Governors are required to declare any relevant interests which are then entered into the publicly available Register of Governors' Interests. The Register is formally reviewed by the Council of Governors annually and is available from the Trust Secretary. Contact with individual governors can be made by request through the Trust Secretary.

## Lead Governor

In line with Monitor's Code of Governance, the Council of Governors elects one of the Public Governors to be the 'Lead Governor'. The main duties of the Lead Governor are to:

- Act as a point of contact for Monitor should the Regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.
- Be the conduit for raising with Monitor any Governor concerns that the Foundation Trust is at risk of significantly breaching its Licence, having made every attempt to resolve any such concerns locally.
- Chair such parts of meetings of the Council of Governors which cannot be chaired by the Trust Chair or Deputy Chair due to a conflict of interest in relation to the business being discussed.

Rekha Wadhwani was Lead Governor from 01/04/17 to 05/05/17 and Tony Ellis was Lead Governor from 06/05/17 to 31/03/18.

## Council of Governors Nominations & Remuneration Committee

The Committee met once during 2017/18. The Committee comprises of the Chairman of the Trust, three public Governors and two staff Governors. The Council of Governors Nomination & Remuneration Committee leads the process for appointing or terminating the role of the Chairman and all Non-Executive Directors, making recommendations to the full Council of Governors; it is also responsible for recommending their remuneration, appraising their performance and setting their targets.

The Committee's main areas of work during the year were;

- To appoint two new Non-Executive Directors in April 2017
- To recommend to the Council of Governors the Chair and Non-Executive Director appraisals 2016-17 and their objectives for 2017-18
- To recommend to the Council of Governors the extension of the appointment of Richard Sumray as Chair and Richard Whittington as Non-Executive Director

## The Board's liaison with Governors and members

Non-Executive members of the Board are expected to attend Council of Governors meetings, both in order to ensure they understand the views of Governors and members as well as permit the Governors to hold them to account. Throughout the year the Chairman and each Non-Executive Director, in turn, has addressed the Council Governors outlining their experience, and what they are focusing on in the Trust. In addition a monthly briefing session for Governors is held with the Chairman where Governors are updated on matters at the Trust and have the opportunity to ask questions of the Non-Executive Directors in particular.

The Council of Governors meetings are held in public and there is an opportunity for members of the public to ask Governors and members of the Board questions. Governors and Members of the Board also attend the Trust's People in Partnership meetings and Annual Members meeting to liaise with members and Governors.

Attendance by Non-Executive members at the four meetings of the Council of Governors

| Non-Executive Board Member | No of Council of Governor meetings attended in 2017/18 (4 meetings held) |
|---|---|
| Soraya Dhillon (Non-Executive Director and Deputy Chair) | 4 of 4 |
| Lis Paice (Non-Executive Director and Senior Independent Director ) | 3 of 4 |
| Keith Edelman (Non-Executive Director) | 2 of 4 |
| Carl Powell (Non-Executive Director) | 1 of 4 |
| Richard Whittington (Non-Executive Director) | 4 of 4 |
| Cheryl Coppell (Non-Executive Director) | 1 of 3 |
| Lynda Burke (Associate Non-Executive Director) | 1 of 3 |

## Membership

The Foundation Trust membership is divided into two categories: public membership and staff membership.

### Public membership

There are four public constituencies, which are collectively known as the Public Constituency. The majority of the public members are drawn from the three public constituencies which cover the electoral wards in Hillingdon borough together with several neighboring electoral wards.

The fourth public constituency covers all other electoral areas in the rest of England. Public membership is open to individuals aged 16 years or over living within the Public Constituency who are not eligible to be a staff member of the Foundation Trust

### Public Membership at 31 March 2018

At 31 March 2018, the Trust had 6,636 public members. The table illustrates the number of public members for each constituency compared to the total population. The objective is to achieve a membership broadly equal to the population base.

The Hillingdon Hospitals NHS Foundation Trust is committed to recruiting members from the diverse population served by the Trust. Membership is open to all those eligible to be a member regardless of gender, race, disability, ethnicity, religion or any other groups covered under the Equality Act 2010.

| | 2nd February 2018 | % of membership | Population Base | % of area |
|---|---|---|---|---|
| Central | 2484 | 37.4 | 197147 | 39.5 |
| North | 1277 | 19.2 | 106046 | 21.2 |
| South | 2594 | 39.1 | 196112 | 39.3 |
| Rest of England | 281 | 4.2 | 0 | 0 |
| Total | 6636 | 100 | 499305 | 0 |

## Membership

The Foundation Trust membership is divided into two categories: public membership and staff membership.

## Staff membership

The staff constituency is a single constituency divided into the following classes:

- Doctors and dentists
- Nurses and midwives (including health care assistants)
- Allied Health Professionals
- Support staff

Staff membership is open to all those employed by the Trust on a permanent basis, those who have a fixed term contract of at least 12 months, and those who have been working at the Trust for at least 12 months. These staff are automatically members of the Staff Constituency unless they 'opt-out' from membership. In addition, those working at the Trust through the temporary staffing 'bank' become staff members providing they have been registered on the Trust's bank for at least 12 months and continue to be registered. Staff membership will cease at the point that the staff member leaves the service of the Trust. Anyone eligible to be a staff member of the Foundation Trust cannot be a public member.

## Staff Membership at 31 March 2018

At 31 March 2018 the Trust had 3398 staff members. Staff membership is validated once a year usually between March – June or when there is an election. The table provides a breakdown by staff group. Each staff group includes bank staff who meet the Trust's eligibility criteria for staff membership:

| Staff class | Number of members |
|---|---|
| Doctors and Dentists | 330 |
| Nurses, Midwives & Healthcare | 1592 |
| Allied Health Professionals, Scientific and Technical | 375 |
| Support staff | 1101 |
| Total | 3398 |

## Membership Development and Engagement

The Trust with the Council of Governors has updated and approved the Membership Development and Engagement Strategy at its meeting in February 2016. The Strategy describes the Trust's objectives for the membership and the approach we will use to ensure the Trust develops and engages with a representative membership. It outlines our plans for raising awareness about membership and for the recruitment, retention and involvement of members. It also defines how we will measure the success of the strategy. The strategy was produced with the guidance and input of the Council of Governors. A high level action plan to deliver the Membership Development and Engagement Strategy has been developed each year with progress periodically reported to the Council of Governors and the Board.

Key actions to grow membership and improve engagement:

- Encourage Governors to attend local groups and events (e.g. Resident Associations and Community Voice) to engage with the public and recruit new members
- Support fund-raising events organized by the Trust or other local organisations
- Attract new members visiting the hospitals during monthly Governor/ member surgeries
- Organise membership recruitment events at Hillingdon and Mount Vernon Hospitals
- Encourage Governors and members to sign up family, friends and members of the public
- Insert a membership form into new patient appointment letters
- Invite ex-staff, their family and friends to become public members
- Utilise existing networks in promoting membership with staff and students at local universities and schools
- Encourage all volunteers to sign up as public members
- Use social media (e.g. Twitter) to attract new members.

## Engagement between Governors and members

The Trust holds 'People in Partnership' meetings which enable the Governors, particularly the Public Governors, to engage with the members they represent. The meetings are held either at Hillingdon or Mount Vernon Hospital during the year and are chaired by a Governor. They are preceded by an opportunity for members and Governors to meet over refreshments. The Trust encourages and facilitates linkages between the Council of Governors and groups and organisations which represent patients, public and the wider community. During 2017/18, Public Governors attended various community events throughout the year. Many Governors participate in activities unrelated to health i.e. local churches, volunteer driving and education and are therefore able to communicate with local residents and public members at these events and report back to the wider Council of Governors in order to ensure that the Council of Governors is aware of public comments and concerns which have been raised.

The Trust provides Governors with information on the Trust's strategy and performance at various meetings such as the formal quarterly Council of Governors meetings, monthly informal meetings with the Chair and Chief Executive, and the joint meetings between the Board and Council of Governors. Governors can then feed this information back to the members and organisations they represent. These meetings also provide the opportunity for Governors to feedback issues of concern raised by members. During 2016/17 such issues included car parking at the Hillingdon site, staffing levels, facilities for patients and the quality of the estate. Governors are also able to communicate with members through the quarterly members' newsletter – 'the Pulse' which regularly features a Governor article.

The Membership Development & Engagement Strategy outlines the Trust's policy on the involvement of members, patients and wider public, including a statement on the Trust's approach to consultation, and addressing the overlap and interaction between the Governors and other consultative and representative groups. The strategy is available on the Trust's website.

# Donations, Creditors and Income Disclosure

## Political Donations

The Trust has not made any donations to political parties.

## Payment of creditors – Better Payment Practice Code

The Non NHS Trade Creditor Payment Policy of the NHS is to comply with both the CBI Prompt Payment Code and the Government Accounting Rules. The Government Accounting Rules state: "The timing of payment should normally be stated in the contract. When there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later."

The Trust aims to comply with the Better Payment Practice Code which is that 95% of invoices in terms of numbers and value are paid by the due date of payment, though has been unable to achieve the target in 2017/18. Details of the Trust's compliance in this matter can be found in note 7.1 of the accounts.

The Trust paid out £34k in 2017/18 for interest on late payments under the Commercial Debts (Interest) Act 1998 (£13k in 2016/17).

**Note 7.1 Better Payment Practice Code – measure of compliance**

| | **31 March 2018** | | 31 March 2017 | |
|---|---|---|---|---|
| | **Number** | **£000** | Number | £000 |
| Total Non-NHS trade invoices paid in the year | **100,997** | **142,815** | 96,716 | 129,037 |
| Total Non NHS trade invoices paid within target | **18,569** | **72,536** | 16,221 | 53,337 |
| Percentage of Non-NHS trade invoices paid within target | **18.39%** | **50.79%** | 16.77% | 41.33% |
| Total NHS trade invoices paid in the year | **2,114** | **22,450** | 2,658 | 12,540 |
| Total NHS trade invoices paid within target | **285** | **14,018** | 489 | 5,931 |
| Percentage of NHS trade invoices paid within target | **13.48%** | **62.44%** | 18.40% | 47.30% |

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

## Income Disclosure

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's 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. In 2017/18, the Trust met this requirement, with 96.5% of the Trust's income generated by activities for the purpose of the health service in England.

As the vast majority of Trust income is categorised as generated by activities for the purpose of the health service in England, it is the Board's view that other income does not detract from NHS provision to any material extent. Where other income is generated it supports the Trust to make optimum use of its assets and is used to directly support principal patient care activities.

# Quality Disclosure

## Annual Quality Report

The Trust's commitment to quality improvement and quality governance is clearly outlined in our Quality and Safety Improvement Strategy (2016-21); this describes a system of quality performance management, and a clear risk management process. Having the right structures and processes in place allied to an appropriate culture with supporting values and behaviors is strongly emphasised.

The 2017/18 Quality Report, contained within this report, provides evidence of progress against our key quality and safety indicators and outlines our priorities for improvement for the forthcoming year. It is aligned to our Quality and Safety Improvement Strategy (2016-21) objectives and our overall Trust Strategy. In terms of consultation on priorities for improvement for the Annual Quality Report the Trust has liaised with clinical and managerial staff via divisional governance Board meetings and divisional review meetings. Key stakeholders, such as the CCG, our governors, Healthwatch and local organisations from the third sector have been engaged to discuss the current year's progress and priorities for the forthcoming year. The Information Team has also undertaken a triangulation exercise examining data sources that they regularly review for potential underlying issues of quality related to performance or data, not otherwise identified. All of the above has assisted the Trust be clear on its priorities and quality targets.

The Trust uses its systems for quality performance management to assess its performance in relation to regional and national comparators for the key quality indicators and associated narrative in the Quality Report. Information on quality is supplied to the Board, its committees and the management team by the Information and the Clinical Governance teams who collect and maintain an overview of quality information. Alongside key quality indicators as part of the integrated quality and performance report, information is also included on clinical audit, clinical incidents, Serious Incidents and the learning from them, complaints and claims. This flow of information ensures that key risks to quality are identified.

The Trust has a comprehensive clinical audit work plan covering both national and local audits. Regular updates on clinical audit are reported to the CGC on a quarterly basis with exception reporting to the Quality and Safety Committee. Progress against national and local audits and actions being taken are detailed in the Quality Report to ensure transparency on our performance against these.

A usual quarterly meeting with our local Healthwatch has supported discussion on the progress of our quality priorities and key quality indicators alongside hearing feedback from service users who access our services and who interact with Healthwatch. This assists in informing our quality improvement work.

## Care Quality Commission

The Trust was inspected by the CQC in October 2014 as part of its planned and more detailed inspection regime. The final reports were published on 10 February 2015. The Trust was rated as 'Requires Improvement' overall. The Trust received a 'good' rating for the 'caring' domain across all of its services; staff were observed to be kind and had a caring and compassionate manner. The Trust has been working through a detailed improvement plan since this inspection and this continues to be presented to the Trust's Quality and Safety Committee on a bi-monthly basis. A more detailed account is provided in the Quality Report.

## Quality Governance

There are key quality governance and leadership structures that support the Trust in ensuring that the quality of care is being routinely monitored across all services. These are outlined in the Trust's Quality and Safety Improvement Strategy. There is two-monthly reporting to the Board in an integrated quality and performance report. The Quality and Safety Committee (QSC), a sub-committee of the Board chaired by a Non-Executive Director, receives more detailed information on safety and quality to ensure there is robust discussion and Board level scrutiny. This includes a rotational programme where each clinical division presents on clinical and quality governance issues, including discussion on areas of risk, performance against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit. There is also a deep dive review at each meeting on the key aims of the Quality and Safety Improvement Strategy.

Clinical divisions review their quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis at their divisional governance boards; divisional exception reports are received by the Patient Safety Committee (PSC) and any concerns on patient safety are escalated to the QSC. Similarly the Regulation and Compliance Committee (RCC) receives bi-monthly updates from the divisional governance boards on their compliance with the CQC standards and other quality and regulatory requirements, reporting by exception to the QSC.

More detailed information on the Trust's quality governance arrangements are also stated in the Annual Governance Statement section of the Annual Report.

## Directors' Disclosure to Auditors

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

- made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

# 2.2 REMUNERATION REPORT

## Annual Statement on Remuneration

The Nominations Committee is a sub-committee of the Board, responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors.

The Remuneration Committee is responsible for setting the remuneration of the Executive Directors and all very senior manager appointments. Further details of the Committee can be found within the Directors' Report section of this document.

The Governors Nomination and Remuneration Committee are responsible for recommending appointments to and the pay of Non-Executives to the Council of Governors.

### Key decisions within the year 2017-18

#### May 2017

The Committee agreed the following changes to Executive pay:

| Role | Current Pay | Median Acute & FT £200-£400 | 1% increase 1 April 2017 | 3.5% 1 April 2017 for DOF | Lower quartile & second year increase for DOF dependent on performance |
|---|---|---|---|---|---|
| CEO | £175,000 | £182,500 | £176,768 | | |
| COO | £116,000 | £122,500 | £117,172 | | |
| DOF | £115,000 | £135,000 | £116,162 | 119,170 | 123,000 |
| DPEN | £114,000 | £117,500 | £118,686 | | |
| DSBD | £106,000 | £115,000 | £107,070 | | |
| DPOD | £105,000 | £107,500 | £106,060 | | |

### November 2017

The Committee agreed to extend the contract of the Medical Director, Dr Abbas Khakoo, by 3 years on a remuneration package of £219,874 with effect from 1 January 2018.

### December 2018

The Committee agreed the remuneration of the newly appointed Director of Patient Experience and Nursing, Jacqueline Walker, at £110,000 with effect from 1 January 2018.

In 2017/18 The Board agreed to reorganise the Executive resulting to the deletion of the post of Director of Strategy and Business Deveopment. The accompanying table gives detail of any substantive changes to senior manager remuneration. Both the table of salaries and allowances of senior managers and related narrative notes and the table of pension benefits of senior managers and related narrative notes have been subject to audit.

## Senior Managers' Remuneration Policy

The Trust's pay policy is to set executive remuneration between the lower quartile and median of comparator Trusts when individuals have a demonstrable track record of high performance against agreed objectives and in their overall contribution to the Trust over a sustained period of time. This policy was established in March 2017. In making decisions on executive remuneration the Remuneration Committee will also consider the organisation's performance, and the individual's experience, marketability and likelihood of moving elsewhere. Executive remuneration does not currently include provisions for bonus payments linked to the delivery of performance targets. No executive pay should be below the maximum scale for Agenda for Change Band 9.

Decisions on executive remuneration made in 2017-18 were taken within this context.

## Service contracts and payments for loss of office

Neither the Chief Executive nor the Executive Directors are currently appointed on fixed term contracts. The Board believes that such contracts would make it harder to attract and retain high-quality Executives in a competitive recruitment environment, and can lead to uncertainty affecting service delivery towards the end of the contract.

The Trust's policy on notice periods and termination payments for Executive Directors is six months, in line with generally accepted practice at this level in the NHS. Any decision to allow an Executive Director to leave the Trust's employment without this full notice period is subject to a risk assessment by the Board of Directors Nominations Committee, in line with the Code of Governance. This risk assessment will include consideration of the individual's performance and the succession planning arrangements in place.

Non-Executive appointments are not within the jurisdiction of Employment Tribunals and there is no entitlement for compensation for loss of office through employment law. The expiry of the terms of office for the Chair and Non-Executive Directors are outlined earlier in the annual report in the section relating to the Board. The Chair and Non-Executive Directors can resign at any time by giving three month's written notice.

All Executive Directors are entitled to sick pay in line with the following table:

| Length of NHS Service | Full Pay | Half Pay |
|---|---|---|
| During the first year of service: | 1 month | 2 months |
| During the 2nd year of service: | 2 months | 2 months |
| During the 3rd year of service: | 4 months | 4 months |
| During the 4th and 5th years: | 5 months | 5 months |
| After 5 years' service | 6 months | 6 months |

In terms of loss of office, all Executive Directors will be entitled to the same redundancy terms associated with Agenda for Change (AfC) and Medical & Dental (M&D) staff i.e. after two years qualifying service, the entitlement for redundancy pay will be one month's salary for each year's service, capped at 24 months payment. For the purposes of redundancy, under the amended Section 16 of AfC salary, redundancy payments will be capped at £80K where relevant. Furthermore, all Executive Directors will be entitled to any annual leave which has been accrued and not taken at the point of a loss of office. Where more annual leave has been taken than already accrued, the Director will need to pay this back to the Trust (payment will be recovered through monthly pay). As mentioned earlier, all Executive Directors will be entitled to a six months' notice period in relation to a loss of office, the only exception to this would be an immediate dismissal, whereby notice periods would not be applicable.

Payments made to Directors at the point when there will be a loss of office would in usual circumstances be in line with contractual rights i.e. redundancy, annual leave etc. Any payments outside of these would be subject to the relevant approval process, which may include NHS Improvement.

Non-Executive Directors are not entitled to redundancy pay, holiday pay or sick pay, as they are 'Office Holders', and not employees of the Trust.

No payments to Executives for loss of office were made in 2017-18.

Details on senior manager pay, the future policy table and fair pay multiple are in the accompanying tables

## Expenses

No material expenses were paid to Executives or Governors within the year 2017-18 Remuneration Report

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

## Table 1 Senior Managers (The Chair, Executive and Non-Executive Directors) Remuneration

| | | Current Year Ending 31 March 2017 | | | | | | Previous Year Ending 31 March 2016 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **NAME AND TITLE** | **Salary and fees 2017/18** | **Taxable Benefits 2017/18 (Note 6)** | **Annual Performance Related Bonuses 2017/18** | **Long Term Performance Related Bonuses 2017/18** | **Pension Related Benefits 2017/18** | **Total Remuneration 2017/18** | Salary and fees 2016/17 | Taxable Benefits 2016/17 (Note 6) | Annual Performance Related Bonuses 2016/17 | Long Term Performance Related Bonuses 2016/17 | Pension Related Benefits 2016/17 | Total Remuneration 2016/17 |
| **Notes** | | **(bands of £5000)** | **(To the nearest £100)** | **(bands of £5000)** | **(bands of £5000)** | **(bands of £2500)** | **(bands of £5000)** | (bands of £5000) | (To the nearest £100) | (bands of £5000) | (bands of £5000) | (bands of £2500) | (bands of £5000) |
| | | **£000s** | **£s** | **£000s** | **£000s** | **£000s** | **£000s** | £000s | £s | £000s | £000s | £000s | £000s |
| **Executive Directors** | | | | | | | | | | | | | |
| | Shane Degaris, Chief Executive | **175 - 180** | **0** | **N/A** | **N/A** | **40- 42.5** | **220 - 225** | 175 - 180 | 0 | N/A | N/A | 55 - 57.50 | 235 - 240 |
| 1 | Abbas Khakoo, Medical Director | **170- 175** | **0** | **N/A** | **N/A** | **17.5 -20** | **180 - 185** | 160 - 165 | 0 | N/A | N/A | 30 - 32.5 | 195 - 200 |
| 2 | Theresa Murphy, Director of Emergency Care | **85 - 90** | **0** | **N/A** | **N/A** | **70 - 72.5** | **160 - 165** | 110 - 115 | 0 | N/A | N/A | 45 - 47.5 | 160 - 165 |
| | Terry Roberts, Director of People | **105 - 110** | **0** | **N/A** | **N/A** | **22.5 - 25** | **130- 135** | 105 - 110 | 0 | N/A | N/A | 85 - 87.5 | 195 - 200 |
| | David Searle, Director of Strategy & Business Development | **105 - 110** | **0** | **N/A** | **N/A** | **15 - 17.5** | **125 - 130** | 105 - 110 | 0 | N/A | N/A | 25 - 27.5 | 135 - 140 |
| | Joe Smyth, Chief Operating Officer | **115 - 120** | **0** | **N/A** | **N/A** | **0 - 2.5** | **120 - 125** | 115 - 120 | 0 | N/A | N/A | 20 - 22.5 | 140 - 145 |
| | Matthew Tattersall, Director of Finance | **115 - 120** | **0** | **N/A** | **N/A** | **45 - 47.5** | **165 - 170** | 110 - 115 | 0 | N/A | N/A | 25 - 27.5 | 140- 145 |
| 3 | Jacqueline Walker, Director of the Patient Experience and Nursing | **95 - 100** | **0** | **N/A** | **N/A** | **105 - 107.5** | **175 - 180** | 10 - 15 | 0 | N/A | N/A | 17.5 - 20 | 30 - 35 |

| | | Current Year Ending 31 March 2017 | | | | | | Previous Year Ending 31 March 2016 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **NAME AND TITLE** | **Salary and fees 2017/18** | **Taxable Benefits 2017/18 (Note 6)** | **Annual Performance Related Bonuses 2017/18** | **Long Term Performance Related Bonuses 2017/18** | **Pension Related Benefits 2017/18** | **Total Remuneration 2017/18** | Salary and fees 2016/17 | Taxable Benefits 2016/17 (Note 6) | Annual Performance Related Bonuses 2016/17 | Long Term Performance Related Bonuses 2016/17 | Pension Related Benefits 2016/17 | Total Remuneration 2016/17 |
| **Notes** | | **(bands of £5000)** | **(To the nearest £100)** | **(bands of £5000)** | **(bands of £5000)** | **(bands of £2500)** | **(bands of £5000)** | (bands of £5000) | (To the nearest £100) | (bands of £5000) | (bands of £5000) | (bands of £2500) | (bands of £5000) |
| | | **£000s** | **£s** | **£000s** | **£000s** | **£000s** | **£000s** | £000s | £s | £000s | £000s | £000s | £000s |
| **Non Executive Directors** | | | | | | | | | | | | | |
| | Richard Sumray, Chair | **45 - 50** | **0** | **N/A** | **N/A** | **N/A** | **45 - 50** | 45 - 50 | 0 | N/A | N/A | N/A | 45 - 50 |
| | Carol Bode, Non-Executive Director (to 30/4/2017) | **0 - 5** | **0** | **N/A** | **N/A** | **N/A** | **0 - 5** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |
| | Linda Burke (from 10/5/2017) | **5 - 10** | **0** | **N/A** | **N/A** | **N/A** | **5 - 10** | 0 | 0 | N/A | N/A | N/A | 0 |
| | Chrlyl Coppel (from 10/5/2017) | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 0 | 0 | N/A | N/A | N/A | 0 |
| | Soraya Dhillon, Non-Executive Director | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |
| | Keith Edelmanb, Non-Executive Director | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |
| | Lis Paice, Non-Executive Director | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |
| | Carl Powell, Non-Executive Director | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |
| | Richard Whittington, Non-Executive Director | **10 - 15** | **0** | **N/A** | **N/A** | **N/A** | **10 - 15** | 10 - 15 | 0 | N/A | N/A | N/A | 10 - 15 |

**Notes on Table 1**

Annual and Long Term Performance Related bonuses have not been paid by the Trust and are not applicable (N/A) Pension Related Benefits have been calculated using the HMRC method advised by Monitor in the Annual Reporting Manual. There were no taxable benefits paid in the year. Table 1 was subject to audit.

## Table 2 – Senior Managers' Pension Entitlements

| NAME AND TITLE | Real increase in pension at age 60 at 31 March 2018 | Real increase in pension lump sum at age 60 at 31 March 2018 | Total accrued pension at age 60 at 31 March 2018 | Lump Sum at age 60 related to accrued pension at 31 March 2018 | Cash Equivalent Transfer Value at 1st April 2017 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2018 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| **Executive Directors** | **(Bands of £2500)** | **(Bands of £2500)** | **(Bands of £5000)** | **(Bands of £5000)** | | | | |
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | |
| Shane Degaris, Chief Executive | 2.5 - 5 | 0 - 2.5 | 35 - 40 | 20 -25 | 388 | 60 | 448 | N/A |
| Abbas Khakoo, Medical Director | 0 - 2.5 | 5 - 7.5 | 50 -55 | 155 - 160 | 988 | 90 | 1078 | N/A |
| Theresa Murphy, Director of Emergency Care | 2.5 - 5 | 10 - 12.5 | 40 - 45 | 130 - 135 | 715 | 113 | 836 | N/A |
| Terry Roberts, Director of People | 0 - 2.5 | 0 - 2.5 | 25 - 30 | 70 -75 | 397 | 46 | 443 | N/A |
| David Searle, Director of Strategy & Business Development | 0 - 2.5 | 2.5 - 5 | 25 - 30 | 80 - 85 | 570 | 58 | 628 | N/A |
| Joe Smyth, Chief Operating Officer | 0 - 2.5 | 0 - 2.5 | 25 - 30 | 80 - 85 | 530 | 56 | 586 | N/A |
| Matthew Tattersall, Director of Finance | 2.5 - 5 | 2.5 - 5 | 35 - 40 | 85 - 90 | 440 | 66 | 506 | N/A |
| Jacqueline Walker, Director of the Patient Experience and Nursing | 5 - 7.5 | 10 - 12.5 | 35 - 40 | 75 - 80 | 512 | 120 | 637 | N/A |

**Notes on Table 2**

The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholders pension scheme. This is therefore shown as not applicable (N/A). Non Executive Directors are not members of the Trust pension scheme. CETV (Cash Equivalent Transfer Value) is the value of a members pension fund at 31 March if he/she were to transfer that pension fund on that date. Table 2 was subject to audit.

## Table 3 – Fair Pay Multiple

| | **2017/18** | 2016/2017 |
|---|---|---|
| Band of Highest Paid Director's Total Remuneration (£000) | **175 - 180** | 175 - 180 |
| Median Total Remuneration | **33,006** | 32,731 |
| Ratio | **5.38** | 5.42 |

**Notes on Table 3**
The HM Treasury Financial Reporting Manual (FReM), requires the Trust to disclose the median remuneration of the Trust staff and the ratio between this and the mid-point of the banded total remuneration of the highest paid director. The calculation is based on full-time equivalent staff of the Trust at 31 March 2018 on an annualised basis. In 2017/18 1 employee received gross remuneration higher than the highest paid director in the band of £215k to £220k. 2016/17 N/A. Table 3 was subject to audit.

## Table 4 – Senior Managers earning more than £150,000

| | **2017/18** | 2016/2017 |
|---|---|---|
| | **(Bands of £5000)** | (Bands of £5000) |
| Shane Degaris, Chief Executive | **175 - 180** | 175 - 180 |
| Abbas Khakoo, Medical Director | **170 - 175** | 160 - 165 |

**Notes on Table 4**
The Annual Reporting Manual (ARM) for NHS Foundation Trusts from 2017/18 requires the Trust to disclose all Senior Managers receiving greater remuneration than £150,000. (For 2016/17 £142,500) For this purpose within table 4 the average of the banding of Total Remuneration in Table 1 is used. The remuneration in table 4 must be disclosed on a full time, part time, or any other pro rata basis. Furthermore the Trust must disclose what steps it has taken to satisfy itself that the remuneration is reasonable. The process the Trust follows is explained below:

The Trust's exec pay policy is to set executive remuneration between the median and upper quartile of comparator Trusts when individuals have a demonstrable track record of high performance against agreed objectives and in their overall contribution to the Trust over a sustained period of time. In making decisions on executive remuneration the Remuneration Committee will also consider the organisation's performance, the individual's experience, marketability, the pay of senior managers on Agenda for Change terms and conditions and the likelihood of them moving elsewhere . Executive remuneration does not currently include provisions for bonus payments linked to the delivery of performance targets.

Executive pay was last benchmarked in 2015 by Hay Group who examined data from annual reports and a national survey conducted by the Foundation Trust Network. The Remuneration then considered all executives and the CEO's salary against the benchmark report and in accordance with the pay policy as set out above.

Remuneration in table 4 excludes pension related benefits in accordance with Monitor instructions.

**Notes**

1 Clinical work in band of £45k - £50k , Director work in band of £120 - £125k
Recharges out to NHS Central London CCG and Imperial College not included in above.
Included in salary was a Clinical Excellence Award in band of £35k to £40k which was funded by the NHS Commissioning Board CCG.
2 Theresa Murphy left the Trust on 31 December 2017
3 Jacqueline Walker became Acting Director of the Patient Experience and Nursing on a salary of £105,000. On 1 January 2018 Director of the Patient Experience on a salary of £110,000.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

# 2.3 STAFF REPORT

## Staff number analysis at 31/3/18

| | |
|---|---|
| Medical and dental | 508 |
| Administration and estates | 815 |
| Healthcare assistants and other support staff | 721 |
| Nursing, midwifery and health visiting staff | 1,045 |
| Scientific, therapeutic and technical staff | 334 |
| Healthcare science staff | 155 |
| **Total** | **3,578** |

## Equality, Diversity and Inclusion

Breakdown at the end of the year of the number of male and female directors, senior managers and employees

The Trust Board has thirteen voting members, nine male and four female.

Women represent 73.2% of senior staff at band 8 and above. The Trust employed 4,323 employees in total this year. Female employees comprised 77% of the workforce and 23% were male.

In common with all other required employers, the Trust published its first Gender Pay Gap Report in 2017. The analysis included in the Gender Pay Gap Report indicates that there is an average hourly rate pay gap in favour of men of 22.6% across the organisation. This is largely accounted for by the awarding of Clinical Excellence Awards (CEA Awards) for consultants, longer length of service for male consultants, and the fact that the majority of VSM (Very Senior Manager) positions in the Trust are held by men. High level actions are in place to address this gap and are described in the Trust's Annual Equality, Diversity and Inclusion Report 2017-18.

| Staff Group split by Gender | | | |
|---|---|---|---|
| **Staff Group** | **Female** | **Male** | **Total** |
| Add Prof Scientific and Technical | 75.70% | 24.30% | 100.00% |
| Additional Clinical Services | 87.81% | 12.19% | 100.00% |
| Administrative and Clerical | 77.58% | 22.42% | 100.00% |
| Allied Health Professionals | 80.47% | 19.53% | 100.00% |
| Estates and Ancillary | 49.38% | 50.62% | 100.00% |
| Healthcare Scientists | 88.89% | 11.11% | 100.00% |
| Medical and Dental | 53.31% | 46.69% | 100.00% |
| Nursing and Midwifery Registered | 90.03% | 9.97% | 100.00% |
| Students | 100.00% | 0.00% | 100.00% |

| Staff Group split by Gender | | |
|---|---|---|
| **Staff Group** | **Female** | **Male** |
| Add Prof Scientific and Technical | 2.42% | 2.66% |
| Additional Clinical Services | 25.61% | 12.18% |
| Administrative and Clerical | 19.34% | 19.14% |
| Allied Health Professionals | 5.17% | 4.30% |
| Estates and Ancillary | 5.92% | 20.78% |
| Healthcare Scientists | 0.72% | 0.31% |
| Medical and Dental | 9.62% | 28.86% |
| Nursing and Midwifery Registered | 31.05% | 11.77% |
| Students | 0.15% | 0.00% |
| **Total** | **100.00%** | **100.00%** |

| Workstream: Bullying & Harassment | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • Communications campaign to raise awareness of reporting routes and processes for bullying & harassment (B&H).<br>• Review of internal systems for reporting B&H/physical violence – Speak In Confidence relaunched<br>• Recruited >700 CARES Ambassadors<br>• Capability training for CARES Ambassadors delivered<br>• Recruited and trained 31 CARES Champions<br>• Relaunch of the Speak in Confidence system | • Continue to build the capacity and capability of our CARES Ambassadors to support bullying and harassment interventions<br>• Reinforce organisational message of Zero Tolerance of violent, bullying and harassing behaviour and actions we have taken.<br>• More training and development to equip staff to deal with occurrences of violence, bullying and harassment<br>• Identify themes from Datix reports for further investigation<br>• Continue with review of internal systems of reporting |

| Workstream: Learning & Development | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • Widened and publicised the spectrum of learning and development opportunities available in the Trust | • Analyse data from Study Leave applications on access to learning and development opportunities by protected characteristics and develop local divisional action plans to address any issues |

| Workstream: Career Progression | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • Implementation of diversity requirement as a mandatory criteria when engaging with external recruitment agencies for both permanent and temporary roles<br>• Training for Equality Champions in recruitment was delivered in August 2017 and these are now sitting on interview panels<br>• Observers have been trained to run our first BAME Development Centre in May 2018<br>• Completed first stage of BAME Mentoring Programme, with ten BAME staff through the Programme so far. | • Evaluate and develop our BAME Board Mentoring programme for staff at band 8A and above<br>• Expand BAME Mentoring Programme to Band 7s<br>• Actively promote internal secondment and project opportunities by division<br>• Implement an inclusive assessment centre framework that recruits, develops and attracts talent in the organisation<br>• Develop the focus of this group to target A&C staff and staff at Band 6 |

| Workstream: Engagement | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • BAME network has been launched, a Chairman has been identified, terms of reference have been agreed and staff have been asked to vote on the name of the network<br>• Board Listening Session has taken place | • Agree work programme for BAME network<br>• Launch LGBT Group<br>• Review need for additional networks around protected characteristics<br>• Further roll out of BAME Board Listening sessions |

| Workstream: Equalities & Disability | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • Work with MENCAP to run pilot within People & OD Directorate - initial placement took place in November 2016 | • Launch work experience placements pilot for people with learning disabilities<br>• Increase % of staff declaring equality categorisations on ESR<br>• Implement programme of planning for roll out of Workforce Disability Equality Standards |

| Workstream: Gender Pay Gap | |
|---|---|
| **Actions completed:** | **Actions for 2018-19:** |
| • N/A | • Target female consultant staff to increase uptake of CEA Award opportunities<br>• Establish interest in a Women's Network<br>• Develop talent management and succession plans to increase the number of women in the VSM pay band<br>• Ensure recruitment agencies understand our desire to have a good selection of women on the shortlist for senior posts |

# Appendix A - The Hillingdon Hospitals NHS Foundation Trust - Annual Accounts 2017-18

## Note 6 Employee costs and numbers

### 6.1 Employee costs

| | **Total** | **31 March 2018 Permanently employed** | **Other** | Total | 31 March 2017 Permanently employed | Other |
|---|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| Salaries and wages | **131,448** | **113,626** | **17,822** | 128,834 | 115,774 | 13,060 |
| Social security costs | **13,868** | **12,407** | **1,461** | 13,353 | 12,273 | 1,080 |
| Apprenticeship levy | **644** | **586** | **58** | - | - | - |
| Employer contributions to NHS Pension scheme | **14,658** | **13,936** | **722** | 14,343 | 13,621 | 722 |
| Termination Benefits | **22** | **22** | | - | - | - |
| Temporary staff - agency/contract staff | **12,645** | **-** | **12,645** | 14,194 | | 14,194 |
| Temporary staff - external bank | **-** | | **-** | - | - | - |
| Recoveries from DHSC Group bodies in respect of staff cost | **(1,335)** | **(1,335)** | **-** | (1,410) | (1,410) | - |
| Recoveries from other bodies in respect of staff cost | **(184)** | **(184)** | **-** | | | |
| **Employee benefits expense** | **171,766** | **139,058** | **32,708** | 169,314 | 140,258 | 29,056 |
| | | | | | | |
| **Of the total above:** | | | | | | |
| Charged to capital | **757** | **757** | **-** | 964 | 825 | 139 |
| Charged to revenue | **171,009** | **138,301** | **32,708** | 168,350 | 139,433 | 28,917 |
| | **171,766** | **139,058** | **32,708** | 169,314 | 140,258 | 29,056 |

### 6.2 Directors aggregate remuneration

| | **31 March 2018 Remuneration** | **31 March 2018 Number of** | 31 March 2017 Remuneration | 31 March 2017 Number of |
|---|---|---|---|---|
| | **£000** | **Directors **** | £000 | Directors ** |
| Executive Directors | **1,097** | **8** | 1,100 | 9 |
| Non Executive Directors* | **141** | **9** | 139 | 8 |
| **Total** | **1,238** | **17** | 1,239 | 17 |
| | | | | |
| **Analysis of Directors Remuneration (£000)** | | | | |
| Gross pay | **988** | | 1,001 | |
| Employer Pension Contributions | **130** | | 115 | |
| Employer National Insurance Contributions | **120** | | 123 | |
| **Total** | **1,238** | | 1,239 | |

*Non Executive Directors are not members of the NHS pension scheme.

** The number of directors denotes the number of individuals employed in a director position at some point during the financial year, not the number of directors simultaneously employed.

## 6.3 Average number of people employed

| | Total | 31 March 2018 Permanently employed | Other | Total | 31 March 2017 Permanently employed | Other |
|---|---|---|---|---|---|---|
| | **Number** | **Number** | **Number** | Number | Number | Number |
| Medical and dental | **508** | **453** | **55** | 484 | 460 | 24 |
| Administration and estates | **815** | **743** | **72** | 785 | 716 | 69 |
| Healthcare assistants and other support staff | **721** | **552** | **169** | 688 | 542 | 146 |
| Nursing, midwifery and health visiting staff | **1,045** | **822** | **223** | 1,019 | 819 | 200 |
| Scientific, therapeutic and technical staff | **334** | **303** | **31** | 339 | 309 | 30 |
| Healthcare science staff | **155** | **142** | **13** | 161 | 138 | 23 |
| **Total** | **3,578** | **3,015** | **563** | 3,476 | 2,984 | 492 |
| **Of the above:** | | | | | | |
| Number of whole time equivalent staff engaged on capital projects | **13** | **13** | **-** | 17 | 15 | 2 |

The table of pay multiples and related narrative notes has been subject to audit

## Staff policies and actions applied during the financial year:

Policies were applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.

### The following policies apply in relation to the above question; Recruitment & Selection Policy, Equality & Human Rights Policy, Employment Checks Policy

The Trust has a positive approach to disability and aims to encourage and support the inclusion of disabled people in accessing the full range of opportunities open to staff, and to promote greater participation in public life.

In line with the policies governing recruitment, selection, disability and the Guaranteed Interview Scheme, disabled candidates for any selection process, who meet the essential criteria, will be short-listed for interview.

Managers responsible for conducting any selection or assessment processes are also responsible for ensuring that reasonable adjustments are made to any candidates who require them, in line with the Trust's Recruitment and Selection Policy/Resourcing Policy.

### Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.

The following policies apply in relation to the above question; Equality & Human Rights Policy

Managers are responsible for ensuring that staff are able to carry out their work in appropriate conditions, including participation in learning and development initiatives and local induction processes. Where necessary, Reasonable Adjustments must be made to equipment, working or learning arrangements and the physical environment to ensure that disabled staff can carry out their work, and access the full range of learning and development opportunities. These adjustments will be carried out with advice from the occupational health department. In certain circumstances the Equality Act 2010 provides that a reasonable adjustment can include treating disabled staff more favourably, such as appointing a disabled member of staff into a role without undergoing a competitive selection process.

### Policies applied during the financial year for the training, career development and promotion of disabled employees.

The following policies apply in relation to the above question; Recruitment & Selection Policy, Equality & Human Rights Policy.

Where appropriate the principles of Positive Action are applied to support the career development and promotion of disabled employees.

## Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.

The Trust sends out regular bulletins to staff to keep them informed of matters which may be of concern to them. Managers are encouraged to disseminate such information at team meetings and-or 1:1 meetings as appropriate. Should employees have concerns which they wish to raise, a number of channels are open to them to do so. These include but are not limited to the following; Raising Concerns at Work Policy, Dignity at Work Policy, Grievance Policy, SpeakInConfidence, escalating concerns to their manager or manager's manager.

- Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.

The Trust has a number of forums in place to consult with employees or their representatives on a regular basis, so that the views of employees can be taken into account in making decisions which are likely to affect their interests. These forums include; the JNCC (Joint Negotiating Consultative Committee), JLNC (Joint Local Negotiating Committee), Terms & Conditions Committee and subgroups such as the PDR Working Group. The Trust also acts upon information received from the results of the Staff Survey and Staff Friends & Family Test. Other initiatives include the monthly Chief Executive briefing and the Team Brief. Where appropriate the principles of the Managing Organisational Change Policy are also applied, especially in relation to changes which impact on working arrangements.

## Actions taken in the financial year to encourage the involvement of employees in the NHS Foundation Trust's performance.

The Trust has a culture of engagement and routes through which it involves and listens to its workforce. The senior team is actively involved in welcoming new employees. The CEO uses his monthly briefings to listen to and engage with the workforce. These briefings are held at both the Hillingdon and Mount Vernon sites.

Trust employees are involved and contribute to clinical decision making at all levels of the organisation through representation on various committees particularly clinical audit committees. These provide a forum for discussion, problem solving, action planning and review of Trust performance.

The Trust continues to promote regular one to one meetings between managers and direct reports and their teams. The Performance Development Rreview meetings provide an additional forum through which staff are involved in decisions about their work, service and performance of the Trust.

Staff are encouraged to submit ideas and activities for improving the quality of the workplace and patient care.

In addition, staff governors take a full part in the governors' role and will bring matters forward from staff to governors' meetings.

We continue to use the findings from the annual staff survey report to engage our staff. With the involvement of staff and teams, action plans are developed from its findings and taken forward for the benefit of staff and patients.

The Trust has a culture of partnership working with its staff and staff-side colleagues. This relationship is supported via three main forums through which staff are consulted in decisions about the organisation. Information on health and safety performance and occupational health

The Trust has an Occupational Health Department which provides information and support to staff. In addition the Trust has an Employee Assistance Program in place, which is open to all Trust employees – details are published on the Trust Intranet page. Occupational Health and Managers will refer staff to the service as appropriate. The Trust also promotes Occupational Health services at internal health promotion events and the Trust's New Joiners Event.

We continue to use the findings from the annual staff survey report to engage our staff.

## Health and safety

Through its Health and Safety Strategy the Trust continues work towards best practice standards of health and safety for all our staff in the workplace, for members of the public, patients, and others who come in to our premises.

**Health and safety governance:** The Health and Safety Committee have met quarterly and the Board has received reports on health and safety issues and performance throughout the year.

**Training:** All new members of staff receive health and safety training during their corporate induction. Fire safety training has been completely reviewed and as a result, attendance has increased.

**Performance:** During this reporting period there were a total of 1,607 incidents reported indicating a slightly increased trajectory in incident reporting.

- Information on policies and procedures with respect to countering fraud and corruption

The Trust has a Counter Fraud Policy in place which highlights to staff what they should do in the event that they suspect fraud or corruption. The Trust also has in place a Raising Concerns at Work Policy (Whistleblowing), and an anonymous dialogue system called "SpeakInConfidence", which can also be used for the purposes of raising concerns.

## Staff survey results

### Survey construction and response rate

53% of staff completed the 2017 survey, an improvement of 7% from 2016.

Responses to individual questions in the survey are categorised into 32 key findings. Each finding is composed of responses to specific questions relevant to the finding. Findings are then grouped under 10 themes.

This report highlights the issues where the Trust should focus its efforts in acting and therefore refers to performance against key finding and specific questions where relevant.

# Summary Results: Staff Engagement and Key Findings (See Appendix)

## Staff engagement

**Staff engagement: 3.83** (3.85 in 2016) – **not statistically significant to last year.**

The staff engagement indicator is a composite of three key findings:

- *Staff members' perceived ability to contribute to improvements at work* (where the Trust is average compared with other acute trusts)
- *Staff willingness to recommend the Trust as a place to work or receive treatment* (where the Trust is average compared with other acute trusts); and,
- *Staff motivation – looking forward to going to work and enthusiastic and absorbed in their jobs* (where **the Trust scores in the best 20%** of all acute Trusts)

## Key Findings: Top 5 indicators compared with other acute trusts

The Trust continues to perform well compared to all acute trusts in some key areas:

| Top Five Indicators Compared to all Acute Trusts | |
|---|---|
| Staff motivation at work | **In the best 20% (4.02 v. 3.92}** |
| % of staff appraised in the last 12 months | **In the best 20% (93% v. 86%)** |
| Quality of appraisals | **In the best 20% (3.20 v. 3.11)** |
| % of staff experiencing physical violence from patients, relatives or the public in last 12 months | **In the best 20% (13% v. 15%)** |
| % of staff/colleagues reporting most recent experience of violence | **Better than average (71% v. 66%)** |

## Key Findings: Bottom 5 indicators compared with other acute trusts

The areas where the Trust performs worst compared to others are:

| | Bottom Five Indicators Compared to all Acute Trusts | |
|---|---|---|
| 1 | % of staff reporting errors, near misses or incidents witnessed in the last month | **In worst 20% (87% v. 90%)** |
| 2 | % of staff experiencing discrimination at work in the last 12 months | **In worst 20% (17% v. 12%)** |
| 3 | % of staff experiencing physical violence from staff in the last 12 months | **In worst 20% (3% v. 2%)** |
| 4 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | **Worse than average (30% v. 28%)** |
| 5 | % of staff believing that the organisation provides equal opportunities for career progression or promotion | **In worst 20% (80% v. 85%)** |

## Key findings: Biggest changes compared to 2016

In addition to top and bottom performing areas, the areas where we have seen the biggest change from 2016 are shown below. These are all adverse changes.

| Largest changes from 2016 | | |
|---|---|---|
| 6 | % of staff working extra hours | Up from 69% to 73% |
| 7 | % of staff feeling unwell due to work related stress in the last 12 months | Up from 31% to 35% |
| 8 | % of staff experiencing harassment, bullying or abuse from staff in the last 12 months | Up from 23% to 27% |
| 9 | Staff satisfaction with resourcing and support | Down from 3.39 to 3.29 |
| 10 | Staff satisfaction with the quality of work and care they are able to deliver | Down from 4.05 to 3.97 |

The Trust has important strengths to build on, including its higher than average staff engagement score and levels of staff motivation in the top 20%. These are strengths that can be developed and leveraged in tackling the areas where performance is poor and where there have been adverse changes since 2016.

It is important to recognise the drivers that are likely to have influenced the adverse results and explain the relative worsening of our position in some key findings. Most notable is the tightened financial climate in 2017, particularly the internal Financial Improvement Programme (FIP). This represents a break from past relative financial stability and has led to an increase in accountability and responsibility and managers making tougher and harder decisions.

# Our response: Corporate, targeted and Divisional actions

## Corporate actions

Since the 2017 survey period, the Trust has begun implementation of the People Strategy 2017-22. The Strategy provides the framework and a set of core actions to respond to the Staff Survey 2017. All five pillars of this Strategy (although particularly 'Educate, train and develop' and 'Nurture our people') include corporate initiatives that will both build on the positive findings and address the negative findings in the Survey.

**People Strategy: corporate actions to address the Staff Survey 2017**

- Values based recruitment to further embed our CARES values and culture
- International and domestic recruitment
- Improving the efficiency of our recruitment processes

Supporting areas **4, 6, 9, 10**

- Ensuring 1:1s are the norm and address the issues staff face
- Ensuring more effective PDRs delivered through a coaching approach
- Providing more learning and development opportunities through the Apprenticeship Levy and the LMS

Supporting areas **5, 6, 9 and 10**

- Ensuring best managerial practice
- Maximising use of e-systems
- Better workforce information available for managers to support staff & address resourcing issues

Supporting areas **1, 6, 7, 9, 10**

- Embedding a coaching culture
- Reward schemes including CARES monthly
- Implementing Development Centres from April 2018
- Hillingdon's 'Listening Into Action'
- Achieving Healthy Workplace Charter Level 2

Supporting areas **1, 2, 3, 5, 7, and 8**

- Introduce new roles, e.g. Nursing Associates to alleviate current workforce pressures
- Better skill mix and understanding of gaps in the workforce

Supporting areas **6, 7, 9, 10**

# Targeted corporate action

## Some of the Survey areas for action will require additional targeted support

- The Trust scores below average for staff being given feedback about changes made in response to reported errors. We will ask the Quality & Safety Committee how their current actions address this and what further actions need to be taken
- Triangulation of data shows that many incidents related to violence and aggression. We have established a group as part of the NHSI Retention Programme who have actions to review & encourage Datix reporting
  - We are reinforcing an organisational messages of Zero Tolerance to violence, bullying & harassing behaviour
  - We are equipping staff to cope with violence, bullying and harassing behaviour through resilience training and Conflict Resolution as part of core skills training

**Summary of all key areas for action**

| | |
|---|---|
| 1 | % of staff reporting errors, near misses or incidents witnessed in the last month |
| 2 | % of staff experiencing discrimination at work in the last 12 months |
| 3 | % of staff experiencing physical violence from staff in the last 12 months |
| 4 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months |
| 5 | % of staff believing that the organisation provides equal opportunities for career progression or promotion |
| 6 | % of staff working extra hours |
| 7 | % of staff feeling unwell due to work related stress in the last 12 months |
| 8 | % of staff experiencing harassment, bullying or abuse from staff in the last 12 months |
| 9 | Staff satisfaction with resourcing and support |
| 10 | Staff satisfaction with the quality of work and care they are able to deliver |

- The biggest changes since 2016 in individual questions relate to survey areas 9 and 10. These questions were: having adequate materials, supplies & equipment to do my job (down 10%); no training, learning or development in the last 12 months (down 9%); and training being identified in appraisal (down 9%). We will need to address this through more innovative ways of working with partners including the Hillingdon Hospitals Charity as well as through increasing training and devleopment

## Summary of Performance

### Sickness absence data

The Trust completed the financial year with a sickness rate of 4.31%. Overall Trust sickness levels decreased for a second consecutive month at year with a reduction of -0.23% in March on February 2018 although this was 1.09% higher than the same time in 2017.

### Vacancy and Turnover rate

Vacancy and turnover rates have continued to reduce during quarter 4 of 2017-18 ending the year at 11.59% the lowest vacancy rate all year, and 13.11% the second lowest turnover rate all year. Voluntary turnover finished the year at 12.15%, which is within the Trust's 13% target. Staff remaining with the Trust after 12 months of joining (retention rate) also increased during quarter 4 ending the year at 88.8% the second highest of 2017/18.

### Performance development review (PDR)

PDR compliance is 98.34% having closed the reporting window well above the 90% Trust target. At the time of closing there were five areas not achieving 100% compliance: CCSS (99.64%), Finance (98.32%), Medicine (95.71%), Surgery (97.4%) and W&Cs (99.39%).

### Mandatory Training Compliance

Statutory and Mandatory Training (StaM) compliance ended the year at 90.15%, which is above the Trust target of 90%.

### Expenditure on HR Consultancy

The Trust expenditure on consultancy services was as follows;

- Foreign Recruitment £29,783
- Physician Associate Recruitment £3,354
- Consultancy £1,643
- Professional Fees £23,177

Professional Fees were for a range of activities including recruitment searches, advice and benchmarking.

### Off payroll engagements

See appendix B.

### Exit packages

Exit packages in 2017/18 were less than £50,000.

## Reporting of high paid off-payroll arrangements

As per the Trust's Standing Financial Instructions, off-payroll or non-standard contract employment arrangements are only be considered by exception and where there is no practical alternative to the Trust employing directly. Before any off-payroll engagements are agreed with an individual a tax status questionnaire must be completed and sent to the Director of People before any engagement is finalised. It is the responsibility of the Director of People to approve all off-payroll engagements or non-standard contract employment arrangements prior to commencement. See appendix B.

# Appendix B - Off Payroll Arrangements

| Table 1: For all off-payroll engagements as of 31 Mar 2018, for more than £245 per day and that last for longer than six months | |
|---|---|
| **No. of existing engagements as of 31 Mar 2018** | 7 |
| **Of which:** | |
| Number that have existed for less than one year at the time of reporting | 2 |
| Number that have existed for between one and two years at the time of reporting | 2 |
| Number that have existed for between two and three years at the time of reporting | 1 |
| Number that have existed for between three and four years at the time of reporting | 0 |
| Number that have existed for four or more years at the time of reporting | 1 |

| Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018, 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 01 Apr 2017 and 31 Mar 2018 | 5 |
| **Of which:** | |
| Number assessed as within the scope of IR35 | 0 |
| Number assessed as not within the scope of IR35 | 5 |
| Number engaged directly (via PSC contracted to trust) and are on the trust's payroll | 0 |
| Number of engagements reassessed for consistency/assurance purposes during the year | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

| Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018 | |
|---|---|
| Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. | 0 |
| Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements. | 17 |

# 2.4 COMPLIANCE WITH NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Hillingdon Hospitals 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 2016.

Following review, the Board confirms it is compliant with the Code.

# 2.5 SINGLE OVERSIGHT FRAMEWORK

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

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

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

The Trust is currently in segment 3. This segmentation information is the Trust's position as at May 2018. 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 67 measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here:

| Area | Metric | 2016/17 | 2017/18 |
|---|---|---|---|
| Financial sustainability | Capital service capacity | 2 | 4 |
| | Liquidity | 4 | 4 |
| Financial efficiency | I&E margin | 1 | 4 |
| Financial controls | Distance from financial plan | 1 | 1 |
| | Agency spend | 3 | 2 |
| **Overall scoring** | | **3** | **3** |

# 2.6 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE HILLINGDON HOSPITALS 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 The Hillingdon Hospitals 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 The Hillingdon Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/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.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

# 2.7 ANNUAL GOVERNANCE STATEMENT 2017/18

## 1. Scope of responsibility

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

## 2. The purpose of the system of internal control

**The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve 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 The Hillingdon Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Hillingdon Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.**

## 3. Capacity to handle risk

The Board is responsible for reviewing the effectiveness of the system of internal control including systems and resources for managing all types of risk. The Trust Board approved Risk Management Strategy and Policy (including Board Assurance Framework) ensures that the Trust approaches the control of risk in a strategic and organised manner. It sets out the responsibilities of Executive Directors and Senior Managers in relation to their leadership in risk management and makes it clear that all employees have a role to play in risk management appropriate to their level.

The Board has established a committee structure to provide assurance on and challenge to the Trust's risk management process. Each of these committees are chaired by a Non-Executive Director to enhance this challenge, and the


chairs report formally to the Board to escalate issues that require further Board discussion.

The main Board committee for risk management is the Audit & Risk Committee (ARC). The ARC provides assurance that there is a sound system of internal control and governance and ensures that risks to the delivery of the Trust's services are identified and addressed. Corporate risks are reported to the Board/ARC via the Trust Management Executive. Local risks are reported and escalated to the corporate risk register via Divisional Governance Boards and Trust Committees such as the Patient Safety Committee, Health and Safety Committee, Information Governance Steering Group etc., as outlined in the Trust's Risk Management Strategy and Policy.

The structure of each divisional team is designed to provide the most coherent possible leadership. Clinical oversight is provided by a triumvirate, which comprises a Divisional Director, an Assistant Director of Operations and an Assistant Director of Nursing. This divisional team is supported by operational management, business development, nursing, financial management and HR.

The Divisional Directors, (who are Medical Consultants) are accountable to the Chief Operating Officer and responsible for the safe and efficient management of the clinical divisions within the Trust. Divisional Directors are professionally accountable to the Medical Director. The Director of Patient Experience and Nursing (DPEN) provides professional accountability and support to the Assistant Directors of Nursing.

Risk management and Health and Safety awareness training is mandatory to all Trust employees and is included in the Trust Induction programme. The Trust's Corporate Governance and Health and Safety teams jointly deliver additional risk management training appropriate to all levels as and when required across the Trust including the Trust Board.


# 4. Risk control framework

## 4.1 Risk Management Strategy

The Trust Board approved the Risk Management Strategy and Policy (including Board Assurance Framework) to ensure that the Trust approaches the control of risk in a strategic and organised manner and sets out the responsibilities of Executive Directors and Senior Managers in relation to risk management. It makes it clear that all employees have a role to play in risk management appropriate to their level.

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. Identified risks are documented on risk registers. These risks are analysed in order to determine their risk score using a risk scoring matrix and assigning a local or corporate management level dependant on their relative importance and mitigating actions required. A target risk score and target mitigation date is assigned to ensure that risks are controlled within a timely manner and to an acceptable level of risk. Risk control measures are identified and implemented via action plans to achieve the target level of risk.

Local risks are managed by the area in which they are found whilst corporate level risks are managed at progressively higher levels within the organisation. Achieving control of the higher scoring risks is given priority over lower scoring risks.

The Trust has a Board Assurance Framework (BAF) which seeks to provide reasonable assurance that management and the Board in its oversight role are made aware in a timely manner of the extent to which the Trust is managing the key risks to achieving its strategic objectives. The BAF provides information and

assurance, cross references the corporate risk register, and highlights where the Board may need to intervene or make decisions. The BAF is reviewed quarterly by the ARC and bi-annually by the Trust Board.

## 4.2 Quality Governance Arrangements

There are key quality governance and leadership structures that support the Trust in ensuring that the quality and safety of care is being routinely monitored across all services; the governance arrangements to review and challenge performance and variation are as follows:

- There is bi-monthly reporting to the Board via the integrated quality and performance report with exception narrative.
- At each Quality and Safety Committee (QSC) meeting a clinical division, presents on clinical and quality governance issues, discusses areas of risk, reviews performance against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit.
- There is a deep dive review at each QSC meeting on the key aims of the Quality and Safety Improvement (QSI) Strategy. Any external quality and safety intelligence is presented at the QSC on a bi-monthly basis, and a summary of performance against the QSI strategy annual action plan is also reported.
- Clinical divisions review their quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis at their divisional governance boards; divisional exception reports are received by the Patient Safety Committee (PSC) and Regulation and Compliance Committee (RCC) any concerns on quality are escalated to the QSC.
- There is a structured process of reporting the investigation of Serious Incidents and the follow up of outcomes and action plans resulting from Serious Incidents (SIs) via a Non-Executive led SI assurance committee. Root cause analysis is used and forms the basis of SI reports together with the creation of action plans which are monitored by divisional governance boards through to completion.
- There are regular visits to clinical departments by the DPEN, Chief Executive Officer and other Board members giving them the opportunity to talk to staff and patients about their experience.
- 'Clinical Fridays' allow the corporate nursing team and divisional senior nurses, alongside the DPEN, to engage with clinical staff, patients and carers on wards and in departments to review the environment and delivery of care. Any issues or concerns are escalated accordingly to the Executive Team and Trust Board.
- There is a robust framework to ensure that all service changes have a Quality Impact Assessment (QIA) which is then reviewed by the Medical Director. Trust-wide QIPP schemes and any schemes where there are quality concerns are reviewed at a multi-professional Clinical Assurance Panel (CAP), with the project leads presenting the scheme and the actions being taken to mitigate any associated risks to quality.
- Listening to Patients/Governors: it is important that there is a range of opportunities to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation which is always striving for quality improvement. Patients can complete local patient experience surveys, including the Friends and Family Test, provide feedback via NHS Choices, in person directly to department managers and matrons or via the PALS/Complaints offices. There is opportunity for patients and members of the public to attend the Trust's People in Partnership (PiP) meetings, Council of Governors meetings and the Trust Board meeting. There are also specialty-based focus and support groups where patient feedback can be obtained. The Board receives patient stories as part of understanding the patient experience; this ensures that the voice of the patient and their families/carers is heard first hand by Board members; stories are captured directly from patients via 1:1 interviews, complaints and PALS feedback.

## 4.3 Well Led Framework

The Trust Board declared compliance against Monitor's 'Well-Led Framework' in January 2017 and has been committed to continuing compliance with the quality governance requirements outlined in the framework during the past year. In response to the revised well led framework (NHSI, June 2017) the Trust instructed KPMG, its internal auditor to undertake a desktop review of the Key Lines of Enquiry in February 2018. The results of the review have been presented at the public board meeting in March. The Trust will now be reviewing the recommendations and will be working through a robust action plan with a view to commissioning an external well-led review in line with NHSI guidance following the publication of the results of the CQC inspection and well led assessment being conducted in April 2018.

## 4.4 Quality of Performance Information

The Trust's Data Quality Improvement Steering Group (DQISG) reports into the Audit and Risk Committee (ARC) on a quarterly basis to provide assurance on accuracy of information provided to the Board. In addition, the Elective Performance Meeting (EPM) reviews data quality risks on a monthly basis and reports to DQISG on progress and actions to address them. Through these groups risks are actively reviewed and addressed through the data quality framework that has been established.

## 4.5 Care Quality Commission (CQC) Compliance

The Trust continues with a rating of 'Requires Improvement' as judged by the CQC as a result of its comprehensive inspection in October 2014. In May 2015, the CQC re-inspected the Trust and noted the many improvements made from its previous visit. A requirement notice against regulation 12; 'safe care and treatment' was however issued at this time; this specifically focuses on infection prevention and control. The Trust has since been inspected by the CQC in March 2018 with an announced comprehensive inspection of all of its core services on the Hillingdon site only. The CQC conducted a review of the well-led domain at end of April 2018 and an assessment was undertaken in May 2018 by NHS Improvement of the Trust's 'Use of Resources'. It is anticipated that the CQC will publish its report of the Trust's compliance to the Fundamental Standards and Key Lines of Enquiry in mid July 2018.

The Trust continues to strengthen its governance arrangements and its compliance with the Health and Social Care Act regulations via its programme of internal peer review and mock inspection ensuring there is evidence of progress of improvement.

The Trust's internal auditor, KPMG recently undertook a review of the Trust's compliance against the CQC's KLOE, as part of the Trust's internal audit programme. The audit report acknowledges the excellent progress and quality improvements made by the Trust since KPMG's last review in 2016 with far fewer recommendations. The Trust's CQC improvement plan has now been refreshed in line with the KPMG review recommendations and is being monitored by the Regulation and Compliance Committee and the Quality and Safety Committee.

## 4.5 Data Security

The Trust has committed to the implementation of a large Cyber Security programme of work to protect data networks, clinical devices and the computing infrastructure.

This work is in addition to the existing security monitoring and protection tools, such as anti-virus.

The cyber security programme includes:

- Vulnerability management software to electronically monitor, identify and mitigate known vulnerabilities in information systems and networks.
- Intrusion Detection System (IDS) that learns and monitors network and machine behaviour and will alert when abnormal or unusual behaviour is detected.

- Anti-exploit software that prevents malicious payloads from executing
- Next generation firewalls to protect diagnostic modalities and medical devices and give an oversight of the network security around these vital clinical systems.

Incidents are reported and monitored at the Information Governance Steering Group, which meets a minimum of four times a year and is chaired by the Trust's Senior Information Risk Owner. Relevant incidents are also reported via the Information Governance Incident Reporting Tool.

## 4.6 The organisation's major risks

The Board oversees the management of all major risks, which are actively addressed by the Audit and Risk Committee. Key controls and assurances, and any identified gaps are continually reviewed and action plans developed and progressed accordingly. Outcomes are confirmed via this process and reported to the Board.

During 2017/18 the Board ensured on-going assessment of in year and future risks and full reference to all major risks is contained within the quarterly Board Assurance Framework paper available via the Trusts public website.

The key financial and non-financial risks faced by The Hillingdon Hospitals NHS Foundation Trust moving forward into 2018/19 include:

- The Trust may fail to achieve 95% A&E target potentially leading to a breach of its Licence
- Suboptimal staffing issues due to risk of inadequate nursing levels as a result of a combination of vacancies, national shortages and additional capacity being opened to meet surge in demand
- The Trust may fail to meet compliance with the expected standards set out by our regulators.
- Effectiveness of the financial control system or inability to achieve the financial plan
- The scale of investment required to improve the Trust's fragile estate infrastructure exceeds the Trust's financial capacity

- The Trust may fail to modernise and reconfigure the Estate & Facilities to meet the needs of our clinical services
- The Trust may fail to deliver high quality patient care as a result of inadequate staffing provision in line with the 7-day workforce initiative
- Failure/delay in escalation of deteriorating patients and the management of sepsis
- The Trust may fail to remain within hospital acquired infection thresholds.

Overall, the Trust will remain focused on the tension between quality, safety, financial efficiency, and risk to ensure that patient care remains uncompromised. The Trust will do this by having regular Board and Executive reviews of progress and delivery of agreed plans and check that all schemes are quality impact assessed.

The Board formally escalated the condition and risks associated with the Trust estate to NHS Improvement in February 2018. The Trust available funds are insufficient to keep pace with the scale of backlog maintenance, many building/ services have failed or are beyond their economic and design life cycle and key facilities such as Theatres, Critical Care and many wards are of a design and condition that does not lend itself to the delivery of modern high quality healthcare. The need for investment in our infrastructure has been highlighted through the Shaping a Healthier Future (SaHF) business case. The case identifies the need for investment, but also flags that though investment would help, it would not resolve all our issues with the current infrastructure. In addition, the Trust is working with partners to develop a longer term solution to the estates issues through the development of a new facility on a university health campus at Brunel University.

## 4.7 Compliance and Validity of the NHS Foundation Trust condition 4 (FT Governance): Corporate Governance Statement

The Trust has assessed compliance with the NHS Foundation Trust condition 4 (FT governance). Assurances to support the validity of the conditions are reviewed in detail bi-annually by the Executive team and the ARC (October 2017 and April 2018) and were agreed by the Board in May 2018. This process also identifies any risks to compliance and mitigating actions. All statements were 'confirmed'.

The Trust believes that effective systems and processes are in place to maintain and monitor the following:

- The effectiveness of governance structures.
- The responsibilities of Directors and sub-committees.
- Reporting lines and accountabilities between the board, its sub-committees and the executive team.
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence.
- The degree and rigour of oversight the board has over the Trust's performance.

However, the following material risks to compliance and actions to mitigate have been identified through the Trusts 2017/18 review process:

**Risk:** The Trust is required to undertake an external governance review against the well led framework as required by NHSI every 3 -5 years. The Trust plans to commission an external review in 2018/19 following outcomes of the CQC well-led inspection.

**Risk:** That committees would not conduct its business aligned with organisational priorities and key issues if Terms of Reference (ToR) and review of functionality is not reviewed at least annually. KPMG's desktop review of the Trust's Well-Led Framework in 2017/18 identified that some ToR were identified as not having been reviewed over the last three years. ToR of all sub-committees of the board will be reviewed in Quarter 1 2018/19 and at least annually thereafter. The Trust will also ensure its reporting lines between officer led committees and how they report in to the governing structure of the board and committees is reviewed on a periodic cycle.

**Risk:** CQC compliance (section 4.5)

**Risk:** The Trust has planned for a deficit of £14m in 2018/19 and having agreed a control total with NHSI is eligible for up to £6.2m of Provider Sustainability Funding to reduce the deficit further. However, the plan contains the following significant risks: a high level of savings (5%); no funding for activity growth above contracted levels, and no contingency.

**Risk:** The Trust has not met the 95% A&E standard in 2017/18. Contributing factors have included continued growth in the number of people attending the department, and 6% increase in ambulance conveyances. The total number of available cubicles in the department to effectively manage flows remains a significant contributing factor impacting on the department's performance. The demand and activity in the A&E Department has exceeded the physical capacity it was initially built for resulting in overcrowding particularly during a surge and/or exit block due to limited bed capacity on the wards.

This risk is mitigated through practice initiatives such as fit2sit, Early First Assessment and Management (EFAM) in an attempt to ensure timely assessment, treatment and discharge/ transfer/admission as clinically appropriate. During A&E exit block as a result of the bed crisis, the Full hospital Protocol is activated with the intention of moving patients who are waiting for admitted beds out of ED into assessment and ward areas. This mitigates the A&E overcrowding to an extent but remains a risk until the planned refurbishment is completed during 2018/19. Over the winter period the lack of beds has caused considerable congestion in the A&E department and was the main contributing factor to performance December 17 – March 18.

Challenges around Sub-optimal pathways and staffing are being addressed and good progress is being made with a comprehensive System Emergency Care Improvement action plan.

**Risk:** The Trust does not have a Fit and Proper Persons procedure for Governors. The Trust has refreshed its FPPT for Board members and will use this as a model to develop the same for Governors in 2018.

## 4.8 Equality, Diversity and Human Rights

**Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with**. Equality impact analysis/assessments (EIA) are carried out as standard procedure for all Trust policies and new developments/service changes. An equality and diversity toolkit is available for staff on the Trust's intranet to support them with completing an EIA. The Trust has an Equality and Diversity Steering Group and an annual report is presented to the Trust Board. The Trust has published its statutory equality & diversity report providing assurance that the Trust is compliant with equality legislation.

## 4.9 Engagement with Stakeholders

The Trust works with its key public stakeholders to manage its risks. This is done through the following mechanisms:

- Engagement with the local External Services Scrutiny Committee.
- Engagement with the local Healthwatch.
- The Council of Governors is consulted on key issues and risks as part of the annual plan.
- Regular People in Partnership Forums enables the Trust to listen to the views and opinions of the communities we serve, share information about what the Trust is doing, and planned future developments, and provides an opportunity for members to meet and communicate with staff, Governors and fellow members.
- Annual Members Meeting.
- Engagement with user and support groups e.g. Fighting Infection Together, Maternity Services Liaison Committee, People Improving Cancer Services, Lay Strategic Forum and the Patient-led Assessment of the Care Environment' (PLACE).
- Inviting public members and local stakeholders to identify priorities for our Quality Report.

In addition, the Trust has established a Lay Strategic Forum made up of patients and carers who use our services providing them with an opportunity to improve the health and wellbeing of the local population, the quality and safety of care and the efficiency and productivity of Trust services. Representatives from this group have joined committees and other groups providing a public viewpoint to discussions.

The Trust has continued to engage with patients and the public on the patient safety and quality agenda and required improvements as part of its Quality and Safety Improvement Strategy. This work continues with the recruitment of patients to our Patient Safety Champion network.

## 4.10 Incident Reporting

There are structured processes in place for incident reporting, the investigation of Serious Incidents and following up outcomes from Board commissioned external reports. The Trust Board, through the Risk Management Strategy & Policy (including BAF) and the Incident Policy (including Serious Incident (SI)), promotes open and honest reporting of incidents, risks and hazards. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. The latest available National Reporting Learning System (NRLS) report (covering 1 April 2017 – 30 September 2017) has shown the Trust to be in the middle 50th percentile for incident reporting.

## 4.11 Emergency Preparedness Resilience and Response

The NHS has a key role in responding to large scale emergencies and major incidents and throughout the year the Emergency Planning and Business Continuity Team has worked to ensure that the Trust is adequately prepared for any such events. Compliance against the NHS England Emergency Planning Resilience and Response Framework 2015 and associated guidance is assessed annually by NHS England and in 2017 the Trust maintained an assurance rating of substantial assurance.

## 4.12 Registration with the Care Quality Commission (CQC)

The Trust is fully registered with the CQC.
The Trust has been issued with its certificate for 2017/18.

## 4.13 Pension Scheme

**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.**

## 4.14 Assessing our Impact on the Environment

**The Hillingdon Hospitals NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.**

The Trust recognises the need to operate as a financially and socially responsible organisation, minimising its impact on the environment in order to deliver the highest quality healthcare to the communities we serve, now and in future. Extensive audits have been carried out on both sites to identify opportunities to reduce energy consumption and associated carbon emissions. Water surveys were also conducted on both sites to understand usage profiles and patterns better and to pinpoint areas where consumption can be optimised. Waste minimisation efforts have been focused on reducing reliability on plastic-based packaging and replacing with either cardboard based or bio-degradable alternatives. All takeaway food in the Trust restaurants is served in compostable packaging. The Trust has widely introduced green recycling bins both in public and department areas and the percentage of waste that is sent for recycling continues to grow reducing the amount sent to landfill. The Trust's procurement contracts require suppliers to demonstrate that they minimise any impact on the environment with the products and services they provide.

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

The following key processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers approved by the Board sets out the decisions, authorities and duties delegated to officers of the Trust.
- Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that an organisation's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
- Robust competitive processes are used for procuring non-staff expenditure items. Above £25k, procurement involves competitive tendering.
- All procurement tendering activities are published within nominated publications and in line with Public Contracts Regulations 2015.
- The Trust's Financial Improvement Programme (FIP) oversees the identification and delivery of efficiency savings.
- This comprises of Divisional and Cross-cutting programmes of work.
- Opportunities are identified on the basis of Model Hospital, national and peer benchmarking, and locally developed analysis.
- Performance is reported via workstream senior responsible officers (SROs) to the Financial Improvement Programme Board, chaired by the Chief Executive. This is in turn reported to the Finance and Transformation Committee.
- All schemes within the Financial Improvement Programme are signed off by an Operational, Clinical, Executive and Finance lead.
- Quality Impact Assessments (QIAs) are completed for all schemes. QIAs scoring under 10 are signed off by the Medical Director, and QIAs scoring above 10 and all cross-cutting schemes are signed off via the Clinical Advisory Group.
- The Programme in 2017/18 resulted in savings of £10m. This was delivered through enhanced governance and focus on efficiency projects and represented more than double the savings delivered in the previous year.

The Trust Board has gained assurance from the ARC that financial and budgetary management is robust across the organisation. The ARC also receives quarterly reports regarding losses, special payments and compensations (with high value – over £50K approved by the Board), write-off of bad debts and contingent liabilities. The value of losses and special payments has remained at an immaterial level (0.044% of Trust turnover in 2017/18). The Trust has a Finance and Transformation Committee that meets monthly to review the Trust's financial performance, transformation programme and major strategic service change business cases. This includes the use of information technology to lever change.

Value for money discussions take place at a management group chaired by the Chief Operating Officer where the discussion is based on service line reporting reviewing how much a service costs to run versus the income it generates and how it is performing both clinically and operationally.

There are a range of internal and external audits that provide further assurance on the quality of financial data, economy, efficiency and effectiveness; these include internal audit reports on financial controls, cost improvement programmes, and business cases. These are all reported to ARC.

## 5.1 Compliance with the Code of Governance

The Board has reviewed itself against the NHS Foundation Code of Governance. The Board has made the disclosures required by the Code in the governance section of the Directors' Report, including explanations for non-compliance with provisions of the Code. Attendance records and coverage of work for each Board committee is also included in this section of the annual report.

## 5.2 Going Concern

Having considered the Trust's circumstances the directors of the Trust have not had any communication indicating that necessary support funding will not be made available to allow the NHS FT to continue into operating existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Given the deteriorating financial context within the Trust and the wider NHS, the directors have also given serious consideration to the financial sustainability of the Trust as an entity in relation to the Trust's available resources and note that:

- The recurrent underlying position of the Trust is a deficit. The deficit in 2017/18 was £8.1m, and the Operational Plan for 2018/19 is a £7.8m deficit. As a consequence, the Trust will receive interim cash support from the Department of Health and Social Care (DHSC) up to the value of the revenue deficit.

- The deficit and requirement for support is consistent with the Trust's original planning trajectory agreed with commissioners. The support was planned to continue until such time as the efficiency benefits are realised from the North West London Shaping a Healthier Future (SaHF) strategy.

- The Trust recognises the need to reduce its deficit ahead of the full implementation of SaHF. Consequently, it is working with partners to increase funding in 2018/19, similar to the increase in funding achieved in 2017/18. Furthermore, the Trust is eligible to receive Provider Sustainability Funding in 2018/19 of £6.2m.

- The Trust has an agreed financial plan for 2018/19 and signed contracts from commissioners.

- The contracts agreed with CCGs in North West London reflect realistic planning assumptions about activity growth. Where commissioner saving schemes are proposed, delivery of these is at the CCGs financial risk.

- The Trust has had consistent and ongoing dialogue with, and reporting to, the regulator in relation to the need for Interim Support from 2017/18 onwards. This included implementing recommendations from a review undertaken by the regulator. Interim cash support will be made available to the level of the Trust's revenue deficit, albeit, the actual cash required must be applied for, and approved by the DHSC, on a monthly basis.

The directors acknowledge that, given the mechanism the DHSC is using for agreeing cash support on a month by month basis, this creates a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, that it may be unable to realise its assets and discharge its liabilities in the normal course of business.

The Trust has been in receipt of financial support throughout 2017/18. There is no indication from the regulator or the DHSC that the support will not continue to be provided. Furthermore, the regulator has not placed particular conditions on the Trust to access financial support. The directors continue to work with partners across Hillingdon and the wider North West London Sustainability & Transformation Plan footprint, to develop and implement a strategy consistent with the resources available.

# 6.Information Governance

The Trust had one information governance incident categorised at level 2 in 2017/18, which has been reported via the Information Governance Toolkit to the Information Commissioners Office (ICO case ref. COM0718742).

The data breach occurred when a member of staff sent a spread sheet containing personal data belonging to staff members (name, NHS email address & pay band) and sensitive data (a code to highlight the individual had a disability) via an NHS net account to a colleague, who was commissioned to undertake a survey on behalf of the Trust without prior removal of the personal and sensitive data.

A formal investigation was undertaken by the Trust and confirmation sought from the recipient that the email received in error had been permanently deleted. The data subjects were individually informed of this data breach and internal information governance/security procedures strengthened. The Trust has received communication from the ICO that no further action is necessary, however recommend that staff are made fully aware that data transfers should be given oversight by Information Governance as per the Data Security Policy.

# 7.Annual Quality Report

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

The Trust's Quality and Safety Improvement Strategy (2016-2021) provides a structure for high quality clinical governance, to ensure on-going improvement in the quality and safety of patient care and supports our purpose "To provide high quality, safe and compassionate care, enhancing the health and wellbeing of the people that we serve". It defines our aims and is informed by the Trust Quality and Safety Committee's own review of effectiveness, national and local priorities and CQC recommendations. It sets out how we create a culture of continuous improvement to increase and sustain the quality of our services for our patients, people and stakeholders. It also takes into account lessons learnt from within the Trust and from others, emerging best practice and national quality improvement initiatives, in particular The Health Foundation guidance on measuring and monitoring safety and work being taken forward by Imperial College Health Partners on patient safety and quality improvement, regulatory and other inspections, as well as the national and local priorities.

The 2017/18 Quality Report provides evidence of progress and priorities for improvement and is aligned with our quality and safety improvement strategy objectives and our overall Trust Strategy. As part of its consultation on priorities for improvement for the Annual Quality Report the Trust has liaised with clinical and managerial staff via divisional governance board meetings and divisional review meetings. Key stakeholders, such as our FT membership, our Governors, our local Healthwatch and local organisations from the third sector have been engaged via a stakeholder event to discuss current year's progress and priorities for the forthcoming year. The Information Team has also undertaken a triangulation exercise examining data sources that they regularly analyse for potential underlying issues of quality related to performance or data, not otherwise identified. All of the above has assisted the Trust be clear on its targets. Determining SMART objectives against our priorities is underway.

The Trust uses its systems for quality performance management to assess its performance in relation to regional and national comparators for the key quality indicators and associated narrative in the Quality Report. Information on quality is supplied to the Board, its committees and the management team by the Information and the Clinical Governance teams who collect and maintain an oversight of quality information. Alongside key quality indicators as part of the integrated quality and performance report, information is also included on clinical audit, clinical incidents, SIs and the learning from them, complaints and claims. This flow of information ensures that key risks to quality are identified.

The Trust has introduced the new Learning from Deaths process and policy following the National Quality Board (NQB) guidance for NHS providers, published in March 2017. This supports the Trust in learning from the deaths of people in our care and identify where we could do more. The Trust has also ensured that it is investigating patient safety incidents and patient complaints thoroughly following clearly defined processes and procedures. This helps our staff to learn from these events and to put changes in place to reduce the risk of these events re-occurring. The Trust is keen to hear from our patients and staff in how we can continually improve the quality of our services, at every opportunity.

The Trust's external auditors are required to undertake testing on specific aspects of the Quality Report which are defined in the Auditors Opinion of the Quality Account within

this report and this will be included as a limited assurance report in the Trust's annual report. This work includes reviewing the content of the Quality Report against the requirements of NHS Improvement's guidance, reviewing the content of the Quality Report for consistency with other sources of information and having the external audit undertake testing on several indicators in the Quality Report.

The Trust continues to have a comprehensive clinical audit work plan covering both national and local audit priorities; this plan has final agreement at the Quality and Safety Committee (QSC). The Clinical Audit and Effectiveness Committee is the working group to drive audit work across the Trust, chaired by a Consultant Anaesthetist. Regular updates on clinical audit are reported to the Regulation and Compliance Committee with exception reporting to the QSC. Progress against national and local audits and actions being taken are detailed in the Quality Report to ensure transparency on our performance against these.

Regular meetings with our local Healthwatch support discussion on the progress of our quality priorities alongside hearing feedback from service users who access our services and who interact with Healthwatch. This assists in informing our quality improvement work.

A framework exists for the management and accountability of quality of performance data and data quality. This is supported by a comprehensive audit programme, the Data Quality Policy, and an overarching data quality group chaired monthly by the Director of Operations. This group reports to an Executive Director-led data quality steering group which sends a quarterly report to the ARC. These quarterly data quality and performance quality reports cover the Monitor compliance data, reported to the Board, and other key data sets used at key committees. This, together with the data audit results, and the use of Data Quality Badges which are included in each monthly performance report, provides assurance to the Board on data quality and data performance issues and strength of internal control.

The integrated performance report gives indications over quality metrics, early warning and trends to enable swift intervention to keep performance on track. The quality of elective waiting time data in particular will continue to be reviewed monthly at the elective performance meeting, ensuring all elective lists are managed and assessed on electronic systems. Areas that have been identified this year where further actions are being implemented include:

1 **NHS Number coverage on clinical systems.**
2 **Trust Board Indicator assurance – regular review and local auditing.**

# 8.Review of effectiveness

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

The Trust's Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the internal audit plan. Work undertaken by internal audit is reviewed by the Audit and Risk Committee. The Board Assurance Framework and Corporate Risk Register is presented to the Audit and Risk Committee on a quarterly basis and all significant risks are presented to the Board bi-annually or escalated quarterly by exception. This provides the Board and I with evidence of the effectiveness of controls in place to manage risks to achieve principal objectives. The Council of Governors plays an integral part in the governance structure within the Trust, ensuring through regular interaction with the Board of Directors, the interests of the Trust's members, and the public, are at the fore when reviewing the risks to, and performance with respect to the principal objectives. The cost improvement plan is always a challenge, however the CAP and appropriate KPIs provide assurance that clinical quality should not be compromised.

My review is also informed by External Audit opinion, inspections carried out by the Care Quality Commission and other external inspections, accreditations and reviews.

The processes outlined below are well established and ensure the effectiveness of the systems of internal control through:

- Audit and Risk Committee review of the Board Assurance Framework and Corporate Risk Register.
- Audit and Risk Committee scrutiny of controls in place.
- Board oversight of all significant risks.
- Review of serious incidents and learning at the Quality and Safety Committee and Board.
- Review of progress in meeting the Care Quality Commission's Fundamental Standards by the Regulation and Compliance Committee.
- Internal audits of effectiveness of systems of internal control.

On balance, I therefore conclude that the Board has conducted a review of the effectiveness of the Trust's system on internal control and found them to be effective.

Given the National and London position with regard to the A&E 4-hour target, if the current levels of high demand continue into 2018/19 this will remain a significant challenge for our Trust alongside the condition of the Trust estate, and staffing levels. The Trust has planned for a deficit of £7.8m in 2018/19 and having agreed a control total with NHSI is eligible for up to £6.2m of Provider Sustainability Funding to reduce the deficit further. However, the plan contains the following significant risks: a high level of savings (5%); no funding for activity growth above contracted levels, and no contingency.

# 9. Conclusion

Other than the comments above, my review confirms that The Hillingdon Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. The Board has extensive and effective governance assurance systems in place. These systems enable identification and control of risks reported through the Board Assurance framework and Corporate Risk Register. Internal and external reviews and inspections provide sufficient evidence to state that no significant internal control issues have been identified during 2017/18 and that these control systems are fit for purpose. A requirement notice against regulation 12; "safe care and treatment", specifically focused on infection and prevention was applied to our Trust in 2015 and this will remain until further inspection takes place. The Trust Board continues to proactively drive forward agreed actions to ensure compliance with CQC regulations.

I can also confirm that, having taken all appropriate steps to be aware of any relevant audit information that should be communicated, and to the best of my knowledge, there is no relevant audit information of which our external auditor, Deloitte LLP has not been made aware.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

# 2.8 ACCOUNTING OFFICER APPROVAL OF THE ACCOUNTABILITY REPORT

As Accounting Officer, I am satisfied that this accountability report provides a true and accurate summary of the performance of the Trust during the year 2017/18.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

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# Quality Report 2017/18

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# To provide high quality, safe and compassionate care, improving the health and wellbeing of the people that we serve.

## About the Trust's Quality Report

### What is the Quality Report?

The Quality Report is produced by NHS healthcare providers to inform the public about the quality of services they deliver. As a Trust we strive to achieve high quality care for our patients. The Quality Report provides an opportunity for us to demonstrate our commitment to quality improvement and show what progress we have made in 2017/18 against our quality priorities and national requirements. The Quality Report is a mandated document which is laid before Parliament before being made available on the NHS Choices website and our own website – (www.thh.nhs.uk).

A glossary is available at the back of the report to provide explanation on terms used.

### What is included in the Quality Report?

The Quality Report is a statutory document that contains specific, mandatory statements and sections. There are also three categories mandated by the Department of Health (DH) that give us a framework in which to focus our quality improvement programme. These are patient safety, patient experience and clinical effectiveness. The Trust undertook extensive consultation in developing this report to ensure that the quality improvement priorities reflect those of our patients, our staff, our partners and the local community.

Part 2 of the report includes information on our quality priorities and improvement plans for 2018/19 and also a series of statements of assurance from the board on particular points.

Part 3 of the report outlines the key quality improvements we have made in 2017/18:

- the areas identified for improvement in 2017/18
- how we performed against these improvement targets
- what this means for our patients
- other key quality indicators and information;
- and the relevant annexes as outlined in the statutory guidance.

# Executive Summary

This Executive Summary provides a brief overview of the information contained in this year's report. The Quality Report provides a summary of performance during 2017/18 in relation to quality priorities and national requirements.

Overall, the Trust has seen some good performance in 2017/18 across a number of quality indicators. In addition, having aligned our activity to the five Delivery Areas and three enablers of the North West London Sustainability and Transformation Plan (STP), we have been implementing integrated care pathways and co-ordinating services in the local health and care economy.

Particular successes that are noted in the report and demonstrate our compliance with performance and quality targets include the following.

- We have maintained our performance against waiting times for cancer, performing better than the national average.
- We are better at making sure patients are assessed for risk of developing Venous Thromboembolism. The Trust is now performing better than the London and national average.
- Our Clostridium Difficile infection rates remain below the London and national average; this means patients are less likely to contract this infection in our hospitals.
- Our Accident and Emergency Department was more likely to be recommended than the average in London and England, as measured by the Friends and Family Test.
- The average length of stay in our hospital wards fell by an average of 0.8 days - from 5.5 days to 4.7 days. This reflects the impact of new ways of working, especially the 'SAFER' bundle of interventions to improve patient flow, the 'RED2GREEN' initiative, and the 'discharge to assess' process.
- We reduced delays in transfers of care from hospital to below the national average. We did this by working closely with the local authority's adult social care department and implementing improved integrated discharge pathways.
- We established Hillingdon Health and Care Partners as a provider of integrated care services involving Central North and West London NHS Foundation Trust (CNWL), Hillingdon Primary Care Confederation of 44 GP practices, and Hillingdon for All (H4ALL) – an umbrella group of five voluntary-sector social care providers.
- We introduced ambulatory pathways to care for the frail and elderly; avoiding long waiting times in the unsettling Accident and Emergency environment. Rapid Access Clinics for Elderly patients (RACE) provides immediate comprehensive older people's assessment, and a short-stay facility.
- We now provide a consultant-led multidisciplinary triage service to support hospital discharge and ensure that the right support is in place for each individual: 'HomeSafe' ensures onward referral to CNWL's Rapid Response team; H4ALL's Take home & Settle service; and local authority services which include adult social care, falls prevention, and re-ablement.
- We have worked with others to develop a system-wide strategy for End of Life Care in Hillingdon which includes building community capacity to accommodate more deaths in usual place of residence; and honouring people's preferences stated in advanced care plans.
- Working with CNWL, we have helped establish 15 Care Connection Teams in GP practices across Hillingdon to increase patients' knowledge, skills and confidence about their health and support self-management of long term conditions among people aged over 65 years.

- We have implemented straight-to-test pathways for prostate and colorectal cancers; this means patients receive an investigative procedure within a few days.

- We co-produced a Carers Strategy, involving patients, carers and staff in its development. This now ensures recognition and support for everybody who is involved in patient care – most notably, friends and family. We are working with our ward staff to ensure the Carer's Action Plan and Charter are consistently being implemented.

- In the 2017 staff survey we achieved a response rate of 53.2% which is a 7% increase from the 2016 rate of 46% and is 7% above the average for acute Trusts in England.

- Our staff engagement score in the staff survey was 3.83, above average. Our staff motivation at work score was 4.02 - in the highest 20% when compared with all Acute Trusts.

- We were in the top 20% for 'Percentage of staff appraised in the last 12 months' and 'Quality of appraisals' when compared with all Acute Trusts.

Other areas of improvement within our clinical services include:

- Our maternity service continues to develop plans to be able to deliver the National Maternity Review (Better Births) five year forward plan. This includes improving continuity of care and reducing poor outcomes. We are working with the NW London Local Maternity System (LMS) on the early adopters' project to improve Continuity of Care in all pathways, which includes strengthening the postnatal care work stream, and building on very strong cross-sector links following the Shaping a Healthier Future (SaHF) Maternity Transition of Ealing services in 2015.

- We are participating in the 'Get It Right the First Time' (GIRFT) national programme which focuses on implementing changes to improve pathways of care, patient experience, and outcomes with significant cost savings. The Trust has moved elective inpatient orthopaedic services to the Mount Vernon Hospital site meaning the inpatient accommodation for adult elective orthopaedic surgery is not shared with emergency surgery services. This builds on our commitment to improve the experience

of patients undergoing elective surgery as part of our Rapid Recovery Programme, as well as reducing surgical site infections in line with national targets.

Notwithstanding these successes, it has proven challenging to achieve all access and quality targets. For instance, we only managed to see 84.6% of patients who attended Accident and Emergency (A&E) within four hours. This was despite introducing an efficient new process to transfer patients who arrived by ambulance. Although we succeeded in reducing average waiting times in A&E, the service was overwhelmed by unprecedented levels of demand as outlined in the report.

Other areas of challenge have included the condition of the Trust estate and the impact this has on being able to deliver effective modern day healthcare services. The annual capital investment available for the estate is aimed at addressing specific extreme risks, and although the level of funding is insufficient to remove the risks, it does enable a risk reduction. However the available funds are insufficient to keep pace with the scale of backlog maintenance; the need for investment has been highlighted through the Shaping a Healthier Future business case.

Finally, we could be more responsive as an organisation. The FFT response rate for A&E only achieved 7.97% compliance against a target of 20%; we achieved a response rate of 8.7% in 2016/17. In relation to patient complaints, only 70.9% were completed within the timescale agreed with the complainant. While this is below our 90% target it was a slight improvement compared to last year.

The challenges outlined above represent priority areas of focus for improvement in the year ahead, as is detailed within this report.

Despite the significant challenges, mostly relating to increased emergency care volume and complexity of patients, there has been continued progress with patient safety improvements. The Trust has introduced the new Learning from Deaths process and policy following the National Quality Board (NQB) guidance for NHS providers, published in March 2017. This supports the Trust in learning from the deaths of people in our care and identify where we could do more. The Trust continues to ensure that it is investigating patient safety incidents and patient complaints thoroughly following clearly defined processes and procedures. This helps our staff to learn from these events and to put changes in place to reduce the risk of these events re-occurring. The Trust is keen to hear from our patients and staff in how we can continually improve the quality of our services, at every opportunity; the Trust has been hosting regular 'SAFE' stands in the restaurant to talk to and hear from staff about patient safety and where we can make improvements.

The Trust has also introduced 'Learning from Excellence'; this is a growing movement in healthcare which aims to redress the balance and recognise examples of good practice so we can learn from these and explore how to improve care alongside learning from our mistakes. The Trust uses an in-house electronic solution called GREATix for staff to report good areas of practice which can then be shared with colleagues to assist in learning.

We continue to ensure that our Trust values, developed in partnership with both staff and patients, are at the heart of everything we do. By guiding our behaviours, the CARES values create a culture where all staff feel valued, engaged and confident in raising concerns. By creating a positive staff experience for everyone we can ensure an environment where staff can thrive and are able to deliver to the needs of our patients. The impact of this is that CARES values are directly linked to achieving excellent patient outcomes we can all be proud of.

In March 2018 the CQC conducted an announced comprehensive inspection of all core services on the Hillingdon site only, with a review of the 'Well Led' domain at end of April 2018 as part of its revised inspection framework. An assessment of the Trust's 'Use of Resources' was undertaken by NHS Improvement in early May 2018. It is anticipated that the CQC will publish its report of the Trust's compliance to the Fundamental Standards and Key Lines of Enquiry in mid-July.

We have set out our quality priorities for 2018/19 and we aim to achieve the following:

| | |
|---|---|
| 1 | Improving the use of digital systems to enhance patient safety and ensuring timely access to information |
| 2 | Ensuring care and treatment is patient-centred through streamlining patient care pathways and improving discharge management |
| 3 | Enhancing patient experience through improving communication and staff attitude, further embedding CARES values |
| 4 | Improving the administration of the patient appointment system and associated communications |

The key indicators that we are aiming to achieve under these priorities are outlined in the main report.

The mandated sections within this Quality Report include information on our participation in national audits and our research activity during 2017/18.

This Quality Report and the priorities for 2018/19 are presented as a result of consultation and engagement with Foundation Trust members, our Governors, patients and the public, our staff, our local Healthwatch and our Commissioners.

# PART 1

# STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE TRUST

**This Quality Report provides the Trust with an opportunity to demonstrate its commitment to delivering high quality care and outlines the improvements that have been made during 2017/18.**

At The Hillingdon Hospitals NHS Foundation Trust we place high quality clinical care and a positive patient experience at the heart of all that we do. Thanks to the professionalism of our staff, volunteers and partners we can be proud of what we have achieved in the past year and are confident for the future of the Trust.

As the challenges continue, it has been a difficult year for NHS Trusts throughout the country with high levels of demand in all areas, particularly emergency care. However, many positive areas of good practice are highlighted in this report and while it is important to acknowledge where we need to make improvements, we have also achieved a great deal and our staff should be very proud.

The Trust has introduced several initiatives in order to improve the management of patients through the Emergency Department, including moving towards expansion with the opening of a new Clinical Decision Unit (CDU) – a dedicated area to care for patients away from A&E to determine if they need to be admitted to hospital or need to go home. Further progress has also been made around areas of patient flow, privacy, communication, care and treatment and discharge. At the end of 2017/18, we also submitted a planning application to expand our A&E department after £1.5m of funding was secured following a successful Trust bid to the Department of Health.

The Trust also received planning approval for a new Skin Centre at Mount Vernon Hospital (MVH). The new centre will streamline services for patients, speed up treatment and diagnosis and provide greater convenience for patients receiving skin cancer services at Mount Vernon Hospital as well as many patients from surrounding areas.

Great strides were also made towards future development of the Trust with the launch of the Brunel Partners Academic Centre for Health Sciences. This partnership, jointly funded by the Trust, Central and North West London NHS Foundation Trust and Brunel University London aims to revolutionise the way health and social care is delivered and how our staff are trained in the future to meet the changing needs of society.

The revised Quality and Safety Improvement Strategy, which was introduced in 2016, continues to clearly set out our aims across patient safety, clinical effectiveness and patient experience.

A number of initiatives to improve the patient experience were also introduced this year including Red2Green to support the safe and efficient discharge of patients. We are also progressing well in implementing the SAFER patient flow bundle and the seven-day service standards.

The key priorities highlighted in this report show that we have performed well in the past year despite a very challenging environment. Areas where we have not performed as well include the A&E department where the emergency volume and demand for the service has been extremely difficult to manage despite new initiatives to improve the flow of patients through the department. As a result patients have had to wait for longer periods in the busy A&E department which impacts on their experience and care. The new expansion of the A&E department will assist our staff in being able to better manage the numbers and complexity of patients and ensure a reduced waiting time and an improved experience for our patients.

This year has again been a challenge with the unprecedented winter bed pressures in the latter part of the year, meaning that some planned elective operating had to be postponed. This affected our performance against the Referral to Treatment waiting times achieving 91.1% for 2017/18 against a target of 92%. Monitoring meetings are being led by the Director of Operational Performance to ensure effective delivery of this pathway in 2018/19. A robust activity plan that better anticipates changes in demand in order to re-programme activity accordingly will be implemented.

Other areas of challenge include managing the risks associated with an aged estate. The Trust is working with partners to develop a longer term solution to the estates issues through a proposed development of a new whole hospital build on the Brunel University London campus.

Our priorities for the year ahead outlined in the report highlight the dedication we have to continuously improve the care and services we provide for our patients.

The level of what we have achieved and what we strive for in the future is reflective of our hard working and dedicated workforce and I am confident that, with our staff, we can ensure that we continue to progress well in our priority areas.

There are a number of inherent limitations in the preparation of this Quality Report which may impact 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 this data and the systems and processes are subject to external assurance, or included in the 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 judgement about individual cases, where another clinician might 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 Trust's Board and management have sought to take all reasonable steps and 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.

Following these steps, and to the best of my knowledge and subject to the data limitations described above, the information in the document is deemed to be accurate, except for the matters detailed under the heading: 'Definitions of the two mandated indicators for substantive sample testing by the Trust's auditors' in Part 2 of this Quality Report.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

# PART 2

# PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

**This section of the quality report describes the areas for improvement in the quality of some of our services that we intend to provide in 2018/19.**

Part 2 of the quality report also includes a series of statements of assurance from the Trust Board on particular points as required by the *Detailed Requirements for Quality Reports 2017/18* (NHSI). The key elements of the Trust's Quality and Safety Improvement Strategy are also outlined in this section alongside some of the healthcare developments that are happening within Hillingdon and in North West London.

## 2.1 Quality priorities for improvement in 2018/19

To develop our quality priorities for 2018/19 the Trust held an engagement exercise with key stakeholders (Foundation Trust members, Healthwatch, Governors, local voluntary organisations). This event included a review of our current position against this year's priorities and a discussion on the quality priorities for the forthcoming year. An outline of the key results from the consultation is included in the table below:

### Quality Report Consultation

| Quality Priority Topic 2018/19 |
|---|
| **Patient Safety** |
| • Medication management and safety<br>• Improving patient discharge<br>• Improved use of technology and existing electronic systems<br>• Improved coordination and communication between services and staff – review of patient care pathways<br>• Coordination between services<br>• Training patients<br>• Availability of and well-functioning equipment |

| Clinical Effectiveness |
|---|
| • Improving the admission process<br>• Improving the appointment system and administration associated with this<br>• Improve the style of operation letter to make appropriate in style and tone<br>• Improve ease of accepting, cancelling and making appointments for diverse groups<br>• Coordination of care and appointments for multiple visits, communication on discharge including improving the quality of discharge letters<br>• Seven-day working – outpatients and diagnostics |
| **Patient Experience** |
| • Focus on patient and individualised care<br>• Reduce variation in standards of experience and improve customer care / implementation and embedding of CARES<br>• Compassion, dignity and empathy<br>• Meeting and greeting / approachability<br>• Better adherence to protected mealtimes<br>• Providing a consistent view |

In addition, the Trust triangulated data from several sources to identify themes and recurring trends. The Trust has engaged with clinical and management staff via divisional governance board meetings and divisional reviews to establish priorities. During the last year there has continued to be active engagement with our local Healthwatch including its members on several of our Trust working groups. This engagement has proved invaluable in being able to hear the feedback that Healthwatch receives from people with which it engages.

The Board has considered all of the suggestions put forward and the review of data and the priorities below have been recommended for inclusion in the Quality Report for 2017/18. These have been identified as falling under the three domains of safety, clinical effectiveness and patient experience as follows:

| No. | Priority | Patient safety | Clinical Effectiveness | Patient Experience |
|---|---|---|---|---|
| 1 | Improve the use of digital systems to enhance patient safety and ensure timely access to information | ✓ | ✓ | ✓ |
| 2 | Ensuring care and treatment is patient-centred through streamlining patient care pathways and improving discharge management | ✓ | ✓ | ✓ |
| 3 | Enhancing patient experience through improving communication and staff attitude, further embedding CARES values | ✓ | ✓ | ✓ |
| 4 | Improving the administration of the patient appointment system and associated communications | ✓ | ✓ | ✓ |

# PRIORITY 1

# Improve the use of our digital systems to improve patient safety and ensure more timely access to information

## Why is this one of our priorities?

The use of digital systems is a growing area in the health service. As demand for services continues to rise, a key enabler for the NHS to continue to sustainably deliver services is to make the best use of new technologies. Shared information systems mean a higher quality of patient care, since they provide accurate and up to date information to clinical decision makers on the best course of treatment. Digital systems will also ensure improved efficiency, as they reduce the time burden of various duties on staff and allow for more time for frontline care. Strategically, digital work has been identified as a key enabler by both the NHS nationally and the local Sustainability and Transformation Plan (STP) footprint in Northwest London.

Having shared information across different providers and care settings is an important component of integration of services and continuity of care across the sector. In addition, the use of technology and electronic solutions will support safer patient care by ensuring more robust capturing and monitoring of patient safety data; this has been identified as an area for improvement as a result of learning from some of the serious patient safety incidents we have seen in relation to care of the deteriorating patient.

## How are we doing so far?

Currently the majority of a patient's summary care record is digitised and shared with other partners in HHCP, our Accountable Care Partnership. This has been as a result of strong collaborative working during 2016/17 and 2017/18. A number of other initiatives, e.g. the use of electronic observations and electronic referrals have been trialled in some Trust areas in 2017/18 and will be rolled out to across our inpatient wards and A&E. The Trust has improved many areas of internal information exchange during the last year, such as the clinical handover. These initiatives have improved care quality and facilitated better discharge planning and efficiency for Trust staff.

## Our aims for 2018/19 are:

- The full implementation of electronic referrals, to improve the accuracy and efficiency of the referral process, to better meet patient needs, making a two-week process into a 24 hour process
- Roll out of electronic observations across all inpatient areas (including adults, paediatrics and to A&E) to improve quality and safety of care and support the discharge process
- Implement project on patient emails, where appropriate, as an alternative to letters. This will ensure that their information is conveyed in a way that is more reliable, easier to access and store and at a reduced cost to the Trust
- Implement Health Information Exchange (HIE), to improve the quality of records when transferring from acute providers and into the community.

## How will we monitor, measure and report on the progress of this priority?

This quality priority will be monitored via the relevant information technology (IT) working group and by the key clinical improvement groups with escalation reports to the relevant Board Committee. Performance on progress will be measured against the key aims of the work-stream. The results will be published in the 2018/19 Trust Annual Report.

# PRIORITY 2

## Ensuring care and treatment is patient-centred through streamlining patient care pathways and improving discharge management

### Why is this one of our priorities?

Ensuring care and treatment is designed around our patients' needs is a strong step towards delivering high quality services; strengthening the Trust's commitment towards streamlining care pathways to better meet the needs of our Hillingdon community. Discharge management forms a core part of this streamlined care as every patient requires effective discharge planning from admission based on individual care needs. During 2017/18 the Hillingdon system partners came together to ensure a simplified discharge process from referral through to post discharge care. This ensures improved, safe and timely discharges from the hospital which support the release of bed capacity for emergency and elective care activity. Healthwatch strongly support the Hillingdon System improvement actions with discharge management given its importance as highlighted in a number of audits.

### How are we doing so far?

The national patient survey highlighted that the Trust has made improvements in discharge care. The Trust's Emergency Care Improvement Programme has overseen the progress of work in 2017/18 with four core work streams, which includes the Integrated Discharge Group. The outputs from this system-led group will continue into 2018/19. The work of this dedicated stream is overseen by the Hillingdon A&E Delivery Board.

A key improvement has been a "Home First" approach known as "Discharge to Assess" where a patient with care needs is discharged home with an assessment for care needs completed within two hours ensuring the right care is in place taking into account the patient's own environment. This improves the timeliness of the discharge, as well as the quality of their care, whilst releasing bed capacity at the hospital to accommodate timely acute admissions.

*SAFER* and *Red2Green* forms one of the four core work streams complementing the Integrated Discharge Group. The Trust has seen reductions in the average length of stay by focussing the MDT and care resources on meeting the needs for safe patient discharge, as soon as the patient is medically fit and no longer requires inpatient hospital care.

## Our aims for 2018/19 are:

- Single referral form and process from the ward teams for both health and social care services to support safe discharge care
- Single Point of Access (SPA) led by the care system matching patient care needs to the appropriate care capacity
- Strengthened Integrated Discharge Team (IDT) consisting of hospital, social care, community and commissioning leads to plan and co-ordinate discharge care
- Implement the Integrated Discharge Improvement plan
- Understanding the patient experience better for the different elements of work associated with this priority.

## How will we monitor, measure and report on the progress of this priority?

This quality priority will be monitored via the Integrated Discharge Group and the Hillingdon A&E Delivery Board. Performance on progress will be measured against the key aims of the work-stream. The results will be published in the 2018/19 Trust Annual Report.

# PRIORITY 3

## Enhancing patient experience through improving communication and staff attitude, further embedding our CARES values

### Why is this one of our priorities?

Staff communication and attitude is absolutely vital, since it impacts every patient interaction and all the Trust's pathways. Patients and other members of the public interact with our services at times of high individual distress and we will do everything that we can to reassure them in this time. This need is demonstrated in monthly quality data. Though there are ongoing efforts to improve attitude and communication, and a positive patient experience as a result of good communication and a caring staff attitude should be part of everyday business, it is always featured in the top three complaints for any given month, frequently being the most common reason for a complaint. This therefore needs ongoing focus.

### How are we doing so far?

To further embed the Trust core values of CARES (which stands for Communication, Attitude, Responsibility, Equity and Safety), a number of Trust initiatives are already underway:

- The first wave of staff have made pledges to be CARES ambassadors, who will promote and demonstrate CARES values amongst their peers. The number of these staff is growing with representation throughout the Trust.
- Beyond ambassadors, staff have also been made CARES champions, whose role it is to challenge behaviours that do not match our values. These staff have received specialist training
- "Join a team that CARES" has been used for Trust promotion and branding, to ensure

that potential recruits are fully aware of the values that the Trust aspires to. This has been distributed through recruitment notices and social media
- The Trust Personal Development Review (PDR) process incorporates feedback on performance against CARES values.

Staff training has demonstrated an impact on attitudes and communication in End of Life Care and when providing care to patients with dementia. The learning from these training packages can be used to better inform all staff across the Trust.

During the previous CQC inspections in 2014 and 2015 the Trust was rated as "Good" when it came to the caring domain, which demonstrates a solid baseline, though there are areas for improvement.

## Our aims for 2018/19 are:

- The implementation of "Always Events", a piece of work across the sector, coordinated by NHS England, designed to improve standards of care by promoting those aspects of care which should always be part of the patient experience
- Triangulation of sources of patient feedback, to better inform the development of patient care initiatives and measure their impact
- The distribution of a revised "Working Together" leaflet, designed with patient input, to better inform staff on the wards
- Customer care training will be provided to large numbers of staff
- Implement coaching for managers' training, to ensure that those who manage staff are equipped to develop their communication skills and improve culture
- Roll out the CARES ambassador role to include every staff member and expand the number of CARES champions.

## How will we monitor, measure and report on the progress of this priority?

This quality priority will be monitored via the Workforce Transformation Board and the Experience and Engagement Group. Performance on progress will be measured against the key aims of the work-stream. The results will be published in the 2018/19 Trust Annual Report.

# PRIORITY 4

# Improving the administration of the patient appointment system and associated communications

## Why is this one of our priorities?

The use of digital systems is a growing area in the health service. As demand for services continues to rise, a key enabler for the NHS to continue to sustainably deliver services is to make the best use of new technologies. We recognise that improving communication between the patient, primary care and the Trust helps to improve efficiency and reduce cost through better visibility to patients and referrers of clinic capacity. Improving communication and use of electronic resource, such as the patient appointment system, will help the Trust to ensure that patients are booked to the right clinic and the right clinician first time thus reducing unnecessary appointments, which will in turn reduce delays to patient care.

Shared information systems within the organisation will lead to a higher quality of patient care, since they provide accurate and up to date information to clinical decision makers on the best course of treatment. Digital systems will also ensure improved efficiency, as they reduce the time burden of various administration duties on staff, therefore releasing time for frontline staff.

Strategically, digital work has been identified as a key enabler by the NHS nationally and the local Sustainability and Transformation Plan (STP) footprint in North West London. Sharing information across different providers and care settings is an important component of integration of services across the sector. Improving the digital process will ensure that referrers will be able to offer choice to patients through the visibility of all available appointments.

## How are we doing so far?

Currently, the majority of a patient's summary care record is digitised and shared with Hillingdon Health and Care Partners (HHCP), our Integrated Care Partnership, which is delivered in the sector and over the last year the Trust has utilised the eReferral Service (eRS) to complete the following:

- 99% services (consultant led and non-consultant services) available electronically on NHS eReferral Service (eRS)
- 55% of GP referrals are made via eReferral Service (eRS)
- Reviewing all clinic utilisation and templates with Service Managers
- Increasing the number of outpatient clinics included in appointment reminder technology
- First trust in North West London to use Advice and Guidance via eRS, managed centrally through outpatient appointment centre.

## Aims for 2018-2019 are:

- Fully implement electronic referrals and ensure that 100% of services are available on the eReferral Service (eRS); the Trust would expect that all General Practitioner referrals are made via the eReferral System improving the accuracy and efficiency of the referral process to better meet patient needs, thus reducing the process from referral to booked appointment
- Reduce the number of outpatient appointment issues to less than 4% (these are monitored as part of the Trust's performance)

- Align the appointments system with the Accessibility Information Standards (AIS) to ensure there is a consistent approach across the Trust, to practically demonstrate that patients with a disability are being communicated to in their preferred format
- To ensure that all patients' referrals are clinically triaged within five working days – through the use of electronic vetting
- Increase the response rate and turnaround time for 'Advice and Guidance' to within two working days
- Implement the project on using patient emails, where appropriate, as an alternative to letters. This will ensure that information is conveyed in a way that is faster, more reliable, easier to access and store and at a reduced cost to the Trust
- Implement Health Information Exchange (HIE), to improve the quality of records when transferring from the acute provider and into the community
- The use of digitisation and the outpatient productivity work stream will enable the organisation to explore ways to reduce the rates of patients who do not attend their outpatient appoint (DNA) to below the national average
- Explore ways to manage and facilitate electronic booking for non-GP referrals

We will take this forward in collaboration with our patients and we will ensure that there is patient representation on key working groups so that the patient voice is central to decisions.

## How will we monitor, measure and report on the progress of this priority?

This quality priority will be monitored via the relevant IT and outpatient productivity working groups. Performance on progress will be measured against the key aims of the work-stream. The results will be published in the 2018/19 Trust Annual Report.

## Our Quality and Safety Improvement Strategy

OUR VISION

To provide high quality, safe and compassionate care improving the health and wellbeing of the people that we serve

During 2017/18 we have continued to focus on measuring and monitoring the quality of our services and the care that is delivered to our patients and their families. The Trust continues to implement the Quality and Safety Improvement Strategy for 2016 to 2021 which supports this work and helps us to achieve our vision, **To provide high quality, safe and compassionate care improving the health and wellbeing of the people that we serve**. The strategy provides a structure for ensuring strong clinical governance and ongoing improvement in the quality and safety of patient care. A clinical quality strategy action plan is reviewed on a quarterly basis at the Quality and Safety Committee (Board committee). Clinical divisions develop local quality action plans based on the overarching Trust action plan. These form part of their business plans and are used to monitor progress at their divisional performance reviews.

The Quality and Safety Improvement Strategy puts Trust staff at the heart of delivering our aims and is supported by our culture and values framework: CARES (Communication, Attitude, Responsibility, Equity and Safety). This framework embraces a culture that empowers staff to report incidents and raise concerns about quality and patient safety in an open, blame-free working environment. This is supported by the statutory Duty of Candour and best practice guidance such as the 'Freedom to Speak Up' initiative.

The development of the Quality and Safety Improvement Strategy for 2016 to 2021 was guided by the Trust Quality and Safety Committee's own review of effectiveness; recommendations arising from the Trust's CQC inspections in October 2014 and May 2015; key reports such as *Francis*, *Berwick* and *Keogh* and other relevant data sources. The strategy clearly articulates our ambitious aims across the domains of patient safety, clinical effectiveness and patient experience. Our quality improvement work will be informed and supported by the learning from and collaboration with colleagues from across the North West London sector as part of the Imperial College Healthcare Partners Academic Health Science Network. Our seven quality aims as part our strategy are as follows:

1. Developing a safety culture in which safety is everyone's business
2. Safer staffing
3. Working towards no preventable deaths
4. Proactively improving systems to reduce harm
5. Improving patient experience as defined by our patients
6. Achieving the best possible outcomes for patients
7. Ensuring people receive care in the right place.

## Whole Systems Partnerships to Deliver Integrated Care

The North West London Sustainability and Transformation Plan (STP) provides a framework for clinicians to collaborate with other providers in the local health and care economy; strengthening pathways to improve clinical productivity. Having aligned our Strategic Plan 2017-21 to the 5 Delivery Areas, and 3 enablers of the STP, the Trust is co-ordinating service delivery in the local health and care economy.

## Hillingdon Health and Care Partners

The Trust is a founding member of Hillingdon Health and Care Partners (HHCP). HHCP represents a partnership of organisations from primary, community, and acute care; as well as the voluntary sector. We collaborate under an Alliance Agreement, to deliver integrated care services. The constituent organisations are:

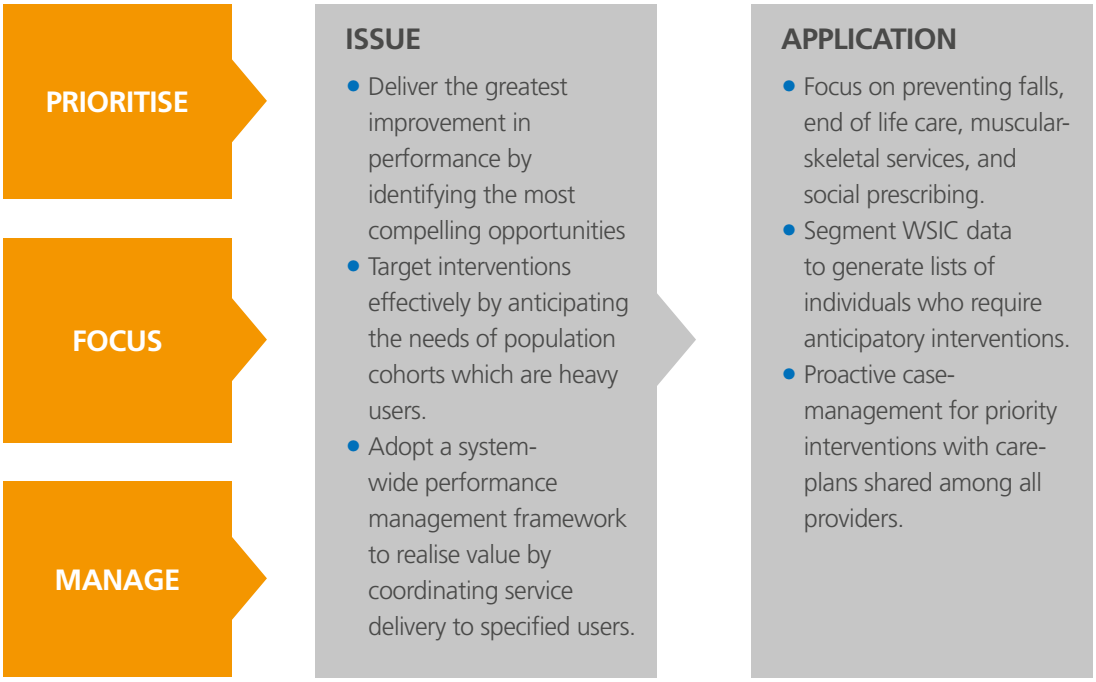
- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central North and West London NHS Foundation Trust (CNWL)
- Hillingdon Primary Care Confederation of 44 GP practices
- Hillingdon for All (H4ALL) – an umbrella group of five voluntary-sector providers of social care.

HHCP's data-sharing capabilities represent the best in class among providers in North West London. To facilitate case management, the Hillingdon Care Record connects, via the Medical Interoperability Gateway (MIG) to EMIS Web (a web based clinical information system) and pulls GP summary, medication history and diagnostic history into the application. As a result, relevant information flows with the patient's movements along pathways. Clinicians and support staff can monitor patients' progress by having full access to necessary case-notes and outcomes reports. This supports earlier interventions, helping to keep patients out of hospital, and also facilitates more self-care and management.

HHCP are harnessing the capabilities afforded by the 'Whole Systems Integrated Care Data Warehouse' by employing a data-driven approach to improving the quality of care for specific population cohorts. This involves identifying people's needs by applying algorithms to their electronic health records; before supporting them pro-actively with appropriate services so they don't need to visit hospital.

HHCP seek to improve the health of people in Hillingdon while also reducing the cost of providing them with care services. Interventions are focused on the borough's 41,100 residents who are more than 65 years old. They represent 13% of Hillingdon's total population of 314,300.

| **Priority: To fulfil the three aims of the 5 Year Forward View** | | | | |
|---|---|---|---|---|
| **Health and Wellbeing** | **Care and Quality** | | **Finance and Efficiency** | |
| **This will be achieved through the 5 delivery areas of the STP** | | | | |
| **Delivery Area 1** | **Delivery Area 2** | **Delivery Area 3** | **Delivery Area 4** | **Delivery Area 5** |
| Radically upgrading prevention and wellbeing | Eliminating unwarranted variation and improving long term condition management | Achieving better outcomes and experiences for older people | Improving outcomes for children & adults with mental health needs | Ensuring we have safe, high quality sustainable acute services |
| Enablers: Estates, Workforce, Digital | | | | |




Within this group of people, about 20% of people remain mostly healthy and aren't big service users. However, 65% of this population group live with one or more long term conditions – and they place larger demands on health and care services. Indeed, 1,220 individuals are heavy users of A&E services, and 530 people are regular inpatients.

Our efforts are focused on this age-group because it has complex needs which are underserved by historic models of service provision. The over 65 population is much more likely to be frail and have multiple Long Term Conditions. The higher proportion of non-elective admissions for this group of patients indicates that care could be better coordinated, more proactive and less fragmented.

Our ambition is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. And, equipped with an outcome-driven approach we know this can be done by anticipating needs, intervening efficiently, and co-ordinating care more effectively.

## Implementing Consistent Pathways across North West London

The Trust is working with partners across North West London to embed consistent pathways across the Sustainability and Transformation Partnership (STP). The objective is to improve the quality of care by reducing unwarranted variation, as well as to deliver gains in clinical productivity. Priority areas of focus are: cardiology; dermatology; gynaecology; gastroenterology; and musculoskeletal services (MSK).

For cardiology, the Trust has been supporting Hillingdon Primary Care Confederation to be more proactive in detecting atrial fibrillation, and in prescribing anticoagulants as first line treatment. In addition, to accommodate next day review of stroke patients, the Trust has extended the number of clinics to treat Transient Ischaemic Attacks (TIA).

In the case of MSK, the Trust is leading HHCP to develop an integrated pathway in Hillingdon. Clinical productivity will be improved by introducing a single point of access, and managing demand for secondary care. Variations in the quality of care will be monitored pro-actively to address instances of under-performance.

Throughout 2017-18, Brunel University London supported these service transformations by hosting a series of masterclasses for GPs in Hillingdon to strengthen clinical practice. Further, individual researchers have provided subject-matter thought-leadership to transform specific pathways (like MSK). Moving forward, the Trust's collaboration with the University is destined to become ever closer:

## Innovating with Brunel University London to Transform Models of Care

Brunel Partners Academic Centre for Health Sciences (BPACHS) was established in 2017. It represents a partnership between Brunel University London (Brunel), The Hillingdon Hospitals NHS Foundation Trust (THHFT), and Central North West London Foundation Trust (CNWLFT). The shared ambition is to deliver radically transformed physical and mental health and social care provision through training, education and research working in partnership with and on behalf of the local community in Hillingdon. Therefore, allowing us to become a leading provider of health and social care.

The Centre will serve as a strategic enabler identifying and implementing innovations that create value for the health system. It will also facilitate the translation of research into clinical practice by working with researchers and health and care professionals; harnessing the very best expertise and knowledge in design, technology, and community engagement to deliver a healthier Hillingdon.

This new system for health and social care delivery will be a genuine testbed for innovative, outcome-focused, solutions. By delivering improved health at reduced cost, and demonstrating an opportunity to move away from point solutions towards a more holistic approach, it will offer a valuable model for other parts of the UK and beyond.

## Recognising staff for improving the quality of care

One of our Diabetic Specialist Nurses was commended at the Bayer/RNIB Ophthalmology Awards for her 'skills, excellent intuition and first-rate knowledge of diabetes and ophthalmology'. The awards recognise exceptional initiatives that demonstrate clinical excellence and innovation by individuals or multi-disciplinary teams.

One of the Trust's midwives also secured a Florence Nightingale Foundation Award to help her continue her studies into the risks of malaria to pregnant women. Her research is designed to help not only women living in malaria-risk zones but provides vital knowledge for pregnant women planning to travel there.

The Ophthalmology Department also scooped further honours in 2017, when the Age-Related Macular Degeneration (AMD) Team won an award following praise by patients. The team won the Clinical Service of the Year category at the Macular Society Awards for 'exceptionally good practice' in caring for people with AMD.

Trust colleagues, in collaboration with North West London Critical Care also won a National Patient Safety Scheme award for developing 'transfer bags'. The 'standardised, ideal bag' won the Patient Safety in Critical Care and Trauma Patients category.

Finally one of our stroke consultants was appointed by the STP to implement new cardiology pathways across North West London. He has been working with partners in primary care to ensure that stroke pathways, which incorporate guidelines for treating atrial fibrillation, are delivered consistently.

## Learning from Excellence within the Trust

In healthcare we often focus on errors in an effort to learn from our mistakes and avoid further harm. Unfortunately this fails to recognise that the vast majority of what we do on a daily basis is good; indeed some of it is excellent.

'Learning from Excellence', is a growing movement in healthcare aiming to redress the balance and recognise these examples. Some examples include how compassionate a member of staff was to a colleague or patient, or demonstration of excellent clinical practice.

Staff can nominate another member of staff for excellence by completing the online GREATix form. Each submitted GREATix is assessed by a nominated departmental reviewer to approve or reject. Feedback is provided to these nominated individuals to recognise excellence.

A register of GREATixes is kept in each department so that learning from good practice can be disseminated to the teams through the governance and team meeting frameworks. We want to be able to share and learn from these examples across our Trust.

Nominees receive a certificate of excellence once their nomination has been approved. GREATix is currently being piloted in the Division of Women and Children's with a view to roll out Trust wide.

# 2.2 Formal Statements of assurance from the Board

## Information for our regulators

Our regulators need to understand how we are working to improve quality so the following pages include specific messages they have asked us to provide.

## Provision of NHS Services

During 2017/18 The Hillingdon Hospitals NHS Foundation Trust provided medicine, surgery, clinical support services and women's and children's NHS services. The 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 these relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2017/18.

## Participation in Clinical Audit

The Hillingdon Hospitals NHS Foundation Trust is committed to continually improving the healthcare we provide to service users and Clinical Audit is a crucial part of the Trust's strategy to improve the healthcare we provide.

The Trust uses Clinical Audit to assess and monitor its compliance against national and local standards, and to review the healthcare outcomes of its service users. It provides healthcare professionals the opportunity to reflect on their individual practice and the wider practices across the clinical directorates and the Trust. The Hillingdon Hospitals NHS Foundation Trust actively encourages all clinical staff, including those in training, to be involved in Clinical Audit.

The Trust's annual Clinical Audit Programme is formulated each year to ensure that the Trust meets all mandatory, regulatory and legislative requirements as laid out by the NHS governing bodies. It is specifically designed to include:

- All applicable national clinical audits and confidential enquiries that the Trust is eligible to participate in
- Relevant published National Institute for Health and Care Excellence (NICE) guidance and NICE Quality Standards
- Local governance and service level priority topics required to ensure compliance with statutory obligations.

## National audits

During 2017/18 42 national clinical audits and five national confidential enquiries covered relevant health services that The Hillingdon Hospitals NHS Foundation Trust provides. During that period the Trust participated in 36 national clinical audits (86%) and 100% of National confidential enquiries of the national clinical audits and confidential enquiries in which it was eligible to participate.

There were five national audits that The Hillingdon Hospitals NHS Foundation Trust was unable to participate in. Four were due to lack of resources and one was due to problems with IT interface and the audit platform. Where resources were an issue business cases for three of the audits are now progressing to enable future participation. Where IT was a problem a programme has now been purchased to enable the IBD database to link to hospital systems and allow for participation in 2018/19. A risk assessment is undertaken where we are unable to participate to ensure any associated risk is mitigated as far as possible.

The national clinical audits and national confidential enquiries that The Hillingdon Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| Audit | Participated | Cases submitted |
|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Yes | 363 cases submitted April – Dec 2017 |
| BAUS Urology Audit – Female Stress Incontinence Audit | No | Unable to participate due to resource issues in the Urology Department |
| BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL) | No | As above |
| Bowel Cancer Audit Programme (NBOCAP) | Yes | 95 cases - 1 April 2015 to 31 March 2016.<br>108 cases - 1 April 2016 - 31 March 2017<br>Data submitted from 1 April 2017 to 31 March 2018 - still to be validated. |
| Case Mix Programme Adult Critical Care (ICNRC) | Yes | 476 cases April 17 – March 31 2018 |
| National Paediatric Diabetes Audit (Royal College of Paediatric and Child Health) | Yes | 181 cases April 16 – March 31 2017<br>17/18 data not yet available or verified |
| Elective Surgery (National *Patient Reported Outcome Measures* (PROMs) Programme) | Yes | April 2017 to Feb 2018:<br>247 cases - Hip Replacement<br>473 cases - Knee replacement<br>72 – cases Groin Hernia<br>55 – cases Varicose Vein |
| Endocrine and Thyroid National Audit | Yes | 100% submission |
| Falls and Fragility Fractures Audit Programme: National Hip Fracture Database | Yes | 212 cases - (100%) |
| Falls and Fragility Fractures Audit Programme: Fracture Liaison Service Database | Yes | 189 cases - (100%) |
| Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls | Yes | 30 cases - (100%) |
| Fractured Neck of Femur | No | Unable to participate due to resources |
| Inflammatory Bowel Disease (IBD) programme | No | Unable to participate due to resources |
| Learning from Deaths (LeDeR) | Yes | 2 cases April 1 2017 – March 31 2018 |
| Major Trauma Audit | Yes | Figures for TARN from April 2017<br>Qtr. 1 65<br>Qtr. 2 50<br>Qtr. 3 21<br>*Qtr. 4 Figures still to be finalised* |
| Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) | Yes | 2 maternal deaths and 42 babies (100%)<br>(1 April 2017 and 31 March 2018) |

| Audit | Participated | Cases submitted |
|---|---|---|
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | 160 cases – 100% submission The number of new breast cancers (invasive/ non-invasive) diagnosed in 2015 |
| National Audit of Dementia Care | Yes | 50 (100%) |
| *National Rheumatoid and early inflammatory arthritis* | No | Unable to participate due to resources |
| National Cardiac Arrest Audit | Yes | 138 cases (100%)<br>April to December 2017 |
| National Chronic Obstructive Pulmonary Disease Audit Programme | Yes | 417 cases (100%)<br>April 2017 to March 2018 |
| National Comparative Audit of Blood Transfusion programme: Use of Blood In Haematology (National Comparative Audit of Red Cell & Platelet Transfusion in Adults) | Yes | 31(100%) April 2017 to March 2018 |
| National Comparative Audit of Blood Transfusion programme: Management of patients at risk of Transfusion Associated Circulatory Overload (TACO) | Yes | 40 (100%) April 2017 to March 2018 |
| National Adult Diabetes Audit : National Foot Ulcer audit | Yes | 23 cases - (100%) |
| National Adult Diabetes Audit : National In-patient Diabetes Audit | Yes | 104 (100%) 17/18 |
| National Adult Diabetes Audit : National Pregnancy in Diabetes Audit | Yes | 47 cases - (100%)<br>1 Jan – 31 Dec 2017 |
| National Core Diabetes Audit | No | 400 cases submitted |
| National Emergency Laparotomy Audit | Yes | 99 cases (100%)<br>01/12/2016 to 30/11/2017- |
| | | |
| National End of Life care audit | Yes | No data collection required for 17/18 |
| National Heart Failure Audit | Yes | 234 cases 1 April 2017 to 31 March 2018 still to be validated |
| National Joint Registry | Yes | Data entered by individual consultants onto the registry |
| National Lung Cancer Audit | Yes | 105 cases - (100%) - 16/17 |
| National Maternity and Perinatal Audit | | 4901 Birth Records submitted (100%) 2016/2017 |
| National Intensive and Special Care (NNAP) | Yes | 485 episodes submitted –(100%) |
| National Ophthalmology Audit | Yes | 2,057 cataract cases (100%)<br>1st September 2016 - 31 August 2017<br>1,315 cataract cases – 100%<br>1 September 2016 to 31 March 2017 |

| Audit | Participated | Cases submitted |
|---|---|---|
| National Prostate Cancer Audit | Yes | 89 cases with a date of diagnosis from 1 April 2015 to 31 March 2016. Data for 1 April 2017 to 31 March 2018 currently unavailable as not validated |
| National Oesophago-gastric Cancer Audit | Yes | 63 - case ascertainment > 90% patients diagnosed between 1 April 2014 and 31 March 2016. |
| Pain In Children (CEM ) | Yes | 18 cases 1 April 17 – 31 March 2018 |
| Procedural Sedation in Adults (care in emergency departments) | Yes | 13 cases 1 April 17 – 31 March 2018 |
| Sentinel Stroke National Audit Programme | Yes | 114 cases submitted (95%) 1 April to December 2017. Data entry for Q4 still to be completed and validated. |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | 5 cases (100%) April 17 – 31 March 2018 |
| UK Parkinson's Audit | Yes | Audit data collated & submitted by CNWL, report to be published March 2018 |
| **1st September 2016 - 31st August 2017** | | |
| 1,315 cataract cases – 100% 1st September 2016 to 31st March 2017 | Yes | Admission questionnaires 5/5 = 100% Clinical questionnaires 2/2 = 100%. |
| Child Health Clinical Outcome Review Programme: **Young People's Mental Health** | Yes | Admission Questionnaires 2/4 = 50% (2 questionnaires were excluded) Organisational Questionnaires 2/2 = 100% |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) **Acute Heart Failure** | Yes | 4 cases included 2 excluded Clinical questionnaires returned 4/4 = 100% Case notes returned = 4/4 = 100% |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) **Perioperative diabetes** | Yes | Anaesthetic clinical questionnaires 5/5 = 100% Surgical Questionnaires 5/5 =100% Case notes 5/5 = 100% |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) **Cancer in Children, Teens and Young Adults** | Yes | In progress, Trust is participating. 1 organisational questionnaire returned = 100% |

The reports of 29 relevant national clinical audits were reviewed by the provider in 2017/18 and The Hillingdon Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

| Audit | Actions |
|---|---|
| Adult Asthma (British Thoracic Society) 2017 | Audit confirmed improvements in patient care; a small reduction from 2016 and compared with the national average in asthma readmissions within the preceding 12 months (from 30% to 27%). A significant improvement from 2016 and compared with the national average in delivering key components of the asthma bundle (50% vs NA 27.8%) - including checking inhaler technique, medication review, follow up arrangements. Length of stay was below national average. |
| Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients (2016) | The blood transfusion policy has been updated to incorporate the most up to date recommendations from the British Society for Haematology including appropriate transfusions for haematology and cancer patients. This includes guidelines on the use of prophylactic platelets and how to manage transfusions for inpatients at high risk of Transfusion Associated Circulatory Overload (TACO). This has been addressed in doctors' induction training and will be a part of e-learning. |
| BAETS - British Association of Endocrine and Thyroid Surgeons National Audit (BAETS) | 100% submission. This is a registry and not specific to the Trust. |
| Intensive Care and National Audit Centre (ICNARC) 16/17 | The following actions have been taken to improve patient care:-<br><br>NWL Critical Care Network admission guidelines are used to ensure that admissions to ITU/HDU are appropriate. If clinically appropriate, patients are discharged from critical care to a general ward within four hours of the decision. The Clinical Site Practitioner is notified as soon as the decision is made and the time is documented. Priority is given to critical care discharges over elective and Emergency Department admissions to ensure a critical care bed is available immediately for emergency admissions.<br><br>Patients are discharged as early as possible in the working day between the hours of 07.00hrs and 21.59hrs. A system using RED2GREEN has been introduced in ITU/HDU to highlight patients who have waited >4 hours. Single sex breach reporting has also been utilised to ensure patients who are delayed discharges are transferred as soon as possible. |
| Inspiring Change: Acute non-invasive ventilation (NIV) NCEPOD 2017 | This NCEPOD review makes a number of recommendations for the organisation of NIV services and the care that needs to be delivered to such patients. Several actions have already been implemented as a result of the publication. An operational policy is being written to incorporate existing comprehensive NIV guideline and recommendations of the NCEPOD report. A review of care on Drayton ward with regard to equipment and staffing levels for NIV is taking place as standards are not currently met. The report also recommends standardized documentation for prescription of NIV and documentation of escalation plans which are in the process of being drawn up. Training of staff involved in caring for patients on NIV is underway to ensure they are competent. There is ongoing improvement work within the deteriorating patient group to target these issues and ensure all issues identified on the NCEPOD safety checklist are reviewed. |

| Audit | Actions |
|---|---|
| MBRRACE Saving Babies Lives (a care bundle for reducing stillbirth): 2017 | Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:<br><br>1. Reducing smoking in pregnancy<br>2. Risk assessment and surveillance for fetal growth restriction<br>3. Raising awareness of reduced fetal movement<br>4. Effective fetal monitoring during labour<br><br>Although we are compliant for the 4 key recommendations, there is further work to be undertaken with a pilot project underway across London (DESIGN trial) looking at the effectiveness of customised growth charts (care bundle 2). |
| MBRRACE saving mothers lives: 2017 | This report, the fourth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2013 and 2015 in the UK. In addition, it also includes Confidential Enquiries into the care of women who died between 2013 and 2015 in the UK and Republic of Ireland from neurological conditions, other medical and surgical conditions, sepsis, anaesthetic complications, haemorrhage and amniotic fluid embolism, as well as Confidential Enquiries into the care of women with morbidity due to uncontrolled epilepsy in pregnancy and those with severe postpartum mental illness. |
| Major Trauma Audit (TARN) Trauma Audit & Research Network (TARN) | TARN performance has improved significantly and is more than 95%. There have been several positive changes in our functioning as a Trauma Unit in the North West London Major Trauma Network. These include a well-established Trauma Director role in place providing clinical leadership representing the Trust at regional and national level. The various Trauma protocols are readily available both electronically and in hard copy and visible in designated area in Emergency Department Resus. The pathways and various issues are regularly reviewed and disseminated in Middle Grade and SHO teachings. There is now faster Image Exchange Portal image transfer and we are working towards a 24/7 Radiographer presence on site to improve our time to CT targets. There is now a dedicated Trauma theatre and a fully rota-ed NCEPOD list, running 24/7. Trauma co-ordinators are on site Monday to Friday to facilitate definitive care in this group of patients. There has been significant improvement in Specialty engagement in the last year with regular MDT meetings. Burns Care is managed through the designated burns network with well-established pathways and protocols in place. The TARN data has been used for two audits on head injury and chest injury, supervised by the Trauma Lead and action plans made based on the findings, which are currently being implemented. |
| Moderate/Acute Severe Asthma Audit – College of Emergency Medicine, May 17 | As a result of this audit here has been a trust wide change in policy so that oxygen treatment is actually prescribed (historically, it has not been common practice to do so). The proforma will be updated and a re-audit performed to identify improvement. |
| Myocardial Ischaemia National Audit Project (MINAP) 2017 | Several actions have been taken to improve patient care. More patients have been referred for inpatient angiograms. Patients who come into A&E are started immediately on the Acute Coronary Syndrome (ACS) protocol. The majority of patients who attend with Myocardial infarction (MI) are seen by a cardiologist. The majority of patients are now referred to cardiac rehabilitation. There is now a designated Cardiology ward to improve patient care. |

| Audit | Actions |
|---|---|
| National Audit of Breast Cancer in Older Patients 2017 | Every patient is discussed in MDT meetings and advice is obtained from anaesthetists and cardiologists. World Health Organisation (WHO) performance score is also assessed and the medical condition if staging is required. The management of these patients is of a high standard and they are cared for under the Breast Team. It is planned to identify a lead from Care of the Elderly to join the multi-disciplinary team meetings. |
| National Cardiac Arrest Audit (NCAA) | Each quarterly report is reviewed at the Resuscitation Committee to identify the Trust's mortality rate. The report also identifies any unexpected non-survivors and these deaths will be reviewed under the Learning from Deaths Audit. The Trust mortality rate following cardiac arrest is below the national average. |
| National Maternal Perinatal Audit (NMPA) | The aim of the NMPA is to produce high-quality information about NHS maternity and neonatal services which can be used by providers, commissioners and users of the services to benchmark against national standards and recommendations where these exist, and to identify good practice and areas for improvement in the care of women and babies. Electronic documentation has been introduced to accurately record information. Reports and dashboards are run monthly from trend analysis and our action plans monitor progress. |
| NCEPOD Children's surgery - are we there yet? | Sixteen actions from the NCEPOD Self-Assessment were completed. A comprehensive transfer guideline is now in place regarding who can operate on and anaesthetise children for elective and emergency surgery.<br><br>Pain assessment is now part of the Paediatric Early Warning Score (PEWS) score and the Paediatric Pain policy is on the intranet.<br><br>There is scenario training twice a month for teams which includes health care professionals who have advanced training in paediatric resuscitation. |
| NCEPOD report 2017 Treat As one – Mental Health in Acute Hospitals | The majority of the recommendations from this study were met. Some of the actions to improve patient experience are: - All trust staff are offered training on mental health to help promote the identification of mental health issues. Mental health training is offered via the learning and development department. Staff are able to access the liaison service 24 hours a day should they wish to discuss an individual patient. The liaison team has been in place since 2012. They offer 24 hour cover 365 days per year. The psych liaison team and acute trust operate with a robust referral and response system. All bleep referrals are actioned within one hour. Any A&E referral is seen within one hour and referrals from the wards within 24 hours unless specified as "emergency". The psychiatric liaison team meet 100% of their response targets. One to one care is regularly provided to patients who present as high risk. |
| National Bowel Cancer Audit 2017 | It was noted that for THHT the risk adjusted length of postoperative stay was worse than the national average. A panel has been instituted to implement the Enhanced Recovery Programme for patients with bowel cancer resections. Regular training for nurses on our ward has also being organised for them to understand the philosophy of the enhanced recovery programme.<br><br>Also, the two year mortality was found to be high and as a Trust, we are a negative outlier. A formal response was sent to the National Bowel Cancer Audit with the issues influencing this outcome. One of the issues was the low uptake of bowel cancer screening in the Borough of Hillingdon, which was shown by our unit. We have been interacting with primary care to try and improve the uptake of the faecal occult blood test for early detection of bowel cancer in the community. |

| Audit | Actions |
|---|---|
| National Diabetes Inpatient Audit 2017 | Audits have continued to show improvement in insulin errors, hypoglycaemia rates which are lower than national average. This is due to the introduction of hypoglycaemic training, hypo-boxes and hypoglycaemia pathways etc. There are also Link Nurses and training by Diabetic Inpatient Specialist Nurse (DDISN). In 2017 twice weekly Consultant Diabetes ward rounds to help support training for DDISN was introduced.<br><br>The staff knowledge and satisfaction score has improved, due to education and training for staff. The DDISN and Consultant are working towards developing e-learning module for safe insulin prescription with the Idevelop team. There is no dedicated Diabetes Dietician and Pharmacist. Most admissions were for other medical reasons than Diabetes (72.1%). Only 5.8% were admitted specifically for diabetes. 22.1% were admitted for surgical cause. There is no dedicated Preoperative Optimisation of Diabetes Clinic; this needs resource to implement. |
| National Emergency Laparotomy Audit (NELA) | Our performance has remained with the national average, with above average in a number of areas, including CT reporting, Consultant Surgeon presence and the involvement of Care of the Elderly team. Access to critical care has been strong immediately post operatively. Areas of improvement involve data collection, recording of risk of death, Anaesthetic Consultant presence, and a slight increase in return to theatre rate. A significant number of improvements have been incorporated, including the introduction of a 24 hour emergency theatre staffed in working hours by a consultant anaesthetist. This is enabling patients to be operated on promptly with appropriate staffing. All trainees are being issued access to NELA database, and ongoing development of a laparotomy pathway. |
| National Audit of Dementia (Royal College of Psychiatrists) 2017 | Tier 2 (more advanced) dementia training has been introduced and a total of 100 staff from across the organisation attended. John's Campaign is actively supported to facilitate carers to stay with their relative to support with the care they need. To support carers who want to stay close to the patient but ensure they have adequate rest, we have guest beds available. We have revised the delirium information leaflet which is now available for patients and their families. The Dementia nurses identify and review patients living with dementia who are admitted to our inpatient wards. This includes ensuring that they have a 'This is Me' document to help the MDT to provide patient centred care. The national dementia audit results were published in July 2017 which had a number of recommendations. These recommendations are being used to plan and develop the Trust's dementia service in the next year.<br><br>There is an activity box with Dementia resources now available on the inpatient wards, Acute Medical Unit, Surgical Assessment Unit, Accident & Emergency and the Clinical Decision Unit to assist the nursing staff to engage and occupy patients within the organisation who are living with dementia. Through training and support, we are empowering ward staff and therapists to use this to provide therapeutic interventions on the ward. On some wards there are regular planned activities such as exercise classes, breakfast clubs, therapy dog visits and we aim to provide these across other ward areas in the future.<br><br>Improvements supporting food and nutrition for dementia patients include flexible meal spaces that use furniture creatively; bulk serving of food so patients can determine portion sizes; coloured glassware to encourage a patient to drink; and a variety of colours in foods, to assist visually impaired patients. In collaboration with facilities, the dementia team have been working to develop a finger food menu; the official launch was April 2018. |

| Audit | Actions |
|---|---|
| National Chronic Obstructive Pulmonary Disease (COPD) Audit | Since this audit was undertaken, a new integrated respiratory service for patients with COPD has been commissioned. The Hillingdon integrated respiratory service provides early respiratory specialist review in patients admitted with an acute exacerbation of COPD. The service aims to provide review within 24 hours of admission. Team members use a range of tools including breathlessness score, spirometry and chest X-ray to help identify patients at risk of deterioration or poor outcomes. All patients reviewed by the integrated respiratory service have a COPD discharge bundle completed to address the need for smoking cessation services, referral to pulmonary rehabilitation, inhaler technique, provision of a self-management plan and rescue medication, and ensure appropriate follow-up on discharge in specialist community clinics. The provision of quality care with early specialist review and discharge bundles is subject to a Best Practice Tariff in the most recent National COPD audit, and Hillingdon Hospital has achieved this to date.<br><br>The integrated respiratory service has also extended the work of the existing COPD outreach team who facilitate early discharge, to provide hospital at home services and admission avoidance schemes. These are aimed at reducing both admission and readmission of patients to hospital and reducing length of stay. The service also provides support to patients, GPs, practice nurses and community matrons via a direct COPD hotline number which is available six days a week. Currently Hillingdon Hospital has lower readmission rates and shorter lengths of stay compared to those reported in the national audit for patients admitted with COPD. |
| National COPD Audit Programme pulmonary rehabilitation: Beyond Breathing Better. Outcomes from the clinical audit of pulmonary rehabilitation services in England 2015. | Although Hillingdon Hospital does not have its own pulmonary rehabilitation programme, pulmonary rehabilitation services for Hillingdon are provided by Harefield Hospital who co-provide integrated respiratory services across Hillingdon. Referral pathways exist to ensure that all patients reviewed by the integrated respiratory team are offered pulmonary rehabilitation during hospital admission, at outpatient clinics and after hospital at home services. All patients who agree to referral are referred. In 2017, 95.6% of patients who consented to referral were referred from the hospital. Harefield Hospital received 271 referrals from the integrated team. Harefield Hospital is one of the largest single site providers of pulmonary rehabilitation in the UK. It is one of the few pulmonary rehabilitation sites which is formally accredited by the Royal College of Physicians and is an extreme positive outlier in terms of outcomes and waiting times. |
| National Heart Failure Audit 2015 | Analysis of the National Heart Failure Audit (HF) data showed that our hospital is placed high on the quality parameters of specialist review, but also on heart failure required treatment. Our hospital scores above the national average in all categories. However, there is still room for improvement in relation to inpatient care, especially if these patients are admitted to non-cardiac wards. Therefore, we have on-going plans to strengthen the hospital heart failure nurse service with an additional nurse, in order to provide better service to inpatients. The audit of HF patients presenting frequently to our hospital, revealed a very high percentage of patients nearing end of their life. This raises the need for early involvement of the palliative team which is work that is being taken forward. |
| National Lung Cancer Audit February 2017 | The change in practice from this audit has been that CT scans in suspected lung cancer cases can now be obtained on the day of the first appointment. |
| National Joint Registry (NJR) | In order to improve results and participation rates, it was agreed that each Consultant would input their own data at the time of surgery. Each Consultant now has a user name and password provided by the local NJR coordinator. |

| Audit | Actions |
|---|---|
| National Neonatal Audit Programme (NNAP ) 2017 | Hillingdon Neonatal Unit met or exceeded the national average for all NNAP domains in the 2017 report of 2016 data. The following are examples of excellent practice identified by this NNAP report:<br><br>We were found to have excellent rates of antenatal steroid administration to expectant mothers who delivered prematurely. This is very encouraging and follows a previous action plan in this area. Our figures for admission temperatures for babies born <32 weeks pre-term were in the top five level 2 neonatal units in the country. Key areas we are working to improve in response to this data include a 2 year follow-up of data and breast feeding rates – the neonatal unit is part of wider Trust work to obtain Baby Friendly Initiative accreditation. |
| National Paediatric Diabetes Audit - NPDA 2017 | Seven key care areas were identified as requiring improvement. The median HbA1C for our Paediatric Diabetes Unit was an outlier averaging at 72mmols, with a national target of 48mmols. The actions taken to address this were:<br><br>● Annual review clinics have been introduced to carry out all necessary checks<br>● HbA1C colour trend charts were devised to be used in clinics to reinforce treating to target of 4-7mmols<br>● Group clinics: This started as of January 2017 and has continued during 2017/18 with the key target age range identified as 13-16years<br>● For patients with identified poor diabetic control, monthly reviews are being undertaken with individualised action plans agreed.<br>● FRED (Food Relationships Exercise Diabetes) workshops were introduced<br>● Evening clinics for transition to adult services were introduced to improve attendance. |
| National Pregnancy in Diabetes 2016 | The following actions are being undertaken to improve our patient experience as identified via the audit: Improve data collection – written patient consent for inclusion in the audit is no longer required (as of Jan 2018); use the GP extranet and inform Practice Managers to improve GP involvement in the review of patient's care; review previous involvement of the Endocrine Clinic in care of women of child-bearing age to ensure this is flagged at the earliest stage – ongoing action by the Endocrinology Consultants; the Fertility Clinic are to improve patient involvement including holding road shows and working with pharmacies to improve preconception knowledge in women. NHS Improvement project team for the National Maternity and Neonatal Safety Collaborative has now been advised (Feb 2018) that diabetes care in pregnancy must be a priority area for improvement – this is to be reviewed by the NHSI project team and the maternity governance group. Staff education is ongoing, with a planned multidisciplinary session to be included in the maternity training programme. |

| Audit | Actions |
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| National Prostate Cancer Audit (NPCA) | The results of the 2017 National Prostate Cancer Audit, which relate to patients newly diagnosed with prostate cancer for the period 1 April 2015 - 31 March 2016, shows a significant improvement in data completeness in all data fields listed for the trust compared to the previous report (2016). The Trust's results compare very favourably to our neighbouring trusts in North West London and to the national averages. The number of records reported is lower than the actual number of prostate cancers diagnosed in that year at the Trust and this is being reviewed. Actions to be undertaken in the coming year are clarifying why the number of records reported is low and addressing this with the NPCA team. Also the Trust is to continue with the live collection of data during MDT meetings via the Somerset Cancer Register to improve data completeness even further. |
| Paediatric National Pneumonia Audit (BTS) | A Quality Improvement project has been initiated, the aim of which is to achieve the national objectives with implementation over the next 6 months. |
| Sentinel Stroke National Audit Programme (SSNAP), incl. Organisational Audit | There are two initiatives in place: the first is Early Supported Discharge Team whose aim is to improve patient care. The second is the Stroke Forum which is a public event held every 3 months involving multi-disciplinary teams. The Stroke Team has also instigated a monthly operational meeting with patient involvement. |
| Serious Hazards of Transfusion (SHOT) Annual Report Summary for Hillingdon Hospital | There were a total of 5 SHOT reports from Oct. 2016 – Oct. 2017. Each of these incidents resulted in different learning outcomes and preventative actions. Common themes were updating laboratory Standard Operating Procedures, updating doctors' induction training and escalating issues within relevant departments so that those departments are responsible for ongoing preventative actions. Training sessions were introduced by the Transfusion Practitioner on specialist requirements including update on the latest British Society for Haematology guidelines, particularly around Cytomegalovirus negative blood. |

The reports of 49 local clinical audits were reviewed by the Trust in 2017/18 and examples of The Hillingdon Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are as follows:

| Audit | Actions |
|---|---|
| Re-audit Completion of WHO checklist, Proforma and Consent Forms in Maternity (Audit 403) | The audit highlighted an improvement in compliance with the completion of the WHO checklist when the 2018 results were compared to the previous results. Work is still required to ensure the compliance rate remains over 90%. Several actions are being taken to address this. An observational audit will be carried out in addition to a retrospective audit on the compliance in completing the documentation. Awareness will be raised of documenting all instruments in the theatre register and all staff informed about the process. All staff need to be aware that the theatre register is a legal document and must be signed by a practitioner. |
| Multi-disciplinary Re-audit of Gynaecology Clinical Record Keeping | Several actions have been taken as a result of this audit to improve patient care. Doctors now have stamps to clearly identify their names, and designation. Staff have been reminded about the correct process for corrections and signing and dating entries in the 'Gossip Corner' (a staff newsletter). Any alerts or allergies are now clearly visible and recorded within the first section of the health record |
| Audit of Clinical Decision Unit (CDU) Admission Protocol (Audit 261) / Transfer & Management of Older Persons to Clinical Decisions Unit (Audit 419) | A new CDU unit opened in 2017 with a strict protocol for admissions. Patients should only be admitted if they met the admission criteria and were likely to stay less than 12 hours. However it was found that beds were often filled with patients staying longer and the audit was to assess whether this was due to inappropriate admissions or other factors. Audit findings confirmed that admission criteria for admitting patients to CDU were not being followed by staff. As a result of the audit the CDU admission proforma has been changed. |
| Febrile neutropenia at Hillingdon Hospital over a 12 month period (Oct 16-17), | There is now teaching and education of medical and nursing staff. A comprehensive strategy has been developed to improve prescribing of regular medications including oral chemotherapy drugs. An automatic email alert is generated via the Patient Administration System (PAS) to alert the Paediatric Oncology Shared Care Unit (POSCU) team of admission of a POSCU patient. There is now a comprehensive admission and care pro-forma for up to 96 hours from admission. |
| Constipation in Children | Following the audit, a patient information leaflet for constipation in children has been produced and pathways have been developed for managing constipation in conjunction with primary care. New guidelines are also being developed for the hospital and community to engage community teams and help reduce the impact of constipation on children. |
| Developmental Dysplasia of the Hip in Neonates Re-audit | Since the previous audit in 2016 there has been increased work within the department to ensure that when requesting the ultrasound scan that the date the scan is due by is written. There has been huge support from the Radiology Department in helping ensure that scans are processed within the correct time limit and that all patients have scan appointments that are within the correct standard. |
| Aspirin for venous thromboembolism (VTE) in Elective Hip and Knee Replacements | Where patients were taking aspirin, the data showed a reduction in re-admission due to infection/ bleeding and no change in the VTE rate. There was improvement in the number of wound complications and rates of further surgery. Overall no large change in complications. Worse in UTI/retention, bowel change, delirium, AKI. No change in DVT/PE rate. As a result of the findings it appears safe to continue aspirin thromboprophylaxis after elective hip and knee arthroplasty. The guidelines have been updated, ratified and published. |

| Audit | Actions |
|---|---|
| Delirium Audit incl. NICE Quality Standard | Not all patients were found to have had the assessment and less than 50% were assessed for drug interactions, nutrition, hip fracture and sleep disturbances within 24 hours of admission. The dementia assessment form has subsequently been updated and publicised across the Trust. Dementia training is now part of the monthly Trust induction and also part of the junior doctor induction. |
| Assessment of the Direct Access Echocardiography Service | Hillingdon Hospital introduced direct access echocardiography to enable GPs to refer patients without the need for a prior cardiology appointment. The aim of the audit was to determine the time taken for such patients to be reviewed and to improve the service of direct access echocardiography at Hillingdon hospital. As a result of the audit a specific clinic has been created to accommodate direct access echocardiography patients. All echocardiogram reports of patients with significant abnormalities are placed on Consultant Cardiologist's desk / in specific 'direct access echocardiogram' tray for clinical review and to agree the best course of care for the patients, whether this should be continued care with the GP or referral into the Cardiology clinic. |
| Diabetic Retina DNA Discharge Failsafe Re-Audit (15/16) | There is now a dedicated Diabetic Retina Failsafe Officer. All diabetic patients that do not attend (DNA) once are offered a 2nd appointment. Patients are now only discharged after a 2nd DNA and clinical review. There is double checking of all patients referred to eye clinic from the Diabetic Eye Screening Programme (DESP). This is regularly monitored to avoid patients being lost to follow up by working alongside the bookings team. Patients who are reviewed out of the catchment area have a full failsafe mechanism in place as they are notified with the recent letter to their allocated DESP area via post after being confirmed by the Failsafe Officer either by email or phone. |
| Use of the Abbey Pain Score Tool | All clinical staff receive training on the Abbey pain tool at Trust induction as a part of the dementia awareness sessions. A specialist pain team support teaching on the adapted Abbey pain tool and support staff in use of the tool. There is ward based training provided by the Dementia Clinical Nurse Specialist. Pain study days are held every three months. The Pain team and Matron advocate the use of the Abbey pain tool as a part of normal practice. |
| Re-audit of Post-Operative Pain Management in Children | There has been a significant improvement in the recording of post-operative pain levels in paediatric patients. There is room for improved compliance with the draft pain assessment form and it is proposed to integrate this document into the mandatory surgical paperwork, such as a day-case surgical booklet for children in order to make additional improvements in the recognition and early management of pain. The use of a validated pain assessment tool on the paediatric early warning system (PEWS) chart, which includes the FACES pain assessment on all children coming to theatre was used in recovery and resulted in an increase in the number of patients receiving analgesia in recovery, suggestive of enhanced early recognition of pain. This may result in a reduction in the number of patients receiving further analgesia on the ward. |
| Standards of Monitoring in Anaesthetics | There is now daily testing of emergency alarms in the operating theatre department by ODPs and increased compliance with documentation of checks of equipment with liaison with the principal ODP. All equipment is checked and this is documented. There is now a new fully operational, anaesthetic machine which has been installed in theatre 6. Paediatric Intraosseous infusion (IO) needles have been ordered and are now readily available in the main theatre complex. |

## Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving relevant health services provided or sub-contracted by The Hillingdon Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 485. In addition, 124 medical staff took part in a research survey to evaluate a key component of NHS England's policy drive for 7-day services.

The Hillingdon Hospitals NHS Foundation Trust has a good research track record for a hospital of its size. Our main research activity is recruiting patients into high quality National Institute for Health Research (NIHR) portfolio adopted multi-centre trials. We participate in commercial research funded by the pharmaceutical industry and non-commercial research which is funded from the DH via the NIHR NWL Clinical Research Network (CRN). In 2017/18 we received £337,270.25 from the NWL CRN for this work. The funding enables the Trust to employ research nurses and data managers to support the clinicians in this area of work.

Our strategic aims for 2014 – 2019 are:

- To expand the number of patients recruited into high quality clinical trials
- To expand the number of specialties that are actively participating in clinical trials
- To adapt to the changing National and Regional organisation of clinical research and funding.

The Trust has an extensive research portfolio with a balance of observational and treatment trials across many clinical areas including Cancer, Stroke, Haematology, Ophthalmology, Critical Care, Maternity and many of the general medicine and surgical specialities. In 2017/18 patients from fifteen different specialities participated in research. Our most research active specialities were Cancer and Reproductive Health.

Participation in clinical research demonstrates The Hillingdon Hospitals NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to the nation's wider health improvement work. This also allows clinical staff to stay abreast of the latest treatment possibilities thus giving patients access to new treatments that they otherwise would not have.

We also support PhD and Masters students from the local universities giving them access to our patients and staff, with their consent, for their projects. In 2017/18 we approved and supported one such university student project.

During 2017/18 we had approximately 80 NIHR Portfolio Studies open or in follow-up and we recruited 609 patients into 42 trials. When compared to other similar sized Trusts in London, our activity appears to be on par.

All of our research activity is scrutinised for quality and compliance to the standards expected by the Research Governance Framework and the Health Research Authority. In addition we work to comply with the DH NIHR objectives.

In November 2017, Brunel University London, The Hillingdon Hospitals NHS Foundation Trust and Central and North West London NHS Foundation Trust, officially launched their pioneering new Centre for Integrated Health Education and Research, which aims to drive change in the way health and social care is delivered in the community to meet the needs of society.

The Brunel Partners Academic Centre for Health Sciences will provide a new setting for researching and developing new methods of healthcare delivery, while training future generations of health and social care professionals to succeed in a changing landscape.

## Lessons Learned from the Investigation of Serious Incidents

During 2017/18, the Trust reported 43 Serious Incidents in accordance with the NHS England Serious Incident Framework. This compares with 47 Serious Incidents in 2016/17.

In May 2017, our Surgical Division reported a Never Event relating to an Ophthalmology patient who had the incorrect power of intraocular lens inserted during cataract surgery. A second Never Event was reported in October 2017 where a retained swab was identified to have been left after a gynaecology procedure. Neither patient experienced any significant harm. Some of the key actions are referenced in the table below.

The types of Serious Incident cases reported, using the categorisation in the Serious Incident Framework during this period include sub-optimal care of the deteriorating patient, delayed diagnosis, delayed treatment, diagnostic incidents, surgical/invasive procedures, screening issues, maternity and obstetric incidents.

Protecting patients from avoidable harm is something to which there is universal agreement and the Trust has clearly defined processes and procedures to follow to help to reduce the risk of these events occurring and recurring. However, where a Serious Incident does occur, lessons need to be learnt and the incident is investigated through a process of root cause analysis (RCA). The RCA investigation leads to the development of learning, recommendations and actions to prevent reoccurrence. Examples of the learning from the Serious Incidents investigated during 2017/18 are:

| Category of incident | Learning Identified |
|---|---|
| Surgical/invasive procedure | • The pre-operative assessment electrocardiograph (ECG) analysis guidance in the Pre-operative Assessment Clinic has been updated. Findings of the investigation have been shared with all relevant staff members to highlight lessons learnt.<br>• Review of a vascular injury guideline on the Neonatal Unit (NNU) to enable staff to have consistent guidance in clinical practice.<br>• Awareness to be raised among staff on NNU with regards to distinguishing arteries and veins when obtaining vascular access, particularly if the antecubital site (crease in the elbow on the inside of the forearm) is used.<br>• Revisiting the NNU care pathway for the assessment and management of pain in preterm babies.<br>• Review the nutrition care pathway in order to assist with understanding how it can be used more effectively, to ensure nutrition is optimised for the high and moderate risk babies thereby reducing the need for PN and vascular access.<br>• Better stock control of donor expressed breast milk to ensure its availability at all times.<br>• Parents are advised as soon as possible after an incident has occurred; even if staff believe that they are unable to provide answers to parents' questions. Consultants should ensure this communication takes place. |

| Category of incident | Learning Identified |
|---|---|
| Treatment delay | • Continuous increase in the inflammatory marker levels considered as an alarm bell to explore possible infection or other underlying complications of a post- surgical patient.<br>• Consideration was taken into the training needs and a new training plan and requirements are being written and undertaken to enhance the early identification of the deteriorating patient this has led to a change in behaviours and competencies. |
| Pressure ulcer | • Awareness of Hospital Policies including Pressure Ulcer Policy and Capacity Assessments has been raised. |
| Maternity/Obstetric | • Every neonatal simulation scenario brief to include prompt to train staff about human factors surrounding how to request crash calls and importance of specific instructions when asking for help.<br>• Structured written PPHN scenarios to be included in simulation for paediatric trainees and consultant paediatricians.<br>• Consideration taken to including uterine activity assessment in the current CTG classifications to provide an accurate assessment of labour and fetal well-being.<br>• Raising awareness of the importance of documenting the assessment of the uterine activity when completing their classification of a CTG.<br>• Women on antenatal ward who require urgent assessment are reviewed by the Obstetric Registrar on duty as a priority before they carry out their routine gynaecology ward rounds. |
| Slips/trips/falls | • If the toilet had had a sensor mechanism for flushing, so the patient did not have to turn to flush, the fall may have been prevented. |
| Screening issues | • To read ultrasound reports in their entirety.<br>• Consideration into including vital information such as viable pregnancy with suspected partial mole in the 'Overall diagnosis' box or summary for future reports. Discuss report layout with Ultra Sonographers<br>• To follow the correct guideline that states there should be a repeat scan with a senior sonographer or consultant.<br>• On clerking people prior to surgery all the relevant documentation and reports are read.<br>• Review and report back to patients their results in a timely fashion in all cases.<br>• Increased awareness that partial molar or molar pregnancy identified on an ultrasound scan are escalated to the consultant gynaecologist.<br>• Results are reviewed and managed appropriately and in a timely manner. |

| Category of incident | Learning Identified |
|---|---|
| Never event – retained swab | • Gynaecology patients at higher risk of retained products of conception should be promptly referred to the Gynaecology Team from A&E.<br>• Clear instructions on the post-operative note by the surgeon if they wish the patient to be seen postoperatively. If there is uncertainty, it should be clarified before the patient is allowed to go home.<br>• Application of a more robust method of counting swabs to ensure the WHO checklist can be thoroughly completed.<br>• When a swab is used to support the performance of a bimanual compression after the swab count has been done; a swab count needs to be repeated.<br>• Although there is a reminder to 'STOP BEFORE YOU BLOCK' on the WHO checklist, as proved in this case, it is not sufficient to ensure the process is carried out consistently across the Anaesthetic Team and clinical specialties |
| Suboptimal of deteriorating patients | • There is an inconsistent use of NEWS protocol throughout the Trust which has been demonstrated by the failure to appropriately follow the escalation protocols and the expertise in recording NEWS scores.<br>• A review of incident involving incorrect application of NEWS policy has been undertaken to consider whether an electronic application can support the correct application of NEWS and the early recognition of deteriorating patients.<br>• The universal good practice in noting NEWS scores is vital for the identification and treatment of Sepsis. Sepsis Protocol is not consistently used across the Trust resulting in delays of identification of deteriorating patients. |
| Never event – incorrect power of intraocular lens | • A review of the "day of surgery" process within Ophthalmology and appropriate changes to be implemented.<br>• The pre-operative assessment should be updated to include a short cognitive check.<br>• Review Safeguarding Adults training to include specific guidance for clinicians on patient communication in such circumstances |

The action plans from Serious Incident and Never Event investigations that are based on the identified learning, are implemented and monitored via the Clinical Divisional Governance Boards until each action is fully completed. A Non-Executive led Serious Incident assurance panel meets to review and approve all Director-led Serious Incident investigation reports and action plans. As part of our duty in being open and honest with patients and their families, the findings from serious incident investigations are shared with them and information is provided on the learning and the actions that the Trust is taking forward to prevent reoccurrence.

Trust-wide actions for two areas of care and practice that have been identified as recurring themes in our serious incidents reported and hence needing more detailed focus are:

**Improving care and escalation of the deteriorating patient** – work here is being led by the Deteriorating Patient and Sepsis working group which meets on a monthly basis reporting to the Patient Safety Committee. The group has been focusing on the training of staff, the implementation of safety huddles and effective clinical handover, the introduction of department specific guidelines and the review of Trust policy. The Trust is now in the process of implementing an electronic solution to the recording of patients' observations (NEWS2) to achieve a more robust mechanism for recording and escalation to medical staff.

**Improving the sharing of patient information and clinical handover** - there are a number of initiatives being taken forward to support improved effectiveness of the clinical handover which includes the use of Nerve Centre. This is an IT system the Trust is using for multidisciplinary and nursing clinical handover and for the RED2GREEN initiative to electronically capture key patient information on progress of care and internal and external delays. The use of patient safety huddles which have been rolled out across the Trust and structured board rounds are all assisting in supporting improved communication amongst multidisciplinary team members. As part of the Trust roadmap to move to digital patient records Nerve Centre will provide electronic handover on desktop and mobile device, integrated with a number of clinical systems including Hillingdon Care Record, Vital Signs monitoring, the Patient Administration System and ePRO (discharge summaries). This provides clinicians with up-to-date, real-time information at their finger-tips to support handover and enable information to be recorded once and shared.

## Learning from Deaths Process

Learning from deaths of people in their care can help providers improve the quality of care they provide to patients and their families where they could do more. In March 2017 the National Quality Board introduced new guidance for NHS providers on how they should learn from deaths of people in their care. The Trust is now following this guidance and reporting as per the national requirements to the Trust Board on a quarterly basis. The quality accounts regulations were updated in 2017 to include new requirements relating to Learning from Deaths to apply from 2017/18 reports. The Trust's data is outlined as below:

**1. During the reporting period of 1 April 2017 to 31 March 2018, 842 of The Hillingdon Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:**

- 191 in the first quarter;
- 173 in the second quarter;
- 219 in the third quarter;
- 259 in the fourth quarter.

**2. By 31 March 2018, 260 case record reviews and seven investigations have been carried out in relation to 364 of the deaths included in item 1 above (see below for the agreed triaging process).**

In seven cases a death was subjected to both a case record review and an investigation where the screening process suggested further in-depth review was required. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 146 in the first quarter;
- 114 in the second quarter;
- Third quarter (notes currently being reviewed by Consultants)
- Fourth quarter (notes currently being reviewed by Consultants)

**3. One of the patient deaths (which represents 0.38% of those deaths that were subject to a case record review) during the reporting period of Q1 and Q2 was judged to be more likely than not to be due to problems in the care provided to the patient; this was escalated as a serious incident for further detailed investigation. In relation to each quarter this consisted of:**

- Nil cases representing 0% for the first quarter;
- 1 case representing 0.6% for the second quarter;
- Third quarter – N/A as awaiting Consultant review;
- Fourth quarter - N/A as awaiting Consultant review.

These numbers have been estimated as a result of the case notes of those patients who have died being triaged by a Mortality Lead Nurse; 77% (Q1) and 66% (Q2) of the total cases were then reviewed by a Consultant not previously involved in the care of the patient using CESDI (Confidential Enquiry into Stillbirths and Deaths in Infancy) criteria for potentially avoidable deaths – this ranges from 'no substandard care' graded as zero to 'substandard care, different management would have been reasonably expected to have made a difference to outcome' graded with a score of three.

**4. What have we learnt from the case record reviews and investigations conducted in relation to the deaths included in section 3 above?**

- Evidence of substandard documentation
- Inadequate documentation and escalation of the deteriorating patient
- Inadequate clinical handover
- Clinical notes not always filed correctly.

### 5. What actions have we taken in the reporting period, and that we propose to take following the reporting period, as a result of what we have learnt as outlined in section 4 above?

- Refreshing key aims and the implementation of the National Documentation audit reflecting on the learning from the review of cases
- Rolling out electronic recording of National Early Warning System (NEWS) using our e-Obs platform
- Rolling out of Nerve Centre (electronic platform) clinical handover tool
- Continued rollout of the Hillingdon Care Record (HCR)

### 6. The following outlines the impact of the actions that were taken during the reporting period as described in section 5 above:

The National Documentation audit has identified some improvements in documentation however, this remains work in progress and is on our Corporate Risk Register. The other actions are all in progress. As electronic solutions take time to be implemented, the full quality and safety benefits will not be seen until 2018-2019.

### 7. Case record reviews and investigations completed between 1 March 2016 and 28 February 2017 which related to deaths which took place before the start of the reporting period:

As this is new to the quality accounts (report) there was no specific reporting for the previous reporting period. However, between 1 March 2016 to 28 February 2017 944 patients died, 579 of these were reviewed (61%) via the Trust mortality review process.

### 8. There were no deaths identified using the CESDI process between 1 March 2016 to 28 February 2017 that were judged to be more likely than not due to problems in the patient care before the reporting period.

### 9. No deaths, representing 0% of the patient deaths during 1 March 2016 – 28 February 2017, were judged to be more likely than not to have been due to problems in the care provided to the patient.

## Commissioning for Quality and Innovation (CQUIN) targets

The key aims of the CQUIN framework are to secure improvements in the quality of services, and better outcomes for patients, whilst also maintaining strong financial management. In 2017/18 there were six acute CQUIN schemes, all of which support national strategies. 2017-19 CQUINs also include two schemes that relate to engagement with local Sustainability and Transformation Partnerships (STPs).

In 2017/18, we have achieved 91% of our acute CQUIN target. This means that the quality of our services, and the care that we deliver to our patients, continues to improve.

2.5% of The Hillingdon Hospitals NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between The Hillingdon Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Each of the national schemes had a value of 10%, with 20% allocated to each of the two STP schemes.

Total CQUIN income for 2017/18, is expected to be £3,193,682 (91%) for national and STP schemes, plus £182,400 (94% of potential available income) for Specialised CQUIN schemes. In the previous year (2016/17) total income was £3,343,366 (95% of potential available income) for national, regional, and local schemes and £167,705 (100% of potential available income) for Specialised Commissioning. The reduction in value is due to lower achievement of some of the CQUIN schemes.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at www.thh.nhs.uk/media/pubs/index.php. Alternatively please contact our PALS team on 01895 279973 if you require a paper copy.

| CQUIN targets 2016/17 | Achievement | Commentary |
|---|---|---|
| **National Schemes** | | |
| Improving the health and wellbeing of NHS staff, visitors and patients | Partial (63%) achievement | This is the second year that the Trust has been working on this three year CQUIN that includes three key aims;<br><br>• to promote clinical uptake of the annual flu vaccination (100% achieved)<br>• to provide healthier food options for patients, visitors and staff (90% achieved)<br>• to support the health and wellbeing of NHS staff members – measured through staff survey results<br><br>The Trust did not achieve the desired improvements in staff feedback regarding health and wellbeing this year, but remains at, or above, the median for all acute hospital trusts. |
| Reducing the impact of Serious Infections (Sepsis and Antibiotic Resistance) | Partial (85%) achievement | The Trust is consistently achieving national targets for sepsis screening, and is currently reviewing and reinforcing local treatment protocols to ensure that, in future, more patients receive antibiotics within one hour of a suspected diagnosis of sepsis<br><br>Audit results show that we are excellent at reviewing antibiotic prescriptions within 24-72hrs.<br><br>We have also performed well in antibiotic stewardship, reducing overall prescription and consumption of antibiotics by almost 8%. |
| Improving services for people with mental health needs who present to A&E | Partial (98%) achievement | This is a joint CQUIN with Central and North West London Trust (CNWL)<br><br>Together, our two Trusts have succeeded in reducing Emergency Department attendances by 49% for a small group of people with primary/secondary mental health needs who consented to take part in a Care Planning trial. In 2018/19 we will repeat the process with a larger group of patients<br><br>We did not achieve 100% because there were some data quality (counting) issues that are currently being addressed |

| CQUIN targets 2016/17 | Achievement | Commentary |
|---|---|---|
| Providing specialist support, advice, and guidance to GPs, that will enable more patients to be cared for out of hospital where appropriate | Partial (92%) achievement | The Trust is providing Advice and Guidance to GPs for almost all services, significantly exceeding the target of 35%, but has found the requirement to respond within two working days to be challenging<br><br>We acknowledge the GPs need for a timely response and are working on improving our turnaround times |
| Supporting proactive and safe discharge – by reducing unnecessary length of stay for older patients | Partial (82%) achievement | Prolonged hospitalisation is not in the best interests of the patient, the hospital, or the NHS as a whole. During 2017/18 we successfully increased the proportion of elderly patients who had a hospital stay of less than seven days<br><br>We were also required to implement a new electronic coding system in the Emergency Department, for which deployment was delayed for both technical and operational reasons. |
| Receiving electronic referrals from GPs | Partial (83%) achievement | Threshold for GPs being unable to find an available appointment is 4%<br><br>The Trust has been unable to provide sufficient capacity to meet this threshold but is in the process of implementing service development plans to address the issue |
| **STP** | | |
| STP Engagement | 100% achievement | |
| STP Risk Reserve | 100% achievement | |

## Care Quality Commission (CQC) registration

The Hillingdon Hospitals NHS Foundation Trust is required to register with the CQC and its current registration status is that it is registered without conditions. The CQC has not taken enforcement action against the Trust during 2017/18. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has however been inspected by the CQC in March 2018 with an announced comprehensive inspection of all of its core services on the Hillingdon site only. A review of the 'Well Led' domain took place at the end of April 2018 as part of its revised inspection framework. An assessment of the Trust's 'Use of Resources' was undertaken by NHS Improvement in early May 2018. It is anticipated that the CQC will publish its report of the Trust's compliance to the Fundamental Standards and Key Lines of Enquiry (KLOE) in mid-July.

The Trust continues at this time with its overall rating of 'Requires Improvement' as a result of its previous comprehensive inspection of October 2014. At this inspection the Trust received a 'good' rating for the 'caring' domain across all of its services; members of staff were observed to be kind and had a caring and compassionate manner. Most of the people that the inspection team spoke with said that care was given in a kind and respectful way.

The Board considered the overall rating ('Requires Improvement') to be fair at that time. All of the recommendations were accepted and the Board agreed a detailed action plan to make the necessary improvements. The findings provided a real impetus to ensure our assessment of the quality of our services fully encompassed review of systems and processes that our staff members follow.

The grid below provides an overview of our existing CQC ratings based on the re-inspection of the Trust on 5 and 7 May 2015 (this was conducted following the comprehensive inspection of October 2014); the latest CQC report for the Trust was published on 7 August 2015.

The Trust's internal auditor, KPMG recently undertook a review of the Trust's compliance against the CQC's KLOE, as part of the Trust's internal audit programme. The audit report acknowledges good progress and quality improvements made by the Trust since KPMG's last review in 2016 with far fewer recommendations. The Trust's CQC improvement plan has now been refreshed in line with the KPMG review recommendations and is being monitored by the Regulation and Compliance Committee and the Quality and Safety Committee.

Moving forward, the Trust has agreed a programme of mock inspections using internal peer review and each core service will continue to be benchmarked against the CQC inspection assessment frameworks to provide assurance on compliance and for key areas of improvement to be identified.

## Our ratings for Hillingdon Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Critical care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Maternity and gynaecology | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Services for children and young people | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| End of life care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |

## Our ratings for Mount Vernon Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Minor injuries unit | Requires improvement | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Surgery | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |

## Data quality

At the time of writing, The Hillingdon Hospitals NHS Foundation Trust is able to report on records submitted during April 2017 to November 2017 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 which included the patient's valid NHS number were:

1. 99.4% for admitted patient care
2. 99.5% for out-patient care and
3. 97.1% for A&E care.

Those which included the patient's valid General Medical Practice Code were:

- 99.9% for admitted patient care;
- 99.8% for out-patient care; and
- 99.3% for A&E care.

The Trust's Board and management seek to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported in relation to the quality indicators outlined in the Quality Report, but recognises that it is nonetheless subject to the inherent limitations outlined within the statement from the Chief Executive Officer earlier in this report.

## Information Governance Toolkit (online system to assess against information governance policies and standards)

The Hillingdon Hospitals NHS Foundation Trust's Information Governance Self-Assessment Report (v14.1) overall score for 2017/18 was 82%. This is termed as satisfactory (colour-coded green) with all requirements achieving level 2 or above with 3 being the highest attainable score.

## Clinical coding error rate

The Hillingdon Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/2018 by the Audit Commission.

## Action taken to improve data quality

The Hillingdon Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue the comprehensive monitoring programme for data quality across the organisation through divisional based groups led by the Director of Operational Performance

# 2.3 Performance against Core Quality Indicators 2017/18

**In this part of the report the Trust is required to report against a core set of national quality indicators to provide an overview of performance in 2017/18. The following page provides information which has been obtained from the recommended sources and is presented in line with the detailed NHSI guidance.**

## Data Inconsistencies

A number of indicators are showing changes to 2016/17 data that was published in last year's Quality Report. There are several reasons for this as follows:

1. The statutory timescale within which the Quality Report is published is very tight. Not all of the latest data was available at the time of publication last year and so the Trust has taken the opportunity to update 2016/17 indicators with full year updates which are now available
2. National Indicators based on statistical methods by definition require re-basing. For example, standardised readmissions, HSMR and SHMI
3. Data quality or data completeness issues may have affected last year's indicators. If these have been identified then they have been rectified in this year's report.

## INDICATOR 1: SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

Trusts are categorised into one of three bands:

- Where Trust's SHMI is 'higher than expected' – Band 1
- Where the Trust's SHMI is 'as expected' – Band 2
- Where the Trust's SHMI is 'lower than expected' – Band 3.

The SHMI for the Trust, published in March 2018, was 0.9433 (benchmark period October 2015 to September 2016) – Band 2 HES data. The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described because it is issued to us by NHS Digital as a result of data submitted and reflects our performance compared to others. The data is monitored at the monthly executive board meetings and triangulated with other data to understand meaning and highlight any issues.

The Trust intends to improve this indicator, and so the quality of its services, by implementing the 2018-19 objectives in the Quality and Safety Improvement Strategy. This includes implementation of an electronic Early Warning System for identifying and treating the deteriorating patient and its link to identifying and treating sepsis, both being major causes of hospital deaths. It also includes further progress with the core 4 standards of the National 7-Day Services Programme, particularly out of hours and weekend senior staff review of patients. The Trust is also working with its partners to look at out of hospital care provision for end of life care patients, as an increasing number of these patients are dying in hospital.

| | 2015/16 Performance | 2016-17 Target | 2016-17 Performance | London Trusts | National | Benchmark Source | Benchmark Period | Lowest Performing Trust | Highest Performing Trust |
|---|---|---|---|---|---|---|---|---|---|
| 1: Summary Hospital-Level Mortality (SHMI) | 0.9489 (Band 2 \| As Expected) | n/a | 0.9433 (Band 2 \| As Expected) | n/a | n/a | NHS Digital | Oct-2016 to Sep-2017 | WYE VALLEY NHS TRUST 1.2473 Band 1 (Higher Than Expected) | WHITTINGTON HEALTH NHS TRUST 0.7270 Band 3 (Lower Than Expected) |
| 2: the percentage of patient deaths with palliative care coded at *diagnosis* | 27.2% | n/a | 21.6% | n/a | 31.2% | NHS Digital | Oct-2016 to Sep-2017 | THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST 11.5% | ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST 59.5% |
| 3: Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages 0-15 [Standardised] (Crude) | 7.00% | n/a | 6.80% | n/a (Local Data Provided in absence of benchmarking data) | | | | The latest NHS Digital publication was on Dec-2013 covering 2011/2012 data see http://content.digital.nhs.uk/qualityaccounts > Access the Indicator Portal which takes you to https://beta.digital.nhs.uk/ Section Compendium of population health indicators > Hospital Care > Compendium - Emergency readmissions to hospital within 28 days of discharge Last Checked 01/03/2018 | |
| 4: Emergency readmissions to hospital within 28 days of discharge from hospital: Adults of ages 16+ [Standardised] (Crude) | 7.20% | n/a | 7.90% | n/a (Local Data Provided in absence of benchmarking data) | | | | | |
| 5: Clostridium difficile | 12 Cases (7.8 Cases per 100,000 Beddays) | 8 Cases (Lapes of Care Only) | 19 Cases (11.1 Cases per 100,000 Beddays) | 13.3 Cases per 100,000 Beddays | 13.2 Cases per 100,000 Beddays | PHE | Apr-2016 to March 2017 | The Royal Marsden 46 Cases (82.7 Cases per 100,000 Beddays) | Liverpool Women's (+2 other Trusts) 0 Cases (0 Cases per 100,000 Beddays) |
| 6: Venous Thromboemolism (VTE) risk assessment | 96.1% | 95% | 96.4% | 95.6% | 95.2% | NHS England | Apr-2017 to Sep-2017 | WESTON AREA HEALTH NHS TRUST 69.5% | BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST 100% |
| 7: PROMS (Health Gain), Groin Hernia, EQ-5D Index/VAS | 0.02 / -11.3 | n/a | 0.0234 /4.5 | n/a | 0.086 / -0.241 | NHS Digital | April-2016 - March 2017 | 'The Hillingdon Hospitals NHS TRUST -11.3 Derbyshire Community Heath Services NHS Foundation Trust -0.1208 | 'University Hospitals Bristols NHS Foundation 9.08696 UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST 0.4215 |
| 8: PROMS (Health Gain), Hip Replacement (Primary), EQ-5D Index/VAS | 0.374 /9.12 | n/a | 0.413 /17.5 | n/a | 0.443 / 13.112 | NHS Digital | April-2016 - March 2017 | NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST 0.285829 WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST 0.114943 | St GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST 0.6116 / IMPERIAL COLLEGE HEALTHCARE NHS TRUST 26.087 |
| 9: PROMS (Health Gain), Knee Replacement (Primary), EQ-5D Index/VAS | 0.305 /2.951 | n/a | 0.7122 / 6 | n/a | 0.322/ 6.850 | NHS Digital | April-2016 - March 2017 | BUCKINGHAMSHIRE HEALTHCARE NHS TRUST 0.225146 ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST -1.25 | ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST 0.465886 / KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST 18.2135 |
| 10: PROMS (Health Gain), varicose vein (Primary), EQ-5D Index/VAS | 0.09/-4.125 | n/a | 0.009 /-4 | n/a | 0.096 /0.081 | NHS Digital | April-2016 - March 2017 | THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST -15.25/ CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST -0.08 | WHITTINGTON HEALTH NHS TRUST 17.5 / EAST SUSSEX HEALTHCARE NHS TRUST 0.3342 |
| 11: 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 of friends | 77.4% (Q1, 2 & 4) | n/a | 60.3% (Q1, 2 & 4) | 79.60% | 79.80% | NHS England | Q2 2017/18 | 42.9%- DORSET COUNTY HOSPITAL FOUNDATION TRUST | 100% - THE ROYAL MARSDEN NHS TRUST |
| 12: Trust's responsiveness to personal needs of our patients | 62% | n/a | Available June 2018 | n/a | n/a | NHS Digital | TBC | TBC | TBC |
| "13: [a] The number, and where available, rate of patient safety incidents reported within the period, and; [b] the number and percentage of such patient safety incidents that resulted in severe harm or death" | 5905 (40.01/1000 beddays) 28 (0.5%) | n/a | 5805 (37.10/1000 beddays) 28 (0.5%) | 42.70/1000 beddays 0.4% | 40.52/1000 beddays 0.4% | NPSA NHSI | Oct-2016 to Mar-2017 | MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST (23.13/1000 beddays) KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST (2.1%) | WYE VALLEY NHS TRUST (68.97/1000 beddays) ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (0.03%) |
| 14: Self certification against compliance with requirements regarding access to healthcare for people with a learning disability | Fully Compliant | Fully Compliant | Fully compliant | n/a | n/a | n/a | April-2016 - March 2017 | n/a | n/a |

## INDICATOR 2: PALLIATIVE CARE CODING

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described because the Trust Palliative Care, Information and Clinical Coding Teams undertook an in-depth review at the end of December 2017 and identified contributing factors for this. Processes were redesigned to ensure full and accurate data capture of patients that receive palliative care. These involved clearer documentation, clinical sign off each month of all the patients discussed at the multidisciplinary team meeting and data completeness charts that are tabled at both the quarterly Data Quality Improvement Steering Group and the Mortality Surveillance Group.

The following chart demonstrates the resulting change in coding rates:

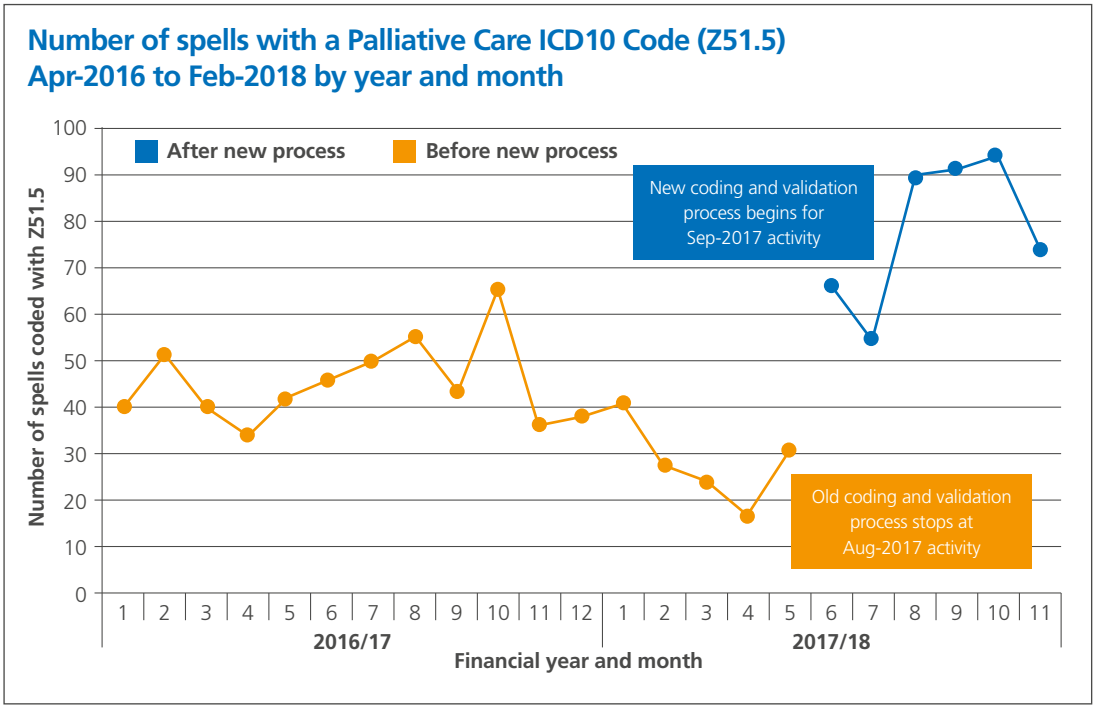
In context, Standardised Mortality Rates are very sensitive to Palliative Care Coding Rates. Correcting the under coding has ensured that measures such as the Dr Foster Hospital Standardised Mortality Rate (HSMR) accurately reflect the Trusts mortality rates.

The Trust intends to improve this indicator, and so the quality of its services, by further strengthening the data validation process via the implementation of monthly data validation.

## INDICATORS 3 AND 4: EMERGENCY READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Emergency readmission to hospital shortly after a previous discharge can be an indicator of the quality of care provided by an organisation. Not all emergency readmissions are part of the original planned treatment and some may be potentially avoidable. Reducing the number of avoidable readmissions improves the overall patient experience of care and releases hospital beds for new admissions. However the reasons behind a readmission can be highly complex and a detailed analysis is required before it is clear whether a readmission was avoidable. For example, in some chronic conditions, the



patient's care plan may include awareness of when his or her condition has deteriorated and for which hospital care is likely to be necessary. In such a case, a readmission may itself represent better quality of care. The Hillingdon Hospitals NHS Foundation Trust monitors the readmission rate using the national data sources and also through *Dr Foster*, an independent leading provider of healthcare intelligence.

1. The automated alerts remain in place, but very few areas are undertaking the same intense system and process to understand the root cause
2. The overall readmission rate has continued to reduce – there are several schemes via the *Better Care Fund*, the Accountable Care Partnership and the ambulatory clinics that continue to contribute towards this, current rate is 7.6%.
3. All of the GPs in the borough continue to receive an automated at risk of readmission score (PAR) for all non-elective patients which some of the practices are actively using as part of their risk stratification process; there are plans for Care Connection teams to be rolled out across the borough and this will help GPs to embed, looking at and using this score.
4. The primary care teams are now supported by the Care Connection Teams covering the localities with a total of 750 patient caseloads across the borough.

The Trust intends to improve this indicator, and so the quality of its services, by continuing to work collaboratively with our partners supporting the many schemes that are helping to reduce re-admission rates and to ensure our patients are cared for in the most appropriate setting.

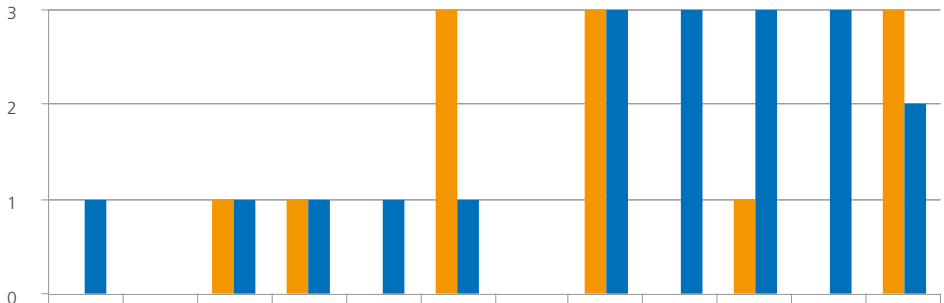
## INDICATOR 5: CLOSTRIDIUM DIFFICILE *(C. DIFFICILE)*

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described because the Trust reported a total of 19 *C. difficile* infections in 2017/18 with two lapses in care (at time of report as several cases remain under review with Commissioners) against a threshold of eight (lapses in care). This reflects an increase of seven cases when compared with 2016/17.

A multidisciplinary Root Cause Analysis (RCA) investigation is undertaken for all cases of Trust attributed *C. difficile*, with the Consultant in charge of care, the Consultant Microbiologist, Lead Nurse Infection Prevention and Control, Ward Sister and responsible Matron forming a panel as part of the process. All RCAs are reviewed by the Director of Infection Prevention and Control.

During 2017/18 all RCA investigation reports were presented to the Clinical Commissioning Group (CCG) for review and scrutiny regarding any lapses in care. Of the 19 cases presented to the CCG two were considered to have lapses in care, with one potentially avoidable as antibiotics were not prescribed in accordance with the Trust Antimicrobial Guidelines and the other found to be as a result of cross infection due to delay in isolating the patient. The remaining 17 cases were predominantly elderly patients presenting as emergency admissions, acutely unwell with a history of clinically indicated antibiotic treatment in line with the Trust's Antimicrobial Guidelines. The majority of cases were classed as mild with patients recovering promptly and two relapse patients received Fidaxomycin, a new treatment for more severe, relapse cases of *C. difficile*. Antimicrobial stewardship continues to be of importance in the prevention of hospital acquired *C. difficile*. The Antimicrobial Pharmacist continues to work across the Trust to improve knowledge of good prescribing practice and antibiotic stewardship.

**Chart 1: Trust attributed *C. difficile* infections**




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/2017 | 0 | 0 | 1 | 1 | 0 | 3 | 0 | 3 | 0 | 1 | 0 | 3 |
| 2017/2018 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 3 | 3 | 3 | 3 | 2 |

The Trust intends to improve performance on this indicator and so the quality of its services by:

- Progressing a refreshed annual infection control action plan with robust oversight by the Infection Control Committee during 2018/19
- Continuing to undertake a full review of all *C. difficile* Trust attributed cases by means of RCA investigation to allow any learning to occur
- Ensure actions are shared where learning is identified with regard to C.difficile
- Continue to drive compliance to the Trust's antimicrobial policy
- Maintain antimicrobial prescribing training at all Infection, Prevention and Control updates
- Improve on a stronger and visible presence at ward level of the Infection Prevention and Control Team
- Continue to undertake joint audit work with the Facilities staff to ensure that on-going standards of cleanliness are maintained.

The CQUINs for 2017/18 covered the assessment of clinical antibiotic review within 24 and 72 hours of patients presenting with sepsis who are still inpatients at 72 hours and the reduction in antibiotic consumption per 1,000 admissions. The Trust will continue with this work to assist in improving antimicrobial stewardship and patient safety further.

## INDICATOR 6: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT

Venous thromboembolism (VTE) or blood clots are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for an individual patient.

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described as VTE risk assessment compliance for the reporting period is 96.4% (of just under 51,000 eligible admissions). This compares with 96.1% for 2016/17, and 94.6% for 2015/16. Compliance is monitored within the Trust's clinical governance system. This data is in line with the England national average of 95% for quarter 1 2017-18 (range low 77% to high 100%).

With regards to diagnosis of thrombosis and morbidity acquired in hospital (HAT hospital acquired thrombosis = VTE which occurs during admission or within 90 days of discharge from hospital), the following data is presented (see table below).

This shows an overall decrease in the number of HAT incidents, although ongoing case review is in progress by the hospital lead consultant and the thrombosis committee.

The VTE risk assessment quality indicator was reviewed by our external auditor, as a local indicator selected by our governors as part of the external assurance on the Quality Report. The audit identified some inconsistencies between national and local guidance, and its application by the Trust, the approval of cohorting arrangements, and the recording of VTE Risk assessments on the system.
There has been an increased focus since the beginning of 2017/18 when a VTE Lead was appointed. During 2017/18 the process has matured as a result and as outlined below, but there is further work to do in 2018/19.

### Actions

The Trust has taken the following actions to improve this indicator, and therefore the quality of its services:

- staff education is ongoing, including junior doctors during their induction and nursing staff during education on documentation and drug administration
- involvement of ward pharmacists as part of the multi-disciplinary team to draw attention to any omissions on drug charts is ongoing
- modification of the drug chart has been completed to highlight the need for assessment within 24hrs of admission and then when patient circumstances change
- standard clinical practice that no patient is admitted to a clinical area without a VTE assessment completed
- HAT RCA reports are undertaken by the lead for VTE and discussed at the Thrombosis committee, to allow learning both at a local and organisational level.

We plan to respond to ongoing issues and learn by:

- Progressing the project to implement electronic prescribing which will contribute to improvements in the level of VTE risk assessment compliance and prophylaxis
- Comparing year on year HAT to identify evidence of learning in addition to HAT divisional governance reporting and monitoring and improve clinical engagement
- Review mandatory training to include VTE to current provision of blood transfusion
- Implementing checklists as a part of routine documentation, which includes VTE assessment, in medical notes.

| Year | No of VTE examinations performed | No of positive tests | No of hospital acquired events |
|---|---|---|---|
| 2015-16 | 1838 | 39 | 12 (31%) |
| 2016-17 | 1893 | 52 | 11 (21%) |
| 2017-18 Q1,2,3 only | 1681 | 172 | 25 (14%) |

## INDICATORS 7, 8, 9 AND 10: PATIENT REPORTED OUTCOME MEASURES (PROMS)

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

PROMs data is obtained through a pair of questionnaires completed by the patient, one before and one after surgery (at least three months after). Patients' self-reported health status (sometimes referred to as health-related quality of life) is assessed through a mixture of generic and disease or condition-specific questions. For example, there are questions relating to mobility, self-care, such as washing and dressing, usual activities, such as work, study, house work, family or leisure activities, pain/discomfort or anxiety/depression.

For the purposes of the Annual Quality Report the PROMs data being reviewed is for the full year 2016/17 because the data is available a year in arrears due to the lag in patients submitting questionnaires in the post-operative period. This is followed by a period of statistical validation and as such 2017/18 data is not expected until February to March 2019.

In 2016/17 there was an increase in the number of patients issued with pre-operative questionnaires however the Trust had to suspend participation for the year 2017/18 for the Groin Hernia and Varicose Veins surveys as the response participation rate was low and the Trust recognised that a review of approach was required. For 2018/19 the Trust will resume participation for these services using a revised approach.

An external company (Quality Health) administers the post-operative PROMs data collection on behalf of the Trust. In 2016/17 the Trust achieved a participation rate of 68% (compared to 68.6% in 2015/16) where 672 post-operative questionnaires were sent out (compared to 601 in 2015/16). This compares to a 74.4% participation rate in England. The number of questionnaires returned by the participating patients was 457 (compared to 412 in 2015/16). This compares to a 65.2% return rate in England.

### Indicator 7: Groin hernia

In 2016/17, the number of post-operative questionnaires returned was less than 30 and this therefore affected the overall performance in this indicator. The Trust only undertakes a few of these procedures and the return rate is in line with other Trusts in England that perform a similar number. However, of the records eligible for modelling, 10% of the patients reported a worsened health gain following the operation.

### Indicator 8: Hip replacement

In 2016/17, patients reported an improvement in health in 59.7% of the modelled records compared to 67.2% in England. The Trust intends to take the following actions to improve this indicator, and so the quality of its services – review patient education programmes as part of the Orthopaedic Joint School to ensure health gain is understood thereby improving the perception of quality of life and experience.

### Indicator 9: Knee replacement

In 2016/17, patients reported an improvement in health in 49% of the modelled records compared to 57.4% in England. The Trust intends to take the following actions to improve this indicator, and so the quality of its services – review patient education programmes as part of the Orthopaedic Joint School to ensure health gain is understood thereby improving the perception of quality of life and experience.

### Indicator 10: Varicose Vein

In 2016/17, the number of post-operative questionnaires returned was less than 30 and therefore affected the overall performance in this indicator. The Trust only undertakes a few of these procedures and the return rate is in line with other Trusts in England that perform a similar number. However, of the records eligible for modelling, 37.5% of the patients reported an improved health following the operation.

The Trust intends to improve these indicators, and so the quality of its services, by continuing to increase its response rate for these four indicators to gain a more accurate picture of the impact of our services. Working with the Commissioners through planned treatment pathway working groups (which include GPs and Hospital Surgeons) the Trust hopes to improve the scores achieved by educating patients and their carers on quality and life indicators and the importance of returning the questionnaires. This will, in turn, inform how services are developed in the local health economy.

## INDICATOR 11: STAFF SURVEY INCLUDING FRIENDS AND FAMILY TEST QUESTION (SFFT)

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The annual staff survey is used to understand staff experience and perceptions on a wide range of subject areas. The survey is undertaken by all NHS organisations enabling comparisons between similar Trusts and to compare the experiences of staff in a particular Trust with the

national picture. The results below demonstrate the overall response to the SFFT questions within the 2017 Staff Survey:

- In response to the question: "I would recommend my organisation as a place to work", 61% "Agreed" and "Strongly agreed" in 2017, compared to the total number of staff that responded. The average (median) for acute Trusts was 61%.

In 2016 the Trust achieved 63%, and in 2015, 65%.

- In response to the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation", 65% "Agreed" and "Strongly agreed" in 2017, compared to the total number of staff that responded. The average (median) for acute Trusts was 71%.

In 2016, the Trust achieved 64% and in 2015, 66%.

The Trust has developed a comprehensive People Strategy which will drive the improvement of this indicator, and so the quality of its services. The Strategy includes a variety of initiatives to provide a sustained focus on improving staff experience. The five pillars of the Strategy are to:

- Attract and recruit for our values – ensuring that our CARES values are embedded across our recruitment processes, that our employer brand is strong and that we recruit to our vacancies
- Educate, train and develop – embedding and maximising use of our new Learning Management System (LMS) and extending training and development opportunities for all staff
- Build a productive, high performing workforce – through developing our e-systems and supporting managers with a range of people management tools
- Transform the workforce model – by working with our Higher Education Institute (HEI) partners and Health Education England (HEE) to understand workforce supply changes and plan for the future
- Nurture our people – supporting all our staff to have the same opportunities to progress and to get the most out of their working lives.

### Workforce Race Equality Standard (WRES)

The scores presented below are split between White and Black and Minority Ethnic (BME) staff, as required for WRES.

## INDICATOR 12: RESPONSIVENESS TO INPATIENTS' PERSONAL NEEDS

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

This is a composite score from five questions taken from the CQC Inpatient Survey.

- Being involved in decisions about your care and treatment
- Finding someone to talk to about worries

| | | Our Trust in 2017 | Average (median) for acute Trusts | Our Trust in 2016 |
|---|---|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 27% | 25% | 24% |
| | BME | 27% | 27% | 22% |
| Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | White | 86% | 87% | 90% |
| | BME | 70% | 75% | 73% |

and concerns
- Being given enough privacy when discussing your condition and treatment
- Informing patients about medication side effects to watch out for after going home
- Knowing who to contact if worried about condition or treatment after leaving hospital.

The Trust is currently awaiting the 2017/18 survey report which will be published in June 2018 with regard to being able to report the composite score of the above five questions. However, the Trust achieved 61.8% in 2016/17 compared with 62.2% in 2015/16.

The Trust intends to improve this indicator, and so the quality of its services, by critically reviewing this data once it is received and formulating an improvement plan.

## INDICATORS 13A AND 13B: THE NUMBER, AND WHERE AVAILABLE, RATE OF PATIENT SAFETY INCIDENTS REPORTED WITHIN THE PERIOD, AND; THE NUMBER AND PERCENTAGE OF SUCH PATIENT SAFETY INCIDENTS THAT RESULTED IN SEVERE HARM OR DEATH

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust has improved its performance within the data described, as prior to uploading to the NRLS all incidents are reviewed, the harm levels of actual and potential are scrutinised by the Patient Safety Team and are coded on a daily basis, in line with the weekly uploads to the NRLS therefore 'real time'. The reason for a decline in incident rate in Apr 16 – 17 is due to a change in process between October 2016 – March 2017 within the clinical governance team whereby incidents were coded at the end of the month as opposed to in as near real time as possible as in previous reporting periods. This resulted in a large proportion of incidents missing the NRLS upload cut-off date for the reporting period. These incidents were included in subsequent submissions. However, improving the process to an improved frequency has improved the rate of incidents reported by 1000 bed days significantly.

The Trust has re-calculated the incident rate (based on local data for Apr 16 - Mar 17) at 40.31 (6313 incidents).

Reconciliation to the NRLS is undertaken weekly. Where incident coding has been adjusted it is picked up almost instantly; this improves the accuracy of the data and the performance. This is reflected in the Trust's April 17 – Sept 17 data where the incident rate has increased to 42.3 which is above the median rate for the Trust's cluster. THH is currently ranked 61 within a cluster of 135 healthcare providers (taking into consideration that the rate of 42.3 is only part year effect, 6 months).

The Trust intends to take the following actions to continue to improve this indicator, by:

- Continuing to raise awareness of the importance of incident reporting and in particular near misses and no/low harm incidents (this will ensure learning to avoid the more harmful incidents from occurring)
- Ensuring there is more robust feedback on actions taken provided to reporters to ensure staff see the value of reporting patient safety incidents
- Continuing to ensure there is detailed root cause analysis investigation of all moderate/ severe/death reported incidents to support learning and changes in practice.
- Continue to accurately and timely code all incidents so that improvements can be made in real time, causing no lag in improving patient safety
- Expand the Trust's Harm Free Care meeting into the organisation where all moderate and above incidents are reviewed more frequently therefore identifying the more serious incidents sooner.

## INDICATOR 14: ACCESS TO HEALTHCARE FOR PEOPLE WITH A LEARNING DISABILITY

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust ensures staff awareness with regard to the need to listen and make reasonable adjustments for those with learning disability. Clinical and non-clinical members of staff receive awareness training as part of their mandatory safeguarding training making them more aware of the needs of learning disability patients and their carers.
- The Trust's Good Practice Guidelines for staff working with people with learning disabilities have been updated in 2017/18. There are also care pathways for patients with learning disabilities in A&E, Outpatients and the Radiology Department. Patients with a learning disability can provide feedback to the Trust on their experience by completing an easy-read survey.

The Trust has remained fully compliant with this key indicator. The Trust intends to improve this indicator, and so the quality of its services, by continuing to raise awareness amongst its staff and ensure that its best practice guidance on caring for patients with a learning disability is followed so as to maintain performance on this indicator.

From March 2017, the Trust hosted one of the Learning Disability Nurses from the community team one day per week. They work with the Head of Safeguarding Adults to support and enhance the care for patients with a learning disability. The programme has since been adapted around maternity cover, with the nurse still providing training and direct patient care.

## Improving services for people with a sensory disability

The Trust has met the key requirements of AIS, namely:

- A working group of relevant Trust staff have met and contributed to the Accessible Information Standard (AIS) solution
- Patient records at The Hillingdon Hospitals NHS Foundation Trust have been adapted to record the communication needs of patients with disability or sensory loss
- The responsibilities of AIS have been communicated to Trust staff
- AIS leaflets are in place in Outpatients and A&E
- Plans are in place to emphasis the role of clinical staff in recording information for patients with a sensory disability, information will be recorded on PAS
- Patients can register for AIS on the Trust web site, https://www.thh.nhs.uk/documents/_Patients/PatientLeaflets/AccessibilityA5Leaflet4.pdf

Hearing loops have also been installed in public areas across the Trust which not only improves communication for these patients but also ensures their privacy, dignity and well-being.

Signage has been improved across both sites to ensure easier way-finding for patients and visitors. In addition the Trust has a contract with One Stop Language Services for the provision of British Sign Language for patients using our services.

Systems are in place for patient information to be sent via email, where appropriate.

## Definitions of the two mandated indicators for substantive sample testing by the Trust's auditors are:

1. A&E Department four-hour target.
2. Referral to Treatment Time for patients on an Incomplete Pathway

Independent auditors are engaged by the Council of Governors of The Hillingdon Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Hillingdon Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2018 and certain performance indicators contained therein.

As a result of the auditor's report, steps will be taken to improve data quality for these two indicators; these are outlined in Part 3 under 'Other key quality indicators and information' – indicators 26 and 27.

# PART 3

# KEY QUALITY INFORMATION AND IMPROVEMENTS WE HAVE MADE IN 2017/18

## LOOKING BACK

## Quality priorities for improvement 2017/18 – How did we do?

### PRIORITY 1

### Improving the discharge process

**We said:** We consider safe and effective discharge to be of central importance in the pathway of care for our patients. We recognise that once the decision has been made that discharge home can take place it is an important element of a patient's experience that this takes place quickly and efficiently. We plan to undertake a programme of work that will be designed to improve and streamline our discharge processes further, based on national best practice.

**How did we do?**
The specific goals that we set and the performance during 2017/18 are outlined opposite.

**What does this mean for patients?**
The work the Trust has put into patient discharge has allowed patients to be home earlier and more safely. Going forward, this will ensure that hospital capacity is available for patients in critical need of inpatient care. By optimising discharge processes, we will improve the experience of patients who use our services. We continue to engage with patients and carers, to ensure that quality of care is a focus, throughout the implementation of these initiatives.

| Quality Priority indicators | 2017/18 performance |
|---|---|
| We will monitor the number of patients that are discharged on the day that was planned; and monitor the time of the day that patients are discharged. | We have established a daily dashboard, with critical success factors in place, providing performance across all areas, including discharge before midday. There is also weekly analysis showing discharge trends across the previous eight weeks. 20% of total discharges now leave the hospital by mid-day. |
| We will ask patients, via the in-patient survey, if they are happy with the preparation that has been made for their discharge. | Preparation for discharge is included in the inpatient survey, though results in year did not show any significant change in preparedness for discharge. The Trust will continue to focus on this area to further improve. |
| We will design and implement a system to capture feedback from patients and carers regarding their satisfaction with their discharge experience. We will triangulate this data with other sources of patient feedback to ensure that the changes we make are improving the quality for our patients. | The Trust uses a number of data sources to measure patient experience and feedback, including views on discharge, to ensure quality of care is maintained.<br><br>This year the ward managers and matrons have begun following up via a telephone call with a randomly select group of patients, following discharge, to gather feedback. The information obtained is provided to the Trust's Experience and Engagement Group for review. This will help with the triangulation of data. This continues as work in progress. |
| We will review our nursing processes and procedures for discharge planning to achieve uniformity in meeting agreed standards. This will include consistent use of the newly revised *Working Together* planning leaflet. | The Working Together planning leaflet has been updated and distributed. Training sessions and other engagement activities on discharge processes, including Red2Green and SAFER, have been held with all staff, including nursing staff. We have worked closely with our local Healthwatch colleagues to improve the information provided to patients and their carers and families. |
| We will ensure patients and carers are actively involved in discharge planning and independent advocacy is arranged when required. | The Trust is dedicated to the involvement of patients and carers in discharge planning, to maintain quality of care. Trust discharge processes take these views into account. We are well supported by our local Healthwatch in hearing from people who use our services to ensure involvement improves. The Trust carer and dementia action plans now address how best to involve carers and independent advocates in clinical decision making. This will continue as work in progress. |
| We will review and develop discharge lounge facilities. | Fleming Ward has been designated as a discharge area, with two bays, containing a mixture of trolleys and chairs set up to facilitate safe and rapid discharge, where appropriate for patients. This area is also flexibly used as additional inpatient bed space. |
| We will work together with partner organisations and voluntary services to implement patient-centred discharge plans and models of care. | Our integrated discharge team is now managed by partner organisations with a mixed staffing model which is representative of the Hillingdon system partners. The team works closely with community health, GPs, the third sector and the local council. Each member has a ward allocated for continuity of care management. |

| Quality Priority indicators | 2017/18 performance |
|---|---|
| Where patients have to be conveyed to hospital and be admitted, utilising improved whole system integrated services, they stay for the least amount of time as possible and will receive support and wrap around care to enable a safe and positive discharge from the Acute Trust | There is now an established Home First assessment service, called *Discharge to Assess*. The service is supported by our Hillingdon system partners. Medically optimised patients are discharged and provided an assessment of their needs in their home environment on the same day. |
| With supported Multi-Disciplinary Team (MDT) services, care connection teams and geriatrician involvement, the aim is also to be able to manage and keep patients who are over the age of 65 at home for longer and avoid the need to readmit to the acute hospital. | Our frailty service, established to support reducing admissions for those patients over 65 years, has worked closely with partners, ensuring admission avoidance and early supported discharge. In the community, care connection teams manage and monitor patients with a high risk of admission. This work will continue into 2018/19. |
| HHCP are ensuring that outcomes from patient and carer audits and feedback are included in clinical design and changes to pathways. | There is a focussed clinical design group, which includes taking into account patient and carer feedback to design services and the care model. A project is underway to assess patient experience and views of the first year of HHCP operation. Good progress has been made and this work will continue into 2018/19. |

# PRIORITY 2

## Improving End of Life Care for Patients

**We said:** EoLC has been recognised as an important national issue: in 2016 NHS England cited EoLC as one of the top three areas for future focus and relates to our STP priority of improving the overall quality of care for people in their last phase of life and enabling them to die in their place of choice and achieving better outcomes and experiences for older people.

EoLC was named a priority in the Trust's Quality and Safety Improvement Strategy and in the Quality Account for 2017/18. A triumvirate leadership model was adopted and a Doctor, Nurse and Manager for EoLC were identified to lead improvements. The Trust also joined the NHS Improvement (NHSI) 150-day Improvement Programme for EoLC May – October 2017. Participating Trusts were encouraged to create their own areas of focus.

The Trust focussed on developing several interventions to improve care as outlined below. The aim of the NMPA is to produce high-quality information about NHS maternity and neonatal services which can be used by providers, commissioners and users of the services to benchmark against national standards and recommendations where these exist, and to identify good practice and areas for improvement in the care of women and babies. Electronic documentation has been introduced to accurately record information. Reports and dashboards are run monthly from trend analysis and our action plans monitor progress.

### How did we do?

The specific goals that we set and the performance during 2017/18 are outlined below:

| EoLC Improvement Subgroup | 2017/18 performance |
|---|---|
| EoLC Resources Improvement Group<br><br>**Goal:**<br>To update and improve the present resource package of tools, national guidance, Patient Information Leaflets and best practice to follow when caring for dying patients | Following national guidance, a bespoke Comfort Care Plan (CCP) and Symptom Observation Chart were developed to guide excellent individualised care for a patient in their last days of life. A 'Caring for a loved one during the last days of life: Information and Advice' leaflet was developed to support carers. A comprehensive wall hung EoLC Resource Area to guide all staff was created on both showcase wards. |
| Ward Based EoLC Improvements Group<br><br>**Goal:**<br>To engage frontline staff on the two test wards to create and implement a suite of innovation designed to improve: (1) staff confidence and ability to deliver excellent end of life care, (2) ward environment and (3) patient centred care | Three modules of EoLC training were delivered to 78 staff (doctors, nurses, health care assistants and ward clerks). This significantly improved staff confidence (compared to 2016 baseline survey), increased the use of the Comfort Care Plan (from 22 to 67% of cases), and established a Consultant led multidisciplinary team process to identify patients likely to be coming towards the end of their lives. This work will now be rolled out to all of our inpatient wards.<br><br>Following a successful bid for £40,000 to Hillingdon Hospital Charity, two day rooms and two staff offices were refurbished, and an all new quiet room for relatives was created. The design of these facilities was based on patient and visitor views of the current environment. |

| EoLC Improvement Subgroup | 2017/18 performance |
|---|---|
| Discharge Summary (discharge letters to GP) Improvement Group<br><br>**Goal:**<br>To improve communication to primary care regarding prognostication and advance care planning | EoLC prognostication involves the identification of patients likely to be in the last year of life. This is an essential first step to undertake advance care planning with patients (a process to ensure patient preferences are central to future care).<br><br>Following a Consultant led multidisciplinary process, patients and their families are encouraged to explore their preferences for care. The creation of bespoke discharge summaries facilitates the communication of individuals' preferences regarding future care to their GPs and other care providers. Use of these summaries has increased from 0 – 63% |
| Improved access to Co-ordinate my Care (CMC) Group<br><br>**Goal:**<br>To improve access by hospital staff to CMC web-based register | Complete, formal advance care plans are stored on an Electronic Palliative Care Coordination System called Coordinate My Care (CMC). This system allows multiple care providers (GPs, District Nurses, Hospitals, London Ambulance Service) to access patients care plans to ensure their preferences are known and adhered to.<br><br>During 2017/18 23 key staff were trained in the use of CMC, thus improving seamless care as patients move between the community and hospital settings. For hospitals this has been technically more difficult to access. |
| Raising Awareness and Profile of EoLC across the Trust group<br><br>**Goal:**<br>To raise awareness about death and dying across the Trust – changing the culture to 'EoLC is everyone's business' | The profile has been raised across the Trust through various means: a monthly update was sent to the Trust Board throughout the 150 day Improvement Programme, for the first time THH participated in Dying Matters Week (engaged with >440 hospital users in two events and >50 staff in another event), EoLC presentations have been given to groups within the hospital: Critical Care Group, Deteriorating Patient Group, Resuscitation Group, and to the Clinical Commissioning Group where useful discussions have taken place to engage with key clinical and management leads. |

Learning and outputs from these subgroups informed the development of the Trust's first EoLC Strategy (2017-2020); this was finalised and signed off in December 2017. Care has been taken to ensure this works in synergy with other strategies including the Trust's Strategic Plan, Quality and Safety Improvement Strategy, Carer's Strategy and the Hillingdon EoLC Joint Strategy.

The Trust received an NHS Improvement award for EoLC Innovation Implemented at a Pace in 2017 for this work.

### What does this mean for our patients?

Wide ranging improvements have been shown to be successful across the two test wards, and these innovations are starting to be embedded across the Trust. The Trust has a clear vision for EoLC:

- Patients at the end of their lives receive the best quality, patient centred, individualized care, with their loved ones involved and supported, all provided by staff who are prepared, able and confident to care.

This is central to the Trust's EoLC Strategy 2017 – 2020.

The Trust plans to fund a full-time substantive EoLC Facilitator role in a joint venture with Macmillan. The development of a Trust-wide EoLC Improvements Implementation Plan, with clear outcome measures and a governance structure with permanent leadership from the Doctor, and Nurse Manager model, will also ensure continuous sustained improvement. The patient and user representatives input into the EoLC Board will bring invaluable insight and feedback to ensure all work is centred on caring for patients and their loved ones.

# PRIORITY 3

## Achieving improvement in relation to seven day working priorities

**We said:** NHS England committed to offering a much more patient-focused service moving towards routine NHS services being made available seven days a week. We agreed this as a priority because evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.

North West London (NWL) as a sector accepted the opportunity to be a national First Wave Delivery Site for the new seven day services programme. As part of this programme, all acute trusts agreed to achieve delivery of four prioritised Clinical Standards by April 2017. These four standards were selected with the Academy of Medical Royal Colleges as having the most impact on reducing weekend mortality.

### How did we do?

The specific goals that we set and the performance during 2017/18 are outlined below:

| Quality Priority indicators | 2017/18 performance |
|---|---|
| **Standard 2: Time to First Consultant Review**<br>(All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital) | The survey data from September 2017 shows this review improved at the Trust to 76% overall, looking across the divisions. Performance is at 84% in Medicine, the division with the largest number of patients. Surgery, trauma and orthopaedics and gynaecology have a non-resident working pattern, which means the most senior doctor is not on site out of hours and this presents a challenge in meeting the standard in those areas. Obstetrics only has four days a week where a senior doctor is on site out of hours. There will need to be more focus for these areas in improving performance; an improved clinical handover could positively contribute to this. Overall the Trust is pleased with its improvement and given the current numbers it will not require too much more work to meet the 90% standard across the Trust. |
| **Standard 5: Access to Diagnostics**<br>(Acute trusts should use their clinical governance processes and discussions with their commissioners to judge which diagnostic tests their patients require access to seven days a week, and whether these are delivered on site or via a formal networked arrangement) | Good progress was made against this standard, with the exception of routine weekend MRI / ultrasound; an on call radiologist has been included for urgent cases 7 days a week. Whilst not essential to patient safety, weekend delays in performing requested tests increases decision making time and subsequently length of stay for some patients. A business case was presented for extended MRI services, however, the cost to benefit ratio did not meet requirements; despite this a second CT scanner is being installed at the Trust. Routine cardiac echo is currently not formally offered at the weekend. There is an informal arrangement that it is available on an ad-hoc basis, provided by the echo technicians. The Trust has agreed that the demand is insufficient to warrant further investment; any urgent cases are referred to neighbouring acute Trusts. |

| Quality Priority indicators | 2017/18 performance |
|---|---|
| **Standard 6: Access to Consultant Directed Interventions** (Patients should receive urgent interventions within a timeframe that does not reduce the quality of their care) | The Trust continues to be compliant with this important standard. All pathways have been agreed in consultation with North West London Collaboration of Clinical Commissioning Groups. |
| **Standard 8: Ongoing Review** (Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care) | This standard was not reviewed as a part of the September audit, though this continues to be a key priority for the Trust. The Trust is running the SAFER programme, which includes daily ward rounds and has taken part in pilots that have demonstrated that an increased therapies presence on the wards reduces patients' length of stay. As such, a business case for seven day therapy and pharmacy has been completed, including a successful winter funding bid. Previous audit showed an improvement in twice daily reviews, though a gap in once daily reviews at the weekend, especially in care of the elderly; this was felt to be partly a sign of a need to improve documentation. |

## What does this mean for our patients?

*NHS Improvement (NHSI)* is supporting all Trusts to meet the four standards identified as being 'must do' by 2020. This will ensure patients:

- do not wait longer than 14 hours to initial consultant review
- get access to diagnostic tests within an appropriate timeframe based on clinical need. For urgent requests, this should be within 12 hours and for critical patients, more rapidly
- get access to specialist, consultant-directed interventions
- with high-dependency care needs receive twice-daily specialist consultant review, and all those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

Significant progress has been made at both Trust and Sector level to deliver these standards, but a number of gaps remain as above. Filling these gaps will come with a cost. However, in some cases faster decision making and improved patient flow will impact positively on patient outcomes and length of stay. Work continues to improve patient flow and documentation, in particular to show which patients do not require daily consultant input, such as those patients on a pre-determined pathway. The Trust is committed to ensuring delivery of the standards and this will remain a key focus for the clinical divisions throughout 2018/19, monitored by the divisional governance boards and via the key workstreams. More recently we have seen an improvement in our weekend patient mortality data being more in line with the weekday figures.

# PRIORITY 4

## Improving the care of patients with dementia

**We said:** Our goal is to provide high quality, person-centred care to our patients by ensuring our staff are well trained, have senior specialist support available and work within a care pathway designed for patients with dementia. Being in hospital, away from their usual care setting can be a frightening experience for someone with dementia who has memory loss and problems with orientation and communication. Of the nine emerging priorities that were identified in the NWL STP, one priority involves improving the overall quality of care for people in their last phase of life and enabling them to die in their place of choice. A key delivery area is to achieve better outcomes and experiences for older people including approximately 5,000 people with advanced dementia and Alzheimer's disease.

### How did we do?

The specific goals that we set and the performance during 2017/18 are outlined below:

| Quality Priority indicators | 2017/18 performance |
|---|---|
| To develop the Trust's next three year Dementia Strategy and implement year one action plan | The Trust's dementia strategy has been developed throughout 2017/18 and was approved in March 2018. |
| To further develop training in line with the DH's Dementia Core Skills Education and Training Framework | Dementia awareness training at the Trust sits at 90% compliance. An e-learning package has been developed and placed on i-develop, the Trust's new online training system. A tier 2, more intense, face to face training series has been delivered to clinical staff, with 100 receiving the training in year. |
| To deliver a more robust and consistent process for dementia screening to achieve 90% screening & assessment for patients over 75 | The Trust has implemented a screening process which has achieved over the 90% target for the year, with referral targets also being met. The Trust is currently working to resolve some technical data entry and IT issues with relation to demonstrating the assessment of patients with dementia. |
| Respond to findings of National Audit of Dementia 2016 with a robust action plan to actively seek and respond to feedback from patients and carers regarding their experience at the Trust | A draft action plan has been created, following the findings of the national audit of dementia. This plan also builds on other avenues of patient and carer feedback obtained by the Trust. The Trust will participate in round 4 of the National Dementia Audit. |
| To consistently provide support for carers, in line with the Carers' Strategy, due to be launched in June 2017 | The Carers' Strategy has been launched, alongside a corresponding action plan, providing additional beds for carer comfort, a carer's charter, which outlines the importance of carers to the Trust and a carer's survey, to continue to respond to their feedback. |
| Develop a pathway of care for people with dementia when they are admitted to hospital, to support compassionate, person-centred care | The pathway of care for people with dementia is in development as a care bundle in order to best meet their needs whilst in hospital; this will be implemented by September 2018. |


## What does this mean for our patients?

Trust initiatives to improve the care for patients with dementia will lead to improvements for them and their carers. Care in this area is particularly challenging and the numbers of patients in this category increases year on year. We will ensure care provided is patient-centred which recognises those who use our services as individuals. We will maximise their abilities and minimise the distress of hospital interactions for them, making sure that dignity is maintained throughout the treatment process.

## Other key quality indicators and information

In this part of the Report we have included the 'Quality of Care' and 'Operational Performance' metrics as outlined in the Single Oversight Framework against which the Trust will be monitored by NHSI. This section does not include some of the key quality indicators that were provided in previous years' reports. The reader should access the Integrated Quality and Performance dashboards that are submitted to the Trust Board on a bi-monthly basis for this other information.

Definitions for the indicators are included in NHSI's 'Single Oversight Framework' (available on https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

| | 2015/16 Performance | 2016/17 Target | 2016/17 Performance | London Trusts | National | Benchmark Source | Benchmark Period |
|---|---|---|---|---|---|---|---|
| 1. Staff Sickness | 3.22% | 3% | 3.86% | n/a | 12.99% | NHS Digital | Apr-2017 to Mar 2018 |
| 2. Staff Turnover | 15.96% | 13% | 13.11% | n/a | n/a | n/a | Apr-2017 to Mar 2018 |
| 3. Executive Team Turnover | 0 | n/a | 1 | n/a | n/a | n/a | Apr-2017 to Mar 2018 |
| 4. NHS Staff Survey (response rate) | 46.0% | n/a | 53.2% | n/a | 45.0% | National NHS Staff Survey report 2017 | 2016 / 2017 |
| 5. Proportion of Temporary Staff | 20.7% | n/a | 22.9% | n/a | n/a | n/a | Apr-2017 to Mar 2018 |
| 6. Aggressive Cost Reduction Plans | £15.6m | £12.5m | £10.2m | n/a | n/a | n/a | Apr-2017 to Mar 2018 |
| 7. Written Complaints - rate | 67.7% | 90.0% | 70.9% | n/a | n/a | n/a | n/a |
| 8. Staff FFT % Recommended Care | 64.0% | n/a | 65.0% | n/a | TBC | nhsstaffsurveys.com | nhsstaffsurveys.com |
| 9. Occurance of any Never Event | 1 | 0 | 2 | n/a | n/a | n/a | n/a |
| 10. NHSE/NHSI Patient Safety Alerts outstanding | 85.7% | 100% | 100.0% | n/a | n/a | Local | n/a |
| 11. Mixed Sex Accomodation Breaches | 0 | 0 | 0 | 0.5% | 0.6% | NHS England | Apr-2017 to Mar 2018 |
| 12. Inpatient Scores from FFT - % positive | 94.7% | 94.0% | 96.9% | 93.6% | 94.8% | NHS England | Apr-2017 to Feb 2018 |
| 13. A&E Scores from FFT - % positive | 94.2% | 94.0% | 95.8% | 84.7% | 86.7% | NHS England | Apr-2017 to Feb 2018 |
| 14. Emergency C-Section Rate | 17.8% | 16.0% | 19.2% | n/a | n/a | n/a | n/a |
| 15. CQC Inpatient Survey | TBC | Available June 2018 | Available June 2018 | | | | |
| 16. Maternity Scores from FFT - % positive | 82.7% | 94.0% | 96.6% | 89.4% | 91.1% | NHS England | Apr-2017 to Feb 2018 |
| 17. VTE Risk Assessment Already on Core List | | | | | | | |
| 18. Cdifficile (lapses in care) - variance from Plan | 2 | 8 | 2 | n/a | n/a | Local | n/a |
| 19.C Difficile - infection Rate Already on Core List | | | | | | | |
| 20.MRSA bacteraemias | 0.7 Cases per 100,000 beddays | 0 | 0.6 Cases per 100,000 beddays | 1.4 Cases per 100,000 beddays | 0.9 Cases per 100,000 beddays | PHE | Apr-2016 to Mar-2017 |
| 21. HSMR | 103.4 (95.8 - 111.5) | <100 | 98.1 (90.9 - 105.6) | 81.7 (80.6 - 82.9) | 100 | Dr Foster | Jan-2017 to Dec-2017 |
| 22. HSMR - Weekend (Rolling 12 Month) | 119.1 (103.2 - 136.9) | <100 | 100.6 (86.3 - 116.6) | 85.6 (83.3 - 88.0) | 100 | Dr Foster | Jan-2017 to Dec-2017 |
| 23. SHMI Already on Core Quality Indicators List | | | | | | | |
| 24. Potential Under-reporting of patient safety incidents Already on Core Quality Indicators List | | | | | | | |
| 25. Emergency Readmissions within 30 days | 7.2% | 8% | 7.9% | n/a | n/a | n/a | n/a |
| 26. A&E 4 hour Target | 84.0% | 95.0% | 84.6% | 89.8% | 89.0% | NHS England | Apr-2017 to Mar 2018 |
| 27. RTT - Patients on Incomplete Pathway | 92.4% | 92% | 91.1% | 88.4% | 89.2% | NHS England | Apr-2017 to Feb 2018 |
| 28. Cancer 62 Day Urgent GP Referral / NHS Screening Service | 89.0% / 95.2% | 85% / 90% | 85.9% / 100% | n/a | 81.9% / 90.9% | NHS England | Apr-2017 to Feb 2018 |
| 29. Maximum 6-week wait for diagnostic procedures | 0.02% | 1% | 0.05% | 1.70% | 1.90% | NHS England | Apr-2017 to Feb 2018 |

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## INDICATOR 1: STAFF SICKNESS

The Trust is reviewing the Trust's Sickness Absence Policy as a means to further reduce sickness rates and improve sickness absence management.

## INDICATOR 2: STAFF TURNOVER

We have implemented a range of retention initiatives in line with our People Strategy and we remain focused on improving nurse retention even further.

We are participating in the NHS Improvement Retention Programme as part of Cohort II, and will be focusing on four key areas: flexible working; staff engagement; promoting respect in the workplace; and, career development. These areas were identified from a range of data sources, including exit interviews and the NHS Staff Survey, as key drivers of turnover. We will be monitoring improvements in retention over a 12 month period to February 2019.

## INDICATOR 3: EXECUTIVE TEAM TURNOVER

In 2017/18, two of the Trust executive directors left their post, the Director of the Patient Experience and Nursing (DPEN) and the Director of Strategy and Business Development (DSBD).

The DPEN was replaced internally by the Deputy Director of Nursing and Integrated Governance, who is a long-standing member of the Trust team, with a strong understanding of the Trust quality requirements and record of delivery against them and continuity of service helping to maintain Trust standards during transition.

The DSBD post was removed as a part of a corporate restructure. Following consultation it was decided to streamline the Executive Team with the removal of this post as part of an initiative to rationalise executive functionality.

## INDICATOR 5: PROPORTION OF TEMPORARY STAFF

There is an ongoing effort by the Trust to reduce reliance on agency and bank staff by improving the Trust's time to recruit permanent staff. There is also greater use and uptake of the e-roster system to effectively plan and anticipate possible shifts needing to be filled by temporary staff.

## INDICATOR 6: AGGRESSIVE COST REDUCTION PLANS

Cost reduction plans have been identified and pursued by all Divisions across the Trust, as part of the NHS wide Financial Improvement Plan (FIP). QIPP and cost reduction programmes have to be ambitious while striking a balance that does not adversely impact patient care. All cost reduction initiatives are subjected to a Quality Impact Assessment (QIA) evaluation with high risk schemes are assessed by a specialist panel. The 2017/18 Plan was developed and monitored in collaboration with external partners, PA Consulting.

The total savings from 2017/18 were £10.2m, the majority of which is recurrent, an improvement on previous years. The process for FIP sign off has been strengthened, with a project not going live until a full Project Initiation Document (PID) has been created and signed off. The PID contains a full risk assessment and the QIA template, to ensure that quality of care is maintained and identified associated risks are understood and can be properly managed.

The Trust continues to rationalise and review expenditure, with a £12m savings target for 2018/19, with schemes in areas such as a corporate restructure, medical productivity and a reduction on premium payments for agency staff. These savings are expected to improve efficiency whilst maintaining the quality of patient care.

## INDICATOR 7: PERCENTAGE OF COMPLAINTS RESPONDED TO WITHIN AGREED TIMESCALES

In 2017/18 the Trust received 338 new complaints, 44 fewer than in the previous year. We aim to acknowledge receipt of complaints within three working days; this year 96.8% were acknowledged within this timeframe.

As the investigation period is typically 30 working days. The number of complaints for which responses are due to be completed during a given financial year differs from the number received, because of investigation time overlap at the beginning and end of the year. There were 354 complaint responses due this year, of which 70.9% were completed within the timescale agreed with the complainant. While this is below our 90% target it was a slight improvement compared to last year.

Performance has been variable each month due to capacity issues either within the central Complaints Management Unit or within the clinical divisions. There has however been continued drive to achieve an improved and more consistent trajectory. Performance in Quarter 1 was below 60% but improved to just over 74% for each of the following quarters.

To progress improvement further in 2018/19 the following actions have been implemented:

- Complaints Policy and investigative pathway reviewed jointly by the Complaints Management Unit and the Assistant Directors of Nursing for each of the clinical divisions
- Embedding of weekly meetings with surgical and medicine divisions to review progress for each of their complaints and resolve any blocks in the process
- Performance tracked on daily basis to identify priorities
- Divisional management teams receive weekly "hotlist" of outstanding complaints to assist escalation within divisions
- All new appointments to Complaints and PALS teams have job descriptions spanning each service to enable flexing of staffing according to demand

When reviewing a complaint, an action plan is drawn up to address the failings identified. Examples of specific improvement actions implemented as a result of complaints include:

### Surgical services - issue identified:

The Trust received a complaint from a patient who had accessed the Trust's urology service. Due to treatment delays the patient required surgery to remove one of their kidneys which with more timely surgical intervention could have been avoided.

### What we have done about it:

Critical to the response to the patient here was an investigation into the time delays for surgical intervention that were seen by the clinician as the major contributing factor to the irretrievable damage to the patient's kidney. The resulting investigation recommended the development and agreement of criteria for the management of high risk renal stone patients including guidance on patient information and timescales for clinical review. This has led to a review of best practice guidance for the management of clinically urgent patients and patients where a planned timescale for surgery is critical. In addition to clinical best practice there has also been a review of escalation processes within the Trust to identify if there are any delaying factors in achieving early clinical review.

The Trust views this investigation response as an example of the vital learning that can take place as a result of patient feedback and demonstrates the important interaction between clinicians and the administration systems that we have within the hospital.

Medical services - issue identified:

The Division of Medicine have received a number of complaints that have involved the Estate and patient environment as not being satisfactory.

### What we have done about it:

A spread sheet was compiled which lists all the outstanding Estates issues across the Division of Medicine. This list outlines actions required, person responsible and when the work is completed. This list has been shared with the Chief Executive Officer and Director of Patient Experience and Nursing. This is reviewed by the Assistant Director of Nursing at the Medical Division Team meeting. Many actions related to minor refurbishment works to improve the environment of care in the inpatient wards.

### Maternity services – issue identified

There are not high numbers of complaints in Maternity however, as part of our commitment to learn from complaints and to improve our safety culture; Maternity used the "Whose Shoes" programme to set the scene in responding to a need for change. A common theme in complaints that were received were related to poor communication and how people were spoken to.

'Whose Shoes' is a values-led, bespoke approach to change management, using facilitated interactive and inclusive sessions via a board game with a focus on a woman-centred approach. A workshop was held with 50 multidisciplinary/agency staff members and at the end of the session each person set themselves a commitment pledge which is to be revisited at six weeks and six months to monitor progress on their pledges. A large bespoke poster was developed from the workshop and hangs in pride of place in the Maternity Unit for patients, staff and visitors to see. Examples of pledges made are:

- *Refrain from calling women anything other than their preferred name*
- *Treat the future mums with happiness and respect; try to use the mum's name instead of saying 'sweet or darling'.*
- *I will listen and treat people how I would like to be treated.*

## INDICATOR 9: OCCURRENCE OF ANY NEVER EVENT

The Trust aims to continually reduce the number of Never Events that occur and encourage a transparent culture where mistakes are reported and learning is shared to improve patient safety. Patients who have suffered harm because of any medical error should rightly expect that what happened to them has been the subject of a thorough investigation to determine what happened, why and what lessons have to be learned.

In May 2017, our Surgical Division reported a Never Event relating to an Ophthalmology patient who had the incorrect power of intraocular lens inserted during cataract surgery. Following the identification of the incident, it was clinically decided, in the best interest of the patient, that leaving the incorrect lens would be more beneficial for the patient, as their sight had improved, than proceeding to change the lens. Learning from this incident was shared among the Ophthalmology department, and as a result, the use of an intra-ocular planning sheet and the use of an electronic system (Medisoft) in the lens check process have been introduced to mitigate any similar incidents in the future.

The Surgical Division reported a second Never Event in October 2017 where a retained swab was identified to have been left after a gynaecology procedure. Fortunately, the patient did not come to any significant harm as a result of the delay in identifying the retained swab. Following this incident, learning was shared and a review of the policy and procedure for swab count within Theatres was instigated.

## INDICATOR 10: NHS ENGLAND/NHS IMPROVEMENT PATIENT SAFETY ALERTS COMPLETED WITHIN DEADLINE

The Trust recognises and accepts its duty to distribute and action safety alert notices received via the Central Alerting System. The Trust ensures that all alerts are communicated promptly to all relevant members of staff and that action to comply with alerts is taken within Department of Health timescales in order to safeguard patients, visitors and staff from harm. There have been no delays to completing Patient Safety Alerts from the Trust to NHS Improvement in 2017/18.

## INDICATOR 11: MIXED SEX ACCOMMODATION (MSA) BREACHES

The Hillingdon Hospitals NHS Foundation Trust is pleased to confirm that it continues to be compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary for example where patients are clinically unwell and need high clinical input such as in the Intensive Treatment Unit. If our care should fall short of the required standard, we will undertake an RCA investigation to identify what led to the lapse and report the breach.

In light of the additional emergency care pressures experienced over the winter months, NHS England and NHS Improvement provided an exemption against this standard nationally over December and January 2017/18. Trusts were expected to ensure local agreement with the CCG during this time supported by a clear plan for maintaining privacy and dignity at all times minimising any negative impact of breaching MSA. The Trust mixed the Male and Female Day Care facilities in order to ensure all clinically urgent and cancer procedures were carried out.

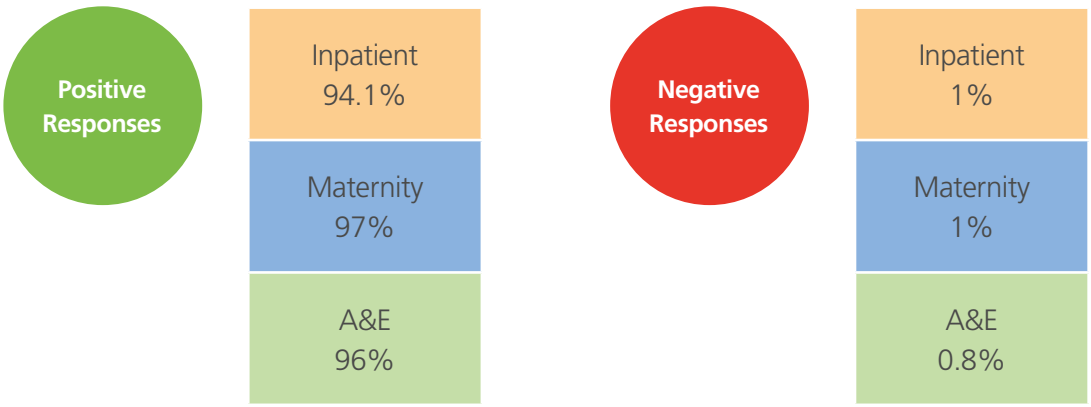
Any breaches of mixed accommodation are reported to the Trust Board and audit results will be discussed with the Commissioners at the contract review meetings.

## INDICATORS 12, 13 AND 16: FFT

Since April 2013, patients have been asked whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment. This means every patient is able to give feedback on the quality of the care they receive, giving hospitals a better understanding of the needs of their patients and enabling improvements.

During 2017/18, the Trust received feedback from 37,518 patients who had either attended the A&E Department, an Outpatient Department or had been an inpatient or a maternity patient during 2017/18. Our results for this period are set out below.

**Indifferent responses:**
Inpatients – 4.9%
Maternity – 2%
A&E – 3.2%



## How do our FFT results compare with others?

The graphs below show the FFT results and response rate compared to others for A&E and Inpatients for February 2018 (the most recently published data):

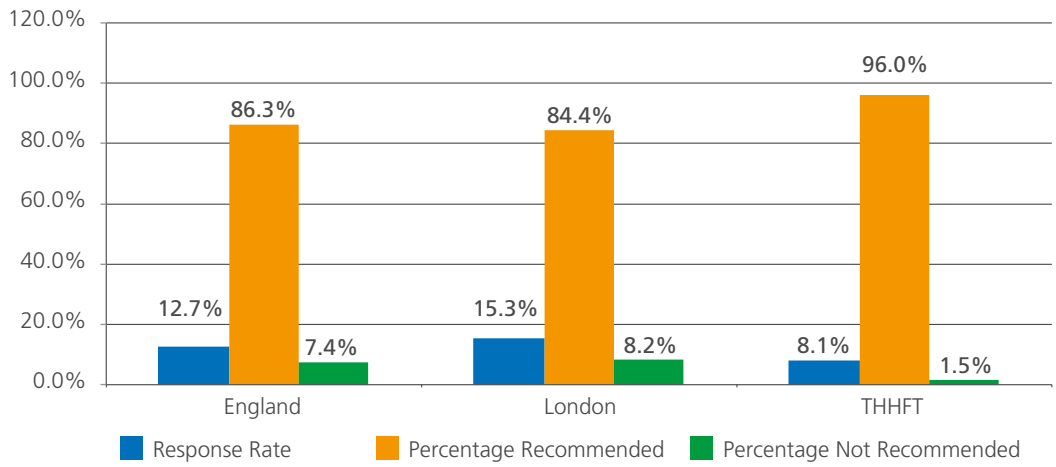
## Response rate and percentage of positive and negative results for A&E

The chart below shows that the response rate for A&E in February is lower than the England and London rate. We do significantly better; however, than England and London in relation to the percentage of people who recommend the service and we have a positively lower percentage for those who do not recommend the service.

## Response rate and percentage of positive and negative results for Inpatients

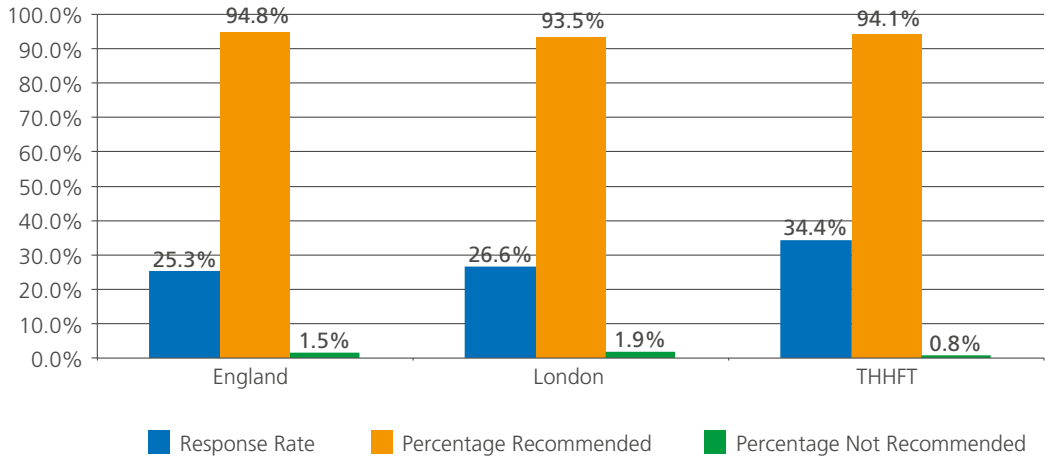
The percentage of people who would recommend is more than the London score, but slightly below the England average. We have a lower percentage of patients who would not recommend in relation to London and England. The response rate for Inpatients was also higher than the London and England rates and this is indicated in the chart below.

### Chart 2: Friends and Family Test: A&E




(April 2017 – February 2018)

### Chart 3: Friends and Family Test: Inpatients




(April 2017 – February 2018)

## What patients have told us is good about their experience

**Inpatient ward**

*"I was very well looked after. Thank you.' (Hayes ward)*

*'Staff were very kind and attentive. Nursing care was good.' (Grange ward)*

**Accident & Emergency**

*'The department was extremely overrun with patients but all staff were still attentive, lovely, caring, answered all of my questions and nothing was too much trouble.'*

**Maternity**

*'Midwives have been exceptional - lovely, caring, helpful, knowledgeable staff from start to finish.' (Labour ward)*

## What patients have told us could be improved

| | |
|---|---|
| **Waiting times in A&E are too long due to lack of capacity** | **Action**<br>**Reviewing patients on an hourly basis to improve patient flow and proposing to expand the A&E department to increase capacity and improve overall environment for A&E patients** |
| **Reduce length of time patients waiting in hospital for assessment and follow up test** | **Action**<br>**Discharge to Assess project has been introduced enabling patients to leave hospital earlier and be assessed at home within two hours** |
| **Need to provide more information and improve communication with patients and carers with regard to care, treatment and discharge planning** | **Action**<br>**Developed and implemented a carer's pack containing a carer's passport, carer's guide, carer's survey and information about links to external organisations which provide support to carers** |

## INDICATOR 14: EMERGENCY CAESAREAN SECTIONS

We have seen continuous improvement in the numbers of women who undergo an elective caesarean section. Part of the work to reduce the numbers has been the introduction of a Consultant Midwife led vaginal birth after caesarean clinic where the options for delivery are explored with the women and clinical team. As part of the North West London Local Maternity System we now have a sector wide maternity dashboard which enables us to compare practice across the six maternity units in North West London and share learning.

2017/18 saw a rise in non-elective (emergency caesarean) sections ending the year at 19.24% against a target of 16%. This rate includes a rise in full dilatation caesarean sections. A deep dive review was undertaken to ensure appropriate decision making had been followed and was presented to our commissioners. The outcome of the review identified appropriate practice and an increasingly more complicated population however, some general learning and actions were identified which are now in place:

- All full dilatation Caesarian Sections have to be reviewed at the clinical handover of each shift and concerns addressed immediately
- All inductions of labour have to be discussed and agreed with a Consultant Obstetrician.

## INDICATOR 15: CQC INPATIENT SURVEY

The Hillingdon Hospitals NHS Foundation Trust commissioned The Picker Institute Europe to undertake the survey for 2017/18. The CQC will use these results when publishing the National Survey of Inpatients in May/June 2018.

The results of our 2017/18 survey are based on responses from 374 patients who completed the survey, giving a response rate of 30%; the average response rate of all Trusts in the Picker survey results was 38.3%.

Overall, the results show a mixed picture for the Trust. The Picker survey showed that the hospital was improving in the way care was perceived by patients, year on year, though that performance was perceived to be worse, on average, than that received at other Trusts.

Positively, the Trust is showing an upward trajectory, with improvements in two areas (supporting inpatients with cleaning and information on care post discharge) and no significant deterioration in any area of the 56 surveyed from previous years

On the less positive side, when compared to other Trusts, there was only one area 'Hospital: shared sleeping area with opposite sex' where the Trust scored above average (better) for those surveyed stating that they did not stay in a shared sleeping area, though there were 32 of the 62 areas which the Trust was below average on, which shows a clear path to improvement.

The Trust will make use of the Picker survey when implementing actions to improve inpatient care across the Trust.

There are a number of transformational and quality improvement programmes underway that have links to the areas for an improved experience for patients; these include improving communication and provision of information, strengthening the patient pathway through the hospital to discharge home, improving recruitment and retention to ensure continuity and a high standard of care is delivered, and driving forward our ambition for strong professional standards and clinical leadership.

## INDICATOR 18: *C DIFFICILE*, VARIANCE FROM PLAN

*C. difficile* cases will inevitably occur as patients need to be treated with appropriate antibiotics. A lapse in care is defined as an element/s or care that could have been done better and that the case could have been avoided. Two cases were considered to have lapses in care in 2017/18, with one potentially avoidable as antibiotics were not prescribed in accordance with the Trust

Antimicrobial Guidelines and the other found to be as a result of cross infection due to delay in isolating the patient. Learning from these cases is presented by appropriate clinical teams at governance meetings. Also, local learning has been shared via Matrons, Link nurses (nurses that share information and provide formal, two-way communication between specialist teams and nurses in the clinical area) and Senior Sisters' meetings.

## INDICATORS 21 AND 22: HOSPITAL STANDARDISED MORTALITY RATE (HSMR)

The Rolling 12 Month HSMR to Dec-2017 is 98.1 (90.9 – 105.6) and is therefore within the expected range given our case mix as the lower confidence limit is below 100. The HSMR for non-specialist London Providers is lower at 81.7 (80.6 – 82.9) but is still as expected given the case mix across those organisations.

The picture is mirrored on the weekend Rolling 12 Month HSMR to Dec-2017. For the Trust it is 100.6 (86.3 – 116.6) and for London it is 85.6 (83.3 – 88.0).

The Trust is tracking the HSMR monthly on a rolling 12 month basis. Analysis in mid-2017/18 revealed below average palliative care and co-morbidity coding which was identified as an issue with clinical coding (which leads to a higher HSMR than is truly the case) and this has now been rectified so recent HSMR data is more representative as will the HSMR data going forward into 2018/19.

The Trust has a robust mortality review process in place reviewing deaths occurring in hospital; this is overseen by the Executive chaired Mortality Surveillance Group (MSG). There has been a new Learning from Deaths Policy approved by the Trust Board which will allow the Trust to identify all avoidable deaths and also key learnings from any care which has been identified as sub-optimal. In 2018/19 the review of deaths will follow the best practice Structured Judgment Review developed by the Royal College of Physicians. These reviews will be monitored by the MSG, but there will be a four-monthly summary presented to the Public part of the Trust Board.

## INDICATOR 26: A&E FOUR-HOUR TARGET (MANDATED INDICATOR FOR EXTERNAL ASSURANCE TESTING)

The year-end performance for 2017/18 for patients attending the A&E Department was 84.6%; with the Trust facing significant challenges over the winter months due to overcrowding in A&E. This was a result of varied daily discharge numbers and a high patient acuity with a consistent Type 1 attendance of over 182 per day compared to 176 in 2016/17. The overall impact was an exit block from A&E, where patients were unable to be moved into a hospital inpatient bed. The Trust has secured £1.5m funding from the regulators and will be putting in place a £2m A&E refurbishment programme in 2018/19. This will create additional 'majors area' (where more serious patient cases are seen) cubicle spaces with a dedicated ambulance streaming area.

London Ambulance Service attendances to A&E also increased by 3.8% when compared with 2016/17.

The Trust made good progress towards delivering against the 4 hour patient care standard in A&E from Q1 to October 2017. The System owned Emergency Care Improvement Plan is in place covering four key areas:

- Demand Management (reducing inappropriate attendances to A&E)
- A&E process and Patient flows (Improving care models and appropriate flows)
- SAFER and Red2Green (making time in hospital matter for patients ensuring no delays in care)
- Integrated Discharge Group (System led discharge improvement as a collective for patients)

Key initiatives that have been prioritised that aim to reduce attendances from the community such as Care Connection Teams, GP extended hours in hubs, divert patients to ambulatory care pathways, hospital ward reconfiguration to create co-located Medical and Surgical Assessment Units and the *Discharge to Assess* care model. The A&E Delivery Board oversees and holds the work stream leads to account for the delivery of the agreed plans.

Quality reporting and data integrity remain a key priority for the A&E department and the Trust. The A&E four-hour standard quality indicator was reviewed by our external auditor as a mandated indicator for testing as stipulated by NHSI. The audit identified a lack of audit trail for some ambulance arrivals and timeliness with which patients are discharged on the system, however it was noted that good progress has been made particularly in the latter part of the year as the recommendations from 2017/18 were implemented. Our auditor recommended that guidance is provided to all staff on the need to document patient activity in the A&E notes promptly, and to complete the stop time on the CAS cards as soon as the patient has been discharged, admitted or transferred.

During 2018/19 the team will take the following actions:

- The improvement requirements will be added to the Matron's weekly "Big 4" (important themes for action) so that all of the nursing teams at handover are reminded of the importance of prompt recording of admission/ transfer/ discharge times on the CAS card
- This will be raised at the daily A&E safety huddle for two weeks to communicate to medical staff
- Spot check audit findings will be presented at middle grade teaching days.

Following this sample collection, the Trust has implemented a new policy and data recording process that will improve compliance to national reporting standards. The A&E Department has the national Emergency Care Data Set (ECDS) now in place which is expected to ensure real time data management through the clinical teams.

## INDICATOR 27: REFERRAL TO TREATMENT (RTT) WAITING TIMES (MANDATED INDICATOR FOR EXTERNAL ASSURANCE TESTING)

The Trust continues to focus on providing patients definitive treatment within 18 weeks of referral. The performance indicator we are monitored against in relation to this standard is the incomplete pathway performance. We perform well against the standard and compared with other Trusts, we are a high performer. This year has again been a challenge with unprecedented winter bed pressures, meaning that some planned elective operating had to be postponed. We have established monitoring meetings led by the Director of Operational Performance overseeing the impact on performance and monitoring the robust delivery of identified action plans. The work going forward is focusing on having a robust activity plan that better anticipates periods of reduced activity due to maintenance work and reprogramming automatic recovery from this.

The RTT waiting time target quality indicator was reviewed by our external auditor as a mandated indicator for testing as stipulated by NHSI. Preliminary feedback identified data quality issues relating to the clock start and stop times recorded for some pathways.

The Trust has taken steps to help improve data quality during the second half of 2017/18. These include continued training, and improved validation processes, particularly around patients waiting longer than 18 weeks. In September 2017, we also completed an exercise to validate 11% of patients on the pathway at that time.

The Trust continues to validate pathways >18 weeks as part of Trust monthly data quality checks. Clinical harm reviews are undertaken for all patients waiting >40 weeks with planned progression of reviewing every patient >30 weeks. This process is included in the updated draft Access Policy which is currently with the CCG for comments. Additionally there is a weekly snapshot random audit of Clinical Outcome Sheets (COS) by the Outpatient Matron (or deputy) to validate accuracy and compliance, identifying any areas for training/ remedial action.

Going forward, we intend to continue making improvements. Incomplete pathways will remain under continuous scrutiny with on-going validation by the divisional teams. There is an on-going training programme, led by the relevant departments for all staff associated with recording and delivering the RTT pathway. The Trust is now part of the national accredited RTT training programme led by the Elective Intensive Support Team. This will enable the Trust to create a pool of 'train the trainer' talent to ensure sustained delivery.

## INDICATOR 28: CANCER 62 DAY URGENT GP REFERRAL / NHS SCREENING SERVICE

Cancer performance is being maintained for all the national waiting times standards. The quality of services is monitored annually via the national Quality Surveillance and Information System (formerly known as the national peer review programme). Tumour specific work programmes also reflect areas for service development. The Trust works closely with Hillingdon CCG, North West London Collaboration of CCGs and the Royal Marsden & Partners Vanguard on the cancer agenda which includes achieving the national cancer waiting times standards, service improvement and survivorship.

## INDICATOR 29: MAXIMUM 6-WEEK WAIT FOR DIAGNOSTIC PROCEDURES

The Trust saw an increase in demand particularly for CT, MRI and ultrasound. This increased the pressure on the radiology service however mitigations were put into place to ensure the target was met.

The Radiology Department has developed new key performance indicators which are used to monitor performance and plan for service

changes. The Trust now has an additional CT scanner and once the workforce is uplifted will provide further additional capacity. There will be on-going modality demand and capacity reviews in all areas.

### Improving Patient Safety

During 2017/18, The Hillingdon Hospitals NHS Foundation Trust has continued to be a member of the Imperial College Health Partners (ICHP) Patient Safety Collaborative (PSC). This is one of 15 PSCs set up to help improve the safety of patients and ensure continual learning sits at the heart of healthcare in England. As the Academic Health Science Network for North West London, ICHP works with its partner organisations and service users to focus on specific areas of local clinical need. Its vision is to support its partners to embed safety in every aspect of their work.

Our PSC continues to make progress with a number of initiatives, turning the potential of innovation in healthcare into reality and to help solve challenges via collaboration. By connecting a network of health experts ICHP is accelerating the adoption and spread of innovation amongst its member organisations. The PSC programme of work is aligned with and supports the work the Trust has been undertaking based on the national Sign up to Safety Campaign, outlined earlier in the report.

## Infection Prevention and Control

### Meticillin Resistant Staphylococcus aureus (MRSA) Blood stream Infections (BSI)

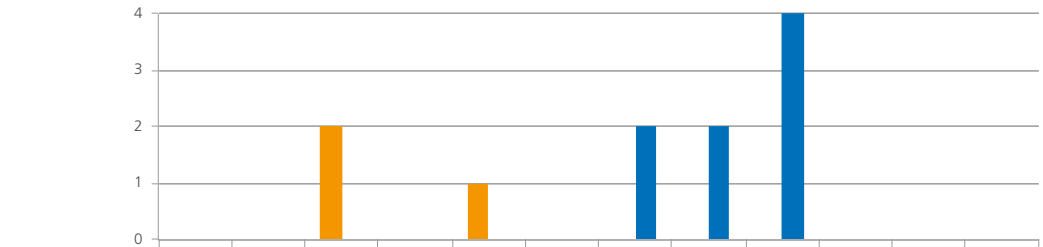
There was one case of MRSA BSI attributed to the Trust in 2017/18. A Post Infection Review (PIR) was undertaken with the outcome noting the case as unavoidable due to systemic MRSA colonisation which was not revealed until one week into admission. As a result there was no financial penalty to the Trust.

MRSA screening criteria was changed significantly in the last quarter of 2016/17 due to the revised national guidance *Implementation of Modified Admission MRSA Screening Guidance for the NHS (2014)* being applied to Trust policy. This resulted in a substantial reduction in the number of MRSA screens undertaken ensuring a continued focus on more high-risk areas instead of the previous 'blanket' approach of screening all patients. Due to the changes in screening, monthly and annual compliance is now measured for Surgery and High-risk areas only.

### Chart 4: Trust attributed MRSA bloodstream infections


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2017/2018 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Chart 5: Trust attributed MSSA bloodstream infections




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2017/2018 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 4 | 0 | 0 | 0 |

### Meticillin Sensitive *Staphylococcus* aureus Blood stream Infections (MSSA)

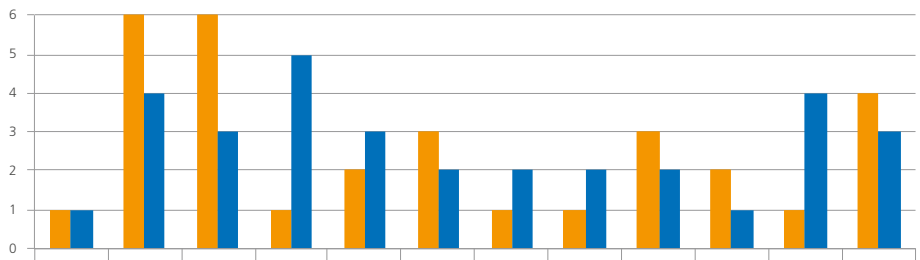
In 2017/18 there were eight cases of MSSA attributed to the Trust, a 62.5% increase when compared to three MSSA cases in 2016/17. Upon review there appears no trend for the increase in MSSA BSIs and it is highly likely previous skin colonisation which a majority of the population carry was the contributing factors to this increase during Q3. There continues to be no mandated threshold for MSSA.

### E. coli Blood stream infections

The Trust has been collating data on E. coli BSIs since 2012/13 via the public health national mandatory surveillance site. Since then it has been recognised that the number of E. coli BSIs are continuing to increase year on year. In 2015/16 there were 40,000 reported cases of E. coli BSIs in England; this is an increase of 20% in the past five years. As a result, in November 2016 The Health Minister addressed the need to reduce gram negative bacteraemia and has highlighted E. coli as a primary focus. The national aim is to reduce these significantly starting with a 10% reduction in 2017/18 and expanding to an overall reduction of 50% by 2020/21.

During 2017/18 the Trust aimed to reduce nosocomial E. coli BSIs linked to catheters and urinary tract infections by ensuring a heightened focus of these two areas of care over the coming year. A Gram-Negative Blood Stream Infection (GNBSI) group was convened and chaired by a Locum Consultant Microbiologist. The Infection Prevention and Control Team have been working collaboratively with continence

## Chart 6: Trust attributed E. coli bloodstream infections




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 1 | 6 | 6 | 1 | 2 | 3 | 1 | 1 | 3 | 2 | 1 | 4 |
| 2017/2018 | 1 | 4 | 3 | 5 | 3 | 2 | 2 | 2 | 2 | 1 | 4 | 3 |

leads across the whole health economy to help improve care and reduce usage and duration of urinary catheters, as well as improving communications across acute and community care settings.

In 2017/18 the Trust reported 32 cases of post 48 hours E.coli BSI which is one more than that in 2016/17, when 31 cases were reported. A much higher number of E.coli cases were seen pre 48hours and therefore attributed to the CCG - 162 cases were reported in 2017/18, a reduction of 17 cases from 179 cases reported in 2016/17.

On 21st March 2018 the Director of Infection Prevention and Control received a letter from Ruth May, Executive Director of Nursing, Deputy CNO & National Director for Infection, Prevention and Control to commend the Trust on an excellent contribution being made to reducing *Escherichia coli* bloodstream infections, based on the Quality Premium 2017-18 (using 2016 data as a baseline). Furthermore, recognising this has been a difficult ambition to achieve, the Trust is one of 59 who have achieved a 10% or greater reduction in the hospital onset *Escherichia coli* bloodstream infections.

The Hillingdon Hospitals NHS Foundation Trust baseline numbers were 42 in 2016 and 33 in 2017, equivalent to a 21.4% reduction in cases. The Trust has been asked to share efforts of improvement plans for these to be provided to others that have not yet made the reductions.

Furthermore in 2017/18 Public Health Surveillance on GNBSIs was expanded to incorporate other gram-negative organisms such as *Pseudomonas aeruginosa* and *Klebsiella spp*. BSIs.

## Pseudomonas *aeruginosa* Blood stream infections

In 2017/18 the Trust reported six cases of post 48 hours *Pseudomonas aeruginosa* BSI, with 12 cases pre 48hrs being attributed to the CCG.

**Chart 7: Trust Attributed Pseudomonas aeruginosa**

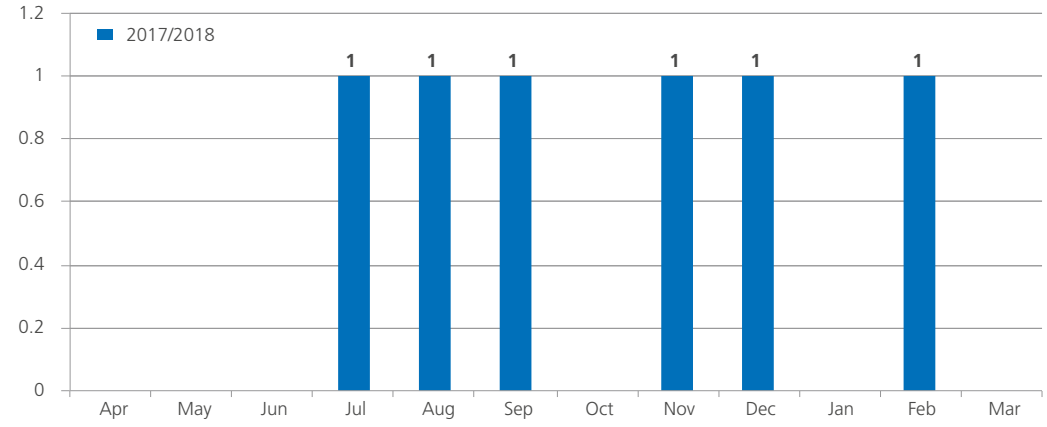
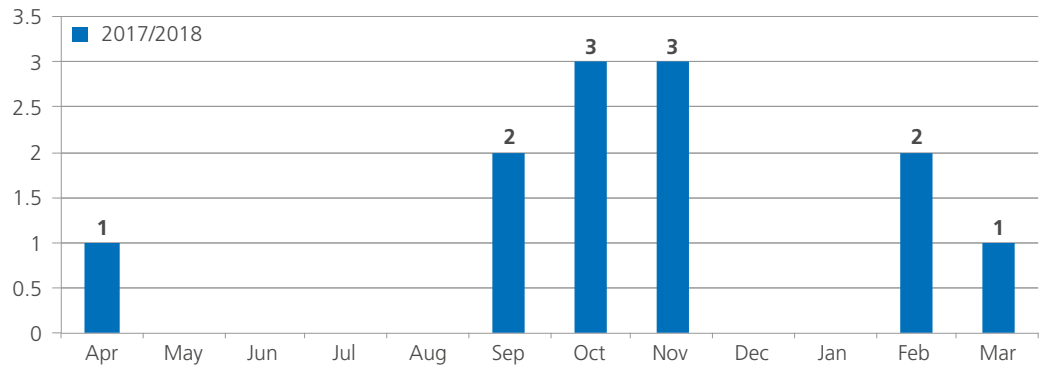


**Chart 8: Trust Attributed *Klebsiella spp*. BSI**




## *Klebsiella spp.* Blood stream infections

In 2017/18 the Trust reported 12 cases of post 48 hours Klebsiella spp. BSI, with 35 cases pre 48hrs being attributed to the CCG.

## Trust Attributed Klebsiella spp.BSI

Whenever Sepsis is diagnosed, quick action by medical staff can help save lives. The Hospital is committed to enhancing staff awareness around Sepsis and implementation of the best practice care bundle, developed by the UK Sepsis Trust – 'Sepsis Six'.

The Sepsis Six care bundle is initiated by the medical team within one hour of suspected diagnosis. It prompts staff to give antibiotics and intravenous fluids, to take a blood sample to assess the severity of Sepsis, and blood cultures to identify the type of bacteria causing the infection. Oxygen is given if levels are low and urine output is closely monitored to safeguard kidney function.

The Trust has a nominated Consultant lead for Sepsis who drives forward improvements in this area and ensures that best practice is shared through staff training and education. Performance is regularly monitored through internal audit and work is ongoing to increase staff awareness and responsiveness when Sepsis could be suspected. Currently, our primary focus is on further improving the speed with which prescribed antibiotics are administered.

# Annex 1

## Response on behalf of the Clinical Commissioning Group

NHS
Brent, Harrow and Hillingdon
Federation of
Clinical Commissioning Groups

14 May 2018

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Mr Shane DeGaris,
Chief Executive,
Chief Executive's Office
The Hillingdon Hospital
Pield Heath Road
UXBRIDGE, Middlesex
UB8 3NN

Dear Shane,

**Re: The Hillingdon Hospitals NHS Foundation Trust Quality Report (Accounts) 2017/18**

The North West London Collaboration of eight CCGs has welcomed the opportunity to review your Quality Report for 2017/18. We note that informal feedback was sent to the Trust for consideration in the final version on the 26th April 2018.

We confirm that we have reviewed the information contained within the Account and it is compliant with the Quality account guidance for NHS Trusts as set out by the Department of Health and NHS Improvement.

The Trust set themselves 4 priorities for 2017/18 and is reporting good progress against these. We acknowledge the work the Trust has done on improving the discharge process; however we do note the on-going pressures the Trust are under and the Trust remains to have a longer average length of stay for both elective and non-elective admissions than the national average (HES data). Going forward, with the changes to practice made during 2017/18, we anticipate seeing improvements in length of stay through 2018/19. We note the Trust has identified discharge management as a priority for 2018/19 and we support the Trust in their work to improve the flows through the hospitals.

The work the Trust has undertaken in end of life care is noted and we applaud the Trust on their achievement of an NHS Improvement award. However, we are disappointed the Trust state they are experiencing difficulty in access to 'co-ordinate my care' due to the number of staff who are trained to use the system and as such have not been able to provide data on whether a patient dies in their preferred place. This is a pivotal part of the end of life care for the patient and their families and we will monitor reporting against this going forward into 2018/19.

It is disappointing the Trust have not achieved 100% of the CQUIN targets. In particular, the CCGs have on-going concern in relation to performance against the reduction of serious infections, especially in relation to patients receiving antibiotics within an hour of a suspected diagnosis of sepsis. We have discussed this in the recent Clinical Quality Review Group



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meeting (9th May 2018) and going forward it has been agreed that 'Sepsis' will be a standing agenda item for discussion at each meeting.

The CCGs welcome the evidence of the achievements made during the year against the 29 standard indicators, particularly the work undertaken in responding to the National Quality Board's guidance on Learning from Deaths. This work is vital to ensure all deaths are reviewed to determine if there have been any lapses in care and learning identified.

The Trust has set itself 4 priorities for 2018/19 and we concur with the Trust these are appropriate given the healthcare landscape and the learning from the review of quality indicators during 2017/18. We are aware of the areas the Trust is reporting where improvements are required and we support working collaboratively with the Trust to achieve the improvements which have been set out.

The report sets out the achievements over the last year and has identified areas for improvement. We welcome the vision described within the Quality Report and look forward to continuing to work with the Trust to monitor the progress against the 2017/18 priorities and the improvements set out in your 2018/19 quality priorities.

Yours sincerely

Diane Jones
Director of Quality & Safety
NHS Brent, Harrow & Hillingdon
Clinical Commissioning Groups

Cc; Jacqueline Walker, Executive Director of the Patient Experience & Nursing, THHFT
Caroline Morison, Chief Operating Officer, Hillingdon CCG
Ian Goodman, Chair, Hillingdon CCG
Mary Mullix, Director for Quality, Nursing and Patient Safety, CWHHE CCGs Collaborative

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The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2017/2018 Quality Report and acknowledges the Trust's commitment to attend its meetings when requested.

The Committee supports the Trust's practice of learning from excellence as well as from when things have not gone quite so well in a move to embed best practice within the organisation. To promulgate best practice, the Trust has been asked to share its efforts of improvement plans regarding E.coli BSI to others that have not yet made the reductions. Taking this further, it is suggested that internal good practices such as GREATix be shared with other Trusts.

In these times of continuing austerity, partnership working has proved key to creating efficiencies, both in terms of service delivery as well as financial savings, that ultimately benefit patients. To this end, the Trust has been working on a number of projects, which include:

- Readmissions – schemes being delivered in partnership through Better Care Fund, ambulatory services and Accountable Care Partnership have contributed towards a 7.6% readmission rate. This has ensured that patients are cared for in the most appropriate setting.
- Delayed Transfer of Care (DTOC) – the introduction of initiatives such as Red2Green, Discharge to Assess and the SAFER patient flow bundle have reduced inpatient length of stay by an average of 0.8 days (from 5.5 days to 4.7 days). The national patient survey has highlighted the Trust's improvements in discharge and patient care which has, in part, been assisted through closer working with adult social care.
- Sustainability and Transformation Plan (STP) – partners are embedding consistent pathways across the STP and improving the quality of care by reducing variation. This work is focussed around cardiology, dermatology, gynaecology, gastroenterology and MSK. Brunel University has supported these service transformations by hosting a series of masterclasses for GPs in Hillingdon.
- Brunel Partners Academic Centre for Health Sciences (BPACHS) – this initiative has been launched in partnership with CNWL and Brunel University and aims to revolutionise the way health and social care is delivered to meet the changing needs of society by providing a setting for research and developing new methods of healthcare delivery across allied health, nursing, social care and medicine.

Members are pleased to note that the Trust's staff engagement score of 3.83 in the staff survey, and 4.02 in relation to staff motivation at work, fall within the top 20% of Acute Trusts. Notwithstanding the Trust's hard working and dedicated workforce, staffing levels have long been an issue in the NHS. As part of NHS Improvement Retention Programme, there has been a focus on staff engagement, promoting respect within the workplace and career development to try to reduce turnover. In addition, although there has been an ongoing effort to reduce reliance on agency and bank staff, no mention has been made in the report about the impact that this work has had.

Hillingdon Hospital's A&E department continues to face challenges with 84.6% of patients being seen within four hours during a period of unprecedented levels of demand. To try to alleviate some of this pressure, the Trust has secured £1.5m of Department of Health funding towards a £2m expansion project planned for 2018/2019 to create additional majors cubicle spaces with a dedicated ambulance streamlining area. The Committee looks forward to being updated on the impact that this project has on the four hour target.

NHS Improvement is supporting all trusts to meet four standards identified as being 'must do' by 2020. Although THH had made significant progress in delivering these standards, there is little evidence to suggest that the investment needed to fill the gaps will reduce patient mortality. The Committee is therefore concerned that the rationale in setting these targets may be flawed if there are elements included therein that remain unproven (particularly at a time when resources are already limited without additional work).

Communication is a theme the runs throughout the report with improvements identified as being needed to manage patient expectations in

relation to hip and knee replacement patients. The Trust is also working with commissioners through planned treatment pathway working groups to stress the importance of completing and returning varicose vein post-operative questionnaires (less than 30 returned during 2017/2018). The survey response rate was also low for CQC Inpatient/Picker Survey at 30% (average across all trusts was 38.3%) and the FFT response rate for A&E only achieved 7.97% compliance during month 12 against a target of 20% (although it is recognised that the feedback from those that did respond was very positive). Members look forward to receiving updates during the course of the year on the impact of action taken to address these issues.

The Committee is very aware of the requirement for the Trust to report its performance on a range of issues to a variety of organisations. As such, Members support the alignment of THH activity to five Delivery Areas and three enablers of the North West London Sustainability and Transformation Plan. Although the report is quite lengthy, it would benefit from the inclusion of contextual information in some areas, possibly in table format, to make the content more meaningful. For example:

- were there any targets associated with the strategic aims for 2014-19 (are these quantifiable) and what progress has been made?;
- it would have been useful to include a comparison with previous years' CQUIN targets and achievements; and
- why did the Trust suspend participation in the year for the Groin Hernia and Varicose Veins surveys.

Looking forward, there are areas where the Trust continues to demonstrate that progress and improvements have been made, particularly in relation to partnership working, but the Committee notes that there are a number of areas where further improvements are still required. We look forward to being updated on the progress of the implementation of priorities outlined in the Quality Report over the course of 2018/19.

# Response on behalf of Healthwatch Hillingdon

## Healthwatch Hillingdon's response to The Hillingdon Hospitals NHS Foundation Trust (the Trust) Quality Report 2017-2018

### Introduction

Healthwatch Hillingdon have continued to work in valued, close partnership with the Trust to monitor service quality and safety and improve patient experience. We are assured through the working groups, meetings and events we attend, that the Trust is committed to the continued improvement it outlines in its Quality and Safety Improvement Strategy 2016 to 2021.

Healthwatch Hillingdon wishes to thank the Trust for the opportunity to comment on the Trust's Quality Report for the year 2017-2018. Overall Healthwatch Hillingdon finds the Quality Report to be a fair and open reflection of the quality and safety of the Trust's services.

## Looking Back

### Quality Priorities 2017/18

### Priority 1 - Improving the discharge process

This priority was very poignant for Healthwatch Hillingdon following the engagement we had carried out in 2016 to inform and benchmark this priority. We are pleased to see the progress made in this area. Especially on the initiatives put in place to meet the recommendations we had made to the Trust around discharge. The Working Together booklet is enabling patients to be more appropriately informed during their stay in hospital and throughout the discharge process. By unifying the discharge process and working in a coordinated way with partners the quality of discharge and the patient's experience of discharge is improving, and importantly, patients are spending less time in hospital because of these improvements to the discharge process.

We still have reservations on the mechanisms the Trust use to capture the patient's experiences and would like to see these enhanced, to ensure there is a robust system in place to capture feedback from patients and carers regarding their satisfaction with their discharge experience.

### Priority 2 - Improving End of Life Care for Patients

We acknowledge the improvements that have been achieved this year towards providing a sensitive patient centred approach to End of Life Care. The Trust have gone a long way

to demonstrate to the public that they are meeting their specific goals and have a solid foundation to take this work forward.

It is good to see partners working in a closer integrated way and organisations further enhancing their use of initiatives, such as Coordinate My Care, to improve patient care. The work being carried out by the Trust is certainly working towards a holistic approach to End of Life Care and will ensure a greater number of people die in their preferred surroundings in the future.

### Priority 3 - Achieving improvement in relation to seven day working priorities

We are pleased to see the achievements made to date against the specific goals outlined. As we indicated last year it is difficult for the public to fully understand this priority and how it will be achieved, especially as the target date is 2020. We are not sure that the explanations outlined in this section are written in a clear way the public will necessarily understand. For example, "Surgery, trauma and orthopaedics and gynaecology have a non-resident working pattern, which will challenge meeting the standard in those areas. Obstetrics has 4/7 day residency, in week, though performance could be improved with improved handover". Besides not giving clarity to the public of what is meant by this, for the majority of the public non-resident and residency refer to a person's country of origin, or the place they live, not a hospital setting.

The section requires a clearer explanation of what is being achieved and the plans the Trust will be putting in place to meet the 4 standards by 2020. If the Trust are also saying here that even if they are given the funding to meet the standards, there is no evidence this will reduce patient mortality at the weekend, then reassurance is also required for the public on how patient mortality will be reduced to match weekday performance.

### Priority 4 - Improving the care of patients with dementia

We again acknowledge the progress made this year in improving the care for patients with dementia. As our engagement programme outlined, for patients with dementia a stay in hospital can be very distressing and providing the right care is challenging. The Trust have invested in a purpose-built dementia ward in recent years and have continue to work hard to put things in place to meet the needs of patients with dementia. The explanations on the 2017/18 performance in this section can be easily understood by the public and show the Trust are working closely with their health and voluntary sector partners. They are well placed to ensure that the services they provide in the future will continue to meet the needs of patients with dementia and support patient's carers and family members.

## Looking Forward

### Quality Priorities 2018-19

We would again thank the Trust for their involvement of Healthwatch, governors, foundation members, staff, patients and the wider public in the consultation of its future quality priorities.

### Priority 1 - Improve the use of digital systems to enhance patient safety and ensure timely access to information

Healthwatch Hillingdon see information technology as an essential enabler to improving the care of patients and their experience of services. Patients have been asking for a long time for a system in which organisations work seamlessly together, where they only tell their story once. Patients are bemused when they are told by staff that the NHS still uses faxes. In the digital age we experience every day most patients do not understand why the NHS lags behind.

We fully agree with this priority and the aims that are set out for 2018/19 in this section.

### Priority 2 - Ensuring care and treatment is patient-centred through streamlining patient care pathways and improving discharge management

Healthwatch Hillingdon see this priority and the outlined aim as a natural progression for the discharge work prioritised last year. It aligns fully with the recommendations we made as part of our work on discharge in 2016/17. One area we would like to be enhanced however as part of this work, is the collection of patient experience data for the different elements of the work, outside of friends and family responses and the national patient survey.

### Priority 3 - Enhancing patient experience through improving communication and staff attitude, further embedding CARES values

Healthwatch Hillingdon agree with the principle of this priority and acknowledge that communication and staff attitude are the 2 areas in which we receive the most concern from the public. We could not argue against the positive impact this would bring to the patient's experience of care. However, we would expect this priority and the embedding of the CARES values to be core to the ethos of all NHS organisations and standard to everyday business, not a standalone quality priority.

### Priority 4 - Improving the administration of the patient appointment system and associated communications

The appointment system is also one of the largest areas of dissatisfaction for the public in Hillingdon and the area they tell us is the most inefficient and resource wasteful. People regularly tell us of their frustrations of choosing an appointment that best suits their needs only for it to be cancelled, the receipt of multiple letters, and accusations of not turning up to an appointment they didn't know they had.

This priority is definitely needed, and we fully agree with it. We would recommend that this work is carried out in co-production with the public from an early stage and incorporates people of different ages, ethnicities and disabilities. We also would recommend that the aims for 2018-2019 are refreshed. Besides duplication with some of the aims in the other priorities, Healthwatch Hillingdon believe that aligning the appointments system with the Trust's legal responsibility under the Accessibility Information Standards (AIS) should be one of the aims for this priority. The Trust has stated that it has met the key requirements of AIS. Although we know that a lot of work has been completed by the Trust, further action is needed to ensure there is a consistent approach across the Trust, to practically demonstrate that disabled patients are being communicated to in their preferred format.

Healthwatch Hillingdon look forward to working with, and supporting, the Trust in the coming year, as it looks to deliver on these priorities and the other quality initiatives outlined within its strategies.

**Healthwatch Hillingdon 11th May 2018**

**Graham Hawkes, Chief Executive Officer**

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SUNSET TO SUNRISE

## The Hillingdon Hospitals NHS Foundation Trust's response to its key stakeholders

The Hillingdon Hospitals NHS Foundation Trust thanks all its stakeholders for their comments about the 2017/18 Quality Report.

The Trust is pleased that its key stakeholders recognise the Trust's commitment to improve the quality of the care and services that we provide and to work closely with them in achieving further improvement. The Trust enjoys a good working relationship with both Healthwatch Hillingdon and with the Hillingdon Clinical Commissioning Group and it looks forward to further collaborative working to help shape the quality agenda and delivery of safe, high quality care.

The Trust is pleased that its key stakeholders are in agreement with its quality priorities for 2018/19, recognising where we have made good progress in quality improvement across a range of quality indicators and also where further work needs to be driven forward to realise the expected outcomes.

The Trust has taken comments on board as part of the consultation for the Quality Report and as such these are aligned with our partners' views on where we need to focus our efforts.

Our stakeholders have recognised and commended our performance on some of the key quality indicators and it has also been acknowledged that the Trust has progressed extensive improvement work in many areas, such as End of Life Care, improving the discharge process with patients spending less time in hospital and improving the experience of patients with dementia needing acute hospital care. The Trust has noted that our commissioners advised in their response that the Trust remains to have a longer average length of stay for both elective and non-elective admissions than the national average. The Trust's emergency length of stay in 2017/18 was 4.74 days and the elective length of stay was 4.05 days. There has been good progress made in response to patient flow improvement schemes including our system led Discharge to Assess model (Home First). Using the Model Hospital, the Trust's emergency length of stay is below the national median.

Areas of underperformance have been acknowledged and the Trust would like to confirm to its stakeholders that these areas will continue to be a key priority for the Trust and a focus in the forthcoming year. This includes A&E performance against the 4-hour target, response rates for FFT in the A&E department, timely identification and treatment of sepsis, patient reported outcome measures for some key surgical procedures and complaints response rates.

The Trust is pleased that the ESSC recognises the amount of work that has been undertaken by the Trust with our partners over the last year in achieving more a more integrated approach to the delivery of care. The Trust also welcomes the acknowledgement by the ESSC of the activity that we have seen through our A&E department and the work that is being taken forward to improve in this area. We will continue to keep our key stakeholders updated on our progress as requested, particularly in light of the A&E expansion. Our stakeholders have recognised that we have presented a robust summary of the overview of quality of care at the Trust, acknowledging, alongside our achievements, that some targets have not been met fully with regard to the quality priorities set for 2017/18. Where comments have been received on suggested amendments or additions to the report to provide improved clarity we have tried to accommodate these.

It has also been recognised that the Trust has been committed to continuing to improve the quality of its services and impact positively on the patients' experience of care despite the unprecedented activity that the Trust has seen in the last year. It is acknowledged that there is further improvement work to be taken forward on improving communication across a range of areas hence this being one of our four priorities for 2018/19. As highlighted by Healthwatch Hillingdon we also recognise that we must ensure we capture patients' experience in a number of different ways, particularly in relation to the discharge process. We also acknowledge that we need to ensure that there is co-production with patients on the improvements we wish to make to the administration of our appointments system and the associated communications.

We look forward to continuing our very positive working relationships with our key stakeholders to support the delivery of improved quality of care and patient experience.

# Independent auditor's report to the Council of Governors of The Hillingdon Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the council of governors of The Hillingdon Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Hillingdon Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained t herein .

This report, including the conclusion, has been prepared solely for the council of governors of The Hillingdon Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting The Hillingdon Hospitals 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 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Hillingdon Hospitals NHS Foundat ion Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

## Scope and subject matter;

- The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
- We refer to these national priority indicators collectively as the 'indicat ors' .

## Respective responsibilities of the directors and auditors

The directors are responsible for the content ana the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Impro vement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 Detailed requirements for external assurance for quality reports; and the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from the Commissioners dated May 2018;
- feedback from the governors dated 14 May 2018;
- feedback from Overview and Scrutiny Committee, dated 16 May 2018;
- the trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018;
- the latest national patient survey dated 31 May 2017;
- the latest national staff survey dated 6 March 2018;
- Care Quality Commission inspection report dated 7 August 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 31 March 2018; 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.

## Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management; testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting document ati on;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual ' and supporting guidance to the categories reported in the quality report; and
- reading the documents.

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

## Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

## Basis for qualified conclusion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with the detailed requirements set out in national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 18 items and so the error rates identified from that sample should not be directly extrapolated to the population as a whole. We identified the following errors: We found that from our sample of 18 records tested:

- for 33% of items in our sample of patients' records tested, the pathway start date was not accurately recorded;
- for 28% of items in our sample of patients' records tested, the pathway end date was not accurately recorded;
- for 6% of items in our sample, the pathway appeared to have been opened incorrectly, affecting the calculation of the published indicator; and
- for 33% of items in our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator for the year ended 31 March 2018 . We are unable to quantify the effect of these errors on the reported indicator.

## Percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge

The "percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator requires the Trust to accurately record the start and end times of each patient's wait in A&E, in accordance with the detailed requirements of set out in national guidance. This is calculated as a percentage of the total number of unplanned attendances at A&E for which patients total time in A&E from arrival is four hours or less until admission as an inpatient, discharge or transfer.

Our procedures included testing a risk based sample of 18 items and so the error rates identified from that sample should not be directly extrapolated to the population as a whole. We identified the following errors:

- In respect of the start time, we found that from our sample of 18 items tested:
- for 22% of items in our sample of patients' records tested, the start of the wait time was not accurately recorded;

In respect of the end time, we found that:

- for 11% of items in our sample of patients' records tested, the end time was not accurately recorded; for 56% of items in our sample of patients' recorded tested, the end time was not consistent with other Trust records; and
- for 6% of items in our sample of patients' records tested, we were unable to obtain sufficient supporting evidence necessary to test the end time of the wait.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

The "Definitions of the two mandated indicators for substantive sample testing by the Trust's auditors" section in Part 2 of the NHS Foundation Trust's Quality Report details the

actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

## Qualified conclusion

Based on the results of our procedures, except for the effects of matters set out in the 'Basis for qualified conclusion' section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;

the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for external assurance for quality reports 2016/17; and the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

**Deloitte LLP St Albans**
25 May 2018

# Annex 2

## Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHSI 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 2017/18 and Supporting Guidance

- content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from Commissioners dated 14/05/2018
  - feedback from Governors dated 08/05/2018
  - feedback from local Healthwatch organisations dated 14/05/2018
  - feedback from Overview and Scrutiny Committee dated 15/05/2018
  - the Trust's Complaints Report published under regulation 18 of the Local Authority Social
  - Services and NHS Complaints Regulations 2009, dated 16/05/2018 (draft copy)
  - the CQC Inpatient Survey – 31/05/2017
  - the national staff survey dated 06/03/2018
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 31/03/2018
  - CQC Inspection Report dated 07/08/2015

- 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 and

- 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.

**Richard Sumray**
Chair
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018

## Glossary

| A | |
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| Accessible Information Standard (AIS) | The standard makes sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. |
| Accountable Care Partnership (ACP) | New organisational form integrating care around patients. A partnership between primary, acute, community, social care and third sector with agreement to take responsibility for providing all care for a given population. |
| Accident and Emergency (A&E) Department | The A&E Department is for patients who are acutely ill, or are experiencing a life-threatening or limb-threatening problem that have either self-referred (come in themselves) or been brought in by ambulance. |
| Acute Medical Unit (AMU) | The first point of entry for patients referred to hospital as emergencies by their GP and those requiring admission from A&E. |
| Acute Myocardial Infarction | Acute Myocardial Infarction is the medical name for a heart attack. Heart attacks occur when the flow of blood to the heart becomes blocked. They can cause tissue damage and can even be life-threatening. |
| Advice and Guidance | A new clinical quality indicator with the goal of improving GP's access to consultant advice, thereby supporting more effective decision-making and better outcomes for patients. |
| Allied health professionals (AHPs) | These are health care professions distinct from nursing, medicine, and pharmacy. AHPs include everything from Podiatrist, Dietitian, and Physiotherapist, Diagnostic Radiographer to Occupational Therapist, Orthoptist and Speech and Language Therapist. |
| Ambulatory care pathway | Allows patients who are safe to go home to be managed promptly as outpatients, without the need for admission to hospital, following an agreed plan of care for certain conditions. |
| Appointment Slot Issues (ASI) | Where patients are unable to directly book their first outpatient appointment through the national e-Referral Service (e-RS); these errors are known as ASIs and result in a poor patient experience and are costly to administer. |
| **B** | |
| Berwick Review | Commissioned following the Mid Staffordshire Hospitals enquiry and publication of the Francis Report. The review includes recommendations to ensure a robust nationwide system for patient safety. |
| Better Care Fund | This is a programme spanning both the NHS and local government. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life. |
| British Sign Language | The sign language used in the United Kingdom (UK), and is the first or preferred language of some deaf people in the UK. |
| British Thoracic Society | Exists to improve standards of care for people who have respiratory diseases and to support and develop those who provide that care. |

| C | |
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| Care Pathway | Anticipated care placed in an appropriate time frame which is written and agreed by a multi-disciplinary team. |
| Care Quality Commission (CQC) | The independent regulator of health and social care in England. www.cqc.org.uk |
| Central Alerting System | A web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others. |
| Clinical audit | A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary. |
| *Clostridium Difficile infection (C. diff)* | A type of infection that occurs in the bowel that can be fatal. There is a national indicator to measure the number of infections that occur in hospital. |
| Commissioners | Responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. |
| Commissioning for Quality and Innovation (CQUIN) | A payment framework enabling commissioners to reward quality by linking a proportion of the Trust's income to the achievement of local quality improvement goals. |
| CQC Inpatient Survey | An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate. The Picker Institute Europe, co-ordinates the survey programme on behalf of the CQC. |
| **D** | |
| Department of Health (DH) | The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk |
| Discharge Summary | A letter written by the doctor in hospital communicating a patient's care plan to the post-hospital care team. |
| Dr Foster | An organisation that provides healthcare information enabling healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency. |
| **E** | |
| EMIS | EMIS Web is a clinical system for delivering integrated healthcare. It allows healthcare professionals to record, share and use vital information so they can provide better, more efficient care joining up healthcare across the NHS from GP surgeries, community care to hospitals to mental health services. |
| Escherichia coli (E. coli) | A bacterial infection that can cause severe stomach pain, bloody diarrhoea and kidney failure. |
| Experience and Engagement Group | A group consisting of patients, FT members, Trust Governors and staff who come together to discuss patient experience and engagement issues and agree actions for improvement. |

| F | |
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| Five Year Forward View | Document first published in October 2014, developed by partner organisations that deliver and oversee health and care services with advice provided by patient groups, clinicians and independent experts to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services. |
| Foundation Trust (FT) | NHS Foundation Trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop health care according to core NHS principles - free care, based on need and not ability to pay. |
| Four-hour A&E target | The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E Department in England must be seen, treated and then admitted or discharged in under four hours. |
| Fragility Fracture | Healthy bones should be able to withstand a fall from standing height; a bone that breaks in these circumstances is known as a fragility fracture. |
| Francis Report | Following failures in care at the Mid Staffordshire NHS Foundation Trust, Sir Robert Francis QC was selected to chair an independent public inquiry into those failings. The report from that enquiry made a number of wide ranging recommendations for change which affected a number of organisations. |
| Freedom to Speak | The Freedom to Speak Up Review was a review into whistleblowing in the NHS in England and it was chaired by Sir Robert Francis. |
| Friends and Family Test (FFT) | An opportunity for patients to provide feedback on the care and treatment they receive. Introduced in 2013 the survey asks patients whether they would recommend hospital wards, A&E Departments and maternity services to their friends and family if they needed similar care or treatment. |
| **G** | |
| Gap Analysis | Comparison of actual performance with potential or desired performance. |
| Governors | The Hillingdon Hospitals NHS Foundation Trust has a Council of Governors. Governors are central to the local accountability of our Foundation Trust and helps ensure the Trust Board takes account of members and stakeholders views when making important decisions. |
| GREATix | Staff can nominate another staff member or team for a GREATix via a bespoke online tool, when they observe excellence in the workplace. |

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| **H** | |
| Health and Social Care Information Centre | An Executive Non Departmental Public Body set up in April 2013. It collects, analyses and presents national health and social care data helping health and care organisations to assess their performance compared to other organisations. |
| Healthcare Assistant | Under the supervision and direction of qualified nursing staff, Healthcare Assistants carry out a wide range of duties to care for, support, and provide information to patients and their families. |
| Healthwatch | The national consumer champion in health and care that has significant statutory powers ensuring voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. |
| Hillingdon Health and Care Partners (HHCP) | HHCP have come together to develop a single, integrated, proactive service keeping people in their own homes with the focus on prevention. |
| HomeSafe | All patients over 65 are screened to identify whether or not they require a comprehensive geriatric assessment. The assessment team identifies the level of support patients will need at home in order to successfully recover, without the need to stay in hospital. Upon discharge from hospital Age UK, Social Services and Central North West London Foundation Trust provide a range of services from short-term rehabilitation to longer term care support. |
| Hospital Episode Statistics (HES) | The national statistical data warehouse for the NHS in England. 'HES' is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations. |
| Hospital Standardised Mortality Ratio (HSMR) | A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares Trusts against a national average. |
| **I** | |
| Indicator | Measure that determines whether a goal has been achieved. |
| Information Governance | The way by which the NHS handles all organisational information – in particular the personal and sensitive information of patients and employees, ensuring that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. |
| Inpatient | A patient who is admitted to a ward and staying in the hospital. |
| **J** | |
| John's Campaign | Launched in November 2014 after the death of Dr John Gerrard. The aim of the campaign is to give carers of those living with dementia the right to stay with them in hospital, in the same way that parents stay with their children. |
| **K** | |
| Keogh Review | A review of the quality of care and treatment provided by those NHS Trusts that were persistent outliers on mortality indicators. A total of 14 hospital Trusts were investigated as part of this review. |

| L | |
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| Laparotomy (Emergency) | A surgical operation that is used for people with severe abdominal pain to find the cause of the problem and in many cases to treat it. A general anaesthetic is given and the surgeon makes an incision (cut) to open the abdomen (stomach area). Often the damaged part of an organ is removed and the abdomen washed out to limit any infection. |
| Local Clinical Audit | A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team. |
| London Quality Standards (LQS) | Professional consensus standards designed to address the unacceptable variations found in the provision of unscheduled care. They mandate timely clinical review by junior, consultant and multi-disciplinary staff; timely access to key diagnostic, interventional and other allied clinical services; robust monitoring of patients with appropriate responses to clinical deterioration; and patterns of extended working seven days per week. |
| **M** | |
| Magnetic resonance imaging (MRI) | A type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. The results of an MRI scan can be used to help diagnose conditions, plan treatments and assess how effective previous treatment has been. |
| Major Trauma | Major trauma is any injury that has the potential to cause prolonged disability or death; this includes head injuries, life-threatening wounds and multiple fractures. |
| Mandatory | Mandatory means 'must' as outlined by an organisation for the role of the staff member. |
| Meticillin-resistant staphylococcus aureus (MRSA) | A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections that occur in hospitals. |
| Meticillin-sensitive Staphylococcus aureus | MSSA can cause serious infections, however unlike MRSA MSSA is more sensitive to antibiotics. |
| Model Hospital | A digital information service designed to help NHS providers improve their productivity and efficiency. |
| Mortality rate | The number of deaths in a given area or period, or from a particular cause. |
| Multi-disciplinary team meeting (MDT) | A meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients. |
| Muskoskeletal service | Deals with injuries or pain in the Muskoskeletal system, including the joints, ligaments, muscles, nerves, tendons, and structures that support limbs, neck and back. |

| N | |
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| National Clinical Audit | A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. |
| National Early Warning Scoring system (NEWS) | An early warning scoring system used to track patient deterioration and to trigger escalations in clinical monitoring and rapid response by the critical care outreach team. The scoring system used to trigger escalation is based on routine observations of respiratory rate, oxygen saturation levels, blood pressure, temperature, pulse rate and level of consciousness combined to give weighted scores that in turn trigger graded clinical responses. |
| National Joint Registry (NJR) | The NJR collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients and clinicians. |
| National Reporting and Learning System (NRLS) | A central database of patient safety incident reports submitted from health care organisations. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. |
| Never Events | Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. Trusts are required to report if a Never Event occurs. |
| NHS Improvement (NHSI) | Responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care. |
| NHS number | A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care. |
| **O** | |
| Intraosseous Injection | IO is the process of injecting directly into the marrow of a bone to provide a non-collapsible entry point into the systemic venous system. |
| Ophthalmology | The branch of medicine that deals with the anatomy, physiology and diseases of the eye. |
| Outpatient | A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in this hospital. |
| Overview and Scrutiny Committee (OSC) | Looks at the work of NHS Trusts and acts as a 'critical friend' by suggesting ways that health-related services might be improved. It also looks at the way the health service interacts with social care services, the voluntary sector, independent providers and other Council services to jointly provide better health services to meet the diverse needs of the area. |

| P | |
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| Palliative care coding | SHMI makes no adjustment for palliative care. As a result, the HSCIC currently publish two contextual indicators on palliative care to support interpretation of the SHMI. One is the 'Percentage of deaths with palliative care coding' providing a basic indication of percentage rates of deaths coded with palliative care either in diagnosis or treatment specialty fields. |
| Patient Safety Incident | Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. |
| Pressure ulcers | Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal. |
| Priorities for improvement | There is a national requirement for Trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes. |
| Patient Reported Outcome Measures (PROMs) | PROMs collect information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. Hospitals providing four key elective surgeries invite patients to complete questionnaires before and after their surgery. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations. |
| **R** | |
| Readmission | A national indicator that assesses the number of patients who have to go back to hospital within 30 days of discharge from hospital. |
| RED2GREEN | A visual management system to assist in the identification of wasted time in a patient's journey. Applicable to inpatient wards this is an approach used to reduce internal/external delays as part of the SAFER patient flow bundle. |
| Referral to treatment (RTT) | In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment. |
| Requirement notice | Used by the CQC when a registered provider is in breach of a regulation or has poor ability to maintain compliance with regulations, but people using the service are not at immediate risk of harm. This is only the case when assessments state the provider is able to improve its standards and in cases when the service provider has no prior history of poor performance. Once issued, the provider is required to deliver a report showing how they will comply with their legal obligations along with an explanation of the action they propose to implement. |
| Root Cause Analysis (RCA) | Method of problem solving that looks deeper into problems to identify the root causes and find out why they're happening. |

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| **S** | |
| Safety Huddle | Short multi-disciplinary briefings designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care. |
| SAFER patient flow bundle | Standardised way of managing patient flow through hospitals. If consistently followed (with minimal variation) the bundle will help improvement |
| Sentinel Stroke National Audit Programme | This aims to improve the quality of stroke care by auditing stroke services against evidence-based standards, and national and local benchmarks. |
| Sepsis | Potentially fatal whole-body inflammation (a systemic inflammatory response syndrome) caused by severe infection. |
| Serious Incident | An event in health care where potential for learning is so great or consequences to patients, families and carers, staff or organisation are significant, that it warrants using additional resources to mount a comprehensive response. |
| Shaping a Healthier Future | A programme to improve NHS services for people who live in North West London bringing as much care as possible nearer to patients. It includes centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and incorporating this into one co-ordinated system of care so that all the organisations and facilities involved in caring for patients can deliver high-quality care and an excellent experience. |
| Statutory | Statutory means 'decided or controlled by law'. |
| Straight to Test | Patients can be seen by their GP, have a phone consultation with a specialist nurse and be given an appointment for an investigative procedure all within a few days. |
| Summary Hospital-level Mortality Indicator (SHMI) | An indicator which reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. |
| Sustainability and Transformation Plan (STP) | Five year plans for the future of health and care services in local areas. NHS organisations have come together with local authorities and other partners to develop the plans in 44 areas of the country. |
| **V** | |
| Venous thromboembolism (VTE) | An umbrella term to describe venous thrombus and pulmonary embolism. Venous thrombus is a blood clot in a vein (often leg or pelvis) and a pulmonary embolism is a blood clot in the lung. There is a national indicator to monitor the number of patients admitted to hospital who have had an assessment made of the risk of them developing a VTE. |
| **W** | |
| Warning notice | The CQC is able to serve warning notices regarding past and continuing failures to meet legal requirements. They include a timescale, which if not met generates further enforcement action. |
| Whole Systems Integrated Care (WSIC) | Aims to improve the quality and experience of care for patients and service users, save money across the local health and social care system, and enhance professional experience by helping people in health and social care, work more effectively together. |

## Languages/ Alternative Formats

Please call the Patient Advice and Liaison Service (PALS) if you require this information in other languages, large print or audio format on: 01895 279973. www.thh.nhs.uk

**Fadlan waydii haddii aad warbixintan ku rabto luqad ama hab kale. Fadlan la xidhiidh 01895 279 973**

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿੱਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਪਤਾ ਕਰਨ ਲਈ 01895 279973 ਤੇ ਸੰਪਰਕ ਕਰੋ

برائے مہربانی ہے تہاؤں اے اطلاع کے اور زبان یا انداز وچ چاہی دی اے تے ہے کرن لئی 01895 279 973 نے رابطہ کرو

தயவுசெய்து, வேற்று மொழிகளில் இத் தகவல்கள், கட்டுமானம் தேவையெனில், கேளுங்கள்.! தயவுசெய்து 01895 279973 இலக்கத்துடன் தொடர்பு கொள்ளுங்கள்.!

Jeżeli chcialbyś uzyskać te informacje w innym języku, w dużej czcionce lub w formacie audio, poproś pracownika oddzialu o kontakt z biurem informacji pacjenta (patient information) pod numerem telefonu: 01895 279973.

如果你需要這些資料的其他語言版本、大字体、或音頻格式，請致電01895 279 973查詢。

إذا كنت تود الحصول على هذه المعلومات بلغة أخرى، بالأحرف الكبيرة أو بشكل شريط صوتي، يرجى الاتصال بالرقم التالي 01895279973 .

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# Statement of Directors' Responsibilities in Respect of the Accounts

# STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. Monitor, with the approval of the Secretary of State, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the Statements of Comprehensive Income, Financial Position, Tax Payers Equity, Cash Flow and all disclosure notes in the Annual Accounts.

In preparing these accounts, Directors are required to:

- Apply on a consistent basis accounting policies according to the NHS Foundation Trust Annual Reporting Manual 2017/18 with the approval of the Secretary of State
- Make judgements and estimates which are reasonable and prudent
- State where applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- Comply with International Financial Reporting Standards.

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

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

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# **Independent** Auditor's Report

## INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

### Report on the audit of the financial statements

### Opinion

**In our opinion the financial statements of The Hillingdon Hospitals NHS Foundation Trust (the 'foundation trust'):**

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Taxpayers' Equity;
- the Statement of Cash Flows; and
- the related notes 1 to 28.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Material uncertainty relating to going concern

We draw attention to note 1.3 in the financial statements and the disclosures in the Annual Governance Statement, which indicate that the foundation trust incurred a net deficit of £8m during the year ended 31 March 2018, and is projecting a further substantial deficit for 2018/19 before impairments and revaluations of £7.8m. In addition, the foundation trust has existing loans of £38m of which £2.8m is due in the 2018/19 financial period.

The foundation trust has identified additional funding is required before the end of 2018/19 to support the foundation trust in meeting its liabilities which is yet to be formally agreed. Without additional funding, the foundation trust will have insufficient working capital to meet its liabilities as they fall due. In addition, the receipt of the Provider Sustainability Fund ("PSF") income is dependent on the foundation trust achieving its efficiency savings plan. If the foundation trust did not receive an extension to the existing loan and the PSF income, it would have to apply for alternative funding from the Department of Health. The outcome of this application is currently uncertain.

In response to this, we:

- reviewed the foundation trust's financial performance in 2017/18 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the current status of contract negotiations with its commissioners and the funding arrangements that have been agreed, confirming to signed loan agreements and regarding management's expectation around further funding requirements;
- reviewed the foundation trust's cash flow forecasts and the foundation trust's financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHS Improvement guidance and by benchmarking information for other acute providers; and
- assessed the historical accuracy of the budgeting process used by the foundation trust.

However, as stated in note 1.3 and summarised above, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

### Summary of our audit approach

| | |
|---|---|
| **Key audit matters** | The key audit matters that we identified in the current year were:<br>• Recognition of NHS Revenue<br>• Investment Property Valuations<br>• Going Concern (see 'material uncertainty related to going concern' section)<br>• Arrangements to secure value for money (see 'matters on which we are required to report by exception – use of resources' section)<br><br>All key audit matters are consistent with prior year. |
| **Materiality** | The materiality that we used for the current year was £5.0m which was determined on the basis of 2% of Revenue. |
| **Scoping** | Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control. The foundation trust does not have any subsidiaries and is structured as a single reporting unit and so the whole foundation trust was subject to a full audit scope. |
| **Significant changes in our approach** | There have been no significant changes in our approach. |

### Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included 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.

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 addition to the matter described in the 'material uncertainty relating to going concern' section and the 'matter described in the matters on which we are required to report by exception – use of resources' section, we have determined the matters described below to be the key audit matters to be communicated in our report.

| **Recognition of NHS Revenue** | |
|---|---|
| **Key audit matter description**  | As described in note 1.7, Income Recognition, and note 1.2, Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients due to:<br>• the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise where this is unsettled; and<br>• the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4.<br><br>Details of the foundation trust's income, including £216.3m of Commissioner Requested Services are shown in note 3.2 to the financial |

| | |
|---|---|
| | statements. NHS debtors are shown in note 18.1 to the financial statements.<br><br>The foundation trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions. |
| **How the scope of our audit responded to the key audit matter** | We evaluated the design and implementation of controls over the Agreement of Balances exercise.<br><br>We performed detailed substantive testing on a sample basis of the validity of unsettled income and evaluated the results of the agreement of balances exercise.<br><br>We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners. |
| **Key observations** | The evidence we obtained from our audit procedures supported the revenue, receivables and provisions balance held by the foundation trust and the appropriateness of the assumptions used in its provision calculation. |
| **Investment Property valuations** | |
| **Key audit matter description** | The foundation trust holds Investment Properties at valuation of £43.1m (2016/17: £32.4m) following a revaluation in 2017/18. This was an increase of £10.7m wholly due to revaluation gains. This can be seen in note 14 to the accounts. Investment property gains differ to operational property gains as impacts are recognised in the control total (the trust-specific bottom line surplus or deficit amount set as a target by NHS Improvement), which can lead to the receipt of additional funding therefore increasing the risk of misstatement in this area. These valuations are by nature significant estimates which are based on specialist and management assumptions for example rental yields and which can be subject to material changes in value. There has not been a revaluation of the main operational estate in 2017/18. |
| **How the scope of our audit responded to the key audit matter** | We evaluated the design and implementation of controls over investment property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. This was focused on the information related to the investment property revaluation.<br><br>We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's investment properties.<br><br>We have reviewed the disclosures in notes 1.12 and 1.13 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.<br><br>We assessed whether the valuation and the accounting treatment of the movement was compliant with the relevant accounting standards. |

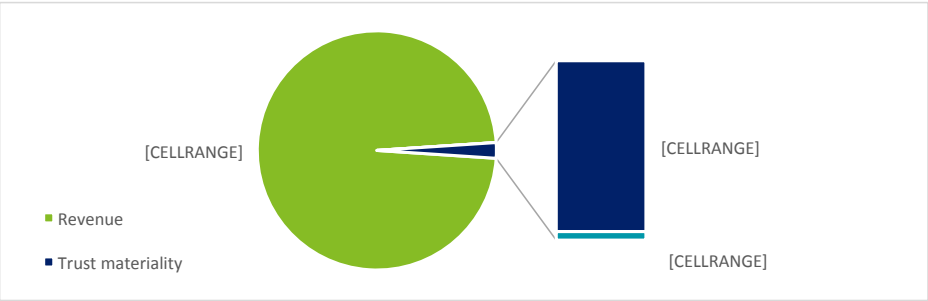
| | |
|---|---|
| **Key observations** | The evidence we obtained from our audit procedures supported the valuation of the investment property assets held by the foundation trust and the appropriateness of the assumptions used in its calculation. |

## Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

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

| | |
|---|---|
| **Materiality** | £5.0m (2016/17: £5.0m) |
| **Basis for determining materiality** | 2% of revenue (2016/17: 2% of revenue) |
| **Rationale for the benchmark applied** | Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements. |




We agreed with the Audit and Risk Committee that we would report to the Committee all audit differences in excess of £250k (2016/17: £250k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit and Risk Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

## An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the foundation trust and its environment, including internal controls, and assessing the risks of material misstatement at the foundation trust level. Audit work was performed at the foundation trust's head offices in Hillingdon directly by the audit engagement team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

## Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report other than the financial statements and our auditor's report thereon.

***We have nothing to report in respect of these matters.***

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

## Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation 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 the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

## Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Report on other legal and regulatory requirements

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

In our opinion:
- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Matters on which we are required to report by exception

***Use of resources***

We are required to report to you if, in our opinion the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Our conclusion is qualified.

*Basis for qualified conclusion*

The foundation trust has described in its Annual Governance Statement the financial challenges it faces and the pressures upon financial sustainability, including matters which are not wholly within the control of the foundation trust. The foundation trust's outturn position for 2017-18 was a deficit of £8m and the foundation trust's 2018-19 plan submission showed a further deficit forecast of £13.8m before PSF ("Provider Sustainability Fund") funding, an operational deficit of £7.8m including PSF funding. The foundation trust is forecasting to remain dependent upon central funding. The foundation trust has also estimated its backlog maintenance to be £236m across the estate but, due to limitations in available funding, has allocated limited funding to capital developments and has a planned capital spend in 2018/19 of £28.6m. The foundation trust is exposed to risks related to the age and condition of the estate that could impact levels of service provision.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

*Qualified conclusion*

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, The Hillingdon Hospitals NHS Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

***We have nothing to report in respect of these matters.***

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

***Reports in the public interest or to the regulator***

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

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

***We have nothing to report in respect of these matters.***

**Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

**Use of our report**

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of The Hillingdon Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding, FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St. Albans, UK
25 May 2018

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# Foreword
to the accounts

## The accounts for the year ended 31 March 2018 have been prepared by the Hillingdon Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form of which the Independent Regulator of the NHS Foundation Trust (Monitor) has, with the approval of the Secretary of State, directed.

In order to present a true and fair view, the accounts of an NHS Foundation Trust must comply with the International Financial Reporting Standards (IFRS) as adopted by the European Union unless directed otherwise. These accounting standards are published by the International Accounting Standards Board. The Annual Reporting Manual is consistent with these standards which the Trust follows in preparing its accounts. Any departures from these standards are agreed with the external auditors and the Audit and Risk Committee.

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
31 March 2018

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# The 2017-18 Accounts

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

| | NOTES | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| Operating Income from patient care operations | 3 | **225,808** | 214,681 |
| Other operating income | 3 | **28,422** | 38,321 |
| Total operating income from continuing operations | | **254,230** | 253,002 |
| Operating expenses of continuing activities | 4 | **(266,158)** | (267,520) |
| **OPERATING (DEFICIT)** | | **(11,928)** | (14,518) |
| **FINANCE COSTS** | | | |
| Finance income | 8 | **20** | 12 |
| Finance expense | 9 | **(2,648)** | (2,097) |
| PDC Dividend expense | | **(4,130)** | (4,137) |
| **NET FINANCE COSTS** | | **(6,758)** | (6,295) |
| **OTHER NON OPERATING INCOME** | | | |
| Gain on disposal of assets | | **-** | 2 |
| Increase in fair value of investment property | 10 | **10,670** | 11,256 |
| **DEFICIT FOR THE YEAR** | | **(8,016)** | (9,555) |
| Other comprehensive (loss)/income | | | |
| Impairments | 12.2 | **-** | (3,213) |
| Revaluations credited to reserves | 12.2 | **-** | 22,789 |
| Total Other Comprehensive Income | | **-** | 19,576 |
| **TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE YEAR** | | **(8,016)** | 10,021 |

The notes on pages 5 to 42 form part of these accounts.

| STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018 | NOTES | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible Assets | 11 | **2,476** | 2,348 |
| Property, plant and equipment | 12 | **140,118** | 142,313 |
| Investment property | 14 | **43,087** | 32,417 |
| Trade and other receivables | 18 | **1,950** | 1,020 |
| **Total non-current assets** | | **187,631** | 178,098 |
| **Current assets** | | | |
| Inventories | 17 | **3,243** | 2,897 |
| Trade and other receivables | 18 | **27,117** | 21,795 |
| Cash and cash equivalents | 19 | **1,099** | 1,060 |
| **Total current assets** | | **31,459** | 25,752 |
| **Total assets** | | **219,090** | 203,850 |
| **Current liabilities** | | | |
| Trade and other payables | 20 | **(35,998)** | (31,164) |
| Borrowings | 21 | **(3,129)** | (3,396) |
| Provisions | 25.1 | **(171)** | (171) |
| **Total Current Liabilities** | | **(39,298)** | (34,731) |
| **Net current liabilities** | | **(7,839)** | (8,979) |
| **Total assets less current liabilities** | | **179,792** | 169,119 |
| **Non-current liabilities** | | | |
| Borrowings | 21 | **(51,053)** | (34,243) |
| Provisions | 25.1 | **(2,150)** | (2,218) |
| Total non-current liabilities | | **(53,203)** | (36,461) |
| **Total assets employed** | | **126,589** | 132,658 |
| **Financed by taxpayers' equity:** | | | |
| Public dividend capital | | **73,426** | 71,479 |
| Revaluation reserve | | **49,837** | 51,129 |
| Income and expenditure reserve | | **3,326** | 10,050 |
| **Total taxpayers' equity** | | **126,589** | 132,658 |

The financial statements on pages 1 to 42 were approved by the Board and authorised for issue on 24th May 2018 and signed on its behalf by:

**Shane DeGaris**
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2018

| STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2018 | NOTES | Total | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Taxpayers' Equity at 1 April 2017** | | **132,658** | **71,479** | **51,129** | **10,050** |
| **Deficit for the year** | | **(8,016)** | **-** | **-** | **(8,016)** |
| **Transfers between reserves*** | 12.2 | **-** | **-** | **(1,292)** | **1,292** |
| **Public dividend capital received** | | **1,947** | **1,947** | **-** | **-** |
| **Taxpayers' Equity at 31 March 2018** | | **126,589** | **73,426** | **49,837** | **3,326** |
| | | | | | |
| Taxpayers' Equity at 1 April 2016 | | 122,637 | 71,479 | 33,165 | 17,993 |
| Surplus for the year | | 5,892 | - | - | 5,892 |
| Impairments Charged to Operating Costs* | 4 | (15,447) | - | - | (15,447) |
| Transfers between reserves | 12.2 | - | - | (1,612) | 1,612 |
| Impairments Due to change in market values | 12.2 | (3,213) | - | (3,213) | - |
| Revaluations - property, plant and equipment | 12.2 | 22,789 | - | 22,789 | - |
| Public dividend capital received | | 1,173 | 1,173 | - | - |
| Public dividend capital repaid | | (1,173) | (1,173) | - | - |
| Taxpayers' Equity at 31 March 2017 | | 132,658 | 71,479 | 51,129 | 10,050 |

* Transfers between reserves is a depreciation adjustment required due to revaluations of land and buildings.

| STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018 | NOTES | For the Year Ended 31 March 2018 | For the Year Ended 31 March 2017 |
|---|---|---|---|
| | | £000 | £000 |
| **Cash flows from operating activities** | | | |
| **Operating (Deficit)** | | **(11,928)** | (14,518) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | | **9,302** | 9,523 |
| Impairments | | **-** | 15,447 |
| Receipt of Donated Assets | | **(137)** | (177) |
| (Increase)/Decrease in Trade and Other Receivables | | **(6,195)** | (3,074) |
| (Increase)/Decrease in Inventories | | **(346)** | 274 |
| (Increase)/Decrease in Trade and Other Payables | | **4,160** | 1,796 |
| (Decrease)/Increase in Provisions | | **(140)** | (129) |
| Other Movements in Cash Flow | | **-** | (116) |
| **Net cash generated from operations** | | **(5,284)** | 9,026 |
| **Cash flows used in investing activities** | | | |
| Interest received | | **20** | 12 |
| Purchase of intangible assets | | **(233)** | (100) |
| Purchase of Property, Plant and Equipment Exchequer Financed | | **(5,568)** | (8,752) |
| Proceeds on disposal of assets | | **-** | 5 |
| **Net cash used in investing activities** | | **(5,781)** | (8,835) |
| **Cash flows from financing activities** | | | |
| PDC dividend received | | **1,947** | - |
| Movement in loans from the Department of Health and Social Care | | **18,054** | 4,610 |
| Capital element of finance lease rental payments | | **(1,877)** | (1,525) |
| Capital element of LIFT | | **(226)** | (217) |
| Interest paid | | **(734)** | (444) |
| Interest Element on Finance Lease | | **(273)** | (248) |
| Interest Element on LIFT | | **(1,457)** | (1,405) |
| PDC dividend (paid) | | **(4,330)** | (3,994) |
| **Net Cash from/(used in) financing activities** | | **11,104** | (3,223) |
| **Increase/(Decrease) in cash and cash equivalents** | | **39** | (3,032) |
| **Cash and Cash equivalents at start of year** | | **1,060** | 4,092 |
| **Cash and Cash equivalents at end of year** | 19 | **1,099** | 1,060 |

# Note 1 Accounting Policies

## 1.1 Basis of Preparation

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

## 1.2 Accounting judgements and key sources of estimation and uncertainty

In the application of the Trust's accounting policies management is required to make judgments, estimates, and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

The provision for credit notes and doubtful debtors has been identified as an assumption about the future and is a major source of estimation uncertainty that has a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

This involves management judgement and is based on reviews of individual accounts including assessments of customer credit-worthiness, current economic trends and analysis of historical bad debts.

- **Going Concern**
  The Trust produces an extensive report to the Board outlining all its assumptions on why it believes it is a going concern, and refers to cash forecasts and other reports to support its solvency predictions. It also refers to the Financial context in which it operates.

- **Asset valuation and lives**
  The Trust conducts regular valuations on its property, utilising specialist third party advisors, and on its equipment. It last conducted a review of its property in March 2017 and of the asset lives of its equipment in March 2017.

- **Impairments of receivables**
  The Trust regularly reviews the collectability of its debtors to ensure these are appropriately impaired. This assessment is based on the latest cash collection records and other external factors impacting relationships with debtors and the health economy.

- **Provisions**
  As at the year end the Trust's only provision was for staff pensions. It uses actuarial tables provided by the Department of Health and Social Care in calculating the provision for future payments to pensioners.

- **Accruals**
  The Trust regularly make evidenced based estimates for income and expenses, where invoices are yet to be raised or received.

**The critical judgements are addressed in the accounting policies that follow.**

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 Going Concern

After making enquiries, the directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. There is material uncertainty regarding outcomes which may affect incoming resources to the Trust. Readers of these accounts are advised to refer to the Annual Governance Statement of the Trust for more detail. The Trust has produced these accounts on a going concern basis.

## 1.4 Accounting convention

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

## 1.5 Current / non-current classification

Assets and liabilities are classified as current if they are expected to be realised within twelve months from the Statement of Financial Position date, the primary purpose of the asset and liability is to be traded, or of loans and receivables where they have a maturity of less than twelve months from the Statement of Financial Position date. All other assets and liabilities are classified as non-current.

## 1.6 Consolidation

The Trusts charitable funds would ordinarily under IAS 27 be considered as a subsidiary entity in that the Hillingdon Hospitals NHS Foundation Trust are corporate trustees and as such exert control over the uses of these funds. The Trust has decided not to consolidate the charitable funds due to the immaterial nature of the balances and instead the summary details are shown by in note 29.

## 1.7 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from NHS commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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

## 1.8 Partially Completed Spells

The Partial Spells accrual relates to patients who remain undischarged at 31 March 2018. The Trust reflects income at the point of discharge in line with the matching concept. The Trust has accrued income on a per patient basis to 31 March 2018 based on average tariff rates for the speciality. Ordinarily this activity is coded once the patient has been discharged and generated a Health Resource Grouper code to which National Tariff rates are applied to calculate the income. Hence an average tariff is applied based on point of delivery and length of stay by speciality.

## 1.9 Expenditure on employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Annual leave allowances are in line with the financial year end of the Trust. Therefore the Trust has considered whether a holiday accrual is required and has deemed this is unnecessary as the Trust policy does not permit unused holiday allowances to be carried forward.

## 1.10 Pensions

### Pension Costs

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

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

### a) Accounting valuation

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

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions

website and are published annually. Copies can also be obtained from The Stationery Office.

### b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

## 1.11 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenditure is recognised in operating expenses except where it results in the creation of a non current asset such as property, plant and equipment..

## 1.12 Property, plant and equipment

### Recognition

Property, plant and equipment is capitalised if:

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

### Componentisation

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

### Valuation

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

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

- Land and non-specialised buildings – market value for existing use;
- Investment Properties - market value and or net rental income stream; and
- Specialised buildings – depreciated replacement cost..

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any

impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets depreciation commences when they are brought into use.

The last full revaluation exercise took place on 31st March 2017. Having consulted with our Trust surveyors, Gerald Eve, it is not considered necessary to carry out a revaluation for the year ended 31st Match 2018.

The surveyors are MRICS qualified and registered valuers and are experienced in the healthcare sector.

New fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

**Subsequent expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Depreciation, amortisation and impairment**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. 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 lease period.

In accordance with the Department of Health and Social Care Group Accounting Manual (DHSC GAM), impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. The valuation performed relies on market prices for similar assets in the local area, level 2 inputs on the fair value hierarchy under IFRS 13.

**Revaluation Gains, Losses and De-Recognition**

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

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

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

**De-Recognition**

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met: 1) the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; 2) the sale must be highly probable i.e. management are committed to a plan to sell the asset; or an active programme has begun to find a buyer and complete the

sale; 3) the asset is being actively marketed at a reasonable price; 4) the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

## 1.13 Investment Property

Investment property is property held to earn rentals or for capital appreciation or both. A key factor in determining classification would be whether property was saleable separately. In considering whether land meets this criteria the Trust would consider whether property had direct public access.

Investment property is accounted for under International Accounting Standard 40. A gain or loss arising from a change in the fair value of investment property is recognised in profit or loss for the period in which it arises.

## 1.14 Donated assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

## 1.15 Assets no longer in use

The Trust regularly reviews assets not in use for the purpose of revaluing them. The relevant accounting standard affecting this is IFRS 13. The Trust is required to re value any asset found not to be in use to market value or if no market exists, scrap value. Due to the large number of assets involved, the Trust has agreed with its auditor to review assets above a net book value of £10k.

## 1.16 Intangible Assets

### Recognition

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

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Foundation Trust (FT) intends to complete the asset and sell or use it;
- The FT has the ability to sell or use the asset;
- How the asset will generate probable future economic 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 and
- Adequate financial, technical, and other resources are available to the FT to complete the development and sell or use the asset during development.

### Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists, and similar items are not capitalised as intangible assets, neither is expenditure on research.

### Impairments

Assets that are subject to amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Any impairment loss is recognised in the Statement of Comprehensive Income to reduce the carrying amount to the recoverable amount.

### Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is capitalised as an intangible asset.

### Measurement

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

and impairments are treated in the same manner as for property, plant and equipment. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell.

### Amortisation

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

- Development expenditure up to 5 years
- Software up to 5 years

## 1.17 Leases

### The Trust as lessee

**Finance leases**

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

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

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

**Operating leases**

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

**Leases of land and buildings**

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

### The Trust as Lessor

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 on a straight-line basis over the lease term.

## 1.18 Local Improvement Finance Trust (LIFT) transactions

HM Treasury has determined that NHS Trusts shall account for infrastructure LIFT schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual lease plus payment is separated into the following component parts, using appropriate estimation techniques where necessary:

**a.** Payment for the fair value of services received; and
**b.** Payment for the LIFT asset, including finance costs.;

The Trust is currently party to a 25-year LIFT lease plus contract.

### Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

### LIFT Asset

LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

### LIFT liability

A LIFT liability is recognised at the same time as the LIFT assets are recognised. It is measured initially at the same amount as the fair value of the LIFT assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the lease plus payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the lease plus payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred.

## 1.19 Inventories

Inventories are stated at the lower of cost or net realisable value. Cost is calculated on a FIFO basis (First In First Out).

## 1.20 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

## 1.21 Provisions

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.

Injury Benefits and Early Retirement: 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.

From 2012/13, the Treasury publishes three discount rates that are to be employed. These are short term less than 5 years. Medium term 5 to 10 years and long term over 10 years. Where cash flows are expected to fall into more than one on these time frames, then multiple discount rates will need to be used when calculating the carrying value of the provision.

The Trust will continue using its long term rate of 3% as there is no material effect in changing the rate used.

The period over which future cash flows will be paid is estimated using the England life expectancy tables as published by the Office for National Statistics.

## 1.22 Clinical negligence costs

NHS Protect (Formerly NHS Litigation Authority) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Protect which in return settles all clinical negligence claims.The contribution is charged to expenditure. The Trust has a legal liability for all clinical negligence cases although NHS Protect is administratively responsible.

## 1.23 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 excess payable in respect of particular claims are charged to operating expenses as and when they become due.

## 1.24 Contingencies

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 not recognised but 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 not recognised but is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

## 1.25 Public Dividend Capital (PDC) and PDC dividend

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

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM

Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Average relevant net assets is defined as the average of the opening and closing reserves less the average of the opening and closing net book value of donated assets, less the average cleared/available balance of the Government Banking Service balances over the year. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## 1.26 Value Added Tax

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

The Trust makes both taxable and exempt supplies and incurs input tax that relates to both kinds of supply. The Trust is therefore classified as 'partly exempt'. Partly exempt businesses must undertake calculations which work out how much input tax they may recover. The percentage relating to partially exempt supplies is currently 1.25% which reduces the Trust's VAT recovery. This percentage is reviewed annually.

## 1.27 Corporation Tax

The Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988).

None of the Trust's activities in the period are subject to a corporation tax liability.

## 1.28 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.

## 1.29 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.

## 1.30 Financial instruments and financial liabilities

### Recognition

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

Financial assets or financial liabilities in respect of assets required or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases in note 1.17.

### De-Recognition

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

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

### Classification and Measurement

Financial assets are categorised as loans and receivables or available for sale as financial assets.

Financial liabilities are classified as other financial liabilities.

## 1.31 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets if receivable in the current reporting period, or in non current assets if outside the current reporting period.

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

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

## 1.32 Other financial liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the reporting period, which reclassified as long-term liabilities.

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

## 1.33 Impairment of financial assets

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

## 1.34 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are recognised in the Statement of Comprehensive Income.

## 1.35 Government Grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS trusts for the provision of services. Where a grant is used to fund revenue or capital expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The exception to this is where specific grant conditions apply regarding the recognition of income.

## 1.36 Financial risk management

International Financial reporting standard (IFRS 7) requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

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

### Currency risk

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

### Interest rate risk

To date, the Trust has only borrowed from the Department of Health and Social Care for capital expenditure and working capital support by way of loans at fixed interest rates over various periods. The Trust has therefore low exposure to interest rate fluctuations.

### Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note 18.

### Liquidity risk

The majority of the Trust's operating costs are incurred

under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament  The Trust is not, therefore, exposed to significant liquidity risks.

## 1.37 Events after the reporting period

Generally accepted accounting principles state that the financial statements should include the effects of all subsequent events that provide additional information about conditions in existence as of the balance sheet date. This rule requires that all entities evaluate subsequent events through the date when financial statements are available to be issued.

There are no post balance sheet events to report.

## 1.38 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

## 1.39 Accounting standards and amendments issued but not yet adopted in the NHS

The following new and revised standards and interpretations were in issue but not yet adopted in the Department of Health and Social Care Accounting Manual. None of these new and revised standards and interpretations have been adopted early by the Trust.

The Department of Health & Social Care released the 2018/19 Group Accounting Manual during May, addressing some, but not all, of the potential NHS-specific issues in implementing IFRS 9 and IFRS 15. There are potential areas where additional guidance may be helpful, including non-contracted income, research income, transaction/merger support funding, and other central funding.

The Trust has not yet performed a full impact analysis of the effect of implementing these standards, and so the Trust is still assessing the impact following publication of the GAM.

| | |
|---|---|
| IFRS 9 *Financial Instruments* | Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the Department of Health and Social Care (DHSC): early adoption is not therefore permitted. |
| IFRS 14 *Regulatory Deferral Accounts* | Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies. |
| IFRS 15 *Revenue from Contracts with Customers* | Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the DHSC: early adoption is not therefore permitted. |
| 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 DHSC: early adoption is not therefore permitted. |
| IFRIC 22 *Foreign Currency Transactions and Advance Consideration* | Application required for accounting periods beginning on or after 1 January 2018. |
| IFRIC 23 *Uncertainty over Income Tax Treatments* | Application required for accounting periods beginning on or after 1 January 2019. |

## Note 2 Finance and Use of Resources Risk Rating

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Capital Service Cover Rating** | **4** | 2 |
| **Liquidity Rating** | **4** | 4 |
| **I&E Margin Rating** | **4** | 1 |
| **I&E Margin Variance from Plan Rating** | **1** | 1 |
| **Agency Rating** | **2** | 3 |
| | | |
| **Overall Financial Sustainability Risk Rating before Over-rides** | **3** | 2 |
| **Overall Financial Sustainability Risk Rating after Over-rides** | **3** | 3 |

## Note 3 Operating Income

| Note 3.1 Operating income (by nature) | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Income From Activities** | **£000** | £000 |
| **NHS Clinical Income** | | |
| Elective income | **29,595** | 30,680 |
| Non elective income | **63,776** | 60,130 |
| First Outpatient income | **15,606** | 15,320 |
| Follow up outpatient income | **22,998** | 20,583 |
| A & E income | **12,451** | 10,689 |
| High cost drugs income from commissioners | **11,112** | 11,895 |
| Other NHS clinical income | **63,042** | 56,849 |
| Ambulance Service | **1,063** | 1,028 |
| Community Services | **2,803** | 3,402 |
| Private patient income | **208** | 153 |
| Other clinical income | **3,154** | 3,952 |
| **Total income from activities** | **225,808** | 214,681 |
| Total other operating income | **28,422** | 38,321 |
| **Total Operating Income** | **254,230** | 253,002 |

| Note 3.2 Operating Income (by source) | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Income from activities** | | |
| NHS England | **15,074** | 15,255 |
| Clinical Commissioning Groups | **201,217** | 194,624 |
| NHS Foundation Trusts | **138** | 172 |
| NHS Trusts | **504** | 563 |
| Local Authorities | **383** | 1,381 |
| NHS other (including Public Health England) | **106** | 0 |
| Non NHS: Private patients | **172** | 153 |
| Non-NHS: Overseas patients (non-reciprocal) | **1,503** | 1,428 |
| NHS injury scheme | **1,182** | 954 |
| Non NHS: Other | **5,529** | 151 |
| **Total income from activities** | **225,808** | 214,681 |
| **Other operating income** | | |
| Research and development | **465** | 517 |
| Education and training | **10,094** | 9,533 |
| Education and training - notional income from apprenticeship fund | **10** | 0 |
| Sustainability and Transformation Fund income | **0** | 7,520 |
| Grants and Donations | **137** | 177 |
| Non-patient care services to other bodies | **8,431** | 8,621 |
| Rental revenue from operating leases | **3,430** | 3,812 |
| Other * | **5,268** | 7,676 |
| Income in respect of staff costs where accounted on gross basis | **587** | 465 |
| **Total other operating income** | **28,422** | 38,321 |
| **Total Operating Income** | **254,230** | 253,002 |
| **** Analysis of Other Operating Income: Other** | | |
| Car parking | **1,680** | 1,746 |
| Estates recharges | **184** | 270 |
| Pharmacy sales | **63** | 72 |
| Staff accommodation rentals | **140** | 128 |
| Clinical tests | **0** | 38 |
| Clinical excellence awards | **113** | 106 |
| Catering | **1,265** | 1,352 |
| Property rentals | **700** | 563 |
| Other | **1,123** | 3,401 |
| **Total** | **5,268** | 7,676 |

| Note 3.3 Overseas visitors (relating to patients charged directly by the foundation trust) | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Income recognised this year | **1,503** | 1,428 |
| Cash payments received in-year (relating to invoices raised in current and previous years) | **340** | 561 |
| Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years) | **(119)** | (90) |
| Amounts written off in-year (relating to invoices raised in current and previous years) | **371** | 236 |

## Note 4 Operating Expenses

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Staff and executive directors costs | **169,555** | 166,977 |
| Non-executive directors | **141** | 139 |
| Supplies and services – clinical (excluding drugs costs) | **34,747** | 27,919 |
| Supplies and services - general | **3,936** | 4,257 |
| Drugs costs (drugs inventory consumed and purchase of non-inventory drugs) | **19,474** | 18,714 |
| Inventories written down (net including drugs) | **82** | 51 |
| Consultancy | **1,643** | 105 |
| Establishment | **4,905** | 5,035 |
| Premises - business rates collected by local authorities | **1,086** | 920 |
| Premises - other | **6,323** | 6,749 |
| Transport (business travel only) | **121** | 152 |
| Transport - other (including patient travel) | **1,739** | 1,364 |
| Depreciation | **8,734** | 8,854 |
| Amortisation | **568** | 669 |
| Impairments net of (reversals) | **0** | 15,447 |
| Increase/(decrease) in impairment of receivables | **642** | 84 |
| Provisions arising / released in year | **30** | 42 |
| Audit services - statutory audit | **101** | 98 |
| Internal audit - non-staff | **119** | 107 |
| Clinical negligence - amounts payable to NHS Resolution (premium) | **6,547** | 4,677 |
| Clinical negligence - excesses payable and premiums due to alternative insurers | **24** | 31 |
| Legal fees | **207** | 297 |
| Insurance | **233** | 253 |
| Research and development - staff costs | **360** | 410 |
| Education and training - staff costs | **1,094** | 963 |
| Education and training - non-staff | **618** | 731 |
| Education and training - notional expenditure funded from apprenticeship fund | **10** | 0 |
| Operating lease expenditure (net) | **373** | 322 |
| Charges to operating expenditure for on-SoFP IFRIC 12 | **521** | 520 |
| Car parking and security | **314** | 144 |
| Hospitality | **36** | 55 |
| Other losses and special payments - non-staff | **5** | 35 |
| Other services | **1,869** | 1,323 |
| Other | **1** | 76 |
| **TOTAL OPERATING EXPENSES** | **266,158** | 267,520 |

All expenses above related to continuing operations.

## Note 5.1 Operating lease income and future receipts (trust as a lessor)

| **Lease receipts recognised as income in year:** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Minimum lease payments | **2,760** | 2,266 |
| Contingent rents | **670** | 1,546 |
| **TOTAL** | **3,430** | 3,812 |
| **Future minimum lease receipts due:** | | |
| **On land leases:** | | |
| - not later than one year; | **1,434** | 1,434 |
| - later than one year and not later than five years; | **5,737** | 5,737 |
| - later than five years. | **96,102** | 97,536 |
| **TOTAL** | **103,273** | 104,707 |
| **on leases of Buildings expiring** | | |
| - not later than one year; | **641** | 493 |
| - later than one year and not later than five years; | **1,481** | 1,655 |
| - later than five years. | **2,554** | 2,749 |
| **TOTAL** | **4,676** | 4,897 |
| **TOTAL LEASES** | **107,949** | 109,604 |

Leasing arrangements are all with bodies external to the UK Government.
Leasing arrangements relate significantly to land rental on both the Hillingdon and Mount Vernon sites.
* Contingent rent relates to additional rent received stated in the lease agreement.

## Note 5.2 Operating lease payments and commitments (Trust as a lessee)

| Lease payments recognised as an expense in year: | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Minimum lease payments | **351** | 309 |
| Contingent rents | **22** | 13 |
| | **373** | 322 |

| Total future minimum lease payments | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **On Buildings** | | |
| Payable: | | |
| Not later than one year | **332** | 320 |
| Between one and five years | **1,328** | 1,282 |
| Later than five years. | **166** | 481 |
| **TOTAL** | **1,826** | 2,083 |
| **On Plant and Machinery** | | |
| Payable: | | |
| Not later than one year | **76** | 36 |
| Between one and five years | **255** | 139 |
| **TOTAL** | **331** | 175 |
| **Total** | | |
| Payable: | | |
| Not later than one year | **408** | 356 |
| Between one and five years | **1,583** | 1,421 |
| Later than five years. | **166** | 481 |
| **TOTAL** | **2,157** | 2,258 |

The Trust is party to a ten year lease agreement for a modular healthcare building on the Hillingdon Hospital site ending October 2023.

# Note 6 Employee costs and numbers

## 6.1 Employee costs

| | Total | 31 March 2018 Permanently employed | Other | Total | 31 March 2017 Permanently employed | Other |
|---|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| Salaries and wages | **131,448** | **113,626** | **17,822** | 128,834 | 115,774 | 13,060 |
| Social security costs | **13,868** | **12,407** | **1,461** | 13,353 | 12,273 | 1,080 |
| Apprenticeship levy | **644** | **586** | **58** | - | - | - |
| Employer contributions to NHS Pension scheme | **14,658** | **13,936** | **722** | 14,343 | 13,621 | 722 |
| Termination Benefits | **22** | **22** | | - | - | - |
| Temporary staff - agency/contract staff | **12,645** | **-** | **12,645** | 14,194 | | 14,194 |
| Temporary staff - external bank | **-** | | **-** | - | - | - |
| Recoveries from DHSC Group bodies in respect of staff cost | **(1,335)** | **(1,335)** | **-** | (1,410) | (1,410) | - |
| Recoveries from other bodies in respect of staff cost | **(184)** | **(184)** | **-** | | | |
| **Employee benefits expense** | **171,766** | **139,058** | **32,708** | 169,314 | 140,258 | 29,056 |
| | | | | | | |
| **Of the total above:** | | | | | | |
| Charged to capital | **757** | **757** | **-** | 964 | 825 | 139 |
| Charged to revenue | **171,009** | **138,301** | **32,708** | 168,350 | 139,433 | 28,917 |
| | **171,766** | **139,058** | **32,708** | 169,314 | 140,258 | 29,056 |

## 6.2 Directors aggregate remuneration

| | 31 March 2018 Remuneration | 31 March 2018 Number of | 31 March 2017 Remuneration | 31 March 2017 Number of |
|---|---|---|---|---|
| | **£000** | **Directors **** | £000 | Directors ** |
| Executive Directors | **1,097** | **8** | 1,100 | 9 |
| Non Executive Directors* | **141** | **9** | 139 | 8 |
| **Total** | **1,238** | **17** | 1,239 | 17 |
| | | | | |
| **Analysis of Directors Remuneration (£000)** | | | | |
| Gross pay | **988** | | 1,001 | |
| Employer Pension Contributions | **130** | | 115 | |
| Employer National Insurance Contributions | **120** | | 123 | |
| **Total** | **1,238** | | 1,239 | |

*Non Executive Directors are not members of the NHS pension scheme.

** The number of directors denotes the number of individuals employed in a director position at some point during the financial year, not the number of directors simultaneously employed.

## 6.3 Average number of people employed

| | Total | 31 March 2018 Permanently employed | Other | Total | 31 March 2017 Permanently employed | Other |
|---|---|---|---|---|---|---|
| | Number | Number | Number | Number | Number | Number |
| Medical and dental | **508** | **453** | **55** | 484 | 460 | 24 |
| Administration and estates | **815** | **743** | **72** | 785 | 716 | 69 |
| Healthcare assistants and other support staff | **721** | **552** | **169** | 688 | 542 | 146 |
| Nursing, midwifery and health visiting staff | **1,045** | **822** | **223** | 1,019 | 819 | 200 |
| Scientific, therapeutic and technical staff | **334** | **303** | **31** | 339 | 309 | 30 |
| Healthcare science staff | **155** | **142** | **13** | 161 | 138 | 23 |
| **Total** | **3,578** | **3,015** | **563** | 3,476 | 2,984 | 492 |
| **Of the above:** | | | | | | |
| Number of whole time equivalent staff engaged on capital projects | **13** | **13** | **-** | 17 | 15 | 2 |

## 6.4 Early Retirements due to ill health

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | Number | Number |
| Number of early retirements on the grounds of ill-health | **1** | 1 |

The cost of early retirement due to ill health is borne by the NHS Business Services Authority who administer NHS pensions.

## 6.5 Exit Packages

| | Number of departures 31 March 2018 | Cost of departures 31 March 2018 | Departures inclusive of Special Payments 31 March 2018 |
|---|---|---|---|
| | Number | £000 | Number |
| Exit package cost band (including any special payment element) | | | |
| <£10,000 | **2** | **7** | **1** |
| £10,000 - £25,000 | **2** | **38** | |
| **Total** | **4** | **45** | |

Last Year there were no exit packages

## 6.6 Staff sickness absence

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | Number | Number |
| **Full Time Equivalent (FTE) days recorded sickness absence*** | **23,516** | 23,446 |
| **Average Full Time Equivalent**** | **2,916** | 2,983 |
| **Average Sick days per FTE***** | **8** | 8 |

The Department of Health and Social Care (DHSC) has provided all NHS Trusts with the above sickness absence information to include in the annual report and accounts per section 2.79 of the Annual Reporting Manual

The DHSC has provided the number of FTE days from electronic Staff Records (ESR)

* Part time staff have been pro rata adjusted to fulltime equivalents for their contracted hours in calculating FTE days.

**The DHSC has provided the average number of FTE

*** This figure indicates the average number of sick days per FTE

## Note 7 Better Payment Practice Code

### 7.1 Better Payment Practice Code – measure of compliance

| | 31 March 2018 | | 31 March 2017 | |
|---|---|---|---|---|
| | **Number** | **£000** | Number | £000 |
| Total Non-NHS trade invoices paid in the year | **100,997** | **142,815** | 96,716 | 129,037 |
| Total Non NHS trade invoices paid within target | **18,569** | **72,536** | 16,221 | 53,337 |
| Percentage of Non-NHS trade invoices paid within target | **18.39%** | **50.79%** | 16.77% | 41.33% |
| Total NHS trade invoices paid in the year | **2,114** | **22,450** | 2,658 | 12,540 |
| Total NHS trade invoices paid within target | **285** | **14,018** | 489 | 5,931 |
| Percentage of NHS trade invoices paid within target | **13.48%** | **62.44%** | 18.40% | 47.30% |

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

### 7.2 The Late Payment of Commercial Debts (Interest) Act 1998

| | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Amounts included in finance costs from claims made under this legislation | **34** | 13 |

## Note 8 Finance income

| | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Interest on bank accounts | **20** | 12 |

## Note 9 Finance expenses

| | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| **Interest expense:** | | |
| Interest paid on Finance leases | **272** | 248 |
| Interest on late payment of commercial debt | **34** | 13 |
| Interest paid on Capital loans from the Department of Health and Social Care | **212** | 236 |
| Interest due on Revenue Support loans from the Department of Health and Social Care | **600** | 195 |
| Interest on LIFT contract | **1,458** | 1,405 |
| Unwinding of Discount | **72** | 73 |
| **Total** | **2,648** | 2,170 |

## Note 10 Other non-operating income

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Increase in fair value of investment property | **10,670** | 11,256 |

Refer to note 14

## Note 11 Intangible Assets

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Cost or valuation brought forward at 1st April** | **6,598** | 6,413 |
| Reclassification from Property, Plant and Equipment | | |
| Other Reclassifications | **463** | 85 |
| Additions - purchased | **233** | 100 |
| **Cost or valuation at 31 March** | **7,294** | 6,598 |
| | | |
| **Amortisation Brought Forward at 1st April** | **4,250** | 3,581 |
| Amortisation provided in Year | **568** | 669 |
| **Amortisation at 31 March** | **4,818** | 4,250 |
| **Net Book Value at 31 March** | **2,476** | 2,348 |

Intangible Assets consists of Software Licences.

# NOTE 12 PROPERTY PLANT AND EQUIPMENT

## 12.1 Property, plant and equipment

| Current Year | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2017 | 174,096 | 50,792 | 73,822 | 1,700 | 1,070 | 30,181 | 18 | 16,420 | 93 |
| Additions - purchased | 6,273 | - | 3,444 | - | 2,297 | 288 | - | 244 | - |
| Additions - Leased | 592 | - | - | - | - | 592 | - | - | - |
| Additions - donated | 137 | - | 28 | - | - | 109 | - | - | - |
| Reclassifications | (463) | - | 27 | - | (709) | - | - | 219 | - |
| Cost or valuation at 31 March 2018 (A) | 180,635 | 50,792 | 77,321 | 1,700 | 2,658 | 31,170 | 18 | 16,883 | 93 |
| Accumulated depreciation at 1 April 2017 | 31,783 | - | 84 | - | - | 19,354 | 18 | 12,262 | 65 |
| Provided during the year | 8,734 | - | 4,431 | 390 | - | 2,347 | - | 1,562 | 4 |
| Depreciation at 31 March 2018 (B) | 40,517 | - | 4,515 | 390 | - | 21,701 | 18 | 13,824 | 69 |
| Net Book Value (A - B) | 140,118 | 50,792 | 72,806 | 1,310 | 2,658 | 9,469 | - | 3,059 | 24 |
| Financed as follows: | | | | | | | | | |
| Owned | 123,209 | 50,192 | 61,195 | 1,310 | 2,658 | 5,387 | - | 2,443 | 24 |
| Finance leased | 4,132 | - | - | - | - | 3,516 | - | 616 | - |
| LIFT | 10,129 | 600 | 9,529 | - | - | - | - | - | - |
| Donated | 2,648 | - | 2,082 | - | - | 566 | - | - | - |
| Total 31 March 2018 | 140,118 | 50,792 | 72,806 | 1,310 | 2,658 | 9,469 | - | 3,059 | 24 |

## 12.1 Property, plant and equipment

| Previous Year | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2016 | 170,599 | 37,327 | 85,012 | 1,193 | 3,192 | 27,962 | 18 | 15,802 | 93 |
| Additions - purchased | 8,670 | - | 7,034 | - | 1,021 | 495 | - | 120 | - |
| Additions - Leased | 1,959 | - | - | - | - | 1,711 | - | 248 | - |
| Additions - donated | 177 | - | - | - | - | 177 | - | - | - |
| Impairments charged to operating expenses | (15,447) | - | (15,447) | - | - | - | - | - | - |
| Impairments charged to the revaluation reserve | (3,213) | - | (3,213) | - | - | - | - | - | - |
| Reclassifications | (1,605) | (1,520) | 2,808 | - | (3,143) | - | - | 250 | - |
| Revaluations | 13,120 | 14,985 | (2,372) | 507 | - | - | - | - | - |
| Disposals/De recognition | (164) | - | - | - | - | (164) | - | - | - |
| Cost or valuation at 31 March 2017 (A) | 174,096 | 50,792 | 73,822 | 1,700 | 1,070 | 30,181 | 18 | 16,420 | 93 |
| Accumulated depreciation at 1 April 2016 | 32,760 | - | 4,845 | 261 | - | 17,095 | 18 | 10,481 | 60 |
| Provided during the year | 8,854 | - | 4,398 | 249 | - | 2,421 | - | 1,781 | 5 |
| Revaluations | (9,669) | - | (9,159) | (510) | - | - | - | - | - |
| Disposals / derecognition | (162) | - | - | - | - | (162) | - | - | - |
| Depreciation at 31 March 2017 (B) | 31,783 | - | 84 | - | - | 19,354 | 18 | 12,262 | 65 |
| Net Book Value (A - B) | 142,313 | 50,792 | 73,738 | 1,700 | 1,070 | 10,827 | - | 4,158 | 28 |
| Financed as follows: | | | | | | | | | |
| Owned | 123,749 | 50,192 | 61,735 | 1,700 | 1,070 | 6,221 | - | 2,803 | 28 |
| Finance leased | 5,427 | - | - | - | - | 4,072 | - | 1,355 | - |
| LIFT | 10,402 | 600 | 9,802 | - | - | - | - | - | - |
| Donated | 2,734 | - | 2,200 | - | - | 534 | - | - | - |
| Total 31 March 2017 | 142,313 | 50,792 | 73,738 | 1,700 | 1,070 | 10,827 | - | 4,158 | 28 |

## 12.2 Revaluation reserve balance for property, plant & equipment

| **Current Year** | **Total £000** |
|---|---|
| **At 1 April 2017** | **51,129** |
| **Depreciation adjustment** | **(1,292)** |
| **At 31 March 2018** | **49,837** |

| Previous Year | Total £000 |
|---|---|
| At 1 April 2016 | 33,165 |
| Depreciation adjustment | (1,612) |
| Revaluation Gain | 22,789 |
| Impairments | (3,213) |
| At 31 March 2017 | 51,129 |

# Note 13 Economic lives of property plant and equipment

## 13.1 Economic lives of property, plant and equipment

| | Min life Years | Max life Years |
|---|---|---|
| **Intangible assets - purchased** | | |
| Software | **5** | 15 |

## 13.2 Economic lives of property, plant and equipment

| | Min life Years | Max life Years |
|---|---|---|
| Buildings excluding Dwellings | **2** | 60 |
| Dwellings | **5** | 5 |
| Plant and Machinery | **2** | 20 |
| Information Technology | **2** | 15 |
| Furniture and Fittings | **5** | 15 |
| Intangible assets (Software licenses) | **5** | 15 |

# Note 14 Investment and surplus properties

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Balance at Beginning of year | **32,417** | 19,641 |
| Reclassification from Operational Buildings | **-** | 1,520 |
| Increase in value of investment and surplus properties* | **10,670** | 11,256 |
| **Balance at End of Year** | **43,087** | 32,417 |

* The increase in Trust investment and surplus properties follows a revaluation exercise by our surveyors Gerald Eve on 31st March 2018. The main driver for the increase was increases in rent for third party occupation.

| | | |
|---|---|---|
| Investment property income | **3,337** | 2,335 |
| Direct operating expense arising from investment property which generated rental income in the year. | **(1,729)** | (1,283) |
| Direct operating expense arising from investment property which did not generate rental income in the year. | **(177)** | (69) |
| **Total net Income from Investment Property** | **1,431** | 983 |

# Note 15 Impairment of assets

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Changes in market price. Operating Expenses* | **-** | 15,447 |
| Changes in market price. Revaluation Reserve | **-** | 3,213 |
| **Total Gross Impairments** | **-** | 18,660 |

* The impairments to Trust buildings follows a revaluation exercise by our surveyors Gerald Eve on 31st March 2017

## Note 16 Capital Commitments

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Property, plant and equipment | 1,395 | - |

## Note 17 Inventory Movement

| Current Year 2017/18 | Total £000 | Drugs £000 | Consumables £000 | Energy £000 | Other £000 |
|---|---|---|---|---|---|
| **Carrying Value at 1st April 2017** | **2,897** | **961** | **1,765** | **20** | **151** |
| **Additions** | **34,206** | **16,559** | **15,534** | **-** | **2,113** |
| **Inventories recognised as expenses** | **(33,778)** | **(16,255)** | **(15,399)** | **-** | **(2,124)** |
| **Write-down of inventories recognised as an expense** | **(82)** | **(66)** | **(16)** | **-** | **-** |
| **Carrying Value at 31st March 2018** | **3,243** | **1,199** | **1,884** | **20** | **140** |

| Prior Year 2016/17 | Total £000 | Drugs £000 | Consumables £000 | Energy £000 | Other £000 |
|---|---|---|---|---|---|
| Carrying Value at 1st April 2016 | 3,171 | 1,036 | 1,952 | 48 | 135 |
| Additions | 34,480 | 16,485 | 15,784 | 13 | 2,198 |
| Inventories recognised as expenses | (34,703) | (16,513) | (15,968) | (41) | (2,181) |
| Write-down of inventories recognised as an expense | (51) | (47) | (3) | - | (1) |
| Carrying Value at 31st March 2017 | 2,897 | 961 | 1,765 | 20 | 151 |

# Note 18 Trade and Other Receivables

| 18.1 Trade and other receivables | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| NHS receivables - revenue | **18,706** | 11,622 |
| NHS Accrued Income | **3,188** | 6,901 |
| NHS provision for credit notes | **(1,761)** | (1,872) |
| Sub Total NHS | **20,133** | 16,651 |
| Prepayments | **2,017** | 1,808 |
| Non NHS Receivables | **5,690** | 3,946 |
| PDC dividend receivable | **57** | - |
| VAT receivable | **786** | 719 |
| Provision for impaired receivables | **(1,566)** | (1,329) |
| **Total current trade and other receivables** | **27,117** | 21,795 |
| **Non-Current** | | |
| Other receivables | **1,478** | 1,324 |
| Prepayments | **810** | - |
| Less Provision for impaired receivables | **(338)** | (304) |
| **Total non-current trade and other receivables** | **1,950** | 1,020 |

| 18.2 Provision for impairment of receivables | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| At 1 April - brought forward | **1,633** | 1,750 |
| Increase in provision | **642** | 84 |
| Amounts Utilised | **(371)** | (201) |
| At end of year | **1,904** | 1,633 |

| 18.3 Ageing of impaired receivables | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| 0 - 30 days | **10** | 10 |
| 30 - 60 days | **10** | 10 |
| 60 - 90 days | **10** | 10 |
| 90 - 180 days | **150** | 147 |
| over 180 days | **1,724** | 1,456 |
| **Total** | **1,904** | 1,633 |

| 18.4 Ageing of non-Impaired receivables past their due date | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| 0 - 30 days | **1,243** | 1,786 |
| 30 - 60 days | **1,243** | 542 |
| 60 - 90 days | **1,912** | 451 |
| 90 - 180 days | **2,978** | 2,147 |
| over 180 days | **2,980** | 1,996 |
| **Total** | **10,356** | 6,922 |

## Note 19 Cash and cash equivalents

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Balance at 1 April | **1,060** | 4,092 |
| Net change in year | **39** | (3,032) |
| **Balance at end of Year** | **1,099** | 1,060 |
| | | |
| **Made up of** | | |
| Cash with Government banking services | **757** | 897 |
| Commercial banks and cash in hand | **342** | 163 |
| **Cash and cash equivalents as in statement of financial position** | **1,099** | 1,060 |
| **Cash and cash equivalents as in statement of cash flows** | **1,099** | 1,060 |

## Note 20 Trade and other payables

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| NHS payables - revenue | **10,927** | 3,093 |
| Receipts in advance | **1,691** | 2,561 |
| Other trade payables - capital | **1,429** | 724 |
| Other trade payables - revenue | **4,443** | 11,124 |
| PAYE and National Insurance | **4,072** | 3,470 |
| Staff Pension Contributions | **2,168** | 1,991 |
| Accruals and deferred income | **11,268** | 8,058 |
| PDC dividend payable | **-** | 143 |
| **Total Trade and Other payables** | **35,998** | 31,164 |

## Note 21 Borrowings

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| Capital loans from Department of Health and Social Care | **390** | 390 |
| Deficit Support Loans from the Department of Health and Social Care | **1,000** | 1,000 |
| Obligations under finance leases | **1,509** | 1,781 |
| Obligations under LIFT contract | **230** | 225 |
| **Total current borrowings** | **3,129** | 3,396 |
| **Non-current** | | |
| Capital loans from Department of Health and Social Care | **5,125** | 5,515 |
| Deficit Support Loans from the Department of Health and Social Care | **31,444** | 13,000 |
| Obligations under finance leases | **2,766** | 3,780 |
| Obligations under LIFT contract | **11,718** | 11,948 |
| **Total non current borrowings** | **51,053** | 34,243 |

The Trust is party to five Department of Health and Social Care loans as follows:

- Loan 1 (for capital investment) received 15th December 2009 for £4.0m. Repayments commenced on 15th March 2010 and will continue until 15th September 2034. The loan carries a fixed interest rate at 4.11%. The balance at 31st March 2018 was £2.64m.
- Loan 2 (for capital investment) received 15th September 2010 for £4.6m. Repayments commenced on 15th March 2011 and will continue until 15th September 2030. The loan carries a fixed interest rate at 3.25%.The balance at 31st March 2018 was £2.875m.
- Loan 3 (for working capital) received 16th November 2014 for £10.0m. Repayments commence on 17th May 2015 and will continue until 15th November 2024. The loan carries a fixed interest rate at 1.74% The balance at 31st March 2018 was £7m.
- Loan 4 (for working capital) received 16th January 2017 for £6.0m. Interest rate is at 3.5% and is paid twice a year commencing March 2017. Capital to be repaid on 18th July 2020.
- Loan 5 Deficit Support received during 2017/2018 of £19.444m. Repayments commence 1st April 2020 at an interest rate of 3.5%.

## Note 22 Finance lease liabilities

The lease arrangements relate to a number of equipment leases which vary in length from three to seven years. All leases are with bodies external to government. Details of the accounting for finance leases can be found in note 1 – accounting policies.

**Amounts payable under finance leases**

| **Gross lease liabilities** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Within one year | **1,677** | 2,005 |
| Between one and five years | **2,691** | 3,685 |
| Later than five years | **354** | 479 |
| **Total of future minimum lease payment** | **4,722** | 6,169 |
| Future Finance Charges | **-447** | -608 |
| **Total net finance lease liabilities** | **4,275** | 5,561 |

| **Net lease liabilities** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Within one year | **1,509** | 1,781 |
| Between one and five years | **2,431** | 3,300 |
| Later than five years | **335** | 480 |
| **Total net finance lease liabilities** | **4,275** | 5,561 |

## Note 23 NHS Local Improvement Finance Trust (LIFT) contract

The LIFT agreement is for a 25 year period which commenced in December 2008. The scheme is for the provision of clinical accommodation on the Mount Vernon Hospital site which comprises four surgical theatres and outpatient suites. The annual lease payment (inclusive of interest, capital and services) is £1,557k per annum. The LIFT agreement is with a body external to government. Details of the accounting for the LIFT contract can be found in note 1 - accounting policies.

### 23.1 LIFT liabilities

**Finance lease obligations payable under the LIFT contract**

| **Gross liabilities** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Not later than one year | **1,071** | 1,082 |
| Later than one year, not later than five years | **4,289** | 4,285 |
| Later than five years | **16,940** | 18,015 |
| **Sub total gross liability** | **22,300** | 23,382 |
| Future Finance Charges | **(10,352)** | (11,209) |
| **Total net liability** | **11,948** | 12,173 |

| **Net LIFT liabilities** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Not later than one year | **230** | 225 |
| Later than one year, not later than five years | **1,105** | 1,027 |
| Later than five years | **10,613** | 10,921 |
| **Total net LIFT liability** | **11,948** | 12,173 |

### 23.2 Total Future Commited Expenditure in respect of LIFT

| **LIFT committed total future expenditure** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Not later than one year | **2,158** | 2,158 |
| Later than one year, not later than five years | **5,627** | 5,627 |
| Later than five years | **21,546** | 23,103 |
| Total | **29,331** | 30,888 |

### 23.3 Payments in year to Operator in respect of LIFT

**The Trust paid the following amounts during the year in respect of LIFT**

| **LIFT expenditure** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| Interest charge | **1,458** | 1,405 |
| Repayment of finance lease liability | **226** | 216 |
| Service element | **474** | 469 |
| Other amounts | **47** | 51 |
| Total | **2,205** | 2,141 |

## Note 24 Related party transactions and balances

Paragraph 25 of IAS 24 allows the Trust; which is a related party because they are under UK government control, to reduce the volume of detailed disclosures thus saving on administration and staff costs.

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

To assist users of the accounts related parties with transctions in excess of £5m in the year are shown below:

**Income**
NHS Ealing CCG
NHS Harrow CCG
NHS Herts Valley CCG
NHS Hillingdon CCG
NHS Hounslow CCG
NHS Slough CCG
NHS England

**Expenditure**
Imperial College Healthcare NHS Trust
HMRC
NHS Pension Scheme

## Note 25.1 Provisions

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Provisions at start of year | **2,389** | 2,445 |
| Arising during the year | **30** | 42 |
| Utilised during the year- accruals | **(42)** | (43) |
| Utilised during the year- cash | **(128)** | (128) |
| Unwinding of discount | **72** | 73 |
| Released unused | **-** | - |
| Provisions at end of year | **2,321** | 2,389 |
| **Expected timing of cash flows:** | | |
| Within one year | **171** | 171 |
| Between one and five years | **500** | 500 |
| After five years | **1,650** | 1,718 |
| Total | **2,321** | 2,389 |

Provisions are liabilities that are of uncertain timing or amounts which the Trust expects to be settled by a transfer of economic benefits. The provision outstanding at year end relate to staff pensions and has been calculated using information supplied by NHS Business Service Authority Pensions Division.

## Note 25.2 Clinical Negligence liabilities

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust | **138,918** | 136,881 |

## Note 26 Contingent liabilities

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Contingent liabilities** | **(46)** | (46) |

Amounts recoverable against contingent liabilities.
The Trust's contingent liabilities relate to potential employee claims (£40k) and to potential public claims (£6k)

## Note 27 Financial instruments

### 27.1 Carrying value and fair value of financial assets - 31 March 2018

| | Book Value 31 March 2018 £000 | Book Value 31 March 2017 £000 |
|---|---|---|
| Trade and other receivables (excluding non financial assets) - with NHS and DHSC bodies | **18,706** | 14,827 |
| Trade and other receivables (excluding non financial assets) - with other bodies | **6,394** | 3,272 |
| Cash and cash equivalents (at bank and in hand) | **1,099** | 1,060 |
| **Total at end of year** | **26,199** | 19,159 |

### Note 27.2 Carrying value and fair value of financial liabilities - 31 March 2018

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Loans with the Department of Health and Social Care | **37,959** | 19,905 |
| Obligations under finance leases | **4,275** | 5,561 |
| Obligations under LIFT contract | **11,948** | 12,173 |
| Trade and other receivables (excluding non financial assets) - with NHS and DHSC bodies | **3,460** | 3,093 |
| Trade and other receivables (excluding non financial assets) - with other bodies | **32,346** | 17,541 |
| Provisions Under Contract | **2,321** | 2,389 |
| **Total at end of year** | **92,309** | 60,662 |

*Book value is equivalent to fair value

### 27.3 Maturity of Financial Liabilities

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| In one year or less | **39,106** | 24,201 |
| In more than one year but not more than two years | **2,767** | 5,036 |
| In more than two years but not more than five years | **32,143** | 11,831 |
| In more than five years | **18,293** | 19,594 |
| **Total** | **92,309** | 60,662 |

Fair values are assumed to be equal to book values for Fianncial Instruments.

## Note 28 Losses and Special Payments

| | 31 March 2018 | | 31 March 2017 | |
|---|---|---|---|---|
| | **Numbers** | **Value** | Numbers | Value |
| **Losses** | | **£000** | | £000 |
| **Losses of cash:** | | | | |
| Overpayment of salaries, wages, fees and allowances | | | 4 | 2 |
| Fruitless payments and constructive losses | | | 1 | 34 |
| **Bad debts and claims abandoned** | | | | |
| Private patients | **3** | **0** | 6 | 0 |
| overseas visitors | **76** | **371** | 79 | 236 |
| Other | **9** | **5** | 9 | 1 |
| **Stores** | | | | |
| Stores Losses | **1** | **81** | 1 | 51 |
| **Buildings** | | | | |
| Theft | **3** | **1** | | |
| **Total Losses** | **92** | **458** | 100 | 324 |
| **Special payments** | | | | |
| Compensation payments | **9** | **43** | 4 | 27 |
| Special severance payments | **1** | **4** | | |
| Other | **10** | **4** | 11 | 3 |
| **Total Special Payments** | **20** | **51** | 15 | 30 |
| **Total Losses and Special Payments** | **112** | **509** | 115 | 354 |
| **Amounts Recovered relating to bad debts previously written off** | | 0 | | 2 |

The amounts reported in this note were incurred as actual costs for the year to date and do not contain any accrued costs. These sums have been reported to and approved by the Audit Committee of the Trust.

## Note 29 NHS Hosted charities

Name of Charity: - The Hillingdon Hospitals Foundation Trust General Amenities Fund and Other Related Charities (The Charity)
Charity Registration Number : 1056493
Corporate Trustee: The Hillingdon Hospitals NHS Foundation Trust

| | **31 March 2018** | 31 March 2017 |
|---|---|---|
| **From Charity's Statement of Financial Activities** | **£000s** | £000s |
| Total Incoming Resources | **193** | 360 |
| Resources Expended | **-264** | -591 |
| Resource surplus | **-71** | -231 |
| Gains/losses on revaluation and disposal | **-** | 54 |
| **Net Movement in funds** | **-71** | -177 |

| **From Charity's Balance Sheet** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000s** | £000s |
| Investments (Non Current Assets) | **657** | 657 |
| Current Assets: | | |
| Cash | **112** | 21 |
| Other Current Assets | **4** | 1 |
| Current Liabilities | **-173** | -8 |
| **Net assets** | **600** | 671 |
| **Represented By:-** | | |
| Restricted Reserves | **26** | 26 |
| Unrestricted Reserves | **574** | 645 |
| **Total reserves** | **600** | 671 |

| **From Charity's Balance Sheet** | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000s** | £000s |
| Opening Balance | **657** | 496 |
| Disposals | **-** | -296 |
| Gains/(Loss) on revaluation and disposal | **-** | 54 |
| Other Movements | **-** | 403 |
| Total | **657** | 657 |

The Charity is controlled by The Hillingdon Hospitals NHS Foundation Trust (The Trust) which acts as Corporate Trustee. Under the accounting standard IFRS 10, the Charity is required to be consolidated within the Trust accounts However the Trust has decided to depart from this standard on the grounds of materiality (Income from the Charity is equivalent to 0.5% of Trust Income); the lack of any meaningful benefit to users of the accounts and the potential excessive costs in terms of management and systems redesign. The detailed accounts of the charity can be found on the Charity Commission website or contacting the Trust's Finance Department to request a copy. The charity is registered in the UK.

The Charity Accounts are unaudited by the Charity Auditors at the signing date of the Foundation Trust Accounts..

This note is not subject to the Foundation Trust audit nor covered by audit opinion in that audit.

## Languages/ Alternative Formats

Please call the Patient Advice and Liaison Service (PALS) if you require this information in other languages, large print or audio format on: 01895 279973. www.thh.nhs.uk

**Fadlan waydii haddii aad warbixintan ku rabto luqad ama hab kale. Fadlan la xidhiidh 01895 279 973**

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿੱਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਪਤਾ ਕਰਨ ਲਈ 01895 279973 ਤੇ ਸੰਪਰਕ ਕਰੋ

برائے مہربانی ہے تہاؤں اے اطلاع کے اور زبان یا انداز وچ چاہی دی اے تے پتہ کرن لئی 01895 279 973 تے رابطہ کرو

தயவுசெய்து, வேற்று மொழிகளில் இத் தகவல்கள், கட்டுமானம் தேவையெனில், கேளுங்கள்.! தயவுசெய்து 01895 279973 இலக்கத்துடன் தொடர்பு கொள்ளுங்கள்.!

Jeżeli chcialbyś uzyskać te informacje w innym języku, w dużej czcionce lub w formacie audio, poproś pracownika oddzialu o kontakt z biurem informacji pacjenta (patient information) pod numerem telefonu: 01895 279973.

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إذا كنت تود الحصول على هذه المعلومات بلغة أخرى، بالأحرف الكبيرة أو بشكل شريط صوتي، يرجى الاتصال بالرقم التالي 01895279973 .