NHS
The Hillingdon Hospitals
NHS Foundation Trust

annual report
hillingdon hospital
2018-19

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The Hillingdon Hospitals NHS Foundation Trust Annual Report and Accounts 2018/19

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Performance report

1.1 Overview of performance

Statement on overview of performance from the Chair and Chief Executive

Hillingdon Hospitals NHS Foundation Trust has come through a difficult year but with a new leadership team now has a clear focus for the future. Lis Paice, Interim Chair and I as the new Chief Executive would like to thank all of our staff for their commitment and dedication to the needs of our patients. We have had the opportunity to work with so many people who are committed to improving the health of the people we serve through dedication and hard work in these exceptionally challenging circumstances.

We would also like to pay tribute to Richard Sumray, the outgoing Chair, for his dedication to the patients and staff here at the Trust and to our Executive and Non-Executive colleagues, through what has been a challenging year.

In July 2018 the Care Quality Commission rated the Trust as Requires Improvement and we are committed to improving the care for our patients, with the Trust focusing on quality, people, performance and value for money.

As part of our responsibility to provide improvements in care for our patients we have introduced a number of initiatives to ensure that our work delivers on quality and safety, working with NSHI and partners to ensure improvements. Our staff are fundamental in ensuring improvement, so we have introduced our ward and department accreditation programme to share best practice, and a 'Themed Friday' which allows staff to focus on a different practice raising staff awareness and support for Trust staff with the right knowledge and tools to demonstrate evidence of continuous quality improvement.

We are all aware that both hospitals suffer from a poor estate with both Hillingdon Hospital and Mount Vernon needing substantial investment, so we are working with NHS England and Improvement to address this. The Trust Board is focused on the future needs of the people we serve and we have identified the need for investment, but also the need to work with partners to develop a longer-term plan.

Due to the unprecedented demand on our services our financial position has weakened during the year and we unfortunately fell short of meeting our efficiency savings.

The future is about working in partnership to improve care of our patients and enabling people to take a more active role in their own health. As a result we want to continue to build strong working relationships with our local MPs, commissioners, local authorities, the Metropolitan Police, and others.

We would like to thank the significant contribution of Hillingdon Hospitals Charity, whose involvement enables us to improve areas of the hospital and support staff, for example; with new equipment, painting a day room or helping with additional training.

Finally, we would also like to thank the Council of Governors who continue to support the organisation to meet the needs of patients and the community and provide support and challenge to the Board.

We know there will always be the need for a hospital to serve the people of Hillingdon and we are committed to ensuring that it is fit for the future, delivering the right care, in the right place, at the right time and value for money.

Professor Elisabeth Paice OBE FRCP
Interim Chair
The Hillingdon Hospitals NHS Foundation Trust

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust

28th May 2019

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.

The Trust provides clinical services to over half a million patients a year, including over 97,000 Emergency Department attendances.

As an NHS Foundation Trust, the Trust has a 25-strong Council of Governors and over 6,300 public members. It employs over 3,500 staff making it one of Hillingdon's largest employers. The Board of Directors, led by Chairman Richard Sumray during 2018/19 was comprised of seven Non – Executive and six Executive Directors. The Trust was rated overall as 'Requires improvement' by the Care Quality Commission (CQC) in 2018 although the Safety and Well Led domains for the Hillingdon Hospital site were rated as "Inadequate".

Overview of the Trust's strategy and business model

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

This statement of purpose is informed by the dual-nature of the Trust's role. The Trust will continue treating people when they are ill, by providing the best available acute care – as has been the focus to date. Looking forward, the Trust 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.

The Trust strategy for 2018/19 is summarised below:

CREATING A BETTER FUTURE

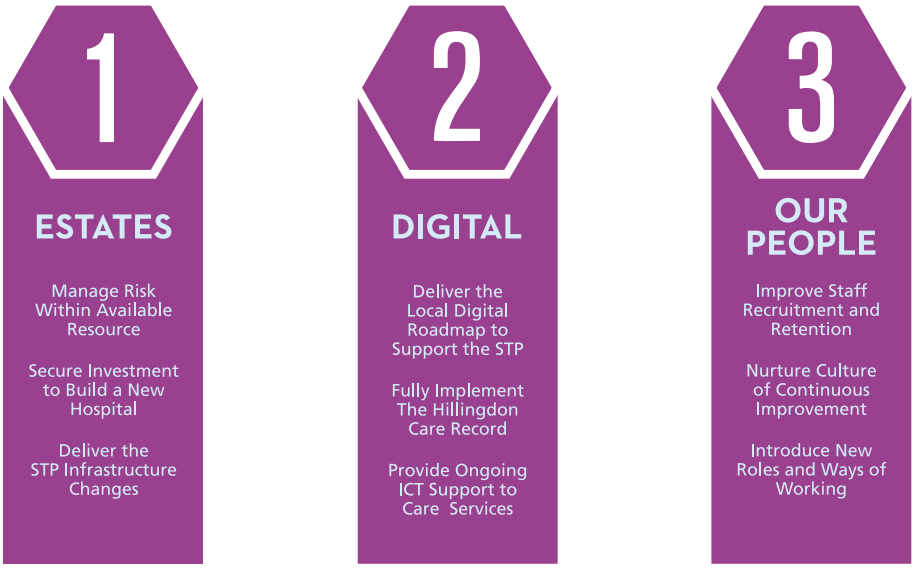
VISION	**To be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide best care where needed.**				
PURPOSE	**To provide high quality, safe and compassionate care, improving the health and wellbeing of the people we serve.**				
AREAS OF FOCUS	Help people to stop smoking. Improve the health of our workforce. Promote better health in the community.	Engage people in their care. Join-up services and integrate care. Empower people to self-manage their long-term conditions	Improve end-of-life care. Provide more care closer to home. Better recognise, and support, the role of carers.	Strengthen crisis support services. Ensure better access to mental health services in acute care.	Strengthen emergency care. Improve clinical and financial productivity. Implement core 7-day service standards. 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: Treat people within 18 weeks of referral Fulfil A&E performance standards 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



The Trust has articulated its ambitions and collated its key strategies in one document. The Strategic Plan 2017/2021 sets out how it intended to address the clinical and financial performance challenges which we face, in common with other acute Trusts.

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 is important that the longer term efforts are geared towards the new context with a particular focus on achieving shared objectives.

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. The STP ambition has been refreshed in 2018/19 and the Trust is responding to this, the 2018 Care Quality Commission report, the performance and financial challenges faced, and the change of sector strategic approach with the discontinuation of the Shaping a Healthier Future plan, with its own refresh of strategy due to take place in 2019/20.

Improvement Strategy

In 2018, the Trust successfully applied to be one of the first wave of seven organisations implementing the NHSI Vital Signs programme, an improvement methodology based on lean and systems-thinking principles. The Trust's implementation of the programme is the Hillingdon Improvement Practice (HIP), and represents a significant strategic engagement in establishing a continuous improvement culture across the organisation.

As the HIP becomes established across the Trust, it will form the single improvement methodology, allowing clear vision and sharing of improvement in all areas. The approach is based on enabling and supporting staff delivering care and services to identify and implement their own improvement, with close links to the voice of patients and service users. The leadership team will support, enable and coach teams to deliver the change that counts for both staff and patients.

Key issues for the Trust

Poor condition of our estate

The Trust has the second largest backlog of repairs for any Hospital in the country. Many of the Trust's buildings and infrastructure continue to be operational well beyond their expected life cycle and are deteriorating and causing significant issues in managing the estate. Much of the estate requires significant investment to bring it up to modern-day standards. The Trust's limited capital investment programme means that we are unable to address the most substantial estates issues.

Attracting and keeping the right staff

During the year, the Trust had used more agency staff than planned. The NHS faces significant challenge in terms of recruitment and we remain focused on prioritising our recruitment campaigns.

Financial Sustainability

The Trust has seen a deterioration in its financial position and has an underlying deficit of over £24m. The plan for 2019/20 contains risk, and the Trust has had to increase its Financial Improvement Programme to £11.7m (4.3%) to plan to meet the control total. This will be monitored throughout the year to ensure delivery.

A & E Performance

The Trust significantly underperformed on meeting the 4-hour standard for patients attending the A&E department throughout the year and did not meet the nationally required 95% performance target. The Trust's 4-hour Emergency Care transit time standard was 82.4%. Additional investment to expand the department, extra assessment areas within Hillingdon Hospital and additional services in the community made only marginal improvements over the winter period.

CQC Inspection

The Trust was inspected by the CQC in March 2018 and April 2018, the outcome of which was an overall rating of Requires Improvement.

The safety and well led domains for the Hillingdon Hospital site were rated as 'Inadequate', deterioration from the 'Requires Improvement' rating from its last inspection in 2015. The effective and responsive domains were rated as 'Requires Improvement' and caring as 'Good'. Three of the Trust's core services were rated as 'Good', three as 'Requires Improvement' and two services were rated as 'Inadequate'. In rating the Trust the CQC took into account the current rating of the core services at the Mount Vernon site which was not inspected at this time. Well led for the Trust overall, and the use of resources were rated as 'Requires Improvement'.

Following these somewhat disappointing results the Trust is working hard to deliver improvement, working in partnership with internal and external partners, to improve services for our patients.


me. If you're tired

Key risks for the Trust

1

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

A key objective for the Trust was to achieve a consistent performance of 90% by the end of March 2019.This was not achieved.

The Trust is working with Central & North West London NHS Foundation Trust, 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.
The Trust is currently reviewing its medical model to strengthen the delivery of clinical pathways emphasising the ambulatory emergency care model and the workforce profile against demand in A&E. The Trust's Emergency Care Programme Board continues to drive improvement and oversees the delivery of the improvement plan.

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 by proactive review of staffing levels by senior nurses and midwives to ensure each area is staffed in line with safety needs. SafeCare, a real time electronic solution which supports dynamic assessment of staffing demand and capacity in light of patient acuity, has been rolled out across inpatient wards. This facilitates effective use of the nursing resource and safeguards patient safety on a daily basis. Average shift-fill rates and Care Hours Per Patient Day are also reviewed retrospectively and triangulated against patient-centred outcome indicators. There has, and continues to be, ongoing and domestic and overseas recruitment. The focus on overseas recruitment has been on potential labour sources outside of Europe.

Each divisional team works in partnership with a recruitment manager and the People Solutions Partner to progress plans specific to the needs of their specialities. The Trust has also focused on recruiting student and overseas nurses already working in the UK, supporting them to achieve registration with the Nursing and Midwifery Council. The Trust is actively progressing a robust nurse staffing retention action plan as part of the national improvement collaborative with NHSI.

3

Delivering high quality patient care with medical recruitment challenges and increased patient acuity.

The Trust has recognised that overnight medical staff numbers do not support the consistent provision of high quality and timely patient care. A programme is in place to implement increased support to overnight teams, as well as increasing the number of registrars on duty. Overseas recruitment for middle grades is underway.

The expectation is that by September 2019/20 we will have recruited a minimum of six middle grade staff, with a further six by the end of the year. The Trust is building on its partnerships with Brunel University London and undertaking a Trust workforce review to develop a workforce model that incorporates new medical associate professions as well as extended roles for nurses, pharmacists and allied health professionals.

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 CQC inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March and April 2018 and rated the Trust overall as requiring improvement. The safety and well-led domains were rated as Inadequate.

We took immediate action and have made improvements since inspection. There was a requirement for the Trust to produce and manage a specific CQC action plan which covered a number of core services.

The original plan was replaced towards the end of the financial year with a new holistic Hillingdon Improvement Plan which has been created so that delivery and assurance reporting can be effectively managed at all levels. An Improvement Board, chaired by the Chief Executive, has been established to meet fortnightly to review progress against the Improvement Plan, highlighting any issues that are challenging the completion of tasks and where support may be required to identify assurance and monitoring arrangements. Key stakeholders including the CQC regional team, CCG colleagues, local Healthwatch colleagues and NHSI have been invited to attend the meetings on a monthly basis. This will ensure positive engagement and provide external assurance on the Trust's improvement work. This board reports to the Trust Management Executive which reports in turn to the Quality and Safety Committee

Effectiveness of the financial control system or inability to achieve the financial plan.

The Trust has planned for a deficit of £2.7m in 2019/20 and, having agreed this control total with NHSI, is eligible for £4.7m of Provider Sustainability Funding (PSF) and £14.8m of Financial Recovery Funding to meet this target. However, the plan contains the following significant risks.

- Achieving a high level of savings £11.7m (4.3%)
- A 1% tolerance on the CCG contract which does not allow for payment of over performance up to this level and a marginal rate of 70%
- There is no contingency funding within the plan for unforeseen events.

The 2019/20 financial plan has been developed and approved by the Board of Directors, and submitted to the regulator. There is robust performance monitoring in place through the Board, Audit and Risk Committee and Finance and Performance 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 or fortnightly risk assessment allows early sight of potential areas of non-delivery to be identified and ensure mitigating actions are put in place to prevent slippage.

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 support development and delivery of the 2019/20 Financial Improvement Programme. All savings schemes have a project initiation document that requires risk assessment. Any significant risks identified require 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 and that service quality is not compromised.

However, there was evidence in 2018/19 that some of these monitoring arrangements did not have sufficient grip and control. This remains a risk for the Trust in 2019-20.

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 completely 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 was highlighted through the Shaping a Healthier Future (SaHF) business case which identified the need for investment, but also flagged investment would assist but not resolve all issues with the current infrastructure. Unfortunately, SaHF did not materialise and the Trust was unsuccessful with its £10m emergency backlog funding bid at the end of the year.

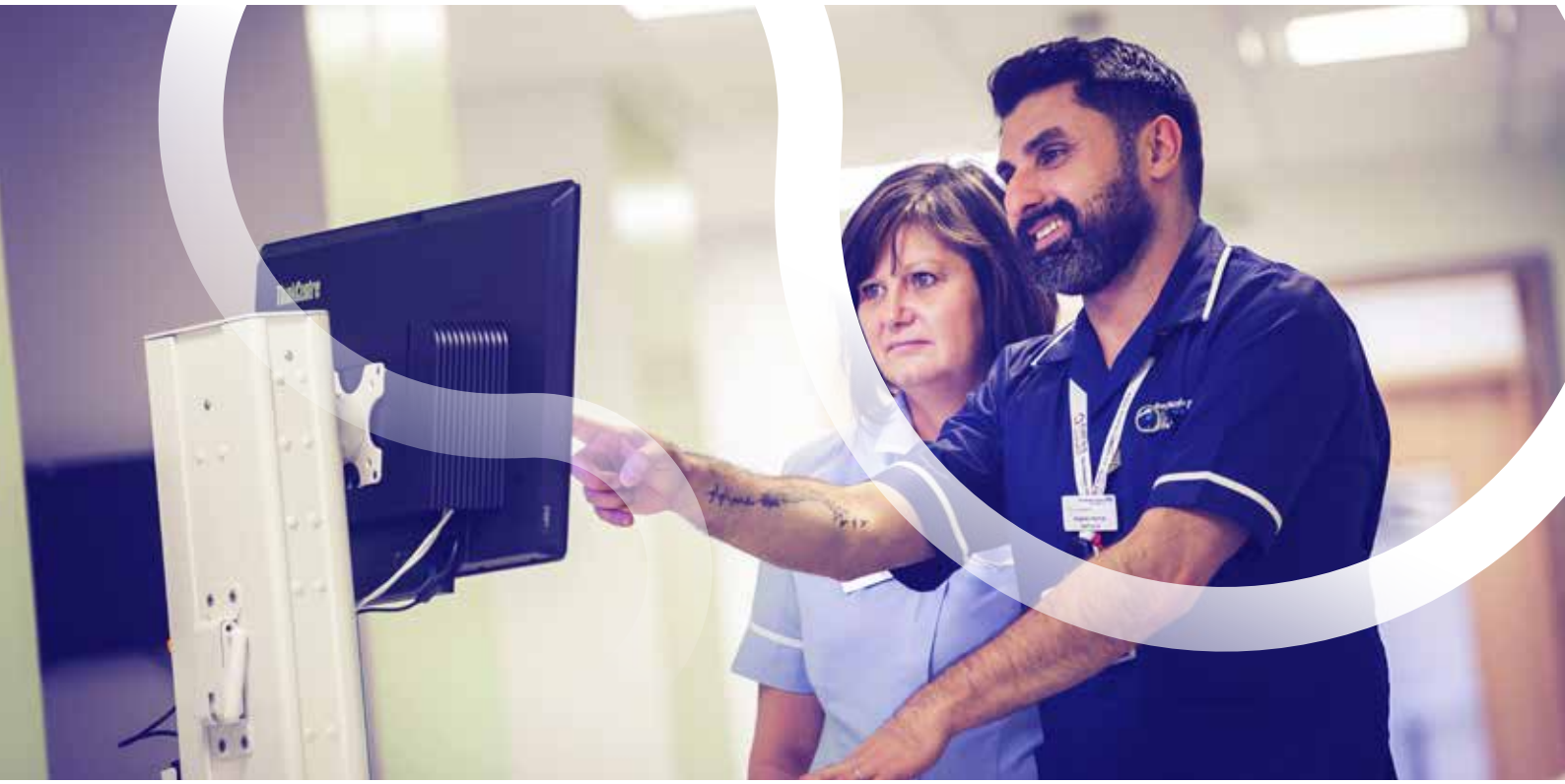
The Trust is working with partners to develop a longer term (5 to 7 year) solution to these estates issues through the development of a new facility on a university health campus at Brunel University and is developing its strategic outline case to progress this.

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

The estate has suffered from underinvestment over an extended period and many building fabric and services are failing or are beyond economical repair and their design life cycle. A recent survey highlighted that 81% of the Hillingdon estate and 51% of the Mount Vernon estate has a condition that is 'operational but major repair or replacement will be required soon' or worse. The Trust completed a condition survey of its estate in 2017 which concluded that the total cost to address the backlog was £191.6m. The survey also revealed the immediate need to invest significant capital over the next four years to prevent the condition of the estate deteriorating further therefore compounding the overall backlog cost.

The Trust recognises the condition of the estate has a direct impact on the ability to provide a safe environment for patients and the importance of a clean, safe environment for all aspects of healthcare should not be underestimated. Unfortunately the condition and age of the estate makes it difficult to meet modern standards and this has the potential to cause infection control issues if not addressed appropriately. We are working hard with our staff to ensure that we have a clean, tidy, welcoming environment for our patients. Inpatient accommodation must be compliant with infection control and privacy and dignity requirements. The building infrastructure must be compliant with current infection control requirements and the building environment must minimise the risk of cross infection and can be easily cleaned. Maintaining and running the estate must be affordable and accordingly the estate has to be maintained within the financial controls set.

We are committed to ensuring that our estate aligns with the needs of clinical services. It needs to change to ensure that service requirements are met now and in the future.



Summary of other performance 2018-2019

Managing our resources well

During a very tough year we delivered £11.7 million of savings of which £8.6m will recur in each new financial year as recurrent. The Trust has been selected to participate in the NHSI Financial Improvement Programme, which should assist in enabling transformational change to take place.

Achieving greater efficiencies

A number of changes improved our efficiency and saved money. These included:

- Better utilisation of our Theatre lists by 3.9% 2018-19 v 2017-18 reducing the need for extra weekend lists
- A continuing reduction in our outpatient 'did not attend' rate (DNA) from 9.8% (2016/17) to 8.5% (2017/18) to 8.4% (2018/19)
- Improved control and reporting of agency staffing, and a drive to increase recruitment and usage of the staff bank, has delivered a 17% (£2.1m) reduction in agency spend across all staff groups, significantly 19% reduction in nursing agency spend(£1.3m)
- Work by our Facilities and Procurement Teams delivered a 19% (£950k) reduction in general supplies and services spend (bedding, linen, facilities management, cleaning & provisions)
- Work in ED and in our ambulatory pathways led to a reduction in emergency admissions of 3.5% (900 admissions) that enabled the winter bed pressures to be managed without the requirement to open Edmunds Ward
- From December 2018, implementation of the Patchwork system for booking to medical shifts has seen Hillingdon's medical staffing bank increase to 320 doctors 92 of whom were external with a further 23 currently joining the bank

Improving our digital services

For 2018/2019 we continued to increase our digital capabilities which aim to improve the digital infrastructure and Digital Care Record Development. The key achievements were:

- The Digital Services Development team have been working with clinical colleagues to develop the hObs application which was rolled out across the Trust and completed in December
- The Hillingdon Care Record (HCR) continues to be developed, working closely with clinical teams to remove paper process with digital forms. This has increased from 3000 to over 4000 a month. Digital Infrastructure has also been enhanced with the upgrade to NHS Wi-Fi completed in December 2019 and the upgrade of 44 servers to Windows 2019 which will continue into 2019/20
- Clinical Handover was completed for nursing and therapies across the organisation significantly enhancing patient safety for our adult inpatients
- Successful piloting of E-Vetting in Ophthalmology, resulting in vetting of referrals being reduced from 19 days down to seven and making the referral available in the HCR, completing the summary care record for patients, to compliment the outpatient letters, inpatient and A&E Discharge summaries, GP record and diagnostic information for a patient
- The Trust undertook some pilot projects for the London Digital Programme generating income and continues this into 2019/20. We also integrated our Digital Care Record information with the Care Information Exchange (CIE) which has the potential to provide patients access to their record

Securing external recognition

The Trust's work has ensured it is recognised in a number of national awards. These include Dr Meng Aw-Yong who was part of a team to win the HSJ Patient Safety Initiative Award, the Nuclear Medicine Team who were shortlisted for the British Nuclear Medicine Society Awards, the Ambulance Handover Project Team shortlisted for the upcoming Health Service Journal Best Patient Safety Initiative Award, the People and Organisational Development Team who are finalists for two awards at the upcoming Healthcare People Management Association Awards and the Beds Maintenance and the Catering teams who have both been shortlisted for the upcoming Health Estate & Facilities Management Association Team of the Year Award.

Maintaining and upgrading our buildings

The Trust invested more than £5 million in improving and maintaining our electrics, specialist ventilation, heating, and major surveys on water pipework in maternity and the main building at Hillingdon. Improvements were made to wards on the Mount Vernon site and to the human resources and estates department buildings at Hillingdon.

£470k was spent on roads and car parks resurfacing works, asbestos removal, door controls, medical gas controls and safety improvements.

Strengthening partnerships

The Trust is working in partnership with Central and North West London NHS FT, H4All, a partnership of third sector organisations, the Hillingdon Clinical Commissioning Group, and the Hillingdon General Practitioner collaborative in continuing to develop Hillingdon's Accountable Care Partnership, Hillingdon Health and Care Partners (HHCP). HHCP's aim is to better support patients to stay in their own homes for longer, to enable earlier identification and treatment of any deterioration in health for patients with long term conditions and multiple co-morbidities, and to reduce the requirement for hospital admission. During 2018/19, HHCP have developed a detailed plan for the achievement of this aim, which has been approved by the partnership for implementation in 2019/20.

The Trust has continued to work in partnership with Central and North West London NHS FT and Brunel University London within the Brunel Partners Academic Centre for Health Sciences (BPACHS). This partnership of academic and clinical organisations aims to revolutionise the way health and social care is delivered in the future. BPACHS is progressing work to address workforce and training, research and innovation, quality improvement, outcome based care, and digital healthcare.

Improving patient facilities

Our A&E redesign project was completed in 2018. A budget of £1.9 million was spent on building works and £200k for preparation works for the next phases scheduled for 2019/20. Work to the female day-care area was undertaken to include a separate male area, costing £400k. We spent £230k to complete final works for the CT scanner.

Funding was received for a new ambulatory care area with 6 chairs, which was completed in January 2019.

Caring for our staff

55% of staff that took part in the NHS national survey said they 'would recommend the Trust as a place to work'. The staff survey identified 10 key areas and we were at or above average in three areas (appraisals, quality of care and safe environment) and only 1% lower than average in another three areas.

The Trust is entering year three of its People Strategy which has seen improvement in learning and development and a growing range of course portfolios involving coaching and wellbeing.

Friends and Family Test

For the year to March 2019, we received 38,738 responses to the Friends and Family Test with 96.3% of patients recommending our services to their friends and family.

1.2 Performance analysis

Approach to measure performance

The Trust has in place an established integrated performance framework to monitor and track performance standards. The framework of 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. These meetings consider performance on constitutional and Trust agreed performance standards. They take a risk based approach to rating the risk of the failure to perform agreed targets and standards and confirm mitigating actions that will take place to reduce the risk of failing to perform.

The Divisional meetings report performance to the Trust Management Executive meeting which in turn report to the respective sub committees of the Board, where further scrutiny considers whether sufficient assurance on mitigating actions has been applied.

A two monthly integrated quality and performance report is presented to the Board which covers the five key domains based on the CQC framework:

1. **Safe**, includes infection control, falls, maternity indicators, safety thermometer, Serious Incidents/Never Events, patient safety and mortality standards
2. **Effective**, covers readmissions and DNAs as well as monitoring performance on the use of Electronic Referral Service (ERS).
3. **Caring**, 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.

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.

Analysis of the Performance of the Trust

The Trust has not consistently met all of the constitutional or local standards it aims to achieve; Referral to Treatment Time (RTT) was at 88% against the 92% standard, Cancer Standards where met in quarter1,3 and 4 (but failed to achieve quarter 2).

The Emergency care transit time standard of 95% is 82.4% for the year. The Trust has worked closely with the regulators, system partners and the staff towards delivering sustained improvements in this key delivery area. 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 comparative for each of the performance standards.

Attendance	2017/2018	2018/2019	Variance
Attendances made to our Accident & Emergency Department	66,454	6,7653	1.8%
Attendances made to our Minor Injuries Unit	27,885	29,581	6.1%
Attendances made to our Accident & Emergency Department and Minor Injuries Unit	94,339	97,234	3.1%
Babies born in our maternity unit	4,660	4,459	-4.3%
Attendances made as out-patients	375,869	379,795	1.0%
Admissions made for emergency treatment	26,131	25,256	-3.3%
Admissions made for planned operations and day-surgery	25,970	27,562	6.1%
Total Contacts	526,969	534,306	1.4%

Performance Table: 3 year comparator (2016/17 to 2018/19)

Indicator	Performance in 2016/2017	Performance in 2017/18	Performance in 2018/19	Target Achieved
Clostridium difficile (Total)	12	19	16	n/a
Clostridium difficile (Lapses of Care)	2	2	4	✓
All cancers: 31 days for second or subsequent treatment (surgery)	100%	100%	99.0% (to Feb-2019)	✓
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	88.4%	85.5%	85.0% (to Feb-2019)	✓
All cancers: 62 days for first treatment from NHS Cancer Screening Service referral	95.0%	96.4%	89.3% (to Feb-2019)	✓
All cancers: 31 days diagnosis to first treatment	98.7%	98.8%	99.3% (to Feb-2019)	✓
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	95.5%	95.3%	94.3% (to Feb-2019)	✓
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)	97.9%	95.3%	92.4% (to Feb-2019)	✓
Maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway	92.4%	91.1%	86.4% (to Feb-2019)	✗
A&E: Total time in A&E less than 4 hours (Accident & Emergency, Minor Injuries Unit, Urgent Care Centre)	84.0%	84.6%	82.4%	✗
Self-certification against compliance with requirements regards access to healthcare for people with a learning disability	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Clostridium difficile

The Trust reported 16 cases for 2018/19. There were four lapses in care during 2018/19 against a threshold of seven lapses in care. Clostridium difficile infection rates remain, however, below the London and national average where 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, in turn, presented to the Clinical Commissioning Group to establish whether there were any lapses in care.

Cancer Performance

The Trust has been compliant in three of the quarters this year for the cancer standards. However, we are expecting to be fully compliant with cancer and diagnostic waiting times in 2019/2020 for each quarter. These planning assumptions are based upon current levels of growth in demand for urgent cancer referrals (2 week waits). Should this demand increase significantly ahead of commissioned levels of growth, there would be some additional risk to achieving the cancer 62 day performances.

Referral to Treatment

The Trust ended the year with a performance of 86.4% against a target of 92%. In light of growth in demand from GP referrals to the Trust for elective care during and the latter half of 2017/18 and 2018/19, the Trust has not yet reached the anticipated sustainable position of achieving RTT compliance. The Trust has adopted the IMAS Intensive Support Team demand and capacity (D&C) modelling tools to identify the scale of investment required in selected specialties with performance challenges. We continue to recognise the importance of achieving this standard.

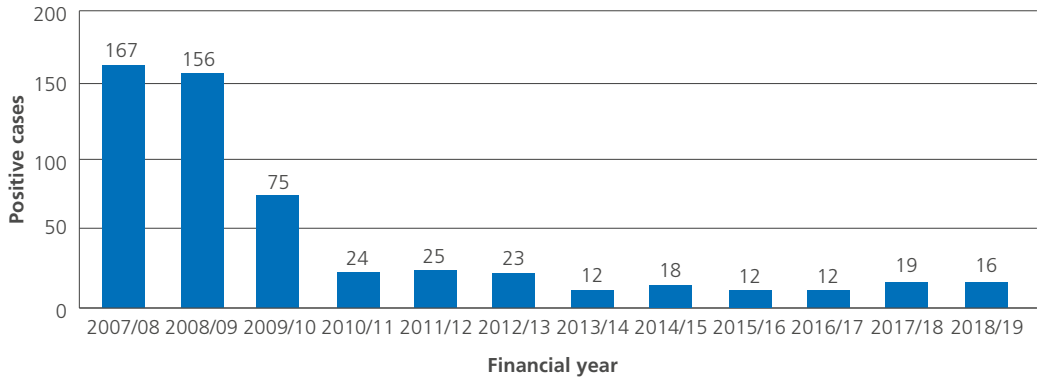
A&E 4 Hour Standard

The Trust did not meet 95% performance for the 4 hour Emergency Care transit time standard achieving 82.4%.

The A&E attendance (Type 1) increased by 1.8% compared to the previous year. Paediatrics went up by 4.3% and blue light

***Clostridium difficile* Toxin Positive**

Source: PHE

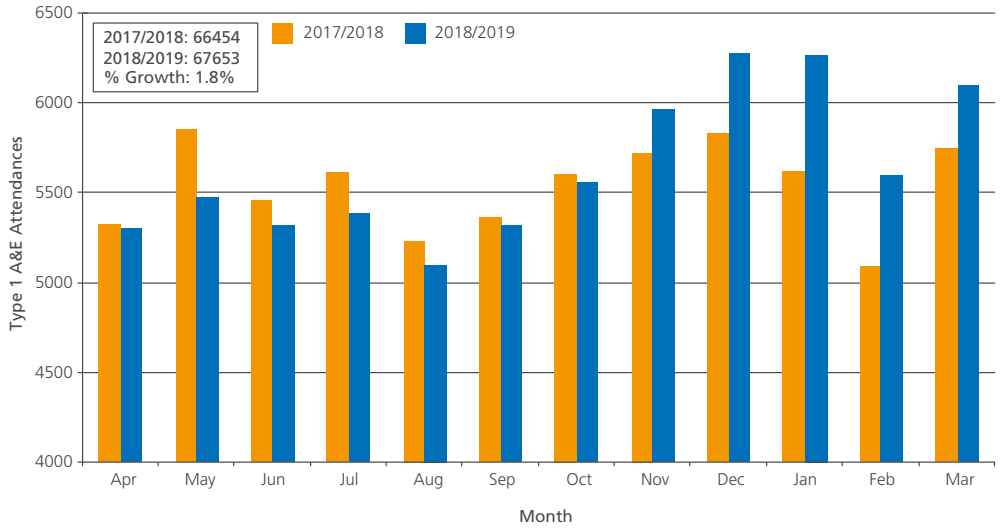


ambulance conveyance was up by 25.6%. These factors culminated in additional demands on the service. The system wide Emergency Care Improvement Programme will remain a priority for the Trust into 2019/20.

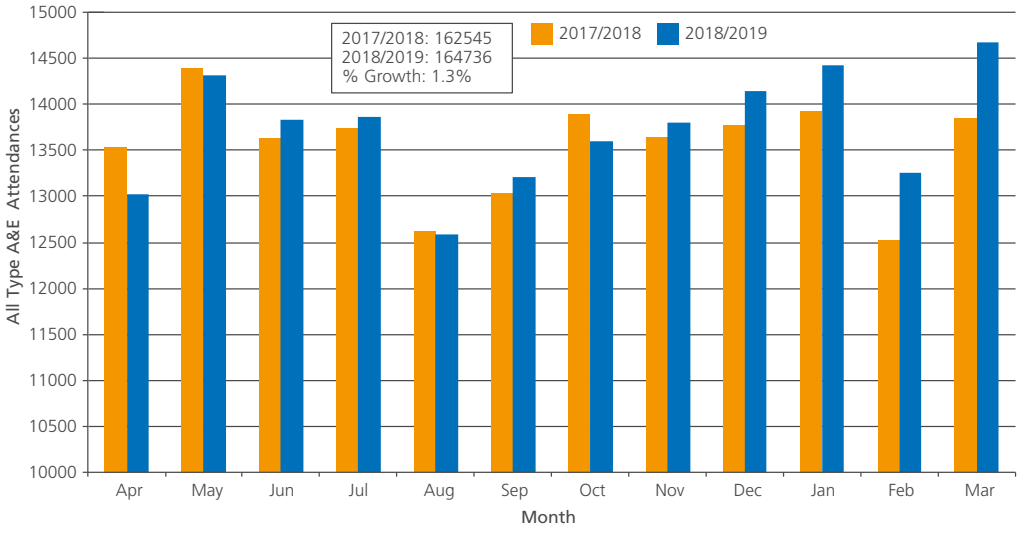
We need to ensure that:

- Ambulance handover times are swifter, using ambulance streaming and a single ambulance location
- The Clinical Decisions Unit functions well with continued improvement in bed flows within specialty wards enabling a quicker transfer of admitted patients
- Patient flows are improving through the Frailty Unit in place ensuring earlier and proactive management of patients within a 72 hour period
- Continue to work with partners to reduce medically optimised and "delayed transfer of care" patients in the hospital.

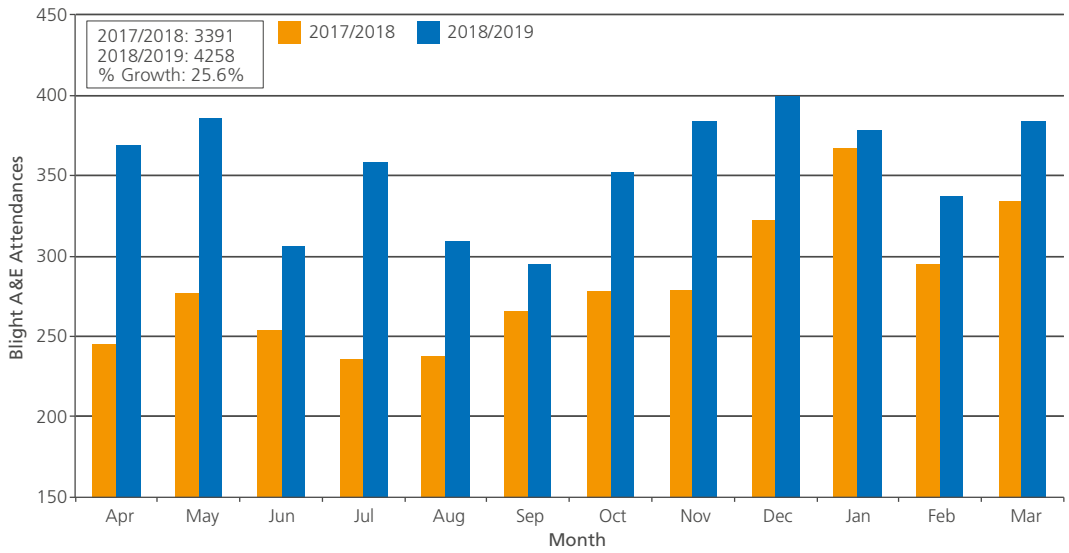
Type 1 (Main A&E) Attendances by Month (Type 1 Attendances Increased by 1.8%)



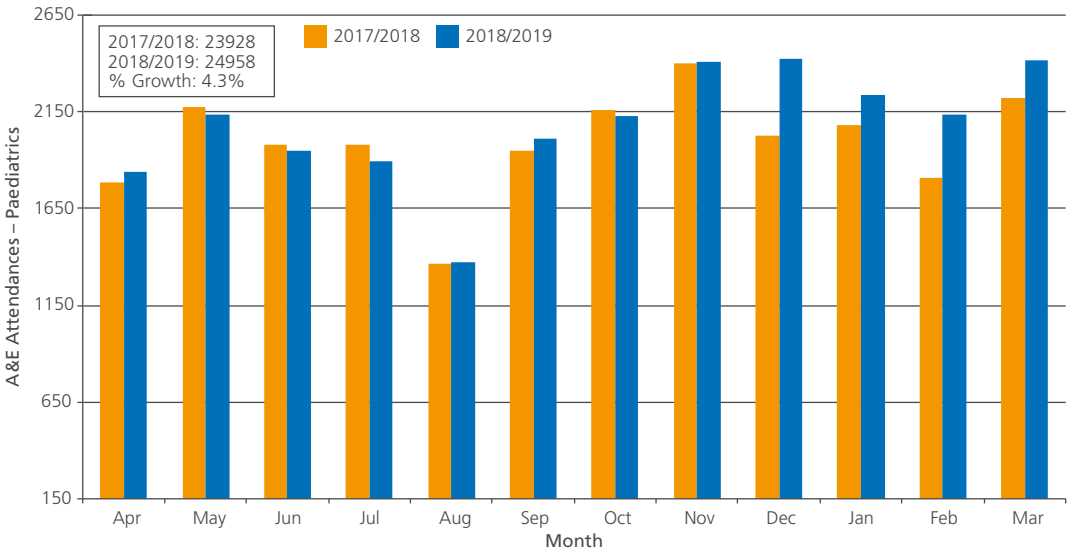
All Types (Main A&E, MIU & UCC) Attendances by Month (All Type Attendances Increased by 1.3%)



Blue Light A&E Attendances by Month
(Blue Light Ambulance Attendances Increased by 25.6%)



A&E Attendances - Paediatric (excl UCC) (Paediatric Attendances Increased by 4.3%)



Financial performance

Overall performance

The 2018/19 financial year proved to be more challenging than 2017/18 from a financial perspective. After some negotiation with NHS Improvement, the Trust was finally able to agree a Control Total of a £7.6m deficit in June 2018.

However due to additional expenditure and under recovery of income the Trust was not eligible to receive the Provider Sustainability Funding (PSF) of £6.2m in year, but it did receive £2m of PSF as part of the end of year general distribution of funds. High levels of agency spend to fill gaps in medical rotas and nursing vacancies, more usage of specialing (one to one patient care) on wards and the exceptional costs of the Joint North West London Pathology Service (a joint venture of Hillingdon, Imperial and Chelsea and Westminster Trusts) meant that the Trust ended the year with a £25.9m deficit. Delivery of savings was £11.7m of which £8.6m was recurrent. The remaining £3.1m was non-recurrent and this included £2.7m of revaluation of investment property.

Trading for the year

The Trust ended the year with a £25.9m deficit, which is £18.2m adverse to plan. This was significantly worse than 2017/18 where there was an £8m deficit. The Trust has experienced pressure on pay costs of £10.4m, and non-pay of £6.8m, which together with the reduction in PSF of £4.1m, gave a deficit of £28.7m. However a favourable revaluation of investment property of £2.7m, reduced the deficit to £25.9m.

Overall, income from planned treatment was as the Trust had projected, but a decrease in the number of expected births, together with a reduction in emergency admissions meant that the income we received for services was £3.4m less than had been expected for the year.

The Trust received £2.7m of additional pay award funding, which offsets a portion of the pay overspend experienced.

Pay was overspent due to the use of high volumes of temporary staff and undelivered financial efficiency schemes.

The Trust saw additional growth in Pathology activity and was impacted by a £1.3m share of the deficit of the North West London Pathology service. Consultancy costs and payment for the Ealing Maternity Hub also caused pressures.

The Trust achieved savings of £11.7m in the year, which was just short of the original target of £12m. £8.6m of this was achieved recurrently, however the remaining £3.1m was non-recurrernt.

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 (£24.5m). £6.2m was to replace PSF not received and the rest was to support the continued supply of services to the Trust through payment of outstanding supplier debt and service interest payments on loans and leases. The year-end retained cash balance of £1m was in line with last year's balance.

Capital investment

During the financial year the Trust invested £10.4m on facilities, equipment and technology used by the Trust to deliver healthcare.

Our physical estate infrastructure remained by far the largest area of investment. Funding was targeted on prioritised risk-based investment to ensure operational buildings remained safe, fit for purpose, and compliant with statutory legislation. £1.3m was spent on refurbishing the Emergency Department, which was opened in November 2018. The remaining phase to relocate the Urgent Treatment Centre will be completed in 2019.

The Trust received additional funding from the Department of Health to support improved flow through the Ambulatory Care pathway. Further funding was also received to support improvements to the public Wi-Fi system, a North West London wide Radiology Network and Pharmacy equipment.

Apart from the physical infrastructure, we also continued to invest in updating medical equipment for clinical services and on information technology infrastructure and capability.

Looking ahead

Given the underlying deficit position, the Trust continues to face financial challenge. In addition to the national efficiency requirement of 1.1%, the Trust faces a number of other cost pressures in 2019/20. The target savings for the Financial Improvement Programme (FIP) are £11.7m. The Financial Improvement Plan was supported by use of the 'Model Hospital' tool provided by NHSI. This provides benchmarking information to support improvements in operational productivity. In addition the Trust will retain the services of Kingsgate consultancy which supported the identification of potential savings schemes for the first part of the year. By April 2019, £5m of plans had been developed and the remaining £6.7m will need to be more transformational in nature, impacting on both hospital and community health services. The savings programme has been back loaded to the latter half of the year to give time for identification and development.

The Trust has signed up to its Control Total of a £2.7m deficit and is thus eligible for £4.7m of Provider Sustainability Funding and £14.8m of Financial Recovery Funding. However, this funding is non recurrent and partly dependent on the Trust meeting its financial plan each quarter.

We have completed a Long Term Financial Model which shows that achieving financial balance is within the Trust's reach but would not occur until 2023/24.

Given its age and condition, managing the Trust's estate infrastructure is an ever increasingly difficult and expensive task. The cost of maintaining our facilities at an acceptable standard continues to remain a drain on our overall resources.

Environmental Performance

Progress on the development of a Sustainable Development Plan

Sustainability reporting enables organisations to assess, understand and communicate their environmental, social and economic performance. By collecting and analysing this information regularly, it ensures that change can be measured effectively against goals and targets. A successful sustainability report transparently communicates both the positive and negative impacts of performance and the resulting impact. The Trust recognises it has more work to do in producing a comprehensive Plan which explains how it will ensure it both reports on and improves its environmental performance in 2019/20 and confirms that such a Plan was not in place for 2018/19. We aim to ensure this is the case for 2019/20.

Overview of 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 it serves, now and in future. 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 (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 UK Climate Impacts Programme 2009 weather projects, to ensure that our obligations under the Climate Change Act and Adaptation Reporting requirements are complied with.

Extensive audits have been carried out on both hospital 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.

The electricity consumption for the period 2018/19 decreased to 15,780,482 kWh from 16,586,787 kWh in 2017/18, a decrease of 5%. In addition, total gas consumption for the year decreased by 17% against 2017/18 figures.

The 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.

Procurement contracts now require suppliers to demonstrate that they minimise any impact on the environment with the products and services they provide.

Looking ahead

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 More investment is required in the energy generation and distribution infrastructure. 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. Having said this, we recognise the need to ensure a Sustainable Development Plan governs our approach to the impact on the environment.

Waste reduction and minimisation

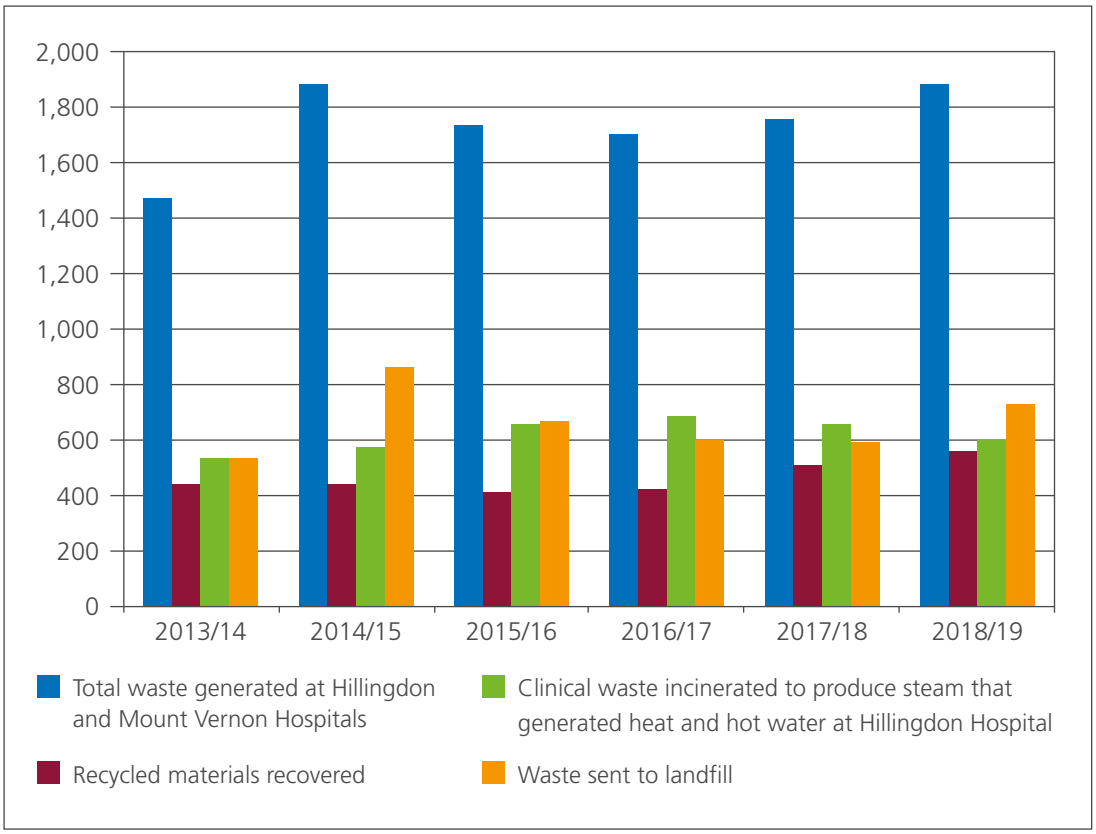
The Facilities waste & recycling service provides the safe collection, management and disposal of materials from our sites.

The Trust ensures that its 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. Food oil is recycled.

The year saw an increase in waste sent to landfill in comparison to the previous year. This was because of an initiative within the Trust led by the Chief Executive requiring all staff to clear their work areas and so it is expected a return to decreasing landfill will take place

	2013/14	2014/15	2015/16	2016/17	2017/18	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	1,889 tonnes
Recycled materials recovered	437 tonnes (30%)	441 tonnes (23%)	409 tonnes (24%)	420 tonnes (25%)	508 tonnes (29%)	553 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%)	604 tonnes (32%)
Waste sent to landfill	502 tonnes (34%)	866 tonnes (46%)	668 tonnes (38%)	602 tonnes (35%)	596 tonnes (34%)	732 tonnes (39%)



again in 2019/20.During the year there has been considerable focus on improving waste segregation and processing and an increased drive to improve our recycling.

Green Travel

The Trust has continued to promote green travel for staff and service users. The Trust Travel Plan Coordinator has undertaken a range of initiatives to encourage green travel in liaison with the Local Authority including cycle to work schemes. We worked on a joint bid with Brunel University to successfully secure a local Santander Cycle Scheme and installed a 10 cycle docking station as part of a schemed to link with further docking stations on the Brunel University Campus and Uxbridge town centre. The Trust has six electric car charging points for staff and the public to encourage carbon reduction and a greener environment. The Facilities Transport fleet has also changed a number of its Trust vehicles to electric or hybrid cars, and these are charged on site. We were also successful in locating and leasing an increased number of local off-site parking spaces for staff.

Community

Both hospitals are 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 members of the public and carers who also contribute to service development and lay members sit on a number of our Committees such as the Quality & Safety Committee, Equality, Diversity and Inclusion Committee and the Experience and Engagement Group.

At a strategic level representatives from the Trust attend the local Health and Wellbeing Board, Overview and Scrutiny Committee. The Chair and Chief Executive meet members from the Local Authority. The Trust has a close relationship with Hillingdon Healthwatch and regular meetings take place.

The Trust continues to work collaboratively with other key local health and care providers, Hillingdon Health and Care Partners (HHCP), its local Accountable Care Partner organisation and Brunel Partners Academic Centre for Health Sciences (BPACHS).

Equality, Diversity and Inclusion - Patients and Service Users

Dementia and Delirium care

The Trust is committed to both improving the level of support and the hospital experience of patients with dementia and their carers. There is a Trust Dementia Strategy in place, which was launched in March 2018. The Dementia Lead Nurse ensures services are progressed in line with this strategy, supported by the Dementia Clinical Nurse Specialist.

Many people who are living with dementia do not have a diagnosis, and so they do not receive the care and support that they require. In order to address this, the NHS has introduced a national dementia screening target to ensure that more cases of dementia are identified on admission. The standard is that at least 90% of people aged 75 years of age and over, admitted as an emergency, have a dementia screen carried out. During 2018/19 91.8% of people aged 75 years of age and over, admitted as an emergency, have been screened for dementia (national target 90%). 94.9% of patients admitted have been screened for delirium which is the first time the Trust has achieved this target since implementation.

The Trust has participated in the National Audit of Dementia to benchmark the organisation against best practice standards and other organisations. The results are due to be published in July 2019.

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 continued to be delivered in specific areas bespoke to the specialities i.e. Acute Medical Unit and Maternity. The Trust is able to refer to the learning disability nurse/service in the community if required. Mencap has supported the Trust by delivering awareness sessions to staff and patients visiting the hospital dining room.

Discharge of older adults and ongoing care needs

Many of the Trust's older patients are frail and are treated on its inpatient Frailty unit (Lister ward). Others are assessed as an outpatient by a Care of the Elderly Consultant. There are also two frailty nurses who work in A&E to prevent hospital admission and also review patients throughout the hospital who need to be transferred to the Frailty unit for intensive input. This is in order to reduce their length of stay, implement care plans for treatment and provide support for early discharge into the community.

Maternity services

As part of the Trust's commitment to engagement, the Maternity Voice Partnership (MVP) has developed as a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners to work together as equals, promoting and valuing participation and enabling people from diverse communities to have a voice.

Facilities

A finger food menu has been trialled on Beaconsfield ward to enable a wider group of patients to eat independently. Based on feedback, minor adjustments have been made to the menu and the ordering process. A picture menu has been developed in preparation for the launch across the Trust in the coming year

We introduced vegan dishes in our hospital restaurant on both sites three days a week to provide more choice to patients, visitors and staff

We delivered improved signage to support patients and visitors navigate around the hospital

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 2018/19 the Trust requested interpreting services on 3,930 occasions supporting patients with 59 languages compared to 3,817 occasions and 51 languages in 2017/18. These figures include requests for British Sign Language (BSL).

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 reported to the Equality, Diversity and Inclusion Committee. Monthly ward level feedback highlights areas of good practice or concerns and will inform key areas of equality focus going forward.

The Trust developed a Patient Experience and Engagement Strategy 2019-2022.

Improving services for people with a sensory disability

Further work is still required to introduce e-mail as a communication option and appoint a braille service provider for outpatient letters

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.

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.

The Trust needs, however, to produce a comprehensive single policy statement as part of its equalities programme in 2019/20.

Response to the potential impact of the UK's exit from the European Union

The Trust made preparations in 2018/19 for the potential impact of the UK's exit from the European Union, including planning for the case of a 'no deal' EU Exit, following recommendations in the Department of Health and Social Care's EU Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

The Trust set up a Local EU Exit Group, to complete an assessment of any risks, covering the following:

- The seven key areas identified nationally
- Potential increases in demand associated with wider impacts of a 'no deal' exit
- Locally specific risks resulting from EU Exit

In terms of governance, the Director of People and Organisational Development was the Trust's EU Exit Senior Responsible Officer, reporting to the Board with effect from January 2019 and the Corporate Risk Register included relevant risks and mitigations in respect of the UK's Exit from the EU and the potential impact was also reflected in other relevant risks.

The Trust has considered material risks, uncertainties and mitigation in relation to EU Exit planning under the following headings:

- Governance and infrastructure
- Medicines and vaccines
- Medical devices and clinical consumable goods (MDCC)
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

The Board was particularly keen to reassure EU nationals who might be affected by EU Exit of their support and all staff were written to individually to this effect.

Important events since the end of the financial year affecting the Trust

Richard Sumray, Trust Chair, resigned from office on 30th April 2019. Lis Paice, the incumbent Senior Independent Director, was appointed as Interim Chair for a period of no greater than six months by the Council of Governors on 30th April 2019. Richard Whittington was appointed as acting Deputy Chair by the Council of Governors on 30th April 2019, and as the acting Senior Independent Director by the Board on 22nd May 2019.

1.3 Accounting Officer's 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 2018/19.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2019

2
Accountability report

2.1 Director's Report

How we are organised

Hillingdon Hospitals NHS Foundation Trust is run by a Board of Directors, comprising a Non-Executive Chair 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 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 every two months and its role is to determine the overall corporate and strategic direction of the Trust, overseeing 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.

The Constitution confirms the procedure to be adopted by the Board and the Council of Governors in the event of a dispute. This process involves informal resolution by the Chair followed by the appointment of a joint Committee or referral to the regulator if still required.

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 normally 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. In late 2018/19 two interim appointments both for periods of three months were made due to retirements.

Well Led Framework

In June 2018, the Trust agreed enforcement undertakings in relation to governance including undertaking an externally commissioned governance review to inform the strengthening of governance arrangements. This review was paused in late 2018 because of leadership changes and will be completed in the summer of 2019. Interim improvement measures from that review indicated that improvements were required and reflected weaknesses in arrangements in 2018/19, with regards to capacity and capability within the Trust's leadership team and project management office, development of Trust strategy, governance structures and membership of groups within those structures, the Board Assurance Framework, arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management.

The Trust received this useful feedback when the review was paused, and this has enabled the trust to triangulate these early findings and action required with the CQC report, which are described in the review of effectiveness section of the Annual Governance Statement within this Annual Report.

The Trust will review the findings from the completed review and develop an action plan to address any weaknesses identified. The Trust is also currently receiving developmental support around risk, quality and governance from the Good Governance Institute.

2018/19 Board of Directors

The Board was comprised of a Non-Executive Chair, six Non-Executive Directors, one Associate (non-voting) Non-Executive Director and six Executive Director (one non-voting). There were two Non-Executive vacancies that arose during the year. There were four Executive vacancies that arose during the year with interim appointments made. Following year end Richard Sumray resigned as Chair on 30th April and Professor Elisabeth Paice was appointed on the same day as the Interim Chair.

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 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 31st October 2017 and the Council of Governors approved its extension for a further 3 years to 31st 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 in 2017.

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.

She is a Non-Executive Director of NHS Digital and was appointed as the Senior Independent Director of that Board in 2018. She was the Academic Manager of the University of Hertfordshire until December 2018. Soraya is the Chair of the Remuneration Committee and sits on the Finance and Performance, Audit and Risk and Nominations Committees. Additionally she is the Board's Digital Champion and Equalities Champion, as well as being the NED link for the Surgery division. Her term of office expired on 31st January 2017 and has been further extended to 31st January 2020. Soraya resigned as Deputy Chair on 27th February 2019.

Professor Elisabeth 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. Her term of office expired on 31st January 2017 and has been further extended to 31st 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. His term of office expired on 30th September 2017 and the Council of Governors approved its extension for a further 3 years to 30th September 2020.

Carl Powell: Non-Executive Director

Carl Powell was appointed on 1st 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. He is also the NED link for Cancer and Clinical Specialism Services as well as being the Boards Revalidation Champion.

Keith Edelman: Non-Executive Director

Keith Edelman was appointed on 1st 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. He resigned from office on 31st December 2018.

Cheryl Coppell: Non-Executive Director

Cheryl Coppell joined the Trust joined the Trust on 10th 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's Division. She resigned from office on 30th November 2018.

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 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 the Human Resources and Learning and Development. She was appointed as an interim NED on 1st February 2018.

Rima Makarem: Non-Executive Director
Rima Makarem has had a distinguished career in the healthcare and the pharmaceutical industries. She currently holds a portfolio of non-executive positions. She is a non-executive director and the Audit Chair at University College London Hospitals (UCLH) and the Senior Independent Director and Audit Chair at the National Institute for Health and Care Excellence (NICE). She chairs the National Travel Health Network and Centre, and is an External Commissioner and the Audit Chair at the House of Commons. She is also an independent member of the Council of St George's, University of London. Dr Makarem brings a wealth of experience from the private sector. She was director of competitive excellence at a global pharmaceutical company, which followed roles at management consultancy firms. She was appointed as an interim NED on 1st February 2018.

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 & 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. He resigned from his post on 31st August 2018.

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 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 but which was unsuccessful, and there is no ongoing relationship. He resigned from his post on 31st January 2019.

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. He resigned from his post on 31st January 2019.

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). He resigned from his post on 31st January 2019.

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 Master's 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.

Derek Smith: Interim Chief Executive: Executive Director

Derek Smith was appointed as the interim CEO for the period September to November 2018. Derek brought with him a wealth of NHS knowledge with over 25 years' experience in both permanent and interim roles at a senior level. He was Chief Executive at Hammersmith Hospitals NHS Trust where he created an effective partnership with Imperial College enabling the creation of the first Academic Health Sciences Centre in the UK and was also CEO at Kings College Hospital NHS Trust.

Derek also held interim CEO positions in Trusts across the country providing skills and expertise in various areas including improving performance in emergency admissions and strategic estates plans.

Sarah Tedford: Chief Executive: Executive Director

Sarah became Chief Executive of Manchester Royal Infirmary, Manchester University NHS Foundation Trust in March 2018. She spent the 6 months prior to this on secondment to NHSI/NHSE as Winter Director London to provide assurance on the systems and processes in place to monitor delivery of the National A&E standard across London. She was eager to return to London and have a role that gave her more scope.

For almost three years' from November 2014 she was Chief Operating Officer at Barking, Havering and Redbridge University Hospitals NHS Trust, helping the Trust to exit 'Special Measures'. Before this she was at Kingston Hospital NHS Foundation Trust as Deputy Chief Executive, a position she acceded to in May 2011.

Sarah spent her formative NHS career at United Lincolnshire Hospitals NHS Trust, initially she had almost 5 years split between two roles; Assistant Director Strategic Development / Modernisation before becoming Hospital Director / General Manager Planned Care. After this she moved to NHS IMAS spending 16 months as Head of Performance / Performance Lead to help improve their cancer waiting times, then until May 2011 she was Director of the Intensive Support Team working with challenged Trusts to deliver access targets. She was appointed on 26th November 2018.

Jason Seez: Interim Deputy Chief Executive Officer and Director of Strategy: Executive Director

With a strong background in strategic development, Jason joined the Trust in February 2019 from Barking, Havering and Redbridge University Hospitals NHS Trust where he was Executive Director of Strategy, Transformation and Infrastructure. Jason was appointed as a Non - Voting Interim Executive until the end of the financial year.

Cathy Cale: Interim Medical Director: Executive Director

Cathy was the Deputy Regional Medical Director, NHSI (since October 2017) and was the GIRFT Clinical Ambassador. Her prior experience includes being the Medical Director of North Middlesex University Hospital and Interim Medical Director Great Ormond Street. She is also a Consultant in Pathology / Immunopathology / Immunology, including Paediatrics.

Her areas of strength include Clinical quality improvement and strategic experience, NHSI and GIRFT, MD experience in an acute setting with demonstrable experience of clinical governance and risk management. She has an acute awareness of financial management and

demonstrates understanding of partnership/ system working. She was appointed on 4th February 2019.

David Stonehouse: Interim Finance Director: Executive Director

David was appointed as Interim Finance Director for the period from 2nd February 2019 until the end of the financial year. David had experience in both permanent and interim Finance Director Posts in acute trusts spanning a period of over 10 years, as well as experience as a Deputy Chief executive in two posts.

Dean Spencer: Interim Chief Operating Officer: Executive Director

Dean Spencer joined the Trust in February 2019 as the Interim Chief Operating Officer. Dean was seconded form his substantive post in NHS Improvement where he was the Delivery & Improvement Director (North West London) meaning he had extensive knowledge of the Trust and the issues it faced when he took up post. Dean has worked in the NHS since 1992 since joining the graduate management training scheme. Over his career he has worked for hospital trust, community providers, commissioning organisations, regulators and the department of health.

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 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 Chair and all of the Non-Executive Directors to be 'independent'.

Performance evaluation of the Board its Committees

The Board reviewed its Committee structure in October 2018 and implemented revisions from that review. In particular the Board refocused the work of the Finance and Transformation Committee to a Finance and Performance Committee in the autumn of 2018. An external review of the Board's effectiveness was undertaken in Autumn 2018 by Deloitte under the Well Led Framework which proposed interim improvement measures but was placed on pause until the summer of 2019 given the turnover in leadership.

Meetings of the Board, its Committees and the Council of Governors 2018/19

The Board

The Board met eight times during 2018/19. 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 2018-19, 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 2018/19;

- Audit & Risk Committee (ARC)
- Quality and Safety Committee (QSC)
- Finance and Transformation Committee which changed to the Finance and Performance Committee in November 2018 (FPC)
- Board of Directors Nomination Committee (NC)
- Board of Directors Remuneration Committee (RC)
- Charitable Funds Committee (CFC)

Audit & Risk Committee

The Audit & Risk Committee met five times during 2018/19. As at 31 March 2019, the Trust's Audit & Risk Committee was comprised of two Non-Executive Directors with two Non-Executive Director vacancies. The Committee meetings were attended by the internal and external auditors, the Local Counter Fraud Specialist, the Finance Director and the Chief Nurse 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. This had taken place in 2016/17 and was not required for the current year.

However, the Chair presented a report to the July meeting of the Committee which found that the Trust's external audit for 2017/18 had been both efficient and effective.

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 agrees 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 reviews the findings of internal audit's work against this plan at its quarterly meetings. Audits undertaken in 2018/19 included;

- CQC action plan
- Outsource contract management
- Consultant job planning
- Data quality (Counting / Completeness)
- Business continuity
- Core financial systems
- Discharge planning
- Retention strategy
- THH Audit and Risk
- GDPR

The GDPR–post implementation audit was not completed within the financial year as had been planned.

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:

A key work theme of the Committee for the year was its role in reviewing the increasing risks of a deteriorating estate through review of the Corporate Risk Register. The Committee felt the requirement to escalate to the Board its concerns on all the highly rated "unassured" risks, a number of which related to the estate. The Committee scrutinised in detail the Trust's approach to inspecting the estate as well as reviewing that there was a clear strategy for strategic estates planning.

The Committee consistently reviewed the Board Assurance Framework, the Risk Register and the findings of the Trust's internal and external auditors and Local Counter Fraud Specialist. The Committee was responsible for reviewing the annual financial statements, with particular focus given to major areas of judgement and changes in accounting policies, discussing with the External Auditor the Trust's status as a going concern, and reviewing the draft Annual Governance Statement. The Committee also reviewed the assurance in place in respect of data quality, information governance and health and safety. The Committee were not assured consistently that Data Quality was robust and escalated its concerns in this respect to the Board. A self-assessment was carried out within the year.

Quality and Safety Committee

The Quality and Safety Committee met ten times during 2018/19. As at 31 March 2019, the Trust's Quality & Safety Committee comprises of three 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:

Following the CQC inspection in summer 2018 the Board agreed the Committee should revert to meeting monthly in order, in particular, to allow sufficient capacity to address the issues arising from the report. It began to do so from the autumn. The Committee had already developed a programme of meeting with Divisional Staff to enable discussion about key risks, demand, resources, clinical learning and face to face discussions on the progress of implementing the changes required following inspection. The change in meeting frequency has allowed the Committee more time to scrutinise whether cultural change in terms of safety standards is becoming embedded and is sustainable.

The Committee has also undertaken the assessment of the quarterly Board and Governor Safety Inspection visits in order to assist in triangulating the evidence being presented in reports.

It also reviewed and reorganised the Serious Incident reporting process in September although improvements in turnaround times and assurance on learning have not significantly improved and remains a challenge for the Committee to resolve.

In the autumn the Committee introduced Statistical Process Control (SPC) performance reporting as a means of ensuring a more consistent and less subjective way of assuring itself on performance, and in 2019 detailed Ward KPI reporting was also introduced.

A self-assessment was carried out within the year.

Finance and Transformation Committee / Finance and Performance Committee

The Finance and Performance Committee met fourteen times during 2018/19. As at 31 March 2019, the Committee was comprised of three Non-Executive Directors with two Non-Executive Director vacancies and six Executive Directors. The Committee's remit is to provide the Trust with a financial strategy and ensure that the right transformation programmes are in place, providing the Board with assurance that these workstreams are progressing appropriately or pointing out the key risks if not. This remit was extended in the Autumn to cover strategic and annual operational planning as well as the review of performance against the NHS constitutional performance and local standards.

Key issues considered by the Committee:

The key focus of the Committee each month was to scrutinise the Trust's financial position and performance against plan and in doing so seek assurance on the quality of the financial data with which it was being presented and report to Board on its findings. The Committee gave very detailed attention to the position of the trust's finances and, in particular, progress on delivering efficiency savings, reviewing activity and income as well as advising Board on recommendations to advise NHSI on formal revisions of the year end deficit. Two additional meetings of the Committee took place in August to facilitate the review of available options in submitting a financial recovery plan to NHSI on 31st August.

The Committee reviewed the detail of the estate condition and the strategic options available for managing the risks the Trust faced in this respect. As part of the overall strategy the Committee approved the strategic outline case for considering, along with its partners, the rebuild of the Hospital on a site at Brunel University London.

On behalf of the Board the Committee also reviewed performance against the standards imposed by the regulator, NHSI in June. These standards related to undertakings the Trust was required to sign in June concerning performance in A&E, finance and governance.

In the autumn the Committee also introduced Statistical Process Control (SPC) performance reporting as a means of ensuring a more consistent and less subjective way of assuring itself on constitutional performance standards although this took longer to embed compared with the Quality and Safety Committee.

In term of transformational projects the Committee was responsible for reviewing the direction and progress of the Hillingdon Improvement Programme, the Hillingdon Healthcare Partnership and the Brunel University Partnership.

Nominations Committee

The Board of Directors Nomination Committee met eight times during 2018/19. As at the 31 March 2018, the Trust's Board of Directors Nomination Committee was comprised of six 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:

- The appointment of both an interim and permanent Chief Executive and other interim and permanent Executive Directors
- Recommendation to the Board in January 2019 of the case for a restructure of the Executive

Remuneration Committee

The Board of Directors Remuneration Committee met eight times during 2018/19. As at the 31 March 2018, the Trust's Board of Directors Remuneration Committee was comprised of six 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 performance.

Key issues considered by the Committee:

The Committee set the appraisal objectives for the Executive, reset objectives for both the interim and new permanent Chief Executive as well as setting the objectives for Executives at the beginning of the year.

The Committee approved the remuneration of the Interim and new permanent Chief Executive although by year end had not confirmed the executive pay of two of the interim Executive appointees.

The Committee discloses that at year end it had not approved the pay arrangements for two Executive Members who were in post although these were interim appointments.

Charitable Funds Committee

The Charitable Funds Committee met three times during 2018/19. As at the 31 March 2018, the Trust's Board of Directors Charitable Funds Committee was comprised of two Non-Executive Directors with one vacancy 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 has been keen to encourage the collapse of donations into a generic fund where donors have agreed the funding does not have to br spent on a specific project and has been successful in doing so.

With a Charities Manager in post the focus of the Committee has been in developing and signing off the Charity Strategy as well as developing the Volunteering Strategy in the latter part of the year.

An Annual Report and Accounts were produced and reviewed.

Attendance at Board and Board Committee meetings 2018/19

The following table outlines Board members' attendance at Board and Committee meetings during 2018/19 against the total possible number of meetings for which an individual was a member. Committee attendance is shown in relation to those Committees where a Director was a formal member or an expected attendee as an Executive Director.

	Board	ARC	QCS	FPC	NC	RC	CFC
Richard Sumray	8/8			14/14	8/8	8/9	3/3
Soraya Dhillon	8/8	5/5		12/14	7/8	8/9	
Linda Burke	7/8		9/10		7/8	8/9	
Cheryl Coppell	4/6		6/6	7/10	4/6	5/7	1/2
Keith Edelman	2/6	3/4		7/11	4/6	3/7	
Lis Paice	7/8		10/10		6/8	8/9	
Carl Powell	3/6	3/4		6/10	4/6	4/7	1/2
Richard Whittington	7/8	4/5	8/10		7/8	8/9	
Rima Makarem	0/1			1/2	0/1	0/1	
Shane DeGaris	2/3		1/4	6/7			
Abbas Khakoo	7/7		6/8	5/5			
Terry Roberts	8/8			1/4			2/3
Joe Smyth	7/7		2/8	9/12			
Matthew Tattersall	6/7			11/12			2/2
Jacqueline Walker	7/8		10/10	9/9			1/3
Derek Smith	2/2		1/2	3/3			
David Stonehouse	1/1			2/2			1/1
Cathy Cale	1/1		2/2	1/2			
Dean Spencer	1/1		1/2	2/2			
Sarah Tedford	3/3		2/4	4/4			

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 Chief Executive Officer 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 2019 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 2018/19 were:

	Name	Date took office and method (see key below)	Term of office expires	Resignation (R) Termination (T)
Public Governors				
North (4)	Graham Bartram	01/04/2014 (CE)	31/03/2020	
	Ian Bendall	01/04/2014 (CE)	31/03/2020	
	Robin Launder	01/04/2014 (CE)	31/03/2020	
	Tony Ellis	01/04/2014 (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	(R) Oct 2018
	Ian Burnell	01/04/2017 (CE)	31/03/2020	
	Kamran Kureshi	12/12/2018 (UE)	31/03/2020	
South (4)	Ahmed Mustafah	11/12/2018 (UE)	31/03/2020	
	Marion Thompson	18/08/2018 (UE)	31/03/2020	
	Des Brown	09/08/2017(UE)	31/03/2020	
	Doreen West	01/04/2014 (CE)	31/03/2020	(R) Oct 2018
	Rekha Wadhwani	01/04/2014 (CE)	31/03/2020	
Rest of England (1)	Amanda O'Brien	01/07/2015 (CE)	31/03/2020	
Staff Governors				
Doctors & Dentists (1)	Dr Ari Basu	01/04/2014 (UE)	31/03/2020	
Nurses, Midwives, Healthcare Assistants (3)	Sheila Bacon	08/04/2014 (UE)	31/03/2020	(R) Dec 2018
	Sheila Kehoe	08/04/2014 (UE)	31/03/2020	
	Gillian Pearce	01/04/2017 (UE)	31/03/2020	
Allied Health Professionals (1)	Lubna Hussain	01/04/2014 (UE)	31/03/2020	
Support Staff (2)	Dee Fisher	01/04/2017 (CE)	31/03/2020	(R) December 2018
	Stephen Ihuanne	01/04/2017 (CE)	31/03/2020	
	Jack Creagh	07/01/2019 (UE)	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	(R) Nov 2018
Hillingdon Healthwatch (1)	Lynne Hill	18/11/2018 (A)	31/03/2020	
London Ambulance Service (1)	Ian Johns	28/02/2018 (A)	31/03/2020	(R) July 2018
London Ambulance Service (1)	Natasha Wills	25/10/2018	31/03/2020	
Joint Negotiating & Consultative Committee (1)	Vacant for year		31/03/2020	

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

In 2018/19 the Council of Governors formally met five 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 was the Chair of the Board, Richard Sumray. He attended all five meetings

Governor	Meetings attended
Graham Bartram (Public)	5 of 5
Ian Bendall (Public)	2 of 5
Des Brown (Public)	2 of 2
Ian Burnell (Public)	5 of 5
Tony Ellis (Public)	5 of 5
Rosemary Jenkins (Public)	4 of 5
Robin Launder (Public)	3 of 5
Ahmet Mustafa (Public)	1 of 1
Kamran Qureshi (Public)	1 of 1
Mohan Sharma (Public)	4 of 5
Terry Thompson (Public)	1 of 4
Rekha Wadhwani (Public)	3 of 5
Doreen West (Public)	0 of 4
Amanda O'Brien (Rest of England)	4 of 5
Sheila Bacon (Staff)	0 of 4
Dr Ari Basu (Staff)	4 of 5
Jack Creagh (Staff)	1 of 1
Dee Fisher (Staff)	2 of 4
Lubna Hussain (Staff)	3 of 5
Stephen Ihuanne (Staff)	2 of 5
Sheila Kehoe (Staff)	5 of 5
Gillian Pearce (Staff)	5 of 5
Graham Hawkes (Appointed)	4 of 4
Lynne Hill (Appointed)	1 of 1
Ian Johns (Appointed)	0 of 3
Dr Angela Joseph (Appointed)	4 of 5
Mary O'Connor (Appointed)	4 of 5
Natasha Wills (Appointed)	1 of 1

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 License, 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
- Tony Ellis was Lead Governor for the whole of the financial year 2018/19.

Council of Governors Nominations & Remuneration Committee

The Committee met three times during 2018/19. 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 interim Non-Executive Directors. The Committee discloses that an external recruitment process was not used for these short-term (3 -month) appointments given the urgency of the requirement to recruit in order to ensure compliance with the requirements to ensure Executives were not in the majority on the Board
- To recommend to the Council of Governors the Chair and Non-Executive Director appraisals 2017/18 and their objectives for 2018/19

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	Number of Council of Governor meetings attended in 2018/19 (5 meetings held)
Soraya Dhillon (Non-Executive Director and Deputy Chair)	5 of 5
Lis Paice (Non-Executive Director and Senior Independent Director)	5 of 5
Keith Edelman (Non-Executive Director)	2 of 4
Carl Powell (Non-Executive Director)	2 of 4
Richard Whittington (Non-Executive Director)	3 of 5
Cheryl Coppell (Non-Executive Director)	2 of 4
Lynda Burke (Associate Non-Executive Director and Non- Executive Director from 1/2/19)	1 of 5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Membership

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

Public membership

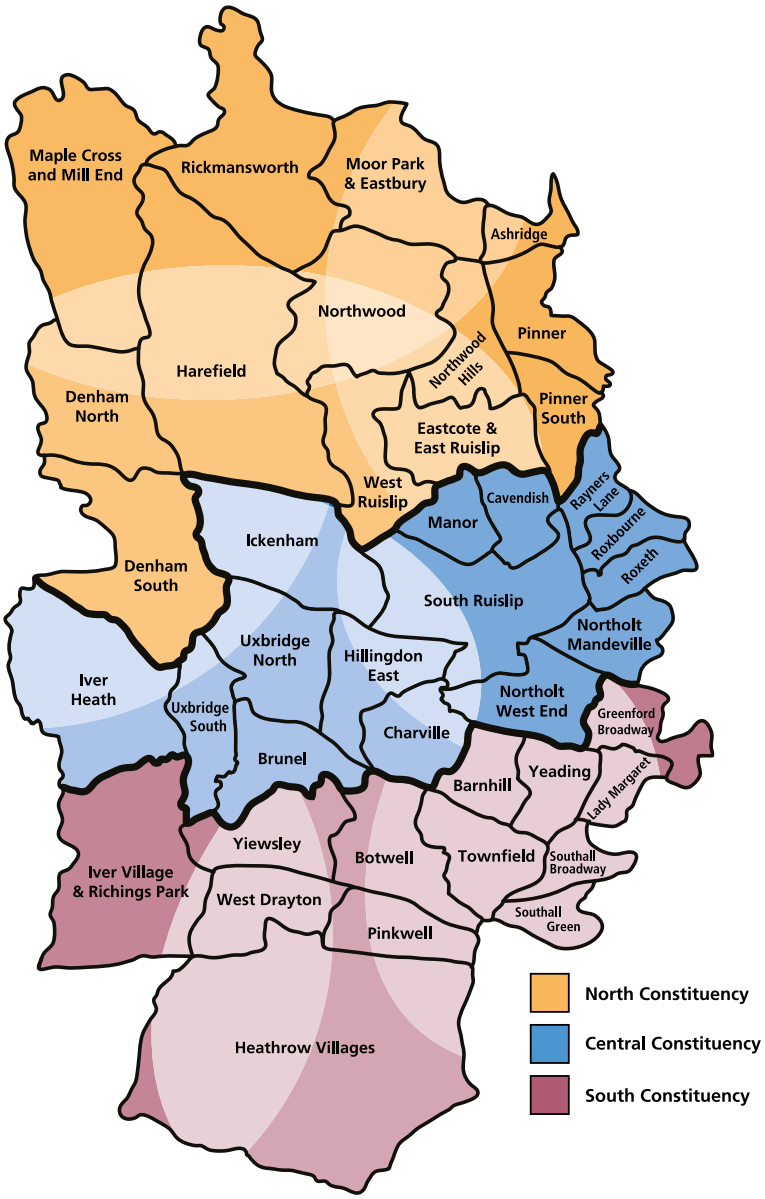
There are four public constituencies, which are collectively known as the Public Constituency. The majority of the public members are drawn from the three public constituencies which cover the electoral wards in Hillingdon borough together with several neighboring electoral wards.

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 31st March 2019, the Trust had 6,382 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 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.



	31st March 2019	% of membership	Population Base	% of area
Central	2,387	37.4	197,961	39.26
North	1,215	19.0	107,025	21.23
South	2,512	39.4	199,250	39.52
Rest of England	268	4.2	0	0
Total	6,382	100	504,236	100.00

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 31st March 2019

At 31st March 2019 the Trust had 3252 staff members. Staff membership is validated once a year 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	374
Nurses, Midwives & Healthcare	1445
Allied Health Professionals, Scientific and Technical	443
Support staff	990
Total	3352

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 2018. 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 organised 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

Summary of Stakeholder relations

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 link between the Council of Governors and groups and organisations which represent patients, public and the wider community. During 2018/19, 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 2018/19 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 2018/19. Details of the Trust's compliance in this matter can be found in note 7.1 of the accounts.

The Trust paid out £12k in 2018/19 for interest on late payments under the Commercial Debts (Interest) Act 1998 (£34k in 2017/18)

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.

The Trust paid out £12k in 2018/19 for interest on late payments under the Commercial Debts (Interest) Act 1998 (£34k in 2017/18).

Note 7.1 Better Payment Practice Code – measure of Compliance

	31 March 2019		31 March 2018	
	Number	**£000**	Number	£000
Total Non NHS trade invoices paid in the year	**88,568**	**135,687**	100,997	142,815
Total Non NHS trade invoices paid within target	**35,851**	**78,415**	18,569	72,536
Percentage of Non-NHS trade invoices paid within target	**36.8%**	**57.8%**	18.39%	50.79%
Total NHS trade invoices paid in the year	**2,155**	**32,231**	2,114	22,450
Total NHS trade invoices paid within target	**220**	**7,686**	285	14,018
Percentage of NHS trade invoices paid within target	**10.2%**	**23.8%**	13.48%	62.44%

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 2018/19, 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 2018/19 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 objectives and our overall Trust Strategy. The Trust has consulted with internal stakeholders 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. External 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 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 March 2018 as part of its planned and more detailed inspection regime. The final reports were published on 24 July 2018. 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 bi-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 Quality and Safety Committee.

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

The Governors' Nomination and Remuneration Committee is responsible for recommending appointments and re-appointments to the Council of Governors. Further details of the Committee can be found within the Directors' Report and the remunerations.

Senior Managers' Remuneration Policy

The Trust's pay policy (May 2017) is to set executive remuneration up to the median band 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, and the individual's experience, marketability and likelihood of moving elsewhere. Executive remuneration does include provision for earnback linked to the delivery of performance targets. No executive pay should be below the maximum scale for Agenda for Change Band 9.

Annual Report on Remuneration

Executive pay decisions made in 2018/19 were made in accordance with this policy. At the time Executive pay was reviewed by the Committee in May 2018, NHSI pay guidelines for 2018/19 had yet to be received and, in their absence, the Committee agreed a 2% pay increase (in line with the minimum increase that band 9 staff would receive unless a previous pay award had been agreed or there was a need to bring pay in line with the lower quartile). The Committee agreed, based on the likelihood that NHSI guidance would increase the median pay point above the recommended pay for the Director of People and Organisational Development, to agree a 2% award in respect of that post.

Director Role	Current pay	Lower Q £200M-400M fy 16.17	Median £200M-400M fy 16.17	Upper Q £200M-400 fy 16.17
Chief Executive	£180,285	£160,000	£182,500	£202,500
Finance	£123,000	£123,000	£135,000	£147,500
COO	£119,503.20	£110,000	£122,500	£146,500
Nursing	£112,200	£103,000	£117,500	£127,500
People & OD	£108,171	£100,000	£107,500	£125,000

In October 2018 the Committee agreed that all Executive Director permanent appointments should include an element of earn-back pay within the remuneration package, (i.e. a requirement to meet agreed performance objectives to earn back an element of base pay, normally at least 10%).

This policy change was made in accordance with NHSI and Treasury requirements. In year pay awards for permanent executive posts were made in accordance with this decision.

In 2018/19 The Board agreed to reorganise the Executive resulting in the addition of the post of Deputy Chief Executive and Strategy. 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.

The Remuneration Committee declares that at year end there were two remuneration decisions that had not been confirmed through the Remuneration Committee. These were the interim appointments of the Finance Director and Chief Operating Officer (the latter by way of a secondment from NHSI) although at 31st March 2019 they were in the employ of the Trust as Board Directors.

Statement of consideration of employment conditions elsewhere in the Trust

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change. The 2018/19 salary scales for Executive Directors were agreed following a review of available salary data provided by NHS Providers.

Policy on Payments for loss of office

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 accordance 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 2018-19.

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

Disclosures required by Health and Social Care Act

The Trust is governed by a Board of Directors. At 31 March 2019, the Board comprised 6 non-executive directors (including the chairman) and 6 executive directors (including the chief executive). There are 25 governor positions (23 were in post as at year end) comprising 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). No material expenses were paid to Executives or Governors within the year 2018-19.

Definition of 'senior managers'

The definition of 'senior managers' for the purpose of this 201/198 report is those persons in voting or non-voting Executive Director or Non-Executive Director roles within the organisation.

Service contracts obligations

Information relating to Directors' service contracts is included within the table Names of Trust Directors during 2018/19.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust

28th May 2019

Future policy table

	Salary/fees	Taxable benefits	Annual performance related bonus	Pension related benefits
Reason for pay: delivery of the strategic objectives of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's strategic and operational objectives	none disclosed	yes	To ensure the recruitment and retention of directors is of sufficient calibre to deliver the Trust's objectives
Performance period	As determined by Remuneration Committee	none disclosed	As determined by Remuneration Committee	As determined by Remuneration Committee
How the component operates	Paid monthly	none disclosed	annually	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	Salaries are determined by the Trust's Remuneration Committee in accordance Senior Managers' Remuneration Policy	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance	Performance Development Review assessed by Remuneration Committee	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Not applicable
Performance measures	Based on objectives agreed by Remuneration Committee	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Contributions are made in accordance with the NHS Pension Scheme

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

		Current Year Ending 31 March 2019						Previous Year Ending 31 March 2018					
	NAME AND TITLE	**Salary and fees 2018/19**	**Taxable Benefits 2018/19 (Note 6)**	**Annual Performance Related Bonuses 2018/19**	**Long Term Performance Related Bonuses 2018/19**	**Pension Related Benefits 2018/19**	**Total Remuneration 2018/19**	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
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 (to 2/9/2018)	**70-75**	**0**	**N/A**	**N/A**	**30-35**	**100-105**	175 - 180	0	N/A	N/A	40- 42.5	220 - 225
	Derek Smith, Chief Executive (from 05/09/2018 to 25/11/2018)	**35-40**	**0**	**N/A**	**N/A**	**0**	**35-40**						
	Sarah Tedford, Chief Executive (from 26/11/2018)	**60-65**	**0**	**N/A**	**N/A**	**30-35**	**95-100**						
	Catherine Cale, Medical Director (from 04/02/2019)	**10-15**	**0**	**N/A**	**N/A**	**70-75**	**85-90**						
1	Abbas Khakoo, Medical Director (to 31/01/2019)	**210-215**	**0**	**N/A**	**N/A**	**605-610**	**815-820**	170- 175	0	N/A	N/A	17.5 -20	180 - 185
	Terry Roberts, Director of People	**105-110**	**0**	**N/A**	**N/A**	**5-10**	**110-115**	105 - 110	0	N/A	N/A	22.5 - 25	130- 135
	Jason Seez, Deputy Chief Executive and Director of Strategy (from 11/02/2019)	**20-25**	**0**	**N/A**	**N/A**	**0-5**	**20-25**						
	David Searle, Director of Strategy & Business Development (to 08/06/2018)	**60-65**	**0**	**N/A**	**N/A**	**0-5**	**60-65**	105 - 110	0	N/A	N/A	15 - 17.5	125 - 130
	Joe Smyth, Chief Operating Officer (to 31/01/2019)	**100-105**	**0**	**N/A**	**N/A**	**70-75**	**170-175**	115 - 120	0	N/A	N/A	0 - 2.5	120 - 125
	Dean Spencer, Chief Operating Officer (from 21/02/2019)	**10-15**	**0**	**N/A**	**N/A**	**0-5**	**15-20**						
	David Stonehouse, Director of Finance (from 03/02/2019)	**20-25**	**0**	**N/A**	**N/A**	**0-5**	**20-25**						

		Current Year Ending 31 March 2019						Previous Year Ending 31 March 2018					
	NAME AND TITLE	**Salary and fees 2018/19**	**Taxable Benefits 2018/19 (Note 6)**	**Annual Performance Related Bonuses 2018/19**	**Long Term Performance Related Bonuses 2018/19**	**Pension Related Benefits 2018/19**	**Total Remuneration 2018/19**	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
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
	Matthew Tattersall, Director of Finance (to 04/02/2019)	**100-105**	**0**	**N/A**	**N/A**	**45-50**	**145-150**	115 - 120	0	N/A	N/A	45 - 47.5	165 - 170
	Jacqueline Walker, Director of the Patient Experience and Nursing	**110-115**	**0**	**N/A**	**N/A**	**90-95**	**200-205**	95 - 100	0	N/A	N/A	105 - 107.5	175 - 180
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
	Linda Burke, Non-Executive Director	**5-10**	**0**	**N/A**	**N/A**	**N/A**	**5-10**	5 - 10	0	N/A	N/A	N/A	5 - 10
	Cheryl Coppell, Non Executive Director (to 30/11/2018)	**5-10**	**0**	**N/A**	**N/A**	**N/A**	**5-10**	10 - 15	0	N/A	N/A	N/A	10 - 15
	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 Edelman, Non-Executive Director (to 31/12/18)	**5-10**	**0**	**N/A**	**N/A**	**N/A**	**5-10**	10 - 15	0	N/A	N/A	N/A	10 - 15
	Rima Makarem, Non-Executive Director (from 1/2/2019)	**0-5**	**0**	**N/A**	**N/A**	**N/A**	**0-5**						
	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 2019	Real increase in pension lump sum at age 60 at 31 March 2019	Total accrued pension at age 60 at 31 March 2019	Lump Sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1st April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	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**	**£000s**
Shane Degaris, Chief Executive (to 2/9/2018)	30-32.5	0-2.5	40-45	20-25	451	52	503	N/A
Sarah Tedford, Chief Executive (from 26/11/2018)	32.5-35	0.25-5	45-50	140-145	876	62	938	N/A
Catherine Cale, Medical Director (from 04/02/2019)	72.5-75	0-2.5	25-30	85-90	655	5	660	N/A
Abbas Khakoo, Medical Director (to 31/01/2019)	605-607.5	80-82.5	85-90	255-260	1,088	717	1805	N/A
Terry Roberts, Director of People	7.5-10	0-2.5	30-35	70-75	447	75	522	N/A
Jason Seez, Deputy Chief Executive and Director of Strategy (from 11/02/2019)	0-2.5	0-2.5	45-50	105-108	689	12	701	N/A
David Searle, Director of Strategy & Business Development (to 08/06/2018)	0-2.5	0-2.5	25-30	80-85	634	-	634	N/A
Joe Smyth, Chief Operating Officer (to 31/01/2019)	72.5-75	0-2.5	30-35	85-90	591	78	668	N/A
Dean Spencer, Chief Operating Officer (from 21/02/2019)	0-2.5	0-2.5	55-60	120-125	801	14	815	N/A
David Stonehouse, Director of Finance (from 03/02/2019)	0-2.5	0-2.5	55-60	130-135	868	15	883	N/A
Matthew Tattersall, Director of Finance (to 04/02/2019)	45-47.5	0-2.5	35-40	85-90	511	97	608	N/A
Jacqueline Walker, Director of the Patient Experience and Nursing	90-92.55	7.5-10	40-45	100-105	637	75	713	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. 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 31st March if he/she were to transfer that pension fund on that date. Table 2 was subject to audit.

Table 3 – Fair Pay Multiple

	2018/19	2017/2018
Band of Highest Paid Director's Total Remuneration (£000)	**180 - 185**	175 - 180
Median Total Remuneration	**33,379**	33,006
Ratio	**5.47**	5.38

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 31st March 2019 on an annualised basis. In 2018/19 1 employee received gross remuneration higher than the highest paid director in the band of £245k to £250k. Table 3 was subject to audit.

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

	2018/19	2017/2018
	(Bands of £5000)	(Bands of £5000)
Shane Degaris, Chief Executive	**N/A**	175 - 180
Abbas Khakoo, Medical Director	**170 - 175**	170 - 175
Sarah Tedfors, Chief Executive	**180 - 185**	N/A

Notes on Table 4
The Annual Reporting Manual (ARM) for NHS Foundation Trusts from 2018/19 requires the Trust to disclose all Senior Managers receiving grater remuneration than £150,000. 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 £95k - £100k , Director work in band of £110 - £115k.
Recharges out to Brunel University and Imperial College Healthcare Trust are 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.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2019

2.3 Staff Report

Equality, Diversity and Inclusion

The Trust employed 3,350 (4,258 including bank) employees in total this year. Women comprised 77% of the workforce and 23% were men, a figure the same as last year. Women represent 70.14% of senior staff at band 8a and above.

In common with all other required employers, the Trust published its first Gender Pay Gap Report in 2018. The analysis included in the Gender Pay Gap Report indicates that there is an average hourly rate pay gap in favour of men of 20.4% across the organisation. This is an improvement of 2.2% on 2017 and continues to be largely attributed to the awarding of Clinical Excellence Awards (CEA Awards) for consultants, longer lengths of service for male consultants, and the fact that the majority of VSM (Very Senior Manager) positions in the Trust were held by men. High level actions are in place to address this gap and will be detailed in the Trust's annual Equality, Diversity and Inclusion (EDI) Report 2018/19

Gender split by Staff Group (excluding bank)						
Staff Group	Female		Male		Total Headcount	Total %
	Headcount	%	Headcount	%		
Nursing and Midwifery Registered	892	90.65%	92	9.35%	984	100.00%
Administrative and Clerical	533	79.08%	141	20.92%	674	100.00%
Additional Clinical Services	501	88.99%	62	11.01%	563	100.00%
Medical and Dental	246	53.83%	211	46.17%	457	100.00%
Estates and Ancillary	193	53.02%	171	46.98%	364	100.00%
Allied Health Professionals	149	78.84%	40	21.16%	189	100.00%
Add Prof Scientific and Technic	68	77.27%	20	22.73%	88	100.00%
Healthcare Scientists	21	75.00%	7	25.00%	28	100.00%
Students	3	100.00%	0	0.00%	3	100.00%

Staff Group split by Gender (excluding bank)				
Staff Group	Female		Male	
	Headcount	%	Headcount	%
Nursing and Midwifery Registered	892	34.23%	92	12.37%
Administrative and Clerical	533	20.45%	141	18.95%
Additional Clinical Services	501	19.22%	62	8.33%
Medical and Dental	246	9.44%	211	28.36%
Estates and Ancillary	193	7.41%	171	22.98%
Allied Health Professionals	149	5.72%	40	5.38%
Add Prof Scientific and Technic	68	2.61%	20	2.69%
Healthcare Scientists	21	0.81%	7	0.94%
Students	3	0.12%	0	0.00%
Grand Total	**2606**	**100.00%**	**744**	**100.00%**

Workforce Equality, Diversity & Inclusion (EDI) Objectives: update and 2019-20 actions

Workstream: Bullying & Harassment	
Actions completed:	**Actions for 2018-19:**
• Communications campaign to raise awareness of reporting routes and processes for bullying & harassment (B&H). • Review of internal systems for reporting B&H/physical violence – Speak In Confidence relaunched. • Recruited >1110 CARES Ambassadors • Capability training for CARES Ambassadors delivered	• Training and recruitment of CARES Champions with continue to build the capacity and capability of our CARES Ambassadors to support bullying and harassment interventions. • More training and development to equip staff to deal with occurrences of violence, bullying and harassment • Identify themes from Datix reports for further investigation to target training to specific high occurrence areas • Continue with review of internal systems of reporting • Refocus the Dignity at work group to implement solutions

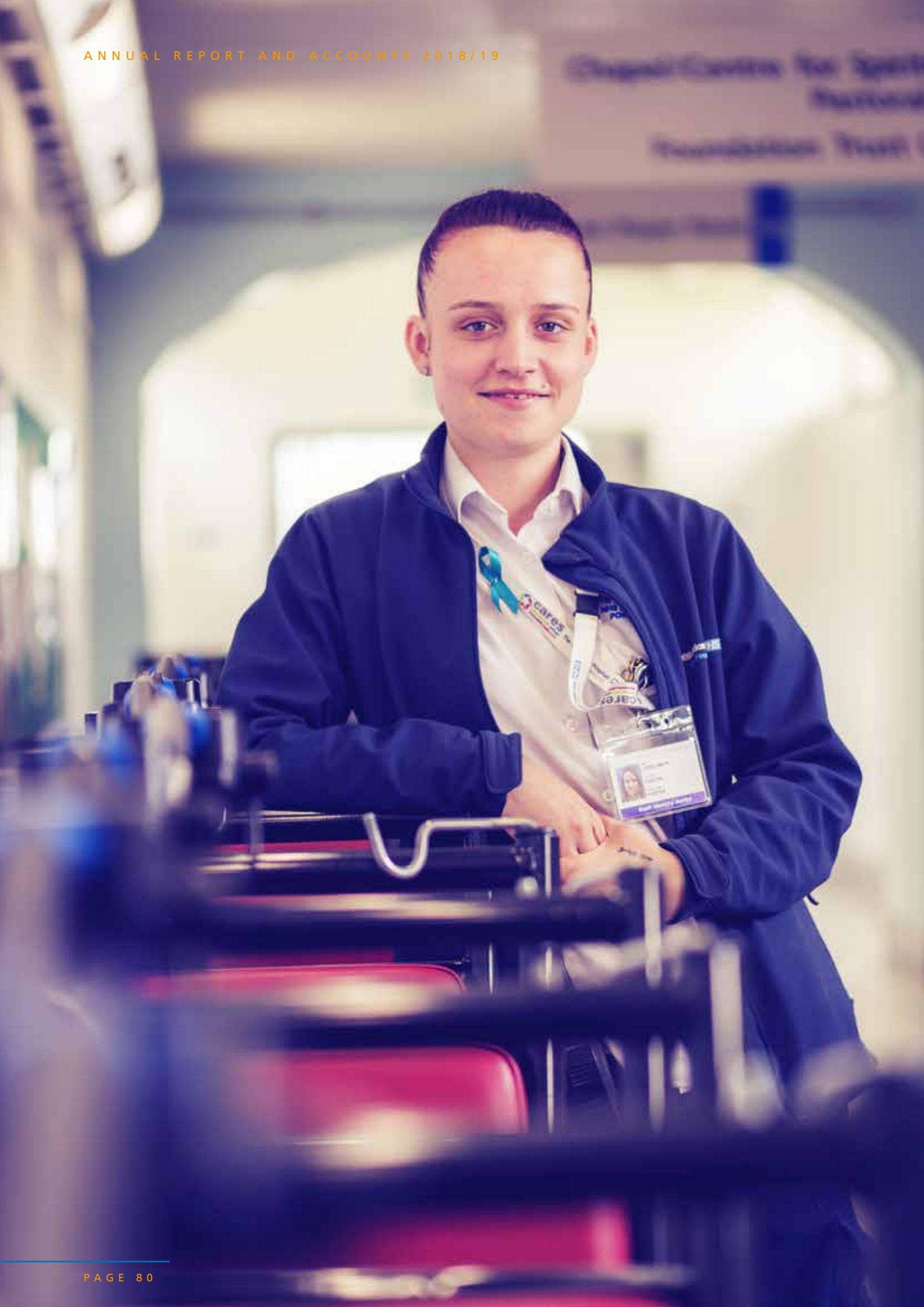
Workstream: Learning & Development	
Actions completed:	**Actions for 2018-19:**
• From first analysis of data from Study Leave applications, 95% of applications stated their gender but only 38.2% of applications provided information on their ethnic origin. • Data shows that 61.8% didn't disclose their ethnic origin. • Of those disclosing 19.6% were BAME and 18.6% White.	• Study leave applications, including those turned down, will be included on iDevelop, so more accurate data can be collected • Data to be used to target areas where there are signs of inequalities • Use the new electronic PDR to collect data on future training requirements • Development and delivery of an in house management development programme as per people strategy which clearly embed WRES and WDES

Workstream: Career Progression	
Actions completed:	**Actions for 2018-19:**
• E-learning developed for staff who recruit band 8a and above to ensure a more ethnically diverse workforce. • Development Centres delivered aimed specifically for band 7 staff to progress to band 8a. To support the recruitments, development and attraction of talent in the organisation • Implementation of diversity requirement as a mandatory criteria when engaging with external recruitment agencies for both permanent and temporary roles • Completed first stage of BAME Mentoring Programme, with ten BAME staff through the Programme so far.	• Continue to deliver Development Centres aimed specifically for band 7 staff to progress to band 8a • Ensure National Leadership Academy training specifically aimed at BAME is promoted widely and also to targeted to those identified as part of PDR • Further training for Equality Champions to support managers who recruit for vacancies 8a+ • Train new Board members in reverse mentoring to support the BAME Mentoring programme for staff at band 8A and above • Actively promote internal secondments and project opportunities by division

Workstream: Engagement	
Actions completed:	**Actions for 2018-19:**
• Launched LGBT Group • Stonewall membership achieved • Further roll out of Ethnic Diversity Network	• Agree and deliver work programme for Ethnic Diversity Network • Grow membership of the LGBT Group • Review need for additional networks around protected characteristics

Workstream: Equalities & Disability	
Actions completed:	**Actions for 2018-19:**
• Collection of Workforce Disability Equality Standards (WDES)	• Complete and submit data to NHS England • Analysis and action plan of WDES data • Engage staff with WDES – support focus groups to help with action planning • Understand and deliver adequate adjustments to enable disabled staff to carry out their work • Information from the Staff Survey 2018 show that there are significantly more people who consider themselves with a disability. Trust wide campaign to increase the data capture on ESR. • Run ESR surgeries to cleanse all EDI data

Workstream: Gender Pay Gap	
Actions completed:	**Actions for 2018-19:**
• Develop talent management and succession plans to increase the number of women in the VSM pay band • Ensure recruitment agencies understand our desire to have a good selection of women on the shortlist for senior posts including VSM	• Target female consultant staff to increase uptake of CEA Award opportunities • Establish interest in a Women's Network • To drive forward the NHSI retention plan which specifically addresses flexible working, retire and return as well as upskilling the workforce in new roles such as Nursing Associate • Provide gender specific coaching, interview skills and link with national leadership academy on women leadership development.



Appendix A - The Hillingdon Hospitals NHS Foundation Trust – Annual Accounts (Audited)

Note 6 Employee costs and numbers

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	119,996	19,505	**139,501**	131,448
Social security costs	13,062	1,623	**14,685**	13,868
Apprenticeship levy	601	89	**690**	644
Employer contributions to NHS Pension scheme	14,863	658	**15,521**	14,658
Pension cost - other	17	9	**26**	-
Termination benefits	102	-	**102**	22
Temporary staff	-	10,453	**10,453**	12,645
Total gross staff costs	148,641	32,337	**180,978**	173,285
Recoveries in respect of seconded staff	(1,709)	-	**(1,709)**	(1,519)
Total staff costs	**146,932**	**32,337**	**179,269**	**171,766**
Of which				
Costs capitalised as part of assets	842	-	**842**	757

Note: The WTE in 2017/18 were overstated by 90 due to the transfer of the Pathology staff to North West London Pathology when the Trust received charges as Clinical Supplies, the wte were removed in Month 11 only.

Directors aggregate remuneration (Audited)	31 March 2019 Remuneration £000	31 March 2019 Number of Directors **	31 March 2018 Remuneration £000	31 March 2018 Number of Directors **
Executive Directors	**1,085**	**13**	1,097	8
Non Executive Directors*	**134**	**9**	141	9
Total	**1,219**	**22**	1,238	17
Analysis of Directors Remuneration (£000)				
Gross pay	**1,003**		988	
Employer Pension Contributions	**104**		130	
Employer National Insurance Contributions	**112**		120	
Total	**1,219**		1,238	

*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.

2017/18 Directors aggregate remuneration	31 March 2018 Remuneration £000	31 March 2018 Number of Directors **	31 March 2017 Remuneration £000	31 March 2017 Number of 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.

Average number of employees (WTE basis)	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	465	58	**523**	508
Ambulance staff	-	-	**-**	-
Administration and estates	718	72	**790**	815
Healthcare assistants and other support staff	579	155	**734**	721
Nursing, midwifery and health visiting staff	856	203	**1,059**	1,045
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	351	33	**384**	334
Healthcare science staff	18	6	**24**	155
Total average numbers	**2,987**	**527**	**3,514**	**3,578**
Of the above:				
Number of employees (WTE) engaged on capital projects	**13**	**-**	**13**	13

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; 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, and issues relating to modern slavery. Staff are able to raise these issues within the management chain, to the Speaking in Confidence Guardian.

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 her 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 review 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 in 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.

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. The Health and Safety team provide advice and support for the Trust on health and safety, fire safety, medical device safety and moving and handling.

- **Health and safety governance:** The Health and Safety Committee has met quarterly and the Audit and Risk Committee has received reports on health and safety issues and performance throughout the year as well as an Annual Report.

- **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 1,769 incidents reported indicating an increase in trajectory compared to 1,607 reports in 2017/18. Incidents relating to health and safety are all assessed by the health and safety team and support, advice and information is provided for managers where necessary to improve the quality of investigation and learning.

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

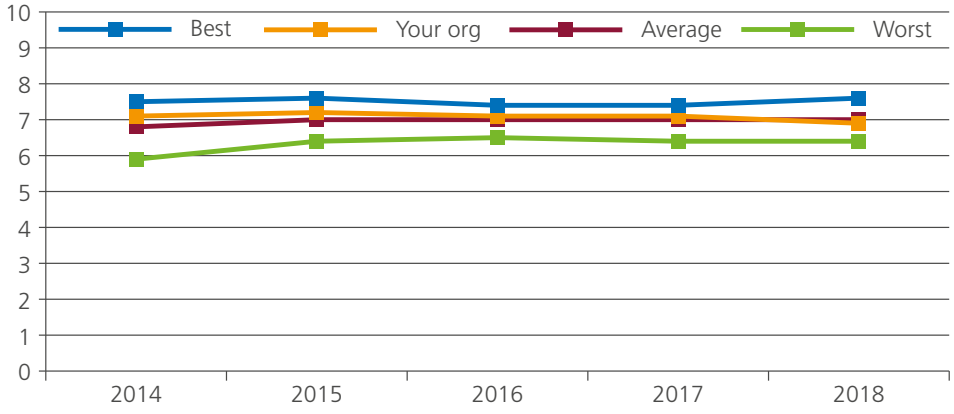
Approach to staff engagement

The Trust has a range of mechanisms through which it listens to and involves its workforce. This year, we have instituted a new programme of monthly briefing sessions ('Team Brief') to listen to and engage with managers across both sites, led by the CEO and Executives. All managers are expected to cascade the messages from this down through their teams. In addition, there are also monthly open forums and weekly blogs to keep all staff engaged with current priorities. There is also a focus on partnership working with Staff Side colleagues through the Joint Negotiation and Consultative Committee (JNCC) as well as specific staff initiatives.

The Trust continues to promote regular one to one meetings between managers and direct reports and their teams. There is an ongoing programme of work to support staff retention and engagement, which focuses on the key areas of: relationships (bullying and harassment); flexible working; and career development. We know that these are the key reasons that people leave the organisation. The annual appraisal process also provides an additional mechanism through which staff are involved in decisions about their work, service and performance of the Trust.

The Trust supports staff health and wellbeing. This includes an Occupational Health Department which provides information and support to staff. In addition there is an Employee Assistance Programme in place, which is open to all Trust employees – details are published on the Trust Intranet page as well as the 'Vivup' online platform, which offers all staff a range of benefits.

2018 NHS Staff Survey Results



Best	7.5	7.6	7.4	7.4	7.6
Your org	7.1	7.2	7.1	7.1	6.9
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4
Responses	801	947	1,429	1,544	1,536

NHS staff survey

The National Staff Survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The ten indicators are; equality, diversity & inclusion, health & wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment – bullying & harassment, safe environment – violence, safety culture and staff engagement.

The response rate to the 2018 survey among trust staff was 50% (2017: 53.2%). Scores for each indicator together with that of the survey benchmarking group are presented below.

The Trust score for staff engagement in the National Staff Survey fell in 2018, indicating a more challenging environment this year. We continue to use the findings from the National Staff Survey report to engage our staff and we undertake Divisional level focus groups to understand the issues and develop action plans to address the findings at a local level.

	2018/19		2017/18		2016/17	
Indicators	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	8.6	9.1	8.7	9.1	8.8	9.2
Health and wellbeing	5.8	5.9	6.1	6.0	6.3	6.1
Immediate managers	6.6	6.7	6.7	6.7	6.8	6.7
Morale	5.8	6.1	X	X	X	X
Quality of appraisals	5.4	5.4	5.7	5.3	5.7	5.3
Quality of care	7.4	7.4	7.6	7.5	7.7	7.6
Safe environment – bullying and harassment	7.7	7.9	7.8	8.0	8.0	8.0
Safe environment – violence	9.4	9.4	9.4	9.4	9.4	9.4
Safety Culture	6.3	6.6	6.5	6.6	6.6	6.6
Staff Engagement	6.9	7.0	7.1	7.0	7.1	7.0

Key Improvements since 2017

The five areas in which the trust made the most improvements in since 2017:

	Most improved from last survey
68%	Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work
56%	Q17a. Organisation treats staff involved in errors fairly
75%	Q11e. Not felt pressure from manager to come to work when not feeling well enough
80%	Q5c. Satisfied with support from colleagues
89%	Q15b. Not experienced discrimination from manager/team leader or other colleagues

Top 5 scores (compared to average of other acute trusts)

	Top 5 scores (compared to average)
71%	Q12d. Last experience of physical violence reported
92%	Q19a. Had appraisal/KSF review in last 12 months
63%	Q2a. Often/always look forward to going to work
75%	Q11e. Not felt pressure from manager to come to work when not feeling well enough
10%	Q11g. Not put myself under pressure to come to work when not feeling well enough

Bottom 5 scores (compared to average of other acute trusts)

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

	Bottom 5 scores (compared to average)
58%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
50%	Q17d. Staff given feedback about changes made in response to reported errors
44%	Q4f. Have adequate materials, supplies and equipment to do my work
61%	Q17c. Organisation takes action to ensure errors are not repeated
65%	Q21b. Organisation acts on concerns raised by patients/service users

Least improved compared to 2017

In addition to top and bottom performing areas, the areas where we have seen the biggest change from 2017 are shown below. These are all adverse changes.

	Least improved from last survey
58%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
27%	Q11a. Organisation definitely takes positive action on health and well-being
55%	Q21c. Would recommend organisation as place to work
70%	Q21a. Care of patients/service users is organisation's top priority
77%	Q3c. Able to do my job to a standard I am pleased with

The Trust has suffered a decline in 9 out of 10 categories. The category of 'Safe environment – violence' has remained the same last year.It is important to recognise the drivers that are likely to have influenced the adverse results and to work closely with staff to address the areas of most concern.

Our response: Corporate, targeted and Divisional actions

Corporate actions

Since the 2018 survey period, the Trust has implementation year 2 of the People Strategy 2017/22. The Strategy provides the framework and a set of core actions to respond to the Staff Survey 2018. 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.

Divisional actions

Results of the divisional performance in the staff survey has been fed back to senior managers and a number of focus groups have been arranged to talk to staff about the "why" behind the data and what would make things different for them. The feedback from these groups will result in divisional action plans and improvement projects with the support of the HR Business Partners and L&OD Delivery Partners where appropriate.

	Dates	Detail
Embargo lifted and more data released	26 Feb	
Board report & Corporate action plan(?)	6 Mar	Inc agreement for framework
Comms to all staff about key themes (including outline of what happens next)	7 Mar	- Bulletin - Posters - Intranet page
Data sent to divisions, analysis completed and priorities agreed	w/c 11 Mar	Divisional team along with HRBP & LODBP
Comms sent from divisions (including invites to focus groups(survey)	w/c 18 Mar	- Briefings - Emails from divisional leads
Focus groups & survey (using open questions) – improve accessibility	w/c 1 & 8 Apr	Survey to ensure access for all staff (night shifts etc)
Analysis of focus groups	w/c 8/15 Apr	
Agreeing action plan & then communicate to all staff	w/c 15/22 Apr	
Monthly review of action plan with divisions	Ongoing	Forum to be decided
You said, we did campaign	Sept 2019	

Trade Union Facility Time

Table 1 – Relevant union officials

What was the total number of your employee who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
12	11.27

Table 2 – Percentage of time spend of facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1-50%	12
51%-99%	0
100%	0

Table 3 – Percentage of pay bill spent of facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spend on paying employees who were relevant union officials for the facility time during the relevant period

First Column	Figures
Provide the total cost of facility time	£26,686.60
Provide the total pay bill	£537,329.74
Provide the percentage of the total pay bill spend of facility time, calculated as:	
(total cost of facility time / total pay bill) x 100	5.0%

Table 4 – Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100*	6.5%

Summary of Performance

Sickness absence data

The Trust completed the financial year with a sickness rate of 3.62% (1.47% short-term & 2.16% long-term) for March and a year-to-date total of 3.98%. Trust sickness levels followed a similar cyclical pattern as last year with rates increasing from September onwards before reducing from February through to March.

Vacancy and Turnover rate

Vacancy rates ended the year 12.19% having seen a noticeable improvement on 2017/18. Voluntary turnover finished the year over the Trust target at 13.72%. Staff remaining with the Trust after 12 months of joining (stability rate) improved on 2017/18 to 89.4% (+0.6%).

Performance development review (PDR)

PDR compliance reached 98.6% in 2018/19 having closed the reporting window well above the 90% Trust target. At the time of closing there were seven areas not achieving 100% compliance: Estates & Facilities (97.52%), Finance (99.15%), Medicine (98.69%), Corporate Nursing (96.67%), Operational Services (94.74%), Surgery (98.42%) and Women's &Children's (97.59%).

Statutory and Mandatory Training Compliance

Statutory and Mandatory Training (StaM) compliance ended the year at 91.44% and above the Trust target of 85%.

Expenditure on Consultancy

The Trust spent £2,025k on consultancy services during the period. Services provided included identification and development of Financial Improvement schemes, review of the Emergency Department, and review of the Trust Governance processes.

Off payroll engagements

See appendix B.

Exit packages (Audited)

Reporting of compensation schemes – exit packages 2018/19

Exit package cost band (including any special payment element)	Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	-	1	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	1	1	**2**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**2**	**3**
Total cost (£)	£73,000	£102,000	**£175,000**

In the period there were 3 Exit Packages; one compulsory redundancy, one Payment in Lieu of Notice and one Compensatory Payment.

Reporting of compensation schemes – exit packages 2017/18

Exit package cost band (including any special payment element)	Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	-	2	**2**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**4**	**4**
Total cost (£)	£0	£45,000	**£45,000**

In the comparative period there were four Exit Packages; two payments in Lieu of Notice and two Compensatory Payments.

Reporting of high paid off-payroll arrangements

In accordance with 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.

Appendix B - Off Payroll Arrangements

Table 1: For all off-payroll engagements as of 31 Mar 2019, for more than £245 per day and that last for longer than six months	
No. of existing engagements as of 31 Mar 2019	5
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	3
Number that have existed for between three and four years at the time of reporting	1
Number that have existed for four or more years at the time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2018 and 31 Mar 2019, for more than £245 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration between 01 Apr 2018 and 31 Mar 2019	3
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	2
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	1
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 2018 and 31 March 2019	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	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.	22

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 Trust confirms it is compliant with all elements of the Code which are required to be disclosed in the Annual Report.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
ARM 2.88		The annual report should contain the following sentence: "[name] NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012."		Accountability Report - Section 2.4 Compliance with NHS Foundation Trust Code of Governance.
2: Disclose	Board and Council of Governors	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	A.1.1	Directors' Report - Council of Governors section. Directors' Report - How we are organised section.
2: Disclose	Board, Nomination Committee(s), Audit Committee, Remuneration Committee	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report	A.1.2	Directors' Report - 2018/19 Board of Directors. Directors' Report - Meetings of the Board, its Committees and the Council of Governors 2018/19.
2: Disclose	Council of Governors	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	A.5.3	Directors' Report - Council of Governors section.
Additional requirement of FT ARM	Council of Governors	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	n/a	Directors' Report - Council of Governors section.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
2: Disclose	Board	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	B.1.1	Directors' Report. All non-executive directors are independent as per the definition in Code Provision B.1.1.
2: Disclose	Board	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	B.1.4	Directors' Report - 2018/19 Board of Directors.
Additional requirement of FT ARM	Board	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	n/a	Directors' Report. - How we are organised.
2: Disclose	Nominations Committee(s)	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	B.2.10	Directors' Report.
Additional requirement of FT ARM	Nominations Committee(s)	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	n/a	Directors' Report - Council of Governors section.
2: Disclose	Chair / Council of Governors	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	B.3.1	Directors' Report - 2018/19 Board of Directors.
2: Disclose	Council of Governors	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	B.5.6	Directors' Report - Council of Governors section.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
Additional requirement of FT ARM	Council of Governors	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	n/a	This power has not been exercised by the Council of Governors.
2: Disclose	Board	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	B.6.1	Directors' Report.
2: Disclose	Board	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	B.6.2	External evaluation of the Board was commissioned by the Trust in 2018/19. This review was paused in late 2018 because of leadership changes and will be completed in the summer of 2019.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
2: Disclose	Board	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.95	C.1.1	Stated in the Statement of the Directors' Responsibilities in Respect of the Accounts. Stated in Directors' Disclosure to Auditors. Quality Governance is included in the Annual Governance Statement 2018/19. The Directors explain their responsibilities in signing the Letter of Representation when presenting the Annual Report and Accounts to its external auditor.
2: Disclose	Board	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	C.2.1	Annual Governance Statement 2018/19.
2: Disclose	Audit Committee / control environment	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	C.2.2	The Trust does not have its own internal audit department. Internal audit services are provided by KPMG, an external provider.
2: Disclose	Audit Committee / Council of Governors	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	C.3.5	The Council of Governors approved the appointment of Deloitte as the Trust's external auditor.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
2: Disclose	Audit Committee	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re¬appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	C.3.9	Directors' Report.
2: Disclose	Board / remuneration committee	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	D.1.3	None of the Executive Directors have been released to serve as a non-executive director elsewhere.
2: Disclose	Board	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non- executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	E.1.5	Directors' Report - Council of Governors section.
2: Disclose	Board / membership	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	E.1.6	Directors' Report - Council of Governors section.
2: Disclose	Membership	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	E.1.4	Directors' Report - Council of Governors section.

Governance disclosures under Schedule A	Relating to	Summary of requirement	Code of Governance reference	Where located in annual report and further explanation
Additional requirement of FT ARM	Membership	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	n/a	Directors' Report - Council of Governors section.
Additional requirement of FT ARM (based on FReM requirement)	Board / Council of Governors	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.	n/a	Annual Governance Statement – Decision Making Staff - Register of Interests

Following review the Trust is declaring compliance with all other requirements of the code on a "comply or explain" basis.

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 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18	2018/19
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	1	4
	Agency spend	2	1
Weighted Average		**2.4**	**3.4**
Overall scoring after Overrides		**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 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 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 and Social Care 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 and Social Care 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
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis

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

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

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 May 2019

2.7 Annual Governance Statement 2018/19

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 2019 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 overall effectiveness of the system of internal control and for managing all types of risk. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and relevant information in respect of the management of risks. During 2018/19 the organisation initiated a significant development programme around risk management, commensurate with the financial and quality challenges we face. This programme extends into 2019/20, with a revision of the risk policy and supporting risk management mechanisms being put in place by July 2019.

The Board Assurance Framework (BAF) sets out the key controls to manage the Trust's strategic aims and identified strategic risks. Executive Directors provide assurance to the Board with

regard to the effectiveness of controls and any shortfalls in risk assurance. Looking forward into 2019/20, the Board is updating the strategic objectives of the Trust and the commensurate recasting of the BAF will be complete and agreed by the Board by July 2020.

The Audit & Risk Committee (ARC) monitors and oversees both internal control matters and process for risk management. Both Internal and External Auditors attend ARC meetings. The Board and the Quality & Safety Committee receive reports that relate to clinical risk.

The Trust approaches the control of risk in line with our current risk policy. This provides that corporate risks are reported to the Board and ARC by the Executive Directors who have a responsibility to advise the Board of any new risks to the delivery of strategic objectives. 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, Data Security and Protection Group etc., as outlined in the Trust's Risk Management Strategy and Policy. The current revision of our risk system aims to simplify and develop risk management, and includes a thorough review of the risk registers and a review of the governance structures as they apply to risk and quality.

This current policy 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. Divisional Directors, (who are Medical Consultants professionally accountable to the Medical Director) are operationally accountable to the Chief Operating Officer and responsible for the safe and efficient management of the clinical divisions within the Trust. The Chief Nurse provides professional accountability and is supported by the Assistant Directors of Nursing.

Risk management and Health and Safety awareness training is mandatory for all employees and is included in the Trust Induction programme. The Trust's Governance Systems

and Health and Safety teams jointly deliver additional risk management training appropriate to all levels as and when required across the organisation, including the Trust Board. The training focuses on the principles of risk management; scenario based risk assessment and associated documentation as well as how to record and manage risks on the Trusts online risk register system. For 2019/20 this will be extended to include a greater focus on improvement and learning that arises from the operation of the risk system.

The Trust, through its peer networks and risk management events, evolves its risk management process in line with best practice examples. The development work initiated in 2019 will build on this incremental approach.

4. Risk control framework

4.1 Risk Management Strategy

The Board is responsible for the strategic direction of the Trust in relation to risk management, supported by the Audit & Risk Committee (ARC) which provides risk assurance to the Board in accordance with the Internal Audit Programme.

The Board Assurance Framework (BAF) seeks to provide reasonable assurance to the Board that the Trust is managing all key risks associated with achieving core strategic objectives. Currently, the BAF is reviewed quarterly by the ARC and bi-annually by the Trust Board and highlights where the Board may need to intervene or make decisions in respect of risk management. As the risk management system and the BAF are developed in 2019, the BAF will be used to drive the agenda of the Trust Board and it's supporting committees.

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 are 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. As stated above, a comprehensive and externally-facilitated review of the risk registers, and the system of escalation is currently being undertaken and the review will reported to the Trust Board in June 2019.

4.2 Quality Governance Arrangements

Key quality governance and leadership systems and structures are in place to support the Trust in ensuring that the quality and safety of care is being routinely monitored across all services, including:

- Reporting to the Board,which meets every 2 months, in the form of an integrated quality and performance report with exception narrative;
- Presentations on clinical and quality governance issues (including discussion on risk areas, performance reviews against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit) are considered at every Quality & Safety Committee (QSC) meeting;
- Deep dive reviews 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 divisional governance Boards review quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis, with divisional exception reports being considered by the Patient Safety Committee (PSC) and Regulation and Compliance Committee (RCC). Any concerns on quality are escalated to the QSC;
- A process of reporting the investigation of Serious Incidents (SIs) and the related follow up of outcomes and action plans 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. The Trust is currently reviewing the system for SI investigation and reporting to improve the quality, timeliness and learning from SI investigations;
- The Trust is reviewing the system of complaints management, with the aim of instituting auditable and proven learning where complaints are received. This will be related to other forms of patient feedback;
- The Chief Nurse, Chief Executive Officer and other Board members make regular visits to clinical departments where they have the opportunity to talk to staff and patients about their experiences;
- 'Themed Clinical Fridays' provide a forum to engage with 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;
- A robust framework is in place to ensure that all service changes are subject to a Quality Impact Assessment (QIA) which is reviewed by the Medical Director. A multi-professional Clinical Assurance Panel (CAP) reviews the QIAs, presented by project leads, for schemes where there are quality concerns to ensure appropriate actions are being taken to mitigate any associated risks to quality;
- Listening to Patients and Governors: A range of opportunities exist to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation striving for quality improvement;
- Opportunities exist for patients and members of the public to attend the Trust's People in Partnership (PiP), Council of Governors and the Trust Board meetings. There are also specialty-based focus and support groups where patient feedback can be obtained.

4.3 Well Led Framework

In June 2018, the Trust agreed enforcement undertakings in relation to governance including undertaking an externally commissioned governance review to inform the strengthening of governance arrangements. This review was undertaken by Deloitte but was paused in late 2018 because of leadership changes and will be completed in the summer of 2019. Interim improvement measures from that review indicated that improvements were required and reflected weaknesses in arrangements in 2018/19, with regards to capacity and capability within the Trust's leadership team and project management office, development of Trust strategy, governance structures and membership of groups within those structures, the Board Assurance Framework, arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management.

The Trust received this useful feedback when the review was paused, and this has enabled the Trust to triangulate these early findings and action required with the CQC report, which are described in the review of effectiveness section of this Annual Governance Statement.

The Trust will review the findings from the completed review and develop an action plan to address any weaknesses identified. The Trust is also currently receiving developmental support around risk, quality and governance from the Good Governance Institute.

4.4 Register of interests for decision-making staff

The Trust maintains a Register of Interests for decision-making staff as required by 'Managing Conflicts of Interest in the NHS'. The Register is available via the Trust public website.

4.5 Workforce Strategies

The approach to strategic workforce planning is integral to the Trusts strategic planning processes and is focused on the size and quality of the workforce. On an annual basis, workforce plans are developed at a divisional level. This process ensures input from relevant clinical, operational and corporate teams, making plans reflective of the clinical environment and issues affecting the Trust as a whole. Workforce plans form part of divisional business plans and are reviewed as part of the quarterly divisional review process. Progress with achievement of the deliverable outcomes of the workforce plan (and the overarching Trust People Strategy) is reported via the Finance and Performance Committee (People Committee from 2019/20), and direct to the Trust Board. Workforce development and performance is also assured through the Board Assurance Framework.

Key workforce planning initiatives include:

- **Skill mix and balancing supply and demand:** the integrated business planning process for 2019/20 includes processes for reviewing skill mix and linking Divisional plans to workforce need. Whilst achieving a balance between supply and demand for staff and skills is a significant challenge, the Trust has plans to do this through a range of initiatives including overseas recruitment for nurses and for medics, use of the Apprenticeship Levy, productive use of our existing staff, and supporting the development and use of new roles;

- **Agency and bank collaborative work across the Sustainability and Transformation Partnership (STP):** with North West London colleagues, the Trust is looking at options for collaborative overseas recruitment; further monitoring of bank and agency rates; and collaborative staff bank arrangements;

- **Apprenticeship Levy:** the Trust continues to utilise the Apprenticeship Levy across the organisation and to support Divisions with their workforce planning so that the Levy is used to maximum benefit. Specific initiatives are being implemented to use the Apprentice Levy to support new roles (see below);

- **Nurse Associate Apprentices:** the Trust is currently planning to recruit for 15 new Nurse Associate Apprentice roles, in collaboration with Bucks New University (BNU). This initiative is being taken forward through Health Education England (HEE) funding. The Trust was unsuccessful in securing funding for BSc Nurse Apprentices in 2018/19 but will pursue this case again in 2019/20;

- **New roles:** the Trust is actively planning to implement and extend the use of new roles, including physician associates, nurse associates, and extended clinical roles;

- **E-Rostering and e-job planning:** the Trust is currently in the final stages of rolling out e-roster use across all medical staff and is planning to further this technology in 2019/20. E-job planning is already in use for consultants and the Trust recognises the importance of expanding both e-job planning and e-rostering for all clinical staff. The Trust is aware of the newly-published Level of Attainment (LoA) and the £26m capital funding to be made available in 2019/20 from NHSI to support this agenda, and intends to submit a bid once the call has been formally made;

- **Overseas staff:** the Trust is supporting EU staff in respect of the UK's exit from the EU. Although this has not reduced EU staff to date, the impact on our workforce (particularly clinical) is regularly assessed. The increase in the immigration health surcharge for overseas staff has been met by the Divisions and has placed an additional financial burden on the organisation at a time when overseas staff are most needed.

4.6 Quality of Performance Information

The Trust's Data Quality Improvement Steering Group (DQISG) reports into the 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 required to address them. Through these groups, risks are actively reviewed and addressed through the data quality framework that has been established.

4.7 Care Quality Commission (CQC) Compliance

The Care Quality Commission (CQC) inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March and April 2018. NHS Improvement (NHSI) visited the Trust in May 2018 to conduct a 'Use of Resources' assessment as part of the revised inspection regime. The outcome of the inspection was published on 24 July 2018.

Overall, the CQC rated the Trust as 'Requires Improvement', the same rating as provided in 2015. The Safety and Well-led domains for the Hillingdon Hospital site were rated as 'Inadequate', deterioration from the Requires Improvement rating from the last inspection. Three of the Trust's core services were rated as

Good; three as Requires Improvement and two as Inadequate. In rating the Trust the CQC took into account the current rating of the core services at the Mount Vernon site which was not inspected at that time. The Trust was rated as Requires Improvement for Well-led and for the use of its resources.

The ratings assigned to the core services for the five key domains presented a mixed picture for the organisation:

- Safety and Well-led were rated as Inadequate in Urgent and Emergency Services and Surgery (a deterioration from Requires Improvement) which resulted in the Inadequate rating for these core services and for the Hillingdon Hospital site overall;
- three core services were rated as Good overall: Maternity, Children and Young People's services and End of Life Care (this was an improvement from the previous rating of Requires Improvement). Four core services were rated as Good for Safety, with two of those services also being rated Good for Well-led, and one as Outstanding;
- there were several areas noted as areas of concern for the inspectors as part of the Well-led assessment which are outlined in the report;
- due to areas of concern in three of the core services, a requirement notice was issued to ensure regulatory compliance; these covered requirements under Regulation 12, Safe Care and Treatment and Regulation 17, Good Governance;
- in respect of core services, the report outlined13 'must-dos': Urgent and Emergency Care (5), Surgery (5), Outpatients (2) and Critical Care (1). In addition, there were 61

'should-do' actions: Urgent and Emergency Care (11), Surgery (8), Medical Care (9), Outpatients (5), Critical Care (22), End of Life Care (4) and Maternity (2). A number of other areas were also identified for improvement under the areas of Well-led and Governance.

The Trust Board take these findings extremely seriously, and has been working through a detailed action plan to address the must and should do actions since the 2018 inspection, which has included following through with the actions resulting from the requirement notice that was issued.

Further to the Quality Summit in late September 2018, where the Trust and key stakeholders met to agree actions in relation to several areas of concern identified in the CQC inspection report (and as agreed with NHSI and commissioners), a thematic action plan was developed to support Trust-wide quality improvement and to support a more transformational approach. This has later been superseded by a single improvement plan which includes all aspects of the Trust's improvement work programme. This will lead the organisation into a business as usual environment within the next three years.

Monthly assurance and evidence meetings have been held with NHSI and commissioners to provide assurance on progress with regard to the Trust's improvement work, which has included observational visits to departments and discussion with department managers and point of care staff. Reasonable and significant assurance has been provided to our commissioners and regulators on their review of actions taken forward since the CQC inspection.

Safety walkabouts undertaken by Non-Executive and Executive Directors, with the support of Trust Governors and senior managers, have supported a review of safety arrangements within wards and departments, discussing challenges and risks with department managers and agreeing department and senior manager-led actions to resolve issues that are impeding improvement.

A ward and department accreditation programme was introduced in March 2019 based on an improvement model utilised successfully to improve CQC ratings in some other organisations. 'Themed Fridays' have also allowed staff to focus on a different practice theme each week to raise staff awareness and to review compliance with best practice standards. The Hillingdon Improvement Practice (HIP) programme will equip support Trust staff with the right knowledge and tools to demonstrate evidence of continuous quality improvement.

4.8 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 which will provide alerts 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 Digital Services Governance Group as well as Data Security and Protect 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 Data Security and Protection Incident Reporting Tool.

4.9 The Organisation's major risks

The Board oversees the management of all major risks, which are actively addressed by the ARC. 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 2018/19, the Board ensured the on-going assessment of in-year and future risks. Full reference to all major risks is contained within the Board Assurance Framework paper available via the Trust's public website.

The key financial and non-financial risks identified by the Trust moving forward into 2019/20 include

- inability to achieve 95% A&E target leading to a breach of the Trusts Licence;
- sub-optimal 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;
- delivering high quality patient care with medical recruitment challenges and increased patient acuity
- inability to meet compliance with the expected standards set out by 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;
- inability to modernise and reconfigure the estate and facilities to meet the needs of clinical services;
- inability to deliver high quality patient care as a result of inadequate staffing provision in accordance with the 7-day workforce initiative;
- inability and/or delay in escalating the treatment of deteriorating patients and the management of sepsis;
- inability to remain within hospital acquired infection thresholds

Overall, the Trust will remain focused on the balance between quality, safety, financial efficiency and risk to ensure that patient care remains uncompromised. The Trust will achieve this by having regular Board and Executive Quality Impact Assessments and progress reviews, where delivery is measured against agreed plans.

The Board formally escalated the condition and risks associated with the Trust estate to NHSI in February 2018. Available funds within the Trust are insufficient to keep pace with the scale of backlog maintenance. Many buildings and services have failed, or are beyond their economic and design life cycle, resulting in major facilities (e.g. Theatres, Critical Care and many wards) whose design and condition are incompatible with the delivery of high-quality, modern healthcare.

The need for investment in our infrastructure has been highlighted through the Shaping a Healthier Future (SaHF) business case. The case identified the need for investment, but highlighted that whilst investment would help, it would not resolve all of the issues with the current infrastructure. In addition, the Trust is working with partners to develop a longer-term solution to estates issues, including through the proposed development of a new facility on Brunel University's health campus.

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

The Trust has assessed its compliance with 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 and were agreed by the Board in May 2019. This process also identified any risks to compliance and mitigating actions. All statements were 'confirmed'.

The following material risks to compliance and actions to mitigate have been identified through the Trust's 2018/19 review process:

Risk: An external governance review has not been completed in 2018/19. The new developmental framework permits such review to take place within a 3-5 year period.

Action: The Trust commissioned an external governance review in 2018/19. This review was paused in late 2018 because of leadership changes and will be completed in the summer of 2019. The Trust received interim improvement measures when the review was paused, and this has enabled the Trust to triangulate these early findings and action required with the CQC

report. The Trust will review the findings from the completed review and develop an action plan to address any weaknesses identified. The Trust is also receiving developmental support around risk, quality and governance from the Good Governance Institute.

Risk: Risk that committees are not completely aligned to support the delivery of the Trusts strategic priorities.

Action: The Trust is currently working with the Good Governance Institute (GGI) to introduce a structured and customised Board development programme in order to improve the impact and overall effectiveness of the Board of Directors. In addition, a review of the Trust's corporate governance and risk management arrangements is underway in order to align the Board committee structure more closely with the Trust's strategic priorities, including review of terms of reference, membership and reporting and escalation arrangements
Risk: Some weaknesses in the Trust arrangements for ensuring the quality of performance data have been highlighted by our external auditor, with reference to their work carried out on the Quality report where errors were found with regard to the A&E 4 hour wait and 62 day cancer performance indicators. MBI also highlighted some data quality issues with regard to Rereral to Treatment (RTT) waiting lists.

Action: An RTT validation group has been established and a weekly RTT recovery Board chaired by the CEO is monitoring progress on our improvement actions.

The required actions to improve data quality will be driven by the Data Quality Steering Group with assurance overseen by the Audit and Risk Committee.

Risk: The Care Quality Commission (CQC) inspection report of the Trust published in July 2018 noted a number of issues that the Trust needed to deal with, and rated the Trust Inadequate in the Safe and Well-led

domains with an overall rating of Requires Improvement. In addition, NHS Improvement (NHSI) noted through its ongoing oversight of the Trust, poor performance in patient surveys (National Inpatient Survey and the A&E Patient Survey) and significant issues relating to sepsis management. A number of internal audits undertaken throughout the year also highlighted some significant weaknesses in governance arrangements.

Based on the CQC's inspection report and NHSI's own work with the Trust, NHSI concluded that there were reasonable grounds to suspect that the Trust was in breach of its provider licence in relation to the delivery of quality.

In June 2018 the Trust agreed enforcement undertakings in respect of the Trust's quality and programme management issues related to A&E, finance and governance.

Our external auditors have also concluded an 'adverse' VFM opinion making reference to the above as significant VFM risks which have contributed toward their opinion.

Action: The Trust has instituted a number of key actions to address the concerns raised as follows:

- developing a comprehensive action plan that addresses the issues raised in the CQC inspection.
- developing a deliverable financial plan to March 2020 which will include an understanding of the underlying financial position and detailed analysis of the causes of the underlying financial position; a well-developed Cost Improvement Programme and a link to workforce optimisation.
- the Trust has produced a plan for A&E performance recovery ("the A&E Plan").
- a performance management and accountability framework and a more robust integrated performance report are under development to ensure there is clarity on expectations and consistency in performance reporting across the Trust, aligned to the Trust's strategic objectives
- the Trust has appointed a Deputy Chief Executive/Director of Strategy
- the Trust has appointed to the Associate Director of PMO role that supports the Financial Improvement Programme the Trust has appointed Kingsgate to support delivery of financial recovery.

Risk: Risk that there may be a lack of capacity and capability to sustainably manage quality issues, as well as performance and financial matters.

Action: The interim Board Chair has a medical background and the chief executive a nursing background. The Board is currently undertaking a skills audit in order to ensure capacity and capability to sustainably manage quality issues, as well as performance and financial matters. Quality impact assessments are built into decision making processes, for example the agreement of the cost improvement programme. The Board is currently reviewing performance and quality dashBoards, supported by external expertise. There is stakeholder involvement in the quality agenda, for example through the governors. The current risk policy and associated escalations processes are being reviewed.

Risk: Lack of Fit and Proper Persons procedure for Governors

Action: Draft procedure rejected by Governors and revise procedure to be presented in July 2019

Additionally the Board is undertaking an externally facilitated skills review to ensure it has the right capacity and capability for the challenges ahead, and that there are development plans to ensure a sustainable, appropriately skilled Board is in place to lead the Trust.

4.11 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. A new People Committee of the Board has been established and will meet from May 2019.

4.12 Engagement with Stakeholders

The Trust works with its key public stakeholders in managing its risks. This is carried out 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 operational planning process
- regular 'People in Partnership' Forums enable the Trust to listen to the views and opinions of the communities we serve, to share information about what the Trust is doing (including planned future developments),
- and to provide an opportunity to communicate with staff, Governors and fellow members
- Annual Members' Meeting
- engagement with user and support groups e.g. Fighting Infection Together, Maternity Voices Partnership, Patient-led Assessment of the Care Environment
- inviting public members and local stakeholders to identify priorities for the Quality Report.

In addition, the Trust has established a Lay Strategic Forum comprised of patients and carers who use 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 in respect of the patient safety and quality agenda and the improvements required as part of its Quality and Safety Improvement Strategy.

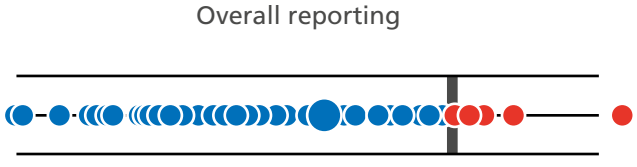
4.13 Incident Reporting

Structured processes and systems are in place in respect of incident reporting, the investigation of Serious Incidents and following up outcomes from Board commissioned external reports. The Board, through the Risk Management Strategy & Policy and the Incident Policy, 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 organisation. The latest available National Reporting Learning System (NRLS) report (covering April 2017 to September 2017 compared to April 2018 to September 2018) does not indicate any evidence of potential under-reporting at the Trust.

4.14 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

Figure 1: Potential under-reporting of incidents to the NRLS (April 2018 to September 2018)



such events. Compliance against NHS England's Emergency Planning Resilience and Response Framework (2015) and associated guidance is assessed annually by NHS England. In 2018, the Trust maintained an assurance rating of 'substantial assurance'.

There is significant uncertainty surrounding the implications of Brexit. The Trust made preparations through 2018/19 for the potential impact of the UK's exit from the European Union, including planning for the case of a 'no deal' EU Exit, including following recommendations in the Department of Health and Social Care's EU Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

The Director of People and Organisational Development has and will continue to be the Trust's EU Exit Senior Responsible Officer, reporting to the Board.

4.15 Registration with the Care Quality Commission (CQC)

The Trust is fully registered with the CQC. The Trust has been issued with its certificate for 2018/19.

4.16 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.

4.17 Assessing our Impact on the Environment

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

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 have also been 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 Trust restaurants is served in compostable packaging and work has been undertaken to reduce patient food waste, including through smaller portion trays. 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 Trust planned for a deficit of £14m in 2018/19 and, having agreed a control total with NHSI, was eligible for up to £6.2m of Provider Sustainability Funding to reduce the deficit further. However, the sustainability plan contained the following significant risks: a high level of savings (5%); no funding for activity growth above contracted levels, and no contingency element.

The Trust ended the year with a deficit of £25.9m, within this total it received £2m of general distribution of Provider and Sustainability Funding.

In order to deliver savings wherever possible, all Trusts are encouraged to keep their current expenditure under review. The ARC advises the Board on the work of Internal Audit in respect of ensuring the economical, effective and efficient use of resources. The Finance and Performance Committee (which meets monthly) receives regular reports on achievement against the savings plan.

The following key governance processes have been established within the Trust:

- a 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. Procurement of items above £25k involves competitive tendering
- all procurement tendering activities are published within nominated publications and in accordance with Public Contracts Regulations (2015)
- the Trust's Financial Improvement Programme (FIP) oversees the identification and delivery of efficiency savings which comprises Divisional and cross-cutting programmes of work
- opportunities have been identified on the basis of the Model Hospital initiative, national and peer benchmarking, and locally developed analysis
- performance is reported via divisional management teams to the weekly Performance and Activity review meetings, chaired by the Chief Operating Officer
- 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; QIAs scoring above 10 and all cross-cutting schemes are signed off via the Clinical Advisory Panel
- the Programme in 2018/19 resulted in savings of £11.7m. This was delivered through enhanced governance and a focus on efficiency projects (this represented more than double the savings delivered in the previous financial year)

The financial performance in 2018/19 has indicated that budgetary management has been inadequate in some areas, and require further strengthening in 2019/20. ARC 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 2018/19). In addition to receiving reports from FIB, the Trust's Finance and Performance Committee reviews the Trust's financial performance, transformation programme and major strategic service change business cases, including the use of information technology to lever change.

There are a range of internal and external audits that have given only partial 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 which are all reported to ARC. Reports indicated that whilst transactional processes were robust; the governance process surrounding budget sign-off was not evidenced, thus contributing to the lack of financial control in some areas. This is drawn out in Deloitte's adverse VFM statement and the Head of Internal Audit opinion.

5.1 Compliance with the Code of Governance

The Board has reviewed itself against the NHS Foundation Code of Governance. Accordingly, the Board has made 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

DHSC group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

The Trust's annual report and accounts have therefore been prepared on a going concern basis.

In considering the Trust's circumstances, 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 in the foreseeable future. The term 'foreseeable future' is defined in International Accounting Standard 1 as being a period of at least 12 months from the entity's reporting date. For this reason, they have continued to adopt the going concern basis in preparing the accounts.

Given the deteriorating financial context within the Trust, the local healthcare economy and the wider NHS, the Directors have also given serious consideration to broader financial sustainability and note that:

- The recurrent underlying position of the Trust is in deficit. The final reported deficit in 2018/19 was £25.9m, and the Operational Plan for 2019/20 currently shows a £2.7m deficit. This position is only achieved by the Trust receiving non-recurrent support of £19.5m from the Provider Sustainability/Financial Recovery Fund

- The Trust has an agreed financial plan for 2019/20. Signed contracts with both the local commissioners (North West London CCGs) and NHS England amount to £198.8m. This provides certainty and underpins 88.7% of the Trust's clinical income in 2019/20

- This plan assumes delivery of £11.7m of back-loaded Financial Improvement Schemes, of which £5.4m have been identified to date

- The Trust's Statement of Financial Position shows net liabilities. In 2018/19 the Trust received £24.5m of central cash support in order to continue operations. Financing support is provided by HM Treasury in order to ensure that essential services continue to be delivered. This financial support is not risk-assessed in relation to the Trust's ability to repay. There is no indication that this support is not likely to continue

The Directors acknowledge that, given the mechanism the Department of Health and Social Care (DHSC) is using for agreeing cash support is on a month-on-month basis, there is 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 it's assets and discharge it's liabilities in the normal course of business.

The Trust has been in receipt of financial support throughout 2018/19, and the plan for 2019/20 also includes significant non-recurrent support. 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 this financial support. The Directors continue to work with partners across Hillingdon and the wider North West London Sustainability and Transformation Partnership footprint to develop and implement a strategy consistent with the resources available.

5.3 Information Governance

Risks to information are managed and controlled in accordance with the Trust's Information Governance Policy. The Trust Caldicott Guardian is responsible for the protection of patient information.

The Trust has implemented the latest guidance for incident reporting issued by NHS Digital. The guidance, based on the requirements of the General Data Protection Regulations, Data Protection Act 2018 and the National Data Security Standards, requires incidents to be reported using the tool in the Data Security and Protection Toolkit (DSPT) which replaced the Information Governance Toolkit.

The Trust reported four incidents to the Information Commissioners Office (ICO) in 2018/19. The reportable incidents were:

i) unauthorised disclosure of personal data affecting up to 3151 people. The ICO has closed the case and no action taken against the Trust;

ii) unauthorised disclosure of excessive personal and sensitive data including information circulated for the prevention of crime. The ICO has closed the case and no action taken against the Trust;

iii) accidental disclosure of personal information including special categories of personal data by email. The ICO has taken no action against the Trust;

iv) accidental disclosure of personal information including special categories of personal data by sending letters to the wrong address and copying in unconnected individuals. The ICO has taken no action against the Trust.

6. 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*.

As stated,the Trust initiated a programme to review and overhaul the quality and risk management arrangements following the findings from the CQC report, various internal audit reports and insight from the new team of executive directors. This section describes the current quality structure which, though cohesive and logically structured clearly needs to be improved upon.

The Trust's Quality and Safety Improvement Strategy (2016/21) provides a structure for high quality clinical governance, to ensure on-going improvement in the quality and safety of patient care supporting our purpose: *"to provide high quality, safe and compassionate care, enhancing the health and wellbeing of the people that we serve"*. The Strategy defines our aims and is informed by the Quality and Safety Committee's own review of effectiveness, national and local priorities and CQC recommendations. It sets out how the Trust creates a culture of continuous improvement to increase and sustain the quality of services for 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 2018/19 Quality Report provides evidence of progress and priorities for improvement and is aligned with the 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 Foundation Trust

membership, Governors, local Healthwatch and local organisations from the third sector have been engaged via a stakeholder event 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 are regularly analysed for potential underlying issues of quality related to performance or data, not otherwise identified. All of the above have assisted the Trust in being clear on its targets and determining SMART objectives against priorities is in process.

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 provided to the Board, its committees and the Executive team by the Information and the Clinical Governance teams who collect and maintain an oversight of quality information. As part of the Integrated Quality and Performance report, which includes key quality indicators, information is also included on clinical audit and incidents, Serious Incidents (and related learning), complaints and claims. This flow of information ensures that key risks to quality are identified.

The Trust follows the National Quality Board (NQB) guidance for Learning from Deaths process and policy which provides the framework for learning from the deaths of people in our care. The Trust has also ensured that it is investigating patient safety incidents and 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 such events re-occurring. The Trust is keen to hear from patients and staff in order to continually improve the quality of our services.

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 three indicators in the Quality Report.

The Trust continues to have a comprehensive clinical audit work plan covering both national and local audit priorities, approved by the 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 and National Institute of Clinical Excellence (NICE) guidelines are reported as exceptions to the RCC with Annual updates and exception reporting to the QSC. Progress against national and local audits and actions being undertaken are detailed in the Quality Report to ensure transparency on the Trust's performance.

Regular meetings with our local Healthwatch support discussion on the progress of quality improvement priorities informed by feedback from service users who access our services and who interact with Healthwatch.

A framework exists for the management and accountability of the quality of performance data, and data quality in general, established under the Trust's Data Quality Policy. As part of a data quality audit programme, an Executive Director-led Data Quality Steering Group reports quarterly to the ARC, which in turn assures the Board on data quality, including the Trust's compliance with Constitutional Standards.

7. 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 processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control are described in this Annual Governance Statement and throughout the report.

The control framework in place within the Trust has been found to be weak during 2018/19. The Care Quality Commission (CQC) inspection report of the Trust published in July 2018 noted a number of issues that the Trust needed to address, and rated the Trust Inadequate in the Safe and Well-led domains with an overall rating of Requires Improvement. In addition, NHSI noted through its ongoing oversight of the Trust, poor performance in patient surveys (National Inpatient Survey and the A&E Patient Survey), together with significant issues relating to sepsis management. A number of internal audits undertaken throughout the year also highlighted some - weaknesses in the internal control environment e.g. consultant job planning; the retention programme; core financial systems; and the Trust's outsourced contract management. The Trust received an overall Internal audit opinion of 'Partial assurance with improvements required'. Our External auditor Deloitte LLP has also concluded an adverse opinion with regard to the Trusts use of resources to secure economy, efficiency and effectiveness in its use of resources.

There are weaknesses in the Trust's risk management arrangements and Board Assurance Framework, which have been identified through the Trust's CQC report and interim improvement measures identified as part of the external governance review. These weaknesses included, but are not limited to:

- The way in which key risks and actions are articulated to the Board and impact on the Board and committee agendas
- The process for capturing and considering emerging risks and reviewing the risk register
- The way in which risks are linked to strategy
- The process for escalation and moderation of risks
- The timely completion of actions to address risks

Based on the CQC's inspection report and NHSI's own work with the Trust, NHSI concluded that there were reasonable grounds to suspect that the Trust was in breach of its provider licence in relation to the delivery of quality.

In June 2018 the Trust agreed enforcement undertakings in respect of the Trust's quality and programme management issues related to A&E, finance and governance.

The Trust accepts that the internal control environment requires significant improvement and has instituted a number of key actions to address the concerns raised as follows:

- Developing a comprehensive action plan that addresses the issues raised in the CQC inspection. This is now included within the Trust's single improvement plan

- Developing a deliverable financial plan to March 2020 which will include an understanding of the underlying financial

position and detailed analysis of the causes of the underlying financial position; a well-
[illegible]ost Improvement Programme and
kforce optimisation

- The Trust has produced a plan for A&E performance recovery ("the A&E Plan")

The Trust has commissioned an external governance review, which is currently being undertaken by Deloitte and is due to be reported in the summer of 2019. The Trust will review the findings from the review and develop an action plan to address any weaknesses identified, but have had the benefit of some first impressions following the initial scoping work for the review. The Trust received this useful feedback when the review was paused, and this has enabled the Trust to triangulate these early findings with the CQC report.

- The Trust is currently working with the Good Governance Institute to introduce a structured and customised Board development programme in order to improve the impact and overall effectiveness of the Board of Directors. In addition, a review of the Trust's corporate governance and risk management arrangements is underway in order to:

  – align the Board committee structure more closely with the Trust's strategic priorities, including review of terms of reference, membership and reporting and escalation arrangements
  – review the quality governance and risk management structures and reporting
  – recast the BAF, and its connectivity to the Trust Board's annual cycle of business
  – review and re-organise the risk registers
  – review the risk policy and develop an updated version for Board agreement in July 2019, ahead of the usual revision time

- The Trust has been bringing together the action plans around well-led, quality and governance into one combined improvement plan and this has been dovetailed with the

Board development plan. The resulting 'development-by-doing' Board development programme is designed to ensure that the well-led framework becomes integral to how the Trust Board discharges its responsibilities

- Aperformance management and accountability framework and a more robust integrated performance report are under development to ensure there is clarity on expectations and consistency in performance reporting across the Trust, aligned to the Trust's strategic objectives

- The Trust has appointed a Deputy Chief Executive and Director of Strategy. This post will provide support to the CEO, managing corporate governance and specifically will lead the development of the clinical strategy. The Deputy CEO will provide support to the Director of Estates, aligning the clinical and the estates strategies. To ensure cohesion across the Trust the post holder will also manage the transformation team. Further, this post will oversee the implementation of the Trust Improvement Plan

- The Trust has appointed to the Associate Director of PMO role that supports the Financial Improvement Programme

- The Board development programme also includes a skills and capabilities audit, to help ensure that individual director development and new recruitments result in a strong leadership team empowered to lead the Trust within a complex environment to ensure the deeper-rooted quality, financial and performance issues are resolved

- The Trust has appointed Kingsgate to support delivery of financial recovery

Weaknesses in the Trust arrangements for ensuring the quality of performance data have also been highlighted by our external auditor, with reference to their work carried out on the Quality report where errors were found with regard to the A&E 4 hour wait and 62 day cancer performance indicators. Deloitte concluded that the recommendations as part of their previous work in this area had not been effectively implemented. MBI also highlighted some data quality issues with regard to Referal to Treatment (RTT) waiting lists.

An RTT validation group has been established and a weekly RTT recovery Board chaired by the CEO is monitoring progress on our improvement actions.
The required actions to improve data quality will be driven by the Data Quality Steering Group with assurance overseen by the Audit and Risk Committee.

The Trust Estate also presents a significant challenge. The available funds within the Trust are insufficient to keep pace with the scale of backlog maintenance. Many buildings and services have failed, or are beyond their economic and design life cycle, resulting in major facilities (e.g. Theatres, Critical Care and many wards) whose design and condition are incompatible with the delivery of high-quality, modern healthcare.

The need for investment in our infrastructure has been highlighted through the Shaping a Healthier Future (SaHF) business case. The case identified the need for investment, but highlighted that whilst investment would help, it would not resolve all of the issues with the current infrastructure. In addition, the Trust is working with partners to develop a longer-term solution to estates issues, including through the proposed development of a new facility on Brunel University's health campus. The Board formally escalated the condition and risks associated with the Trust estate to NHSI in February 2018.

There is more to do. The Trust is working with NHSI and external partners to build a deliverable and sustainable financial improvement and recovery plan. In addition, improvement plans are being developed and implemented to address the governance concerns raised by the CQC, NHSI and auditors. These will be kept under close monitoring review by the Board and Audit and Risk Committee. The well-led report from Deloitte will be an important check-in point in the summer of 2019.

8. Conclusion

As set out above, significant internal control weaknesses have been identified during 2018/19. This annual governance statement, accountability report and specifically the paragraphs above identify what they are and how they are being addressed.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
28 May 2019

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 2018/19.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
28 May 2019

3

Quality Report

2018/19

Table of contents

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

About the Trust's 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 and this report provides an opportunity to demonstrate our commitment to quality improvement and the progress made in 2018/19 against our quality priorities and national requirements. The Quality Report is a mandated document which is laid before Parliament, prior to being made available on the NHS website (www.nhs.uk) and our own website (www.thh.nhs.uk).

A glossary, explaining the terms used throughout the report, is available towards the end of the report

What is included in the Quality Report?

The Quality Report is a statutory document containing specific, mandatory statements and sections. It also contains three categories, which are mandated by the Department of Health (DH), and provides us with a framework in which to focus our quality improvement programme. These are:

- patient safety
- patient experience and;
- clinical effectiveness

The Trust undertook extensive consultation with internal and external stakeholders in developing this report to ensure that 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 2019/20, whilst a series of statements of assurance from the Trust Board, on particular elements, are also included.

Part 3 of the report outlines the key quality improvements we made in 2018/19 and provides an overview including:

- the areas identified for improvement in 2018/19
- how we performed against these improvement targets
- what this means for our patients
- other key quality indicators and information
- 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 is a summary of performance during 2018/19, in relation to our defined quality priorities and national requirements.

Overall, the Trust has seen some good performance across several quality indicators in 2018/19. However, after the Care Quality Commission (CQC) published its report on 24 July 2018 where it rated the Trust as Requires Improvement - the same rating as provided in 2015, this report recognises the areas we must improve in and the indicators we will use in doing so.

We simply must do more to improve the services we deliver to our patients, their families, their carers and our local communities and we have a robust Quality and Safety Improvement Plan in place to do just this. This plan, which is being delivered through close partnerships with service users, carers, communities and with our own workforce, is designed to ensure that the improvement work is well-managed and delivered upon, leading to the Trust working in a business as usual environment within the next three years.

The Quality Report provides further details but in summary some of the Trust's successes and developments in 2018/19 include:

- Receiving a 'good' rating for the 'caring' domain across all its services, as assessed in the CQC report, with members of staff observed to be kind and having a caring and compassionate manner

- Achieving and maintaining performance for national cancer waiting time standards, service improvement and survivorship

- The Trust's maternity team being recognised by Health Education England after winning several awards for the introduction of Manual Vacuum Aspiration. This innovative treatment approach offers an additional choice for women who are experiencing a miscarriage and who want surgical management but wish to avoid having a general anaesthetic. This treatment has seen high success rates and good patient satisfaction

- The Trust's work on improving medicine safety in paediatric services being recognised by the Royal College of Paediatrics and Child Health Quality Improvement team. The initiative was established to reduce preventable adverse drug events by 25% year-on-year, whilst also reducing prescription error rates

- The Trust is doing better at ensuring patients are assessed for risk of developing Venous Thromboembolism, and is performing better than the London and the national average

- The Trust's clostridium difficile infection rates remaining below the London and the national average; meaning patients are less likely to contract this infection in our hospitals

- New complaints received at the Trust falling by 34 in 2018/19, where it received 303 complaints, compared to 337 new complaints in 2017/18

- The percentage of people who would recommend the Trust's A&E service is being significantly better than in England and London

- Elective caesarean sections continuing to be within the recommended target of 13% and at the end of 2018/19, the average was 12%

Whilst these successes are to be celebrated, our focus for the forthcoming year is clear and includes:

- Improving patient safety
- Improving clinical effectiveness and;
- Improving the patient experience

We remain committed to ensuring our patients receive the very best of care and we will continue to work to ensure that we support our staff to provide the high standards of care our patients deserve.

Our priorities for 2019/20, as set out in this Quality Report, are clear and highlight our commitment to improve services and care to ensure that we deliver our number one priority - to provide high quality, safe and compassionate care, improving the health and wellbeing of the people and communities we serve.

1 Part One Statement on quality from the Chief Executive of the Trust

The vision of The Hillingdon Hospitals NHS Foundation Trust is "To provide high quality, safe and compassionate care improving the health and wellbeing of the people that we serve". Preparing this Quality Report has enabled us to reflect on how we have performed against this over the last year. Whilst the commitment of our staff to provide compassionate care remains clear, we have not always delivered the high quality care we would want to.

The Trust was inspected by the Care Quality Commission (CQC) in March and April 2018, the outcome was published July 2018 and the CQC gave the Hillingdon Hospital site a rating of Inadequate. The Mount Vernon Hospital Site was not inspected and therefore retained its previous rating of Requires Improvement.

The overall rating for the Trust was Requires Improvement. The Trust was rated Inadequate for the Safe domain. The rating for the Caring domain was Good. In response to this, we developed an action plan to address the improvements needed.

This has been augmented in 2019 by a comprehensive Hillingdon Improvement Plan which will drive the further work needed to improve the quality of care we provide to our patients. Delivery of this plan is underpinned by training in quality improvement methodology which is being rolled out across the Trust. The Trust is undertaking this work as part of the NHS Improvement Vital Signs Programme. Key to improving the experience of our patients is to ensure that we equip our staff with the right knowledge and skills. We will continue to work to ensure that we support our staff to provide the high standards of care our patients deserve.

Some of our patients have been waiting for longer than we would like in our A&E Department, which may impact on their experience and care. Whilst we have made

significant improvements to the times that ambulances wait, there is more work to be done to ensure that patients receive all their treatment in a timely manner. We are part way through an expansion of the A&E Department which will assist our staff in being able to deliver better care for the patients in a more appropriate setting.

We are keen to be a learning organisation. We know that during 2018/19, we reported an increased number of serious incidents compared with 2017/18. We had reviewed our incident reporting processes, which may have resulted in more appropriate identification of incidents that require reporting as Serious Incidents according to the NHS England Serious Incident Reporting Framework. We are committed to learning from these incidents in addition to mortality reviews, complaints and patient feedback to improve patient care.

Other areas of challenge include managing the risks to good delivery of patient care associated with an aged and exceptionally challenging estate. We are working with partners to develop a long-term solution and we are looking at options for a new build. In parallel, we are working to ensure that the maintenance of our current estate is improved, including applying for emergency capital funding.

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

There are inherent limitations in the preparation of this Quality Report which may impact the reliability or accuracy of the data reported. These include the variety of data sources used (not all of which are subject to external audit) and local circumstances requiring interpretation of national definitions.

The Trust's Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but they also recognise 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.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
28 May 2019

2 Part Two Priorities for improvement and statements of assurance from the Trust Board

This section of the report describes and outlines the intended areas for improvement in service quality during 2019/20.

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 2018/19 (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 2019/20

To formulate our quality priorities for 2019/20 the Trust has engaged with key stakeholders including Foundation Trust members, Healthwatch, the Trust's Governors, the CCG, local voluntary organisations, local residents and patients via a quality priority setting event held in January 2019. This engagement event involved reviewing our current position against this year's priorities and discussions on identifying the quality priorities for the forthcoming year.

The table below outlines the key themes that came out of the engagement process.

Quality Report Consultation

Quality priority topic 2019/2020
Patient safety
• Medication management and safety • Improving patient discharge • Improving use of technology and existing electronic systems • Improving coordination and communication between services and staff – review of patient care pathways • Improving the systems in place for sharing learning from incidents to allow sharing across traditional provider boundaries • Improving access to 'on the job' training given the financial challenges in accessing traditional taught courses
Clinical effectiveness
• Improving the appointment system and associated administration • Improving the style of patient operation appointment letters to enhance the tone • Improving the ease of accepting, cancelling and making appointments for those in diverse groups • Improving the coordination of care and appointments for patients making multiple visits • Improving the communication on discharge, including the quality of discharge letters • Seven-day working – outpatients and diagnostics • Opening up opportunities for further staff development to ensure they are abreast of changes in the way in which services are commissioned and provided • Improving partnership working to reduce variation in care • Improving Trust participation in clinical research to allow widened treatment options and opportunities for improved outcomes available locally
Patient experience
• Improving communication during the patient pathway - including digital and paper light options • Improving engagement with children and young people to better prepare them for transition into adult services • Improving specific patient pathways by streamlining the amount of contacts with services towards diagnosis and treatment • Improving the way in which we signpost patients to locations where services are provided - including on-site signage and on patient letters • Demonstrate an improvement in compassion, dignity and empathy which will be measured through patient feedback • Improving the quality of patient meet and greet and enhance the approachability at different service contact points

In addition to the above, the Trust has gathered additional data from several sources to identify themes and recurring trends to support the priorities for 2019/20. We have also engaged with both clinical and management staff to agree and set the priorities.

During the last year we have actively engaged with our local Healthwatch and its members have participated in several of our Trust working groups. This engagement has proved invaluable in gathering and acting on feedback the Healthwatch team receives and we seek to continue to engage in this manner.

The Board has considered the suggestions put forward, as well as reviewing the additional data and endorsed the priorities in the table below for 2019/20 and will be reported against in our Quality report for 2019/20.

These have been identified as falling under three domains of:

- Patient Safety
- Clinical effectiveness and;
- Patient experience

No.	Priority	Patient safety	Clinical Effectiveness	Patient Experience
1	Improve the offering of digital solutions in the types of communication to our patients and decision-making as they navigate their pathway of care	✓	✓	✓
2	Increase the engagement programmes to focus on children and young people so that there is an improved contribution to the way services are commissioned and provided for transition of care to adult services	✓	✓	✓
3	Improve the way in which we offer training to staff providing care across the whole system to reduce the variation in approach and standardise the improvement in knowledge and skills	✓	✓	✓
4	Improve the way in which we engage with patient groups and support groups of patients with increased needs such as those with Autism, Learning Disabilities and Dementia	✓	✓	✓

Priority 1

Improve the offering of digital solutions in the types of communication to our patients and decision-making as they navigate their pathway of care

Why is this a priority?

The format in which information is available is changing at pace, as well the change in patient expectations.

With the continued growth and development of digital healthcare platforms there are opportunities to create solutions that better meet patient needs, whilst ensuring the NHS makes the best use of such technologies to sustainably deliver services. Advances in both information and administration systems present some opportunities for driving efficiencies in the delivery of healthcare services. This includes improving the accuracy and timeliness of information being processed, which is an important part of clinical decision-making on the best courses of treatment. Furthermore, the efficiencies to be gained by improving digital systems allow for healthcare organisations to offer different forms of communication, as we continue to cater for patients with diverse needs.

The use of digital systems is a growing area in the health service. As demand for services continues to rise, the NHS must make the best use of such technologies to continue to sustainably deliver services.

Shared information systems will mean a higher quality of patient care, since they provide accurate and up-to-date information to clinical decision makers. Digital systems will also ensure improved efficiency, reducing the administration time burden on staff to increase their time in providing frontline care.

Strategically, digital work has been identified by the NHS nationally and the Northwest London Health and Care Partnership to improve efficiencies. Having information which can be shared across different providers and care settings is an important component of the integrating sector services.

How are we doing so far?

Currently, the majority of a patient's summary care record is digitised and is shared with organisations that make up the Hillingdon Health and Care Partners (HHCP), our Accountable Care Partnership.

Electronic observations and sepsis management has been developed internally and is now utilised across all inpatient wards across the Trust. Nursing handover noting is also fully digitised and implemented across all wards and has led to an improvement in quality of care as communication between teams has become more efficient and accurate.

Further digitisation of previously paper processes has taken place across the Trust, with digital forms developed and created as part of the patient's record. All electronic clinical summary information is now fully digitised and sent to community care organisations to support the continuity of care in the community. The digitisation of Discharge Assessment notices to Social Care has also led to improvements in the provision of timely information to Social Care in the London Borough of Hillingdon.

The Trust has improved many areas of internal information exchange, such as the clinical handover and the recent implementation of a new emergency care system. These initiatives have improved care quality and facilitated better discharge planning and efficiencies for Trust staff.

Our aims for 2018/19 are:

- Full implementation of electronic handover for doctors to complement the nursing handover which was implemented in 18/19
- Expansion of the electronic observation system to Paediatrics and A&E which will support safer care in these settings
- Provide easily accessible outpatient kiosks at the Mount Vernon Hospital site to allow patients to update and record personal information and preferences.

How will we monitor, measure and report on the progress?

This quality priority will be monitored through the Digital Transformation Group and the Trust Management Executive.

Digital transformation programmes are, and will continue, to be implemented by clinical improvement groups which are set up specifically to monitor and track the progress and implementation of the projects. The Trust Board is sighted on delivery progress and associated risks through escalation reports from Board Committees including the Quality and Safety and the Audit and Risk committees.

The results will be published in the 2019/20 Trust Annual Quality Report.

Priority 2

Increase the engagement programmes to focus on children and young people so that there is an improved contribution to the way services are commissioned and provided for transition of care to adult services

Why is this a priority?

During 2018/2019, young people aged 16 - 19 years accounted for 3,500 accident and emergency attendances, 500 emergency admissions, 270 elective admissions and 7,500 outpatient attendances at the Trust. Each of these episodes of care was experienced within an acute adult setting without modification in respect of adolescent need.

The Trust currently does not have any adolescent facilities across its services. Improving young people's experience of both emergency and planned care will be best achieved if opportunities to engage in the co-design and adaptation of current and future services are extended to them and their families/carers.

A smaller, yet significant, group of young people who transition from paediatric to adult services post the age of 16 years are children who receive long-term care for single or multiple conditions. Ensuring young people, and their families/carers, are prepared for this is a priority. Transition begins from the age of 13 and will typically include a programme that encourages independence and self-care.

We know from patient feedback that those children with the most complex needs can find the experience daunting and the transition from paediatric to adult services needs to be improved.

How are we doing so far?

Children and young people are a focus of the Trust and a Children's and Young People's Board which was created in 2017. This group is chaired by a member of the Executive Team and representatives include; members of the community paediatric team, mental health services, Child Development Centre services, a parent representative, Hillingdon Clinical Commissioning Group (HCCG) and clinicians from adult specialties.

Feedback from children and young people is currently gathered and analysed via a variety of means including: the friends and family test, patient surveys and more informally, via direct communication, from those children accessing paediatric specialties on an ongoing basis.

A key priority for the Board is to ensure that care is planned and coordinated before, during and post transition to adult care.

Our aims for 2019/20 are:

- Implementation and audit of the transition policy for children with long term conditions or complex needs.
- Improved communication and coordination between, health, mental health, education and social care.
- Increase the range of feedback received from children and young people via digital media.

How will we monitor, measure and report on the progress?

This will be monitored via the Trust Children's and Young People's Board at the Trust, as well as against the overarching Hillingdon Improvement Plan. The experience of the transitioning patients and their carers is a key improvement objective. Performance on progress will be measured against the key aims of the work stream and the results will be published in the 2019/20 Trust Annual Report.

Priority 3

Improve the way in which we offer training to staff providing care across the whole system to reduce the variation in approach and standardise the improvement in knowledge and skills

Why is this a priority?

By ensuring staff training is clearly linked with departmental and divisional Training Needs Analyses (TNA), in addition to training identified and reflected in Staff Personal Development Reviews (PDR). We aim to reduce the current variation which has been highlighted in staff surveys and in feedback.

Recognising the emergence of the North West London integrated care service objectives, it is important that the Trust works with all partners to deliver training that will strengthen standardised approaches to care delivery across traditional delivery boundaries.

The Hillingdon Health Care Partnership will provide the blueprint for training requirements and will be supported by Brunel Partners Academic Centre for Health Sciences (BPACHS), which is an innovation partner.

How are we doing so far?

Our electronic PDR system was launched in April 2019 and has the function of collecting staff training needs and requirements.
In 2018-19 we fully utilised the allocated training budget from Health Education England.

However there were marked variations in spend across the Trust, with some areas underspending and whilst others overspending against the allocated budgets.

Our aims for 2019/20 are:

- To analyse the TNA data from staff PDR's - due to be available in July 2019
- Create divisional training plans and allocate funding
- Support divisions to spend their training allocations in the most creative and cost-effective way ensuring equality of access
- During Year 3 of the People Strategy; the Trust will develop and deliver a management and leadership programme that ensures managers and staff are better equipped to predict training needs
- To increase the number of apprenticeships to utilise the Levy
- To use Levy funds for Advanced Clinical Practitioner roles, as well as approved continuing professional development (CPD)
- To use the Levy to introduce new roles into the organisation which will enhance the workforce and increase patient safety

How will we monitor, measure and report on the progress?

Applying for training funding and its application will be monitored via workforce data that will be reviewed at the newly-created People Committee. Data will be matched to departmental spend and the equality diversity indicators. Those applications which are refused will equally be monitored to highlight trends that will feed into targeted actions.

Additionally, monitoring of the CPD indirect funds contract and apprenticeship returns will help to identify progress against the Trusts Operational Plan and Quality and Safety Improvement Strategy. The results will be published in the 2019/20 Trust Annual Quality Report.

Priority 4

Improve the way in which we engage with patient groups and support groups of patients with increased needs such as those with Autism, Learning Disabilities and Dementia

Why is this a priority?

The NHS Long Term Plan has identified dementia, learning disabilities and autism as areas for focussed work to achieve improvements nationally. The plan has committed to:

"Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment."

Within this plan a number of actions were highlighted and include:

- Continue to champion the insight and strengths of people with 'lived experience' and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families

The review of our own patient and carer feedback, via incidents and complaints, user surveys and engagement at events demonstrates similar findings. Work is already underway to improve the experience of patients with dementia, learning disabilities and autism and will continue at pace.

How are we doing so far?

The Trust's commitment to providing accessible and supportive care for people with dementia and their carers has been renewed, with the organisation signing up to the Dementia Friendly Hospital Charter. We have also refreshed our Dementia Strategy, with clear aims that are in line with the national strategy. The supporting work plan focusses on priorities identified for the Trust via our participation in the National Dementia Audit.

To facilitate delivery of patient-centred care we have rolled out the use of 'This is Me' – a document for all patients living with dementia, as well as the 'patient passport' for patients with learning disabilities. We are actively working with patients, relatives and carers to help us complete this document for all patients within these groups.

Over the last year we have worked with support groups for people with lived experience in learning disabilities and autism, to ensure their voices are heard by our staff. Specifically, Certitude and Mencap have delivered several staff training events, which have been well attended and positively evaluated. We have also been supported with dementia training across the Trust by Alzheimers Society. This has included first-hand experience of a dementia patient carer who was treated at Hillingdon Hospital presenting to staff in the Emergency Department, describing their experience of care.

Aims for 2019-20 are

- Further progress engagement with people with lived experience of dementia, learning disabilities and autism, with a continued partnership approach to training, patient and carer involvement in ongoing service design
- Appoint a Learning Disability Nurse to drive improvements in care and develop a comprehensive training strategy
- Create a network of 'Treat Me Well' learning disability champions across the Trust
- Implement a dementia care bundle to ensure patients with dementia consistently receive comprehensive and supportive patient-centred care
- Increase the number of trained volunteers providing support and companionship to people with dementia receiving care at the Trust
- Improve staff understanding of the Mental Capacity Act and its application to ensure appropriate and reasonable adjustments are made for all patients with increased needs

How will we monitor, measure and report on the progress?

Progress will be monitored through the Dementia Strategy Steering Group and the Safeguarding Committees. Performance will be measured against delivery of the targets identified in the supporting annual work plans. The results will be published in the 2019/20 Trust Annual Quality Report.

Our Quality and Safety Improvement Strategy

During 2018/19 we have continued to focus on measuring and monitoring the quality of our services and the care delivered to our patients, their families and carers. The Trust continues to implement the Quality and Safety Improvement Strategy for 2016 – 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 and implement local quality action plans, based on the overarching Trust action plan. These both form part of the Trust business plans and are used to monitor progress at each divisional performance review.

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 which includes 'Freedom to Speak Up' – an initiative described later in the report.

The development of the Quality and Safety Improvement Strategy for 2016 - 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 for 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 quality aims, as part our strategy, are:

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 to strengthen pathways and improve clinical productivity.

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

The Trust's Strategic Plan 2017-21 is aligned to the five delivery areas and three enablers

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				

of the STP – as outlined above. An outcome of the STP's Delivery Area 2 is that the Trust now coordinates service delivery in the local health and care economy through Hillingdon Health and Care Partners (HHCP). This stated an ambition to 'integrate third sector organisations within Accountable Care Partnerships with single points of access and geographically-based consortiums'.

Hillingdon Health and Care Partners (HHCP)

Formed in April 2017 as an Accountable Care Partnership, HHCP delivers integrated care services. It is not a constituted body but represents a collaboration of statutory and third sector providers which operate within the framework of an alliance agreement.

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 has adopted an outcomes-focussed approach, transforming pathways to improve the quality of care whilst working with commissioners to close a widening system financial deficit. The table below outlines the forecast deficit in the absence of an intervention as calculated in April 2018.

HHCP seeks to improve the health of people in the Hillingdon area, whilst also reducing the cost of providing them with care services. Initially, activities were exclusively focused on the borough's 41,100 residents aged 65+who represent 13 % of Hillingdon's total population of 314,300. Subsequently, the scope extended to include people of all ages.

Hillingdon has higher non-elective admission rates in several areas when compared to England and the peer group average. In 2019, HHCP activity will focus on preventing unnecessary, unplanned hospital admissions and Emergency Department (ED) attendances for the 15 % of the population who are at the greatest risk. This cohort includes patients in care homes, those at risk of falls, those people in the final year of life and frequent ED attenders. Proposed interventions are evidence-based and fully compliant with the NHS Long Term Plan.

The activity integrates health and care through a 24/7 population-based model. Built from general practice across eight neighbourhoods, with wrap-around community and mental health services, the model provides high quality care through proactive and preventative action to stop people becoming unwell.

Three core services will be provided by multi-disciplinary teams in the home and community:

1. Integrated neighbourhood teams working with GPs to manage local population health
2. Active case management reducing hospital admissions by 15% to the population at greatest risk

April 2018	£m		
Do nothing gap	**2018/19**	**2019/20**	**2020/21**
Hillingdon CCG	0	14.5	28.9
THH NHSFT	22.8	25.9	29.0
CNWL NHSFT	9.7	13.7	17.9
Hillingdon GP Confederation	0	0	0
H4ALL	0	0	0
Total forecast system deficit	**32.5**	**54.1**	**75.8**

3. Time limited, integrated, health and social care services to minimise time spent in hospital

The third component of the model is of greatest relevance to the Trust. It comprises a reformed intermediate tier of services to support faster recovery from illness. This includes preventing unnecessary stays in hospital and premature admission to long-term residential care, as well as facilitating timely discharge from hospital and maximising independent living.

The ambition is to fundamentally improve the care the Trust offers to older people, supporting them to stay independent for as long as possible. Equipped with an outcome-driven approach, we know this can be done by anticipating needs, intervening efficiently and coordinating care more effectively.

Innovating with Brunel University London to transform models of care

Brunel Partners Academic Centre for Health Sciences (BPACHS) was established in 2017 and represents a partnership between Brunel University London (BUL), 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 by working in partnership with, and on behalf of, the local community in Hillingdon to allow us to become a leading provider of health and social care.

The Centre serves as a strategic enabler, identifying and implementing innovations that create value for the entire health system. It also facilitates 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 is 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 offers a valuable model for other parts of the UK and beyond.

Recognising staff for improving the quality of care

The Trust runs an annual staff awards event with categories that recognise individuals and teams for their outstanding work in quality and innovation, compassionate care and 'CARES' values. CARES, standing for Communication, Attitude, Responsibility, Equity and Safety, is the acronym that represents the Trust's behavioural model that was developed by our staff and patients.

Quality and Innovation Award - This award is for an individual or team that has made an innovative contribution to improving the quality of a service, system, process or care pathway at the Trust.

Compassionate Care Award – this award is open only to public nominations and is awarded to an individual or team that have excelled at 'seeing the person in the patient' and delivered compassionate care.

CARES Award - this is awarded to an individual or team that provides exceptional service and commitment to enhance the reputation and success of the Trust. This can include someone who is providing excellent service / patient care, or someone who has made an outstanding contribution to 'living the CARES values'.

National and regional achievements

Our maternity team have been recognised by Health Education England at the Association of Early Pregnancy Units (AEPU) conference in Sheffield after winning several awards for the introduction of Manual Vacuum Aspiration at the Trust. This innovative treatment approach offers an additional choice for women who are experiencing a miscarriage and who want surgical management, but want to avoid having a general anaesthetic. There is very good evidence that has shown it is a safe procedure, with high success rates and good patient satisfaction.

Our work on improving medicine safety in paediatric services has also been recognised by the Royal College of Paediatrics and Child Health (RCPCH) Quality Improvement team. The innovation at the Trust now features as a safety webinar on the QI website - 'STAMP: a continuous improvement approach to improve paediatric prescribing and medication safety'. The initiative was established to reduce preventable adverse drug events by 25 % year-on-year whilst also reducing prescription error rates.

Learning from excellence within the Trust

In healthcare, we often focus on errors in an effort to learn from 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 which aims to redress the balance and recognise such examples. Some examples include how compassionate staff members were to colleagues or patients, or demonstrate excellent clinical practice.

Staff can nominate colleagues for excellence by completing the online GREATix form. Each GREATix is assessed by a nominated departmental reviewer who will assess and then approve or reject nominations. Feedback is provided to all nominated individuals.

A register of GREATix nominees is kept in each department so that learning from good practice is disseminated to the teams through the governance and team meeting frameworks to enable the Trust to share and learn from all examples.

Nominees receive a certificate of excellence once their nomination has been approved and this initiative has been rolled out Trust-wide in 2018/19.

2.2 Formal statements of assurance from the Board

Information for our regulators

Our regulators need to be assured we are working to improve quality and the following pages include specific messages they have asked us to provide.

Provision of NHS Services

During 2018/19 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 data available to them on the quality of care in each of these relevant health services. The income generated by the health services reviewed in 2018/19 represents 100 % of the total income generated from the provision of the relevant health services by the Trust for 2018/19.

Participation in clinical audit

The Hillingdon Hospitals NHS Foundation Trust is committed to continually improving the healthcare we provide to people who use our services and clinical audits are a crucial part of the Trust's strategy to improve the healthcare we provide.

The Trust uses clinical audits to assess and monitor compliance against national and local standards whilst also reviewing 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 participate in clinical audits.

The Trust's annual Clinical Audit Programme is formulated each year to ensure that the Trust meets all the mandatory, regulatory and legislative requirements as laid out by the NHS governing bodies is met. 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 2018/19 there were 54 national clinical audits and nine national confidential enquiries that covered relevant health services that The Hillingdon Hospitals NHS Foundation Trust provides. During that period the Trust participated in 49 national clinical audits (91 %) and 100 % of the national confidential enquiries in which it was eligible to participate. These are summarised in Appendix 1. There were five national audits that The Hillingdon Hospitals NHS Foundation Trust was unable to participate in. These are highlighted in grey in the table in Appendix 1, alongside the reasons for non-participation.

The Trust faced some resource challenges in participating in the 2018/19 programme. As part of its commitment to maintain good participation in audits, there are business cases being progressed with a view to enabling future participation in three audits. For some audits it was a challenge to collect data manually and the Trust is piloting a new Information Technology platform to support improved data entry and collection for 2019/20 onwards.

The Hillingdon Hospitals NHS Foundation Trust participated in 37 of the relevant national clinical audits in 2018/19. The table in Appendix 1.1 gives a summary of the key findings and actions planned to improve the quality of healthcare provided.

The Trust also undertook 61 local-initiated clinical audits in 2018/19. The table in Appendix 1.3 shows examples of the actions being taken to improve the quality of healthcare provided

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

9,850 patients receiving relevant health services provided or sub-contracted by The Hillingdon Hospitals NHS Foundation Trust in 2018/19 were recruited to participate in research, approved by a Research Ethics Committee. In addition, 131 staff took part in Health Services & Delivery research surveys.

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, funded from the Department of Health, via the National Institute for Health Research (NIHR) North West London Clinical Research Network (CRN). In 2018/19 we received £335,580 from the NWL CRN for this work. The funding enables the Trust to employ research nurses and data managers to support clinicians in this work.

Our strategic aims for 2014/2019 were:

- 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, maternity and many of the general medicine and surgical specialities. In 2018/19 patients from 12 different specialities participated in research and our most active research specialities were cancer and anaesthesia.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making a positive contribution to the nation's wider health improvement. It also allows clinical staff to stay abreast of the latest treatment possibilities, giving patients access to new treatments they otherwise would not have.

We also support PhD and Masters Students from local universities, giving them access to patients and staff for their projects. In 2018/19 we approved and supported five such university student projects.

During 2018/19 we had approximately 80 NIHR Portfolio Studies open or in follow-up and we recruited a total of 981 patients and staff into 35 trials. When compared to other similar sized Trusts in London, our activity appears to be on par.

All Trust 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 Department of Health NIHR objectives.

We continue to collaborate with The Brunel Partners Academic Centre for Health Sciences in order to 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 2018/19 the Trust reported 80 Serious Incidents (SI's) in accordance with the NHS England Serious Incident Framework. This compares with 43 Serious Incidents in 2017/18. During 2018/19 the Trust reviewed its process for reporting and declaring SI's. This has resulted in a significant increase in the number of SI's declared in 2018/19, however the numbers remain in line with national reporting.

The Trust reported three never events in 2018/19 which included a wrong site surgery, a wrong implant and the third received treatment scheduled for another patient of the same name (although the patient did require this treatment). In all cases, the patients did not experience significant harm.

Protecting patients from avoidable harm is something to which there is universal agreement in the Trust. The Trust has clearly defined processes and procedures to follow which help to reduce the risk of these events occurring and recurring. However, where a SI does occur, the incident is investigated thoroughly through a process of root cause analysis (RCA). The RCA investigation leads to the development of associated and appropriate learning resulting in recommendations and actions identified to prevent reoccurrence. Examples of the learning from the SIs investigated during 2018/19 by themes are:

Out-of-hours deterioration of patients

- The Trust has implemented an electronic observation system to aid correct calculation of National Early Warning Scoring System (NEWS) scores. The Trust is also reviewing how it provides critical care outreach support 'out-of-hours'.

Never Events (biopsy serious incidents within dermatology)

- The division involved has carried out a 3-year thematic review and is implementing standard operating procedures, which will include clear roles and responsibilities for clinicians.

Delayed clinical reviews

- There were some SI's relating to delays in clinical reviews when requested from multidisciplinary teams and the failure to follow the correct escalation channels when this delay occurs. The Trust is currently reviewing the escalation policy and implementing a standard operating procedure to ensure all staff, including bank and agency staff, are aware of the escalation route.

The action plans from SI's and Never Event investigations are implemented and monitored via the monthly Clinical Divisional Governance Boards with oversight at the Patient Safety Committee. There is Executive oversight and sign off of all SIs.

As part of our duty in being open and honest with patients and their families, the findings from SI investigations are offered to patients/families/carers unless they decline to receive this. In sharing the findings, the patient/family carer will be able to see the learning and the actions the Trust is taking to prevent re-occurrence. The patients and their families are invited in to meet with a senior clinician, should they wish to discuss the investigation and the contents of each report.

Where the Trust identifies a similar or recurrent theme of a SI occurring, a thematic review process may be undertaken. The purpose of such reviews is to identify common themes from SIs that have previously been investigated by the Trust. The review will also provide assurance that recommendations and actions from previous cases have been implemented, embedded into practice and to identify where any further actions are required to prevent re-occurrence.

Trust-wide actions for two of the areas of care and practice that have been identified as recurring themes from our reported SI's and require detailed focus are:

Improving care and escalation of the deteriorating patient – the Trust Deteriorating Patient and Sepsis Working Group, which meets on a monthly basis is leading the work associated with this. The Group reports to the

Trust Patient Safety Committee. A new Trust-wide sepsis lead has been appointed who will also support the working group. There have been a number of serious incidents that have evidenced a delay in escalation of a deteriorating patient during out-of-hours, and a policy has been produced and implemented to ensure the correct process is followed by all staff.

The Trust has implemented an electronic solution to the recording of patients' observations (NEWS2) to achieve a more robust mechanism for recording and escalation to medical staff. Work is underway to roll this out to A&E and paediatric departments whilst they use paper versions of NEWS2. The NEWS project group are rolling out a training programme to ensure that all clinical staff are confident with using the new system.

Documentation in clinical records – the Trust Clinical Records Committee is leading the improvement work required. They have reviewed the documentation audits that were carried out across the Trust and they have formulated a Trust-wide action plan which is being implemented.

The business case to move from paper records to digital care records (DCR) has been submitted and was approved by the Trust Board in November 2018. Some of the key requirements outlined in the specification document include:

- Moving data easily from old systems to our new DCR
- The ability to share relevant data securely with GPs and other care staff
- Compatibility with other systems, where necessary
- Functionality to support all clinical, administrative and operational processes, including:
  - tracking patients through emergency departments, planning theatre lists and managing our mums' journey through maternity services
  - flagging specific patient needs, for example, people with learning disabilities or those with infectious diseases service reporting and future planning
  - The Trust is working with London North West University Hospitals NHS Trust towards the procurement and implementation of a comprehensive digital care record. The Trust is currently in the active bidding and procurement phase and we hope to have a decision on funding by late summer 2019.

To support the sharing of learning from the investigations of SI's and Never Events across the Trust, the executive summary of each SI investigation report is circulated and discussed via Divisional Governance meetings, the Divisional Triumvirates and the Patient Safety Committee. The investigation report is also shared with the staff involved in the incident. Reflection sessions, newsletters and presentations have been used to share the learning more widely across the Trust. In collaboration with the Medical Education Centre, SI's are also used in Grand Round presentations and multi-professional simulation training.

As part of the Trust's ongoing commitment to patient safety, in 2018/19 the Trust commissioned an expert to deliver a series of workshops. These workshops supported the investigation and learning from SIs, utilising root cause analysis and human factor methodologies, as well as other workshops to support staff in being open as part of the Duty of Candour.

Learning From Deaths Process (LFD)

During 2018/19 the Trust developed its Learning from Deaths (LFD) process, with Structured Judgement Reviews (SJR) being implemented in all specialties. Where concerns are found, and deaths were deemed to require investigation via the Serious Incident route, the SJR was not completed. Two deaths were investigated as SI's and two are currently undergoing investigation.

Sharing learning and making changes to practice is the most important part of the LFD process. Learning is shared via a variety of forums and changes to practices are made, where needed. Serious Incident investigations and outcomes of SJR's are presented at the Patient Safety Committee, Divisional Clinical Governance Forums, the Nursing & Midwifery Forum and Care Accounts meeting. All patient deaths are discussed and presented at the various specialities Morbidity and Mortality meetings, as well as SJR's with a score of five or below.

Nine patients with identified learning disabilities died in 2018/19. All these deaths were referred to the Learning Disabilities Mortality Review (LeDeR) Programme for investigation. The LeDeR programme has been commissioned by NHS England to support local areas to review the deaths of people with a learning disability to;

- Identify common themes and learning points
- Provider support to local areas in their development of action plans to take forward the lessons learned.

There have been delays in the LeDeR programme within the Hillingdon borough and at the time of writing the annual report, the reviews of the deaths were ongoing. In order to avoid any immediate local learning that can be gained from reviewing these deaths, the Trust has changed its process and from April 2019, all patient deaths where a the patient had an identified learning disability will reviewed as part of the SJR process.

	Q1	Q2	Q3	Q4
No. of inpatient deaths	181	181	205	226
No. of patients with Learning Disabilities	3	1	2	3
Structured Judgement Reviews (SJR) undertaken	22	19	21	13
Investigated as a Serious Incident (therefore no SJR)	1		2	2
SJRs undertaken (as a percentage of all deaths)	12%	10%	10%	6%
Percentage of which were unavoidable (broken down below)	77%	68%	86%	85%
Score 6 – deaths that were unavoidable	17	13	18	11
Score 5 – deaths that had slight evidence of avoidability	4	3	2	1
Score 4 – deaths that were possibly avoidable but not very likely (less than 50:50)	1	3	1	1

	Q1	Q2	Q3	Q4
No. of inpatient deaths	191	173	219	259
No. of patients with Learning Disabilities	0	1	0	0
No. reviewed using CESDI criteria	146	114	153	162
Percentage classed as unavoidable (broken down below)	5%	8%	9%	5%
CESDI grade 1 (minor lapses in care)	8	9	14	8
CESDI grade 2 (more serious lapses in care)	3	3	3	0
CESDI grade 3 (major lapses in care - avoidable)	0	1	0	0

Although many of the deaths that were reviewed were identified as being unavoidable there were still lessons, issues and good practice identified from the review process. The main themes were,

Documentation

- Completion of food and fluid balance charts is not always to the expected standard
- Poor or no documented evidence of timely discussions between family and medical staff
- Poor documentation regarding hand over of patients particularly when patients are moved from one ward to another
- Poor documentation of outcomes mental capacity assessments and deprivation of liberty safeguards
- There are also examples of excellent documentation

Communication:

- Conversations with families need to start early so that fewer misunderstandings take place and the family feel and are more involved
- There have also been some examples of very good conversations with families

Through this process, we have found that feedback to appropriate staffing groups has been invaluable as this has given staff the opportunity to review their own practice and make amendments as appropriate, as well as having a better awareness of where issues can and do arise. The triangulation of SI's and coroner's cases has helped with distributing the SJR's and ensuring that there is no overlap.

From April 2017/March 2018 the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) framework has been used as method to assess whether the death was avoidable. This has meant that almost all in-patient deaths had a short review by a consultant. The table below provides a breakdown of the number of case record reviews relating to deaths that occurred in 2017/18.

In April 2018 some consultants underwent training to enable them to complete this more in-depth investigation. This resulted in 10% of all in-patient deaths in 2018/19 being investigated using this system. For 2019/20 20% of inpatient deaths will be investigated via SJR. However it has been impossible to provide a revised estimate for the 2017/18 deaths as the Learning from Deaths, Structured Judgement Review process was introduced after the end of the reporting period.

Commissioning for Quality and Innovation (CQUIN) targets

The key aim of the Commissioning for Quality and Innovation (CQUIN) framework is to secure improvements in the quality of services and therefore better outcomes for patients, whilst also maintaining strong financial management.

A proportion of The Hillingdon Hospitals NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between The Hillingdon Hospitals NHS Foundation Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2018/19 there were six National CCG CQUIN schemes agreed for Acute Trusts. Total CQUIN income for the Trust in 2018/19 was agreed to be £4,589,258. In the previous year (2017/18) total income was £4,691,174.

CCG CQUIN Schemes 2018/19	Achievement	Commentary
National Schemes		
STP Engagement	100% achievement	
Improving services for people with mental health needs who present to A&E	85% achievement	This is a joint CQUIN with Central and North West London Trust For THHFT, there were two parts to the CQUIN; 1. reducing unnecessary ED attendances and 2. implementing an electronic records system Together, our two Trusts have succeeded in reducing Emergency Department attendances by 40% for a group of nearly 50 people with primary/secondary mental health needs who consented to take part in the Care Planning trial. The target was 20%. There are some ongoing issues with data completeness in the new electronic records system is continuing to be developed to address these.
Reducing the impact of Serious Infections (Sepsis and Antibiotic Resistance)	80% achievement	The Trust has reviewed and updated local guidelines and protocols for the treatment of sepsis. We have fully achieved sepsis screening targets throughout the year and have implemented a locally developed electronic system for recording patient observations. The system 'flags' when patient observations suggest that sepsis should be considered by the clinical team and this system is helping us to ensure that, in future, more patients receive treatment as quickly as possible. Currently, 78% of patients are given antibiotics within one hour of a suspected diagnosis. The national target is 90%. Audit results show that we are excellent at reviewing antibiotic prescriptions within 24-72hrs and we have also performed well in antibiotic stewardship, reducing overall prescription and consumption of antibiotics over the last two years.

CCG CQUIN Schemes 2018/19	Achievement	Commentary
Improving the health and wellbeing of NHS staff, visitors and patients	63% achievement	This is the final year of a three-year CQUIN that includes three key aims; • to promote clinical uptake of the annual flu vaccination (100% achieved) • to reduce sales, from all hospital premises, of drinks, sweets, and sandwiches that contain high levels of sugar, salt or fat (90% achieved) • to support the health and wellbeing of NHS staff members – measured through staff survey results 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.
Providing specialist support, advice, and guidance to GPs, that will enable more patients to be cared for out of hospital where appropriate	67% achievement	The Trust is providing advice and guidance to GPs for 90% of services, significantly exceeding the 75% target. More than 80% of queries are responded to within seven days but we have only been able to respond to 52% within the two-day target. We acknowledge that GPs need a timely response and are working on improving our turnaround times.
Reducing ill health from Risky Behaviours: Alcohol and Tobacco	Partial (63%) achievement	This is a new CQUIN, introduced in April 2018, which aims to ensure that every patient who is admitted to our hospital is asked about their drinking and smoking habits. Where patients are found to be current smokers, or to drink alcohol at greater than low risk levels, the hospital will offer advice and, if appropriate, onward referral to specialist services. Significant advances have been made within the year. We are now achieving some of the targets and are working towards further improvement.

Care Quality Commission (CQC) registration

The Hillingdon Hospitals NHS Foundation Trust is required to register with the CQC and is currently registration without conditions. The CQC has not taken enforcement action against the Trust during 2018/19. 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 at the Hillingdon Hospital site only. A review of the 'Well Led' domain took place at the end of April 2018, as part of the CQC's revised inspection framework. An assessment of the Trust's 'Use of Resources' was undertaken by NHS Improvement in early May 2018.

The CQC published its report of the Trust's compliance to the Fundamental Standards and Key Lines of Enquiry (KLOE) on 24 July 2019. The Trust received an overall rating of 'Requires Improvement'. The Mount Vernon Hospital site was not included in the 2018 inspection by the CQC. The Hillingdon Hospital site was rated as Inadequate. The Trust received a good rating for the caring domain across all 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 the time. All of the recommendations made by the CQC following the inspection were accepted by the Trust, and the Board agreed a detailed action plan to make the necessary improvements. Following a Quality Summit, held with partners from the CCG, patient representatives and regulators, the Trust has revised the detailed action plan to include transformational objectives, with a view to sustaining the changes that were being implemented.

The tables below provide an overview of our existing CQC ratings, based on the inspection of the Trust in March, April and May 2018, as indicated in the latest CQC report for the Trust, published on 24 July 2018.

The Trust's internal auditor, KPMG continued a programme to review 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 2017, 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 ward and department accreditation using an internal peer review approach where each core service is benchmarked against the CQC inspection assessment frameworks. The aim of this is to provide assurance on compliance and for identification of key areas of improvement. External reviews and oversight of progress is also undertaken by the quality arms of the Hillingdon Clinical Commissioning Group and NHS Improvement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Hillingdon Hospital	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Hospital	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Overall trust	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for The Hillingdon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jul 2018	Inadequate Jul 2018	Requires improvement ↓ Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Medical care (including older people's care)	Good ↑ Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Surgery	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Critical care	Requires improvement →← Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Maternity	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018
Services for children and young people	Good ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
End of life care	Good ↑ Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
Outpatients	Requires improvement Jul 2018	N/A	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Data quality

At the time of writing, The Hillingdon Hospitals NHS Foundation Trust is able to report on records submitted during April 2018 to March 2019 to the Secondary Uses service, for inclusion in the Hospital Episode Statistics and these are included in the latest published data. The percentages of records in the published data which included the patient's valid NHS number were:

1. 99.0% for admitted patient care
2. 99.8% for out-patient care and;
3. 97.6% for A&E care

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

- 100% for admitted patient care
- 100% for out-patient care and;
- 100% for A&E care

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

Data Security & Protection Toolkit (online system to assess against information governance policies and standards)

The Hillingdon Hospitals NHS Foundation Trust's Data Security & Protection Toolkit self-assessment for 2019 was submitted to NHS Digital, following approval received from the Board. The Trust's improvement plan to achieve 'Standards Met' by 31st July 2019 has been reviewed and agreed by NHS Digital.

Clinical coding error rate

The Hillingdon Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/2019 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, the Data Quality Steering Group and the Elective Performance Meeting

- A focus has been placed on improving data quality around the constitutional standards including Referral To Treatment (RTT) and A&E

  – Improved validation through a risk focused approach and training for RTT
  – Data completeness in A&E improving with new plan and leads in place

Seven Day Services

In line with the formal introduction of a Board Assurance Framework to measure the delivery of Seven Day Hospital Services, the Trust undertook a self-assessment to measure compliance. This has been introduced in a trial form and was completed in February 2019, before full implementation in March to June 2019. Full details of the February 2019 submission are available in Appendix 2.1. This demonstrates that at weekends there is still a lot of work to be done to achieve consistent and timely consultant initial and re-review of patients, especially in surgical specialties. The Trust is also working to achieve the clinical standards for continuous improvement and the table in Appendix 2.2 shows the detail of the achievements in 2018/19. This is monitored as part of the Trust's Board Assurance Framework which is overseen by the Audit and Risk Committee.

Freedom to Speak Up

The Trust has several approaches to ensuring individuals can raise concerns or speak up about:

- Bullying and improper behaviour
- Tell us what we should stop doing
- Discuss ideas and improvements
- Report fraud or wrong-doing, amongst many other issues

This process is outlined in the Raising Concerns and Speaking Up (whistleblowing) Policy. This has been in place since 2013 and outlines the process to be followed when raising concerns. The policy was implemented with a robust consultation with stakeholders that included the appointed internal auditors and Union representatives. The overall purpose is to protect patient safety and the quality of care, improve the experience of all workers and promote learning and improvement. The reviews of the policy have included the recommendations of the Freedom to Speak Up Review.

The Trust also has a Freedom to Speak Up Guardian working in line with national guidelines. The Freedom to Speak Up Guardian provides an additional route for staff to speak up. The remit of this role is to escalate concerns raised on behalf of staff to the relevant manager and or leader. The role also promotes a culture of openness and transparency, where speaking up becomes usual practice and all staff, particularly the most vulnerable, should have effective routes to enable them to speak up if they are genuinely concerned about any risk, malpractice, wrongdoing or anything they feel uncomfortable about.

The Trust recognises that not all individuals may be confident to speak up and has an independent initiative called 'Speak in Confidence' which offers a portal for staff to raise concerns, anonymously.

2.3 Performance against Core Quality Indicators 2018/19

The Trust is required to report against a core set of national quality indicators to provide an overview of performance in 2018/19. The following page provides information which has been obtained from the recommended sources and is presented in line with the detailed NHS Improvement (NHSI) guidance.

	2017/18 Performance	2018/19 Target	2018-19 Performance	London Trusts	National	Benchmark Source	Benchmark Period	Lowest Performing Trust	Highest Performing Trust
1: Summary Hospital-Level Mortality (SHMI)	0.9366 (Band 2 | As Expected)	n/a	0.9746 (Band 2 | As Expected)	n/a	n/a	NHS Digital	Jan-2018 to Dec-2018	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST 1.2264 Band 1 (Higher Than Expected)	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST 0.6993 Band 3 (Lower Than Expected)
2: the percentage of patient deaths with palliative care coded at *diagnosis*	27.4%	n/a	42.0%	n/a	34.0%	NHS Digital	Jan-2018 to Dec-2018	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST 15.0%	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST 59%
3: Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages 0-15 [Standardised] (Crude)	https://www.nhs.uk/using-the-nhs/about-the-nhs/quality-accounts/about-quality-accounts/ has a link to the 2018/2019 QA Data DIctionary. The text in relation to this indicator states: Please note that this indicator was last updated in December 2013. There is an ongoing review by NHS Digital of emergency readmissions indicators across frameworks, and it is intended that the Compendium of Population Health readmissions indicators will be updated and published in April/May 2019. As part of the update, certain elements of the existing specification will be updated to align with other frameworks (NHS Outcomes Indicator Set and CCG Outcomes Indicator set), e.g. length of time to readmission will be 30 days and mental health admissions will not be excluded.								
4: Emergency readmissions to hospital within 28 days of discharge from hospital: Adults of ages 16+ [Standardised] (Crude)									
5: Clostridium difficile	12 Cases (7.7 Cases per 100,000 Beddays)	8 Cases (Lapes of Care Only)	16 Cases (10.9 Cases per 100,000 Beddays)	13.7 Cases per 100,000 Beddays	13.7 Cases per 100,000 Beddays	PHE	Apr-2017 to Mar-2018	The Royal Marsden 52 Cases (91.0 Cases per 100,000 Beddays)	Liverpool Women's (+2 other Trusts) 0 Cases (0 Cases per 100,000 Beddays)
6: Venous Thromboemolism (VTE)	95.7%	95%	95.1%	95.5%	95.6%	NHS England	Apr-2018 to Dec 2018	MEDWAY NHS FOUNDATION TRUST 70.9%	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST 100%
7: PROMS (Health Gain), Groin Hernia, EQ-5D Index/VAS	https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for varicose vein and groin hernia procedures for 2016/17 and for April 2017-September 2017 has now been published. Historical data will be unaffected.								
8: PROMS (Health Gain), varicose vein (Primary), EQ-5D Index/VAS									
9: PROMS (Health Gain), Knee Replacement (Primary), EQ-5D Index/VAS	0.282 / 5.88	n/a	0.261/6.68	n/a	0.345 / 8.23	NHS Digital	Apr-2018 to Sep-2018	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST 0.067 IMPERIAL COLLEGE HEALTHCARE NHS TRUST -37.5	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST 0.609889 GEORGE ELIOT HOSPITAL NHS TRUST 26
10: PROMS (Health Gain), Hip Replacement (Primary), EQ-5D Index/VAS	0.431 / 11.28	n/a	0.596/15.84	n/a	0.489 / 15.58	NHS Digital	Apr-2018 to Sep-2018	MEDWAY NHS FOUNDATION TRUST 0.178667 SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST -11.75	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST 0.9865 NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST 50
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									
12: Trust's responsiveness to personal needs of our patients									
"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"	5805 (37.10/1000 beddays) 28 (0.5%)	n/a	6324 (41.34/1000 beddays) 25 (0.4%)	49.36/1000 beddays 0.3%	44.06/1000 beddays 0.3%	NPSA NHSI	Apr-2018 to Sep-2018	WESTON AREA HEALTH NHS TRUST (13.1/1000 beddays) MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST (1.2%)	CROYDON HEALTH SERVICES NHS TRUST (107.37/1000 beddays) MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST + 1 Other Trust (0%)
14: Self certification against compliance with requirements regarding access to healthcare for people with a learning disability									

Data Inconsistencies

Several indicators are showing changes to 2017/18 data which was published in last year's Quality Report. There are several reasons, as follows:

1. The statutory timescale within which the Quality Report is published is very tight. Not all the latest data was available at the time of publication last year and so the Trust has taken the opportunity to update 2017/18 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, Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital Level Mortality Indicator (SHMI)
3. Data quality or data completeness issues may have affected last year's indicators. If these have been identified, 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 2019, was 0.9746 (benchmark period October 2017 to December 2018) – Band 2 HES data. The Trust Governors selected this indicator for testing by our auditor and at the time of testing the Trust's SHMI score for the 12 months to 30th September 2018 was 0.9588 (Band 2 – As Expected).

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 other Trusts. 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, the quality of its services, by making further improvements to the objectives set out in its Quality and Safety Improvement Strategy, which enters its final year in 2019/20. This includes implementation of an electronic Early Warning System for identifying and treating deteriorating patients 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 Severn Day Services Programme, particularly out of hours and weekend senior staff's 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.

INDICATOR 2

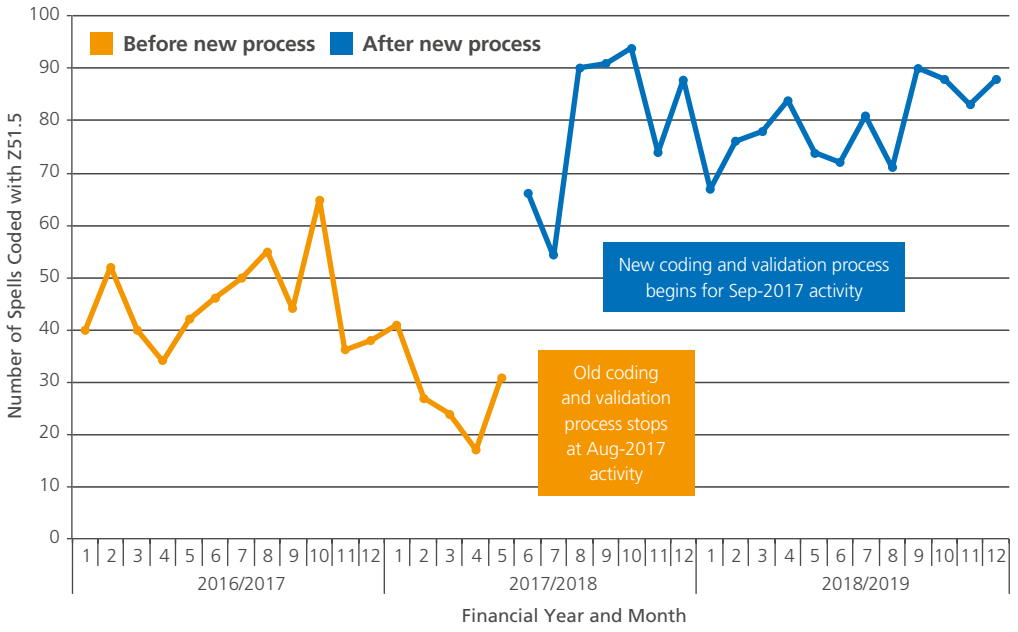
Palliative Care Coding

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 which identified contributing factors for this. Processes were re-designed to ensure full and accurate data capture of patients that receive palliative care. These involved clearer documentation, clinical sign off of all patients discussed at the multidisciplinary team meeting each month 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, in turn, the quality of its services, by further strengthening the data validation process via the implementation of monthly data validation.

Number of Spells with a Palliative Care ICD10 Code (Z51.5) Apr-2016 to March-2019 by year and month



INDICATOR 3

INDICATOR 4

Emergency re-admissions to hospital within 28 days of discharge

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the reasons outlined below.

Emergency re-admission to hospital, shortly after a previous discharge, can be an indicator of the quality of care provided by an organisation. Not all emergency re-admissions are part of the original planned treatment and some may be potentially avoidable. Reducing the number of avoidable re-admissions improves the overall patient experience of care and releases hospital beds for new admissions. However, the reasons behind a re-admission can be highly complex and a detailed analysis is required before it is clear whether a re-admission 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 re-admission may, itself, represent better quality of care. The Hillingdon Hospitals NHS Foundation Trust monitors the re-admission 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 re-admission rate has continued to reduce – there are several schemes via the Better Care Fund, Accountable Care Partnership and the ambulatory clinics that continue to contribute towards this. The current rate stands at 7.6%.
3. All of the GPs in the borough continue to receive an automated at risk of re-admission score (PAR) for all non-elective patients and 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 this practice, 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 therefore the quality of its services, by continuing to work collaboratively with our partners to support 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 16 C. difficile infections in 2018/19, of which four lapses in care occurred against a threshold of seven. This reflects an overall decrease of three cases when compared with 2017/18.

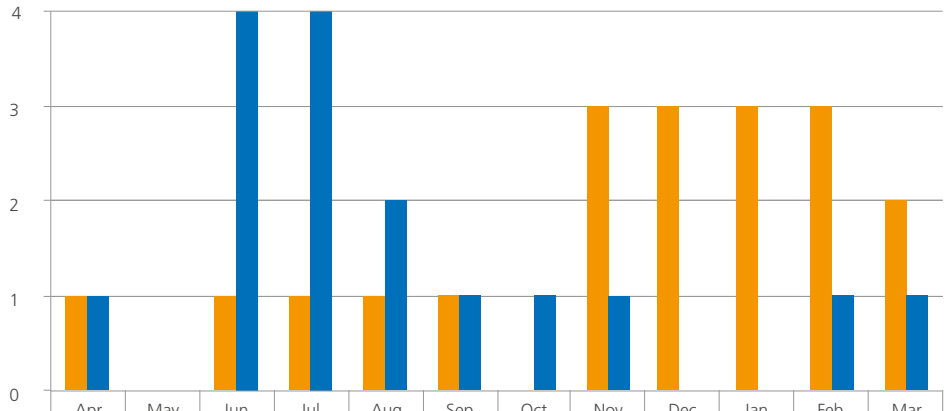
A multi-disciplinary panel is convened to undertake RCAs for all cases of Trust attributed C. diff, comprising of the Consultant in charge of care, Consultant Microbiologist, Lead / Senior Infection Prevention and Control Nurse, Ward Sister and a responsible Matron forming a panel as part of this process. All RCAs are reviewed by the Director of Infection Prevention and Control and are, in turn, reviewed by the Clinical Commissioning Group to ascertain if there are lapses in care. Of the four cases considered to have lapses in care, two were due to delays in sampling and the cases were linked in both time and place. The other two cases were potentially avoidable as antibiotics were not prescribed in accordance with the Trust Antimicrobial Guidelines. The remaining 12 cases were predominantly elderly patients with multiple co-morbidities leading to increased risk factors such as antimicrobial and proton pump inhibitors usage. The majority of cases were classed as mild with patients' recovering promptly.

The Trust will continue to work to reduce the number of C. difficile cases by ongoing improvements towards quality services by:

- Continuing to undertake a full review of all C. difficile Trust attributed cases by means of root cause analysis (RCA) to allow any learning to occur
- Ensure actions are shared where learning is found with regard to C.difficile
- Continue to drive compliance to antimicrobial policy
- Maintain antimicrobial prescribing training at all Infection, Prevention and Control (IP&C) updates
- Improve on a strong 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 standards of cleanliness are met and maintained.

Antimicrobial stewardship continues to be of paramount importance in the prevention of hospital acquired C. difficile. The antimicrobial pharmacist continues to work throughout the Trust to raise awareness and knowledge of good prescribing practice and stewardship. The Trust improved performance on this indicator

Chart 1: Trust attributed *C. difficile* infections



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	1	0	1	1	1	1	0	3	3	3	3	2
2018/2019	1	0	4	4	2	1	1	1	0	0	1	1

and, therefore, 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.

Since April 2016, the Trust has participated in CQUINs, covering the assessment of clinical antibiotic review within 24 and 72 hours of those patients presenting with sepsis, who are still inpatients at 72 hours, and the reduction in antibiotic consumption per 1,000 admissions. Following conclusion of the CQUINs in March 2019, the NHS Standard Contract requires all NHS Trusts to have regard for key national guidance on antimicrobial stewardship and to strive to make reasonable endeavours to achieve ongoing reductions in their use of antibiotics. The Trust managed to achieve 100% performance on this CQUIN throughout 2018/19. The Trust is fully committed to these principles and will aim to reduce antibiotic use wherever this is clinically appropriate and not in conflict with provision of good patient care.

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 because VTE risk assessment compliance for April 2018 to January 2019 is 95.11% (of 43,516 eligible admissions). The table below shows how this performance compares to previous years.

This indicator is monitored within the Trust's clinical governance system. This data is in-line with the English 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 [hospital acquired thrombosis (HAT) = VTE which occurs during admission or within 90 days of discharge from hospital], the following data is presented.

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

Year	VTE risk assessment compliance
2015-16	94.6%
2016-17	96.2%
2017- 18	96.2%
2018-19	95.2%

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	2256	231	34 (15%)
2018-19	2462	219	41 (19%)

The Trust has taken action to improve the quality of its services

(VTE lead since June 2017) and the Thrombosis Committee. The Trust has taken steps to standardise the Doppler scans for patients with suspected DVT to ensure the data is consistent with national approaches. Historically, the HAT has captured below knee DVT, which is often clinically insignificant and therefore may be over-diagnosed and therefore treating potentially clinically insignificant calf vein DVTs. To be in line with NICE guidance, radiology now scan the proximal leg only and the DVT algorithm for suspected DVT reflects this.

Actions

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

- Staff education is ongoing and this includes junior doctors, during their inductions, and nursing staff, during education on documentation and drug administration
- Ongoing involvement of ward pharmacists, as part of the multi-disciplinary team, to draw attention to any omissions on drug charts
- Modification of the drug chart has been undertaken to highlight the need for VTE assessment within 24 hours of admission and then when patient circumstances change
- Standardise clinical practice to ensure that no patients are admitted to a clinical area without a complete VTE assessment
- HAT RCA reports are undertaken by the lead for VTE and discussed at the Thrombosis Committee. This allows learning both at a local and organisational level. The HAT summary was presented at junior doctor teaching sessions to disseminate lessons learnt.
- Completed an audit on Patient Information Leaflet distribution to raise awareness.

Further actions:

- 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 to improve clinical engagement
- Review administration of blood and blood products training to include VTE awareness
- Revision of the medical record to include VTE assessment prompts

INDICATOR 7

INDICATOR 8

INDICATOR 9

INDICATOR 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, housework, family or leisure activities, pain / discomfort or anxiety / depression.

For the purposes of the Annual Quality Report the PROMs data reviewed is for the full year 2017/18. This is due to the data 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 2018/19 data is not expected until February to March 2020.

In 2017/18 there was an increase in the number of patients issued with pre-operative questionnaires. In 2016, NHS England consulted on the future content of the national PROMs programme and the results of this have been published. As a result of the feedback, a decision was made to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections, effective from 1 October 2017. This presents a challenge for the purposes of reporting as the data does not represent a full year. Going forward, the Trust continues to monitor this with the commissioners as part of the standard NHS contract, however benchmarking will not be possible given that the will be no national benchmarking dataset.

Indicator 7: Groin hernia

In 2017/18, the number of post-operative questionnaires returned was less than 30 and this 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 of operations. There were further limitations to monitoring this as the national PROM benchmarking exercise was discontinued.

Indicator 8: Hip replacement

In 2017/18, patients undergoing total hip replacement reported an improvement in health in 64.2% of the modelled records compared to 65% 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. This will be part of the Musculoskeletal Services Clinical Working Group, which reviews and monitors the quality outcomes on behalf of the commissioning-provider partnership.

Indicator 9: Knee replacement

In 2017/18, patients reported an improvement in health in 55.6% of the modelled records compared to 59.7% in England. The Trust intends to take the following actions to improve this indicator and improve the quality of its services in line with the actions for those patients undergoing total hip replacements. The Trust recognises the need to take the same action to improve response rates.

The main learning and areas identified for quality improvement included the need to improve the rates of uptake of PROMS hip and knee forms. These include exploring and adopting new methods for both the distribution and collection of the forms, with a view to encourage patients to engage with PROMs. A higher response rate would provide a better representation of the Trust's data and statistics, with the intention of further improving the health gains for patients.

Indicator 10: Varicose Vein

The Trust only undertakes a few of these procedures and the return rate is in line with national proportions. In 2017/18, the number of post-operative questionnaires returned was less than 30 (the number required for statistical analysis). There were further limitations to monitoring this as the national PROM benchmarking exercise was discontinued.

The Trust intends to improve these indicators, and therefore 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 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 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 nationally.

The results below demonstrate the overall response to the SFFT questions within the 2018 staff survey:

- In response to the question: "I would recommend my organisation as a place to work", 55.1% "Agreed" and "Strongly agreed" in 2018, compared to the total number of staff that responded. The average (median) for acute Trusts was 62.6%. In 2017 the Trust achieved 61.4%, and in 2016, 63.1%.
- 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", 57.4% "Agreed" and "Strongly agreed" in 2018, compared to the total number of staff that responded. The average (median) for acute Trusts was 71.3%. In 2017, the Trust achieved 64.7% and in 2016, 63.9%.

The Trust has developed a comprehensive People Strategy which will drive the improvement of this indicator, and therefore 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 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 allowing us to plan for the future

- Nurture our people – supporting all staff to have the same opportunities to progress and to get the most out of their working lives

The Trust is also implementing an organisation-wide Improvement Plan, which will be supported by an organisational development programme to build staff skills and capability.

Workforce Race Equality Standard (WRES)

The scores presented below are split between White and Black and Minority Ethnic (BME) staff, as required for WRES.

The Trust undertook work as part of the Equality Diversity and Inclusion Annual Workplan to address the imbalance between White and BME scores. This included implementing BME mentorship and development stations, as well as a group to review and implement solutions to promoting dignity and respect at work. It also became a requirement that interviews for roles at Band 8a and above included a panel member from a BME background trained in unconscious bias. Further work is being undertaken in 2019/20 with the Ethnic Diversity Network, working alongside the Trust in co-designing solutions.

		Our Trust in 2018	Average (median) for acute Trusts 2018	Our Trust in 2017
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	27%	26%	27%
	BME	29%	29%	27%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	82%	87%	86%
	BME	70%	72%	70%
Percentage staff experiencing discrimination from a manager, team leader or other colleague in the last 12 months	White	9%	7%	9%
	BME	14%	15%	17%

INDICATOR 12

Responsiveness to an in-patients 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 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 you are worried about condition or treatment after leaving hospital

The Trust is currently awaiting the 2018/19 survey report, which will be published in June 2019. However, during 2017/18 the Trust achieved 62.8% compared to 61.8% in 2016/17.

The Trust intends to improve this indicator, and therefore the quality of its services, by critically reviewing this data once it's received and formulating an associated improvement plan.

INDICATOR 13a

INDICATOR 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 above are current figures published from National Reporting and Learning System (NRLS). They are based on the incidents that have been reported at the Trust and uploaded to the NRLS. The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons.

Between April 2018 and September 2018, 3173 incidents were reported to the NRLS. The Trust reporting rate per 1000 bed days in this period was 42.78, a slight increase compared to the same period in 2017 (42.73). Organisations that report more incidents usually have a better and more effective safety culture and learning as a result. Prior to uploading to the NRLS all incidents are reviewed and scrutinised by the Trust Patient Safety Team to maintain data quality and accuracy of harm grading.

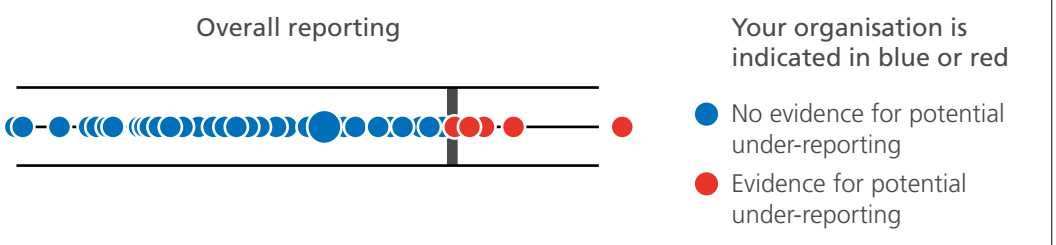
Incidents graded as moderate and above harm are reviewed daily by the Trust Patient Safety Team to facilitate prompt early escalation and instigation of investigations. These incidents are reviewed and discussed at the weekly Serious Incident Review meeting with the Medical Director and Chief Nurse to ensure that the appropriate level of investigations and external

Period	No. Incidents reported to NRLS	Reporting Rate NRLS (1000 bed days)	Severe harm or death
Apr 18 – Sept 18	3173	42.78	14
Apr 17 – Mar 18	6324	40.00	12
Apr 16 – Mar 17	5805	37.1	28

Reporting culture and reporting patterns

There is always scope to improve safety culture. Evidence for potential under-reporting (Figure 1) and reporting rate (Figure 2) are indirect indicators of potential problems with culture or reporting. They can be affected by many factors – for example, the services provided, populations served, and local safety issues and concerns. Increased reporting over time may indicate an improved reporting culture (Figure 2). Reporting patterns must always be interpreted alongside other information such as your NHS Staff Survey results on reporting culture and practice.

Figure 1: Potential under-reporting of incidents to the NRLS (April 2018 to September 2018)



reporting are carried out in a timely manner and mitigating actions are taken to minimise any identified risks. This is a change from the way incidents were managed in 2017/18 and could account for the increased number of SIs reported in 2018/19.

The Trust indicator shows that there is a good reporting culture and there is no evidence of potential under reporting. This is demonstrated in the insert below from the NRLS report on the Trust.

However, there is always scope to improve patient safety culture and therefore 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 near misses and no/low harm incidents (this will ensure learning to avoid the more harmful incidents)
- The Trust has commissioned an external expert to educate key members of the workforce in undertaking root cause analysis, human factors, applying and understanding Duty of Candour, with the intention that this will continue to be delivered in-house
- Providing the reporters of incidents with feedback through the Datix incident reporting system so staff see the value of reporting patient safety incidents
- Reviewing how feedback and learning is shared more widely across the organisation, utilising a variety of platforms and forums to maximise the target audience
- Improving performance against serious incident investigation timescales to ensure lessons are learned, actions implemented and shared in a timelier manner to prevent re-occurrence.

INDICATOR 14

Access to healthcare for people with a learning disability

The Trust provides training to ensure staff are aware of the need to listen and make reasonable adjustments for those patients with a learning disability. Clinical and non-clinical members of staff receive awareness training as part of their mandatory safeguarding training. The Trust also held a one-day learning disability awareness event, facilitated by Certitude, which was attended by over 80 staff.

The Trust's Best Practice Guidelines for staff working with people with learning disabilities remain in place. There are also care pathways for patients with learning disabilities in A&E, outpatients and the radiology department. Patients with a learning disability are invited to provide feedback to the Trust on their experience by completing an easy-read survey or by talking to staff who can write down their comments on their behalf.

The Trust has remained fully compliant with this key indicator. The Trust intends to improve this indicator, and the quality of its services, by continuing to raise awareness amongst staff to ensure that its best practice guidance on caring for patients with a learning disability is followed. In order to assess and further improve performance the Trust has participated in the Improvement Standards Data Collection exercise coordinated by NHS Improvement.

The Trust liaises with Learning Disability Nurses from the community team, who work with the Head of Safeguarding Adults to support and enhance the care for patients with a learning disability. A business case has been submitted to fund a Trust Learning Disability Nurse in order to enhance care delivery and improve the experience and outcomes for patients.

Improving services for people with a sensory disability

The Trust has met the key requirements of Accessible Information Standard (AIS) which include:

- The Patient Administration System (PAS) now has an indicator to alert staff to patients with a disability or sensory loss with a specific communication need
- The responsibilities of AIS have been communicated to Trust staff
- AIS leaflets are in place in both outpatients and A&E
- Plans are in place to emphasise the role of clinical staff in recording information for patients with a sensory disability and this information will be recorded on PAS
- Patients can register for AIS on the Trust website – https://www.thh.nhs.uk/documents/_Patients/PatientLeaflets/AccessibilityA5Leaflet4.pdf

Hearing loops have also been installed in some of the public areas across the Trust which, not only improves communication for these patients, but also ensures their privacy, dignity and wellbeing.

Signage has been improved across both sites to ensure patients and visitors find it easier to find their way across the site. The Trust also 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. Cancer 62 Day Urgent GP Referral

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 2019 and the certain performance indicators contained therein.

As a result of the auditor's findings (please refer to auditor's report to the Council of Governors in Annex 1), steps will be taken to improve data quality for these two indicators and these are outlined in Part 3 under 'Other key quality indicators and information' – indicators 26 and 28.

3 Part Three Key quality information and improvements we have made in 2018/19

LOOKING BACK

Quality priorities for improvement 2018/19 – how did we do?

Priority 1

Improve the use of digital systems to enhance patient safety and ensure timely access to information

We said:

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 staff duties and allow for time to frontline care.

How did we do?

The specific goals we set and the performance during 2018/19 are outlined below.

What does this mean for patients?

The work the Trust has put into patient discharge has allowed patients to be home earlier, 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	2018/19 performance
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	Successful pilot of E-Vetting in Ophthalmology, which resulted in vetting of referrals reducing from 19 days down to 7. This referral system is now available in the Hillingdon Care Record (HCR), completing the summary care record for all patients which complements the outpatient letters, inpatient and A&E discharge summaries, GP records and diagnostic information for a patient.
Roll out of electronic observations across all areas, including adults, paediatrics and A&E, to improve quality of care and support the discharge process	We have rolled out the hObs (electronic observations) application across the Trust adult inpatient departments in December 2018. We continued to make improvements to this solution, which has supported quality improvements in the identification of the deteriorating patient and those at risk of sepsis. We were also able to incorporate the NEWS2 algorithm into this solution, making us one of the first Trust's in the country to implement an electronic observation based on the NEWS2.
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	The Trust has implemented a hybrid mail service which went live in May 2019. This facility has the option to send letters to patients via email, change in processes are required at patient contact points to collect patient preferences for email and this will be initiated and monitored through the data quality groups in 2019/20.
Implement Health Information Exchange (HIE), to improve the quality of records when transferring from acute providers and into the community	The Hillingdon Care Record (HCR) continues to be developed, working closely with clinical teams to remove paper process with digital forms. This has increased from 3,000 a month to over 4,000 per month over the last 12 months and includes referrals to social care. Digital infrastructure has also been enhanced with the upgrade to NHS Wi-Fi completed in December and the upgrade of 44 servers to Windows 2019 and this will continue into 19/20.

Priority 2

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

We said:

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 their 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. The requirements identified in this summit informed the work within this priority area in order to ensure improved, safe and timely discharges from the hospital to support the release of bed capacity for emergency and elective care activity. Healthwatch strongly support the Hillingdon System improvement actions regarding discharge management, which has been highlighted in a number of audits.

How did we do?

The specific goals that we set and the performance during 2018/19 are outlined below.

What does this mean for patients?

Work undertaken on this priority has improved the efficiency of the various teams working on the discharge pathway. As well as improving working relationships across the system, this has released capacity for practitioners to spend more time delivering essential care to ensure patients are discharged safely. This, in turn, has improved the patients' experience. There is more improvement work planned for 2019/20, with a focus on mapping the improvements across a wide ranging suite of indicators including length of stay for patients who could receive appropriate ongoing care in a different setting.

Quality Priority indicators	2018/19 performance
Single referral form and process from the ward teams for both health and social care services to support safe discharge care	This form was introduced and is integrated into the Hillingdon Care Record (electronic solution). This increases visibility to all Trust practitioners involved with the process of discharge. It also offers a full audit trail of the referral process and has removed issues of lost forms. Although currently only for Hillingdon residents, there is scope to introduce this to other areas as we continue to work with partners in NWL.
Single Point of Access (SPA) led by the care system matching patient care needs to the appropriate care capacity	This was successfully implemented and brought all stakeholders in the discharge triage process together and was co-ordinated by a member of the Integrated Discharge Team for each discharge. This has the benefit of releasing capacity for care practitioners to dedicate more time to patients.
Strengthened Integrated Discharge Team (IDT) consisting of hospital, social care, community and commissioning leads to plan and co-ordinate discharge care	This was fully implemented with the benefit of bringing stakeholders in the discharge process closer together through the use of technology (conference calls, sharing patient details electronically in advance of discharge to support advance planning of discharges). Quarterly system-wide workshops have been run in 2018/19, where shared learning and co-design of processes and systems to improve discharge, have been experienced.
Implement the Integrated Discharge Improvement plan	Criteria Led Discharge has been implemented on four wards. Work with Hunter PLC in implementing ECIST codes to identify and categorise reasons for delays to discharges. Standard Operating Procedures for Board Rounds have been developed and implemented. This included work with clinicians to use SORT model to review patients in order of priority that would support safe care and facilitate effective flow through the Trust. A Clinical Improvement Lead has been appointed on a secondment and to support and drive this project.
Understanding the patient experience better for the different elements of work associated with this priority.	Always Events™ methodology has been piloted on The Stroke Unit, with a focus on improving the patient experience on discharge. The wards are also undertaking post-discharge telephone calls in order to support and signpost patients to appropriate help, should they be experiencing difficulties.

Priority 3

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

We said:

Improving staff communication and attitude was identified as a quality priority due to the significant positive impact this would have on the patient experience.

How did we do?

The specific goals that we set and the performance during 2018/19 are outlined below.

What does this mean for patients?

As outlined in our People Strategy this means that we can continue to make strides towards achieving our objective to retain, attract and recruit staff that embody the Trust values. This subsequently creates an environment for our patients to be cared for by highly-trained and skilled staff who work in a productive environment to improve the outcomes and safety of our patients. As we work with our partners to improve the care pathways, this work has enabled us to put patients at the centre of decision-making to improve their experience.

Quality Priority indicators	2018/19 performance
The implementation of "Always Events".	Implementation is underway and is guided by NHSE Collaborative. An Oversight Team, which includes patient representatives, is in place to strategically drive this model of patient improvement. A Point of Care Team is in place and is implementing the first patient co-designed "Always Event" improvement on The Stroke Unit, focussed on communication. A second Point of Care team is being scoped.
Triangulation of sources of patient feedback, to better inform the development of patient care initiatives and measure their impact	Patient experience data, including feedback from complaints, PALS contacts and patient surveys, is presented and reviewed at the Experience and Engagement Group on a quarterly basis. This is used to identify areas for improvement.
The distribution of a revised "Working Together" leaflet	Funding was awarded by the NHS England's "Better Care Small Grants" budget in Q4 2017/18 to fund the production of the revised leaflet. This is now available across all wards and departments.
Customer care training will be provided to large numbers of staff	Customer care training has been delivered to 487 staff in 2018/19 so far (243 via eLearning and 244 through face-to-face training).
Implement coaching for managers' training, to ensure that those who manage staff are equipped to develop their communication skills and improve culture	Coaching for managers is an intensive two-day in-house run course. It has now been delivered to 28 staff through a pilot programme. Six courses are now available for staff to book onto, starting from March 2019. We are also training two further in-house trainers to expand our capacity and capability in this area.
Roll out the CARES ambassador role to include every staff member and expand the number of CARES champions.	We now have 1028 recorded CARES Ambassadors, which equates to more than a third of staff. These are supported by 33 CARES Champions, who provide more intensive support to staff. We continue to develop our Champions through monthly meetings, communication and training and development.

Priority 4

Improving the administration of the patient appointment system and associated communications

We said:

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 with the right clinician first time, reducing unnecessary appointments, which will in turn reduce delays to patient care.

How did we do?

The specific goals that we set and the performance during 2018/19 are outlined below.

What does this mean for patients?

Building on the priorities in 2018/19, patients and staff groups across different care settings will receive more timely information with greater accessibility, with more choice about how they wish to be communicated with whilst accessing their own information. The sharing of timely information across different care settings electronically will also ensure there is continuity and consistency of information to support patient care across different health care settings.

Quality Priority indicators	2018/19 performance
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	The Trust was able to implement the paper Switch Off project and achieved of having 100% of services available electronically in 2018/19. Since the Switch Off project started, the Trust received very minimal GP referrals outside of eRS. Almost all referrals were returned to be re-submitted via eRS. In the last three months (Q4), Trust accepted just one non-eRS referral from a GP due to urgency of the referral.
Reduce the number of outpatient appointment issues to less than 4% (these are monitored as part of the Trust's performance)	The Trust continues to struggle with capacity to meet the demand of outpatient services. This remains a priority for delivery in 2019/20 as the Trust continues to work with the divisional management teams and the clinical working groups to implement plans to address capacity issues. This is monitored at a director-led meeting weekly.
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	The Trust's main patient administration system was updated to facilitate the recording of patient's preference for receiving information. Business processes are being embedded across the Trust to ensure patients are asked for their preferences at service contact points.
To ensure that all patients' referrals are clinically triaged within five working days – through the use of electronic vetting	This was rolled out in Ophthalmology with a demonstrable improvement in vetting times. A further review of Trust resourcing, as a result of the pilot, is taking place in 2019/20 to support clinical triage electronic process across all specialities.
Increase the response rate and turnaround time for *'Advice and Guidance'* to within two working days	The Trust struggled to meet the turnaround time of two days to provide advice and guidance to referring clinicians. This is being reviewed in 2019/20 with an improved model to provide response within seven days. This is being developed with the commissioning groups to ensure it meets the needs of the primary care practitioners.
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	Patient emails are now routinely collected when presenting to services. The mechanism for providing email functionality will be available as part of a hybrid mail solution being delivered in Quarter 1 2019/20.
Implement Health Information Exchange (HIE), to improve the quality of records when transferring from the acute provider and into the community	Full integration with the Health and Care Information Exchange (HCIE) is in place. The Trust has created 281,000 electronic records which are accessible by other acute providers and community services.
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	Full automated calls and text reminders are in place for outpatient appointments and cover 80% of all services. The Trust's DNA rate for 2018/19 was 8.4%, which is 1.8% less than National Average (Model Hospital data).
Explore ways to manage and facilitate electronic booking for non-GP referrals	Electronic self-referral management is in place for maternity and further work will take place in 2019/20, looking at other specialities and how this can be supported in a standardised way.

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. This is available at https://www.thh.nhs.uk/about/performance/index.php

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

The table below summarises the indicators being described in the following section of the report

	2017/18 Performance	2018/19 Target	2018/19 Performance	London Trusts	National	Benchmark Source	Benchmark Period
7. Written Complaints - rate	70.9%	90.0%	77.2%	n/a	n/a	n/a	Apr-2018 to Mar 2019
11. Mixed Sex Accomodation Breaches	0.0	0	1.9	0.7	1.1	NHS England	Apr-2018 to Mar 2019
12. Inpatient Scores from FFT - % positive	93.9%	94.0%	97.4%	93.4%	94.7%	NHS England	Apr-2018 to Mar 2019
13. A&E Scores from FFT - % positive	95.9%	94.0%	96.1%	85.8%	86.5%	NHS England	n/a
14. Emergency C-Section Rate	19.2%	16.0%	19.2%	n/a	n/a	n/a	Apr-2018 to Mar 2019
16. Maternity Scores from FFT - % positive	72.0%	94.0%	96.7%	87.6%	90.5%	NHS England	Apr-2017 to Feb 2018
17. VTE Risk Assessment Already on Core List							
18. Cdifficile - variance from Plan							
19.C Difficile - infection Rate Already on Core List							
20.MRSA bacteraemias	1.3 Cases per 100,000 beddays	0	1.4 Cases per 100,000 beddays	1.42 Cases per 100,000 beddays	0.8 Cases per 100,000 beddays	PHE	Apr-2017 to Mar-2018
21. HSMR (Rolling 12 Month)	102.9 (95.7 - 110.5)	<100	93.8 (87.0 - 100.9)	83.5 (82.3 - 84.6)	100	Dr Foster	Feb-2018 to Jan-2019
22. HSMR - Weekend (Rolling 12 Month)	94.3 (80.8 - 109.4)	<100	89.3 (76.1 - 104.1)	87.4 (85.1 - 89.7)	100	Dr Foster	Feb-2018 to Jan-2019
23. SHMI Already on Core List							
24. Potential Under-reporting of patient safety incidents Already on Core List							
25. Emergency Readmissions within 30 days	7.9%	7%	7.3%	n/a	n/a	n/a	n/a
26. A&E 4 hour Target	84.7%	95.0%	82.4%	88.6%	88.0%	NHS England	Apr-2018 to Mar 2019
27. RTT - Patients on Incomplete Pathway	91.1%	92%	88.5%	86.4%	86.3%	NHS England	Apr-2018 to Mar 2019
28. Cancer 62 Day Urgent GP Referral / NHS Screening Service	86% / 96.2%	85% / 90%	85.3% / 89.7%	n/a	79.1% / 88.1%	NHS England	Apr-2018 to Mar 2019
29. Maximum 6-week wait for diagnostic procedures	99.9%	99%	95.3%	97.6%	97.3%	NHS England	Apr-2018 to Mar 2019

INDICATOR 1

Staff sickness

The Trust provides training to ensure staff are aware of the need to listen and make reasonable adjustments for those patients with a learning.

The Trust has recently updated its Managing Sickness Absence Policy and the supporting guidance. This includes clearer triggers and timeframes for managing both short and long-term sickness and is being rolled out, supported by a communications plan, which has been developed jointly with Staff Side.

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 are 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 colleague turnover. We have supplemented this data with focus groups and have identified key 'hotspot' areas in which to focus our efforts.

INDICATOR 3

Executive Team turnover

In 2018/19 the following changes to the Executive Team occurred:

- The Chief Executive Officer left on 31 August and was replaced by an interim CEO during the period 5 September to 26 November. In turn, the new substantive CEO took up post on that date
- The Chief Operating Officer left on 31 January and was replaced by an interim COO on 21 February, pending the appointment of a substantive COO in 2019/20
- The Director of Finance left on 31 January and was replaced by an interim DoF from 3 February, pending the appointment of a substantive DoF in 2019/20
- The Medical Director left on 31 January and was replaced by an interim MD on 4 February, pending the appointment of a substantive MD in 2019/20

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.

This year we have rolled out the use of HealthRoster® for medical staff and implemented the use of the locum booking system, Patchwork. Together, these have increased the number of doctors working on the bank and increased our fill rates. In line with the requirements set out in the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Trust continues to work on detailed plans to reduce the gaps in our rotas.

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). The Quality, Innovation, Productivity and Prevention (QIPP) and cost reduction programmes must be challenging, whilst ensuring that patient care is not adversely impacted. All cost reduction initiatives are subjected to a Quality Impact Assessment (QIA) evaluation, with high risk schemes reviewed by the Clinical Assurance Panel. Projects cannot go live until a full Project Initiation Document (PID) and QIA have been signed off.

The total savings from 2108/19 were £11.7m, an improvement on previous years, and of which a significant proportion is recurrent. The process for FIP sign-off has been further strengthened, with input from NHSI, requiring the Medical Director and Chief Nurse to review every scheme and PID. The PID contains a full risk assessment and the QIA template, the requirement for Medical Direct and Chief Nurse review, ensures that quality of care is maintained and that identified associated risks are mitigated and managed appropriately.

The Trust continues to review expenditure, with a £11.7m savings target for 2019/20 in areas such as an administration restructure, medical productivity and transformation programmes in the Emergency Department, Outpatients and Theatres. These savings are expected to improve efficiency, whilst maintaining the quality of patient care and have been developed with external partners (Kingsgate).

INDICATOR 7

Percentage of complaints responded to within agreed timescales

Although often uncomfortable to hear, complaints provide us with the opportunity to learn from our patients and their families to review and improve the services and care we provide. Once a complaint has been reviewed and investigated, an action plan is agreed to address any failings identified.

In 2018/19 the Trust received 303 new complaints, compared to 337 new complaints in 2017/18, 34 fewer than last year. We aim to acknowledge receipt of complaints within three working days and this year 96% 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 due to the investigation time overlap at the beginning and end of the year. There were 289 complaint responses due this year, of which 77.2% were completed within the timescale agreed with the complainant. Performance improved each quarter throughout the year from 59.4% in Quarter 1 to 91.8% in Quarter 4.

Performance has been variable during the year due to capacity issues, either within the central Complaints Management Unit or within the clinical divisions. Performance exceeded the 90% target in four months of the year.

To progress improvement further in 2019/20 the following actions have been implemented:

- Complaints Policy and Investigative Pathway will be reviewed jointly by the Complaints Management Unit and the Assistant Directors of Nursing for each of the clinical divisions
- Continue to hold weekly meetings with surgical and medicine divisions to review progress for each of their complaints and resolve any blocks in the process
- Performance will be tracked on daily basis to identify priorities
- Divisional management teams will 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

Examples of specific improvement actions implemented as a result of complaints include

The Division received a complaint from a patient with diabetes who needed a procedure carried out in theatre under the care of the chronic pain team. The procedure was to be undertaken under local anaesthetic (i.e. not under general anaesthetic therefore no starving required). However the patient was sent a standard admission letter which gave starving instructions that were relevant to general anaesthetic. The theatre list did not reflect the patient's diabetic status and on arrival in theatre she had a very low glucose level and felt unwell, requiring glucose and fluids to rectify this. The trust apologised unreservedly and as an action plan tasked the admission team to work with the pain consultants to develop a standardised letter for patients undergoing local anaesthetic procedures who are not required to starve prior to their procedure.

In maternity the Trust has seen a reduction in the number of complaints received however a common theme which runs through most relates to staff attitude and women feeling they thave not been listened to. The themes of all complaints are discussed at ward and management level so that staff receive direct feedback of how they are perceived by the women and if necessary additional training and support is given to the staff. The Trust is working to implement 'continuity of carer' so that the number of midwives the woman see both in the antenatal and postnatal period is reduced thereby enabling her to build a relationship with her named midwife. By so doing, it is anticipated the number of complaints will again be reduced further.

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.

Examples of the incidents include:

- Wrong patient received laser treatment that had been scheduled for a different patient.

Both patients had the same surname and therefore when Patient B was called, Patient A attended the call and received the treatment. No harm occurred as Patient A required the treatment they received.

- Insertion of incorrect implant during hip surgery

The patient was informed of the incident and was seen for a follow up appointment where the surgeon explained to the patient that there was a slight difference in the implant which was planned to used, but this should not affect their mobility, and the patient would not require any intervention as a result of the error.

- Wrong site surgery

A patient with multiple lesions on their scalp had the incorrect lesion removed. The patient was recalled and the correct lesion was identified for removal.

The Trust is monitoring the increase in never events and immediate actions were taken to ensure that similar incidents do not occur. The actions that are formed as part of the investigations will be monitored at the Divisional Governance Meeting to ensure that shared actions are implemented and sustained and they will be monitored until it is evidenced that that actions are embedded.

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 and respond within the set deadline. 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 2018/19.

INDICATOR 11

Mixed sex accommodation (MSA) breaches

The Hillingdon Hospitals NHS Foundation Trust 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.

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.

INDICATOR 12

INDICATOR 13

INDICATOR 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 all patients in these wards and departments are 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 2018/19, the Trust received feedback from 34,971 patients, who had either attended the A&E department, an outpatient department or had been an inpatient or maternity patient during 2018/19.

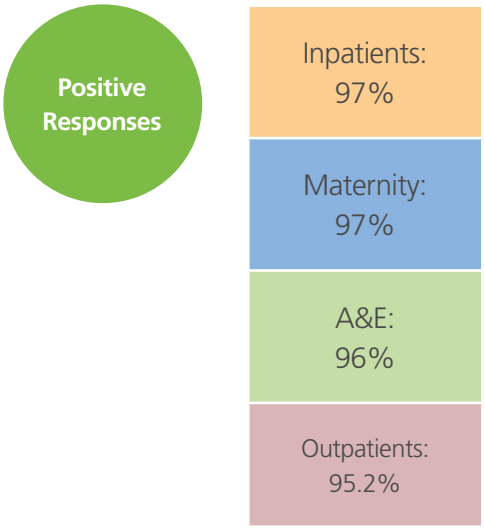
Our results for this period are set out below:

How do our FFT results compare with others?

The graphs below show the FFT results and response rate for A&E and inpatients for February 2019 (the most recently published data). The England and London figures are for April to February 2019 (latest available information).

Response rate and percentage of positive and negative results for A&E

The chart below shows that the response rate for A&E is lower than the England and London rate. We do, however, perform significantly better than England and London in relation to the percentage of people who recommend the service and positively lower for those who do not recommend. The response rates shown below are lower than England and London and the Trust is introducing options to provide feedback by text message in 2019/20.



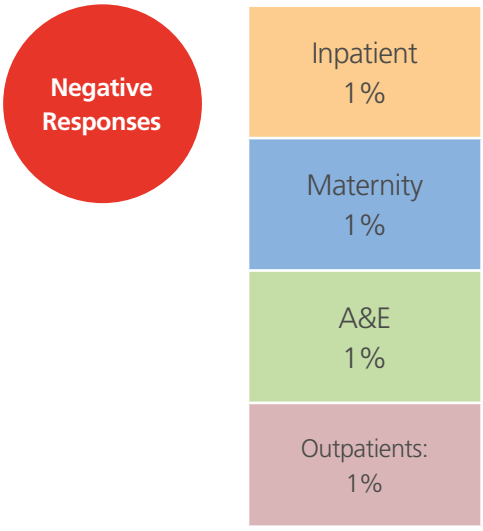


Chart 2: Friends and Family Test: A&E (April 2018 - February 2019)

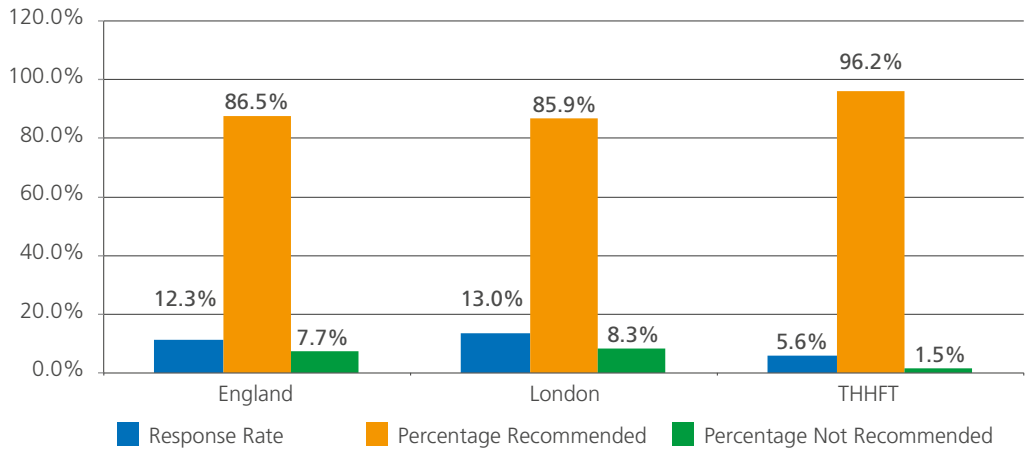
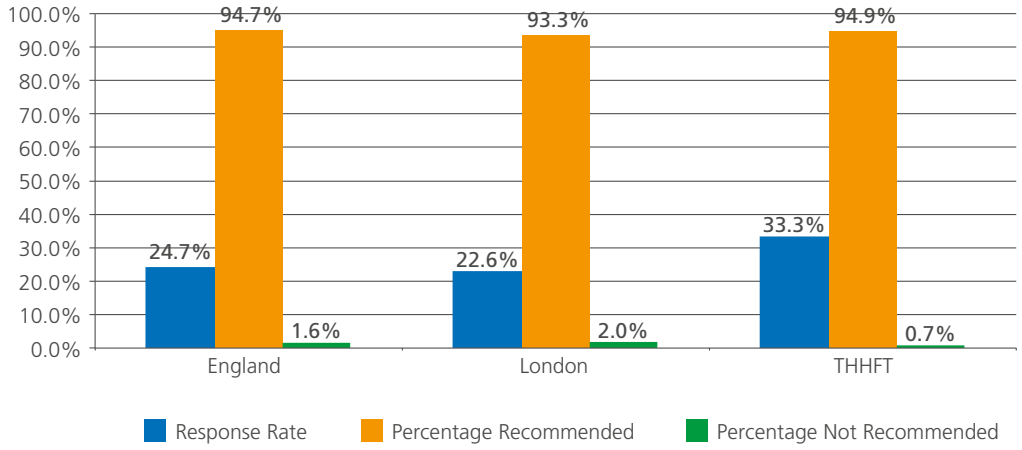


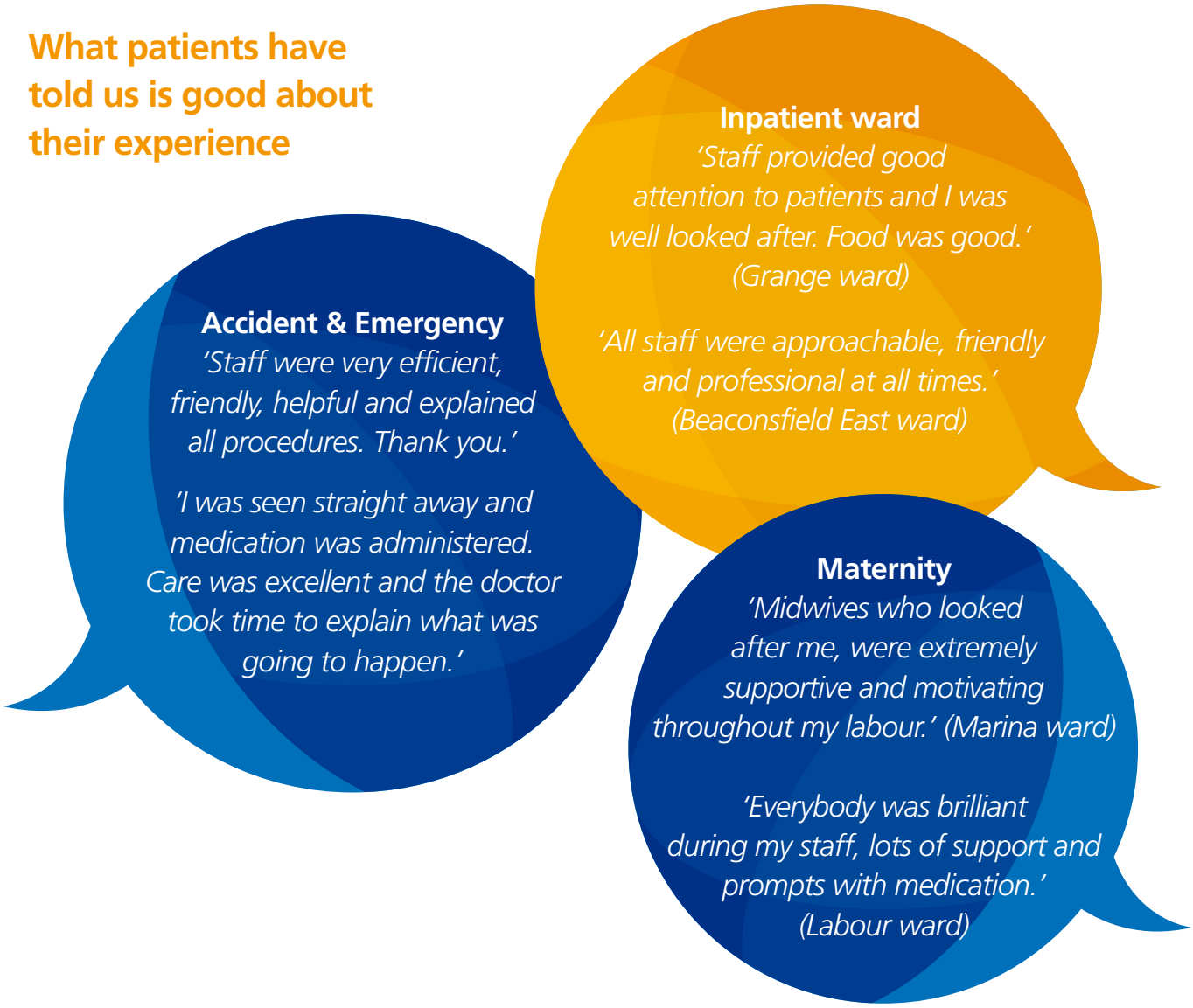
Chart 3: Friends and Family Test: Inpatients (April 2018 - February 2019)



Response rate and percentage of positive and negative results for inpatients

The chart below shows that the response rate for inpatients is higher than the England and London rate. The percentage of inpatients who would recommend the Trust is higher than the England and London score. We have a lower percentage of patients who would not recommend in relation to London and England.

What patients have told us is good about their experience



What patients have told us could be improved

'I did not receive an update or feedback regarding waiting time in A&E.'

Action – It is difficult to provide waiting time with any accuracy as this time is based on clinical priority. Patients are generally advised at triage of the waiting time which is the most useful indicator the department can offer until additional electronic systems can be accessed in the future

'Staff were busy but perhaps a little more interaction and chats with my father may have been helpful.'

Action – Staff are reminded of the importance of communicating with patients to keep them informed and to be available to discuss concerns

INDICATOR 14

Emergency Caesarean Sections

Elective caesarean sections continue to be within the recommended target of 13%. At the end of 2018/19 the average was 12%. We continue to support women considering elective caesarean via our birth options clinic, which is managed by the Consultant Midwife.

Non-elective (emergency) caesarean sections continue to be a challenge and we ended the year at 19.25%, whereby the target was 16%. Although there was an improvement in these figures toward the latter half of the financial year, following a deep dive review of processes which identified learning, for example in relation to induction of labour management. The review identified that the decision making was appropriate and is reflective of the increasing complexity of women accessing Maternity Services at the Trust. Our rate of non-elective caesarean sections is similar to rates across North West London.

As part of the North West London Maternity System, we continue to use the sector wide maternity dashboard to monitor data which enables us to compare practice and share learning. We also work closely with our commissioners via the Clinical Quality Review Group to ensure full scrutiny of our performance and openness.

INDICATOR 15

CQC Inpatient Survey

The Hillingdon Hospitals NHS Foundation Trust commissioned The Picker Institute Europe to undertake the survey for 2018/19. The CQC will use these results when publishing the national survey of inpatients in late Spring 2019.

The results of our 2018/19 survey are based on responses from 446 patients who completed the survey, giving a response rate of 38%; the average response rate of all Trusts in the Picker survey results was 43%. The inpatient survey includes 62 questions ranging from admission to discharge.

Overall, the results show a mixed picture for the Trust. The Picker survey demonstrated that it was improving in the way care was perceived by patients, year on year, though performance was perceived to be worse, on average, than that received at other Trusts.

Positively, the Trust is showing an upward trajectory, with an improvement in the quality of food and no significant deterioration in 59 areas surveyed from previous years.

On the less positive side, when compared to other Trusts, there were no areas where the Trust was above average for those surveyed, though there were 17 of the 62 areas which the Trust was below average, 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 the provision of information, strengthening the patient pathway through the hospital to discharge, 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 of care that could have been done better and where the case could have been avoided. Four cases were considered to have lapses in care during 2018/19. In two of the cases there was a delay in sampling, potentially increasing the likelihood of cross infection, with one potentially avoidable as antibiotics were not prescribed in accordance with the Trust Antimicrobial Guidelines and the last 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.

INDICATOR 21

INDICATOR 22

Hospital Standardised Mortality Rate (HSMR)

The 12-month rolling HSMR data to December 2018 is 95.2 (range 88.5-102.4) and is within the expected range. The picture is mirrored for weekend-only admissions, which have 12-month rolling of 91.6 (range 78.5-106.2). Further to identified coding problems in 2017-18 and the implementation of new processes, the Trust continues to track palliative care coding, which has been maintained.

The Trust reviews this indicator via the Executive chaired Mortality Surveillance Group (MSG) and Quality and Safety Board sub-committee. Appropriate actions are taken if trends are identified or rates fall outside the expected range. This includes case note reviews as required.

INDICATOR 26

A&E four-hour target (mandated indicator for external assurance testing)

The year-end performance for patients attending the A&E department who are seen within 4 hours was 82.4%; with the Trust facing significant challenges over the winter months due to overcrowding in the department as a result of varied daily discharge numbers and high patient acuity, with a consistent attendance of over 182 patients per day. This led to blocks to patient flow through and out of the hospital. The Trust has secured £1.5m funding from the regulators and has been undergoing a £2m A&E refurbishment programme, with Phase 1 and 2 completed in 2018/19 and Phase 3 due for completion October 2019/20. This will create a better flow for the patients between the Urgent Treatment Centre (UTC) and the A&E department.

The A&E attendance (Type 1) increased by 1.8% compared to the previous year. Paediatric attendances increased by 4.3% and blue light ambulance conveyances were up by 25.6%. 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 2019/20.

Key initiatives that have been prioritised that aim to reduce attendances from the community are; Care Connection Teams, GP extended hours in hubs, divert patients to ambulatory care pathways, reducing the long length of stay patients, increasing the numbers of patients going home with Discharge to Assess. The A&E Delivery Board oversees and holds the workstream leads accountable 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. Our auditor identified inconsistencies in the Trust data against the national guidance which requires that, for ambulance cases, the clock should start "when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier". This means that there are for some of our records the handover times recorded were inconsistent with the guidance. This was particularly the case when ambulance staff handed over patients without completing the time of arrival on their paperwork and also when patients were referred to A&E from the Urgent Treatment Centre (UTC).

During 2019/20 we will take the following actions:

- Reception staff will be given training and guidance relating to the need to back-time clock starts with reference to ambulance arrival times, and to ensure they do so in all cases of patients being referred from UTC.
- Undertake spot check audits with findings being presented at the departmental meeting and the emergency care delivery board meeting

Following similar testing last year, 2017/18, our auditor had identified inconsistencies in some of our records (when compared to Trust data) in 2018/19 relating to the time recorded to indicate care and treatment within A&E to have ended. This was noted to be an improvement from 2017/18 which the Trust attributes to the interventions put in place last year particularly around the education of clinical teams. The Trust continues to work to fully implement the national Emergency Care Data Set (ECDS) which is expected to ensure real time data management through the clinical teams. This will be achieved through additional validation and dissemination of findings from validation audits to all reception staff.

INDICATOR 27

Referral to Treatment (RTT) waiting times

The national compliance standard continued to set out that at least 92% of patients should be waiting less than 18 weeks between referral to treatment. During the year 2018/19, the volume of patients waiting over 18 weeks for treatment grew in a number of our specialities and the overall standard was not delivered in any single month. Our non-compliance has resulted from a growth in outpatient referrals and a reduction in the first half of the year in the volume of elective procedures undertaken, following a prolonged winter pressure period.

Data quality and issues of recording accurately patients on the waiting list has been highlighted as a significant issue. The trust has sought the support of two organisations, the Intensive Support Team (IST) and MBI (a company specialising in support NHS organisations in making improvements to the completeness and quality of data), to provide support in validation and provide training to ensure our staff are equipped with the tools necessary to provide the best quality care for our planned patients. This work is expected to continue throughout 2019/20.

The management of unanticipated growth and the change in RTT compliance for 2019/20 will be monitored weekly through our Elective Patient Management Meeting and recovery against trajectory will be monitored through the RTT Recovery Board.

For 2019/20 the Trust has committed to deliver a performance percentage month-on-month of no less than 87%, whilst striving to deliver an aggregate performance across all Divisions of 92%.

INDICATOR 28

Referral to Treatment (RTT) waiting times

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.

The Cancer 62 Day Treatment quality indicator was reviewed by our external auditor as a mandated indicator for testing as stipulated by NHSI. Our auditor identified that in a small proportion of the records reviewed there were no date stamps on referral letters. Date stamps are key to identifying the clock start time for everyone involved in the management of the patients' pathway so that all actions taken are in an effort to ensure treatment is completed on or before day 62 from the start of the pathway.

During 2019/20 the Trust will take the following actions

- Undertake a refresher training exercise for all staff handling cancer referrals covering the importance of date stamping all referrals.
- The Cancer Office will also undertake quarterly audits of a sample of referrals saved in the 'holding folder' and incorporate this into routine validation checks.

In addition, the findings will be monitored via the Trust's Elective Performance Monitoring meeting, which is a director-led meeting.

INDICATOR 29

Maximum 6-week wait for diagnostic procedures

High levels of demand also brought challenges for achievement of the maximum six week wait for a diagnostic test. The increase in demand presented some challenges in meeting this standard for ultrasound in November 2018. The performance was recovered in time for this standard to be achieved in all radiology modalities by March 2019. A review of activity shows that the increase in demand is expected to persist in 2019/20. Whilst the service experiences challenges due to the reduction in the consultant workforce, additional sessions provided by core staffing are essential to maintaining the delivery of the 6-week standard.

Improving Patient Safety

During 2018/19, 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 several 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.

The Trust benefited from the support of ICHP in the implementation of the locally built electronic observations system 'hObs' and the work undertaken to improve Sepsis awareness,

including the identification and treatment using the Sepsis 6 in 60 bundle.

The Trust has also implemented a series of 'Themed Fridays' where baseline audits of patient safety subjects are undertaken. The output of the Themed Fridays has informed improvement projects with associated trajectories which then become part of the overarching Hillingdon Improvement Plan. This has helped us to focus attention on issues that are not part of routine quality indicator reporting and monitoring.

The Trust has also worked on some joint initiatives with Brunel Partners Academic Centre for Health Sciences ranging from scoping for the future of digital healthcare with Apple to reviewing current care pathways across the local health system.

Infection Prevention and Control

Meticillin Resistant *Staphylococcus aureus* (MRSA) Blood stream Infections (BSI)

There were two cases of MRSA BSI attributed to the Trust in 2018/19 reported in October 2018 and March 2019. Post Infection Review's (PIR) were undertaken on both cases. For the October 2018 case, the PIR panel concluded that there were no lapses in care as the patient had a transient bacteraemia as they were clearly septic and required antimicrobial therapy. As a result, there was no financial penalty to the Trust.

For the second case in March 2019, the PIR panel noted that the patient had a pre-existing medical diagnosis which was identified clinically as the likely sources of MRSA blood stream infection. As the MRSA screens were negative, the PIR panel concluded that there were no lapses in care. However, there were some learning actions identified for the case. The patient unfortunately passed away and MRSA septicaemia was suspected to be a cause of death and, as such, the case is under investigation following the Serious Incident Framework.

MRSA screening criteria were changed significantly at the end of 2016/17 whereby the revised national guidance Implementation of Modified Admission MRSA Screening Guidance for the NHS (2014) was applied to Trust policy. In 2018/19, this resulted in a substantial reduction in the number of MRSA screens undertaken throughout the Trust, however we have maintained a continued focus on more high-risk areas instead of the previous 'blanket' approach of screening all patients. A more targeted compliance audit is now undertaken with consideration for Surgery and High-risk areas only as an assurance measure.

Meticillin Sensitive *Staphylococcus aureus* Blood Stream Infections (MSSA)

In 2018/19 there were five cases of MSSA attributed to the Trust, compared to eight in 2017/18. There continues to be no mandated threshold for MSSA. A cluster review of the three cases in May 2018 revealed no trends for this increase in MSSA BSIs. It remains highly likely that previous skin colonisations, of which a majority of the population carry, was a contributing factor.

E. coli Blood Stream Infections

The Trust continues to collate data regarding E. coli BSIs and has done since 2012/13, via the Public Health England Health Care Associated Infection Data Collection System (HCAIDCS), which is a national and mandatory requirement. The national ambition is to achieve a notable reduction of 50% over a five-year period by 2020/21.

The Trust established that the figures reported for 2016/17 included that of another Trust and this has been rectified retrospectively with Public Health England. The IP&C Team implemented several control and checking measures from 2017 to ensure Gram-Negative Blood Stream Infection (GNBSI) data is being reported accurately, including reports issued directly from laboratory and clinical staff entering and quality checking data, evidenced by the matching figures reported from the 2018/19 period.

Data from the 2018/19 period totals a hospital-onset E.coli BSI total of 35. This is an increase of two on last year's total of 33, however, it must be recognised, like with the MRSA figures that the increase in visibility of the sepsis agenda, may have instigated more blood cultures to be taken within this period. In 2017/18 the Trust reported 32 cases of post 48 hours E.coli BSI, which is one more than in 2016/17, when 31 cases were reported. This increase was also seen in the CCG with higher numbers of E.coli cases reported in 2017/18 (162 cases) and 2018/19 (186 cases).

The Trust's aspirations for 2019/20 to reduce nosocomial E. coli BSIs linked to catheters and urinary tract infections still stand, with the planned implementation of a catheter passport and new catheter monitor chart being addressed through GNBSI working group meetings and the Continence Steering Group, which are both consultant led. The Infection Prevention and Control Team have been working collaboratively with both groups, and 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.

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 2018/19 the Trust reported three cases of post 48 hours pseudomonas aeruginosa blood stream infections and this reflects a 50% reduction when compared to 2017/18.

Klebsiella spp. blood stream infections

In 2018/19 the Trust reported seven cases of post 48 hours Klebsiella spp. blood stream infections, which equates to a 42% reduction when compared to 12 cases Trust attributed in 2017/18.

When 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 6 in 60'. The Sepsis Six Care bundle is initiated by the medical team within one hour of suspected diagnosis. Incorporated into our electronic observations tool, the Sepsis 6 in 60 care bundles gives prompts to staff to improve compliance with this important initiative. Performance is regularly monitored through internal audit and work is underway to increase the level of monitoring and scrutiny at relevant patient safety and care quality board committees.

Annex 1

Statements from our stakeholders and Independent auditor's report to the Council of Governors of The Hillingdon Hospitals NHS Foundation Trust on the Quality Report

The Trust regrettably did not present a draft copy of this Quality Report to the stakeholders in time for their statements to be included. The Trust was subject to a lot of changes in the management team positions at the time of drafting this report. This was a contributing factor to the timeliness of the completion of the steps required to grant the stakeholders sufficient time to consult on the draft Quality Report. The stakeholders with which this report has been submitted for consultation are the North West London Collaboration of Clinical Commission Groups, Healthwatch Hillingdon and the Hillingdon Council Oversight and Scrutiny Committee. The Trust will still review the feedback from the stakeholders and ensure that these are incorporated into any work relating to the quality priorities for 2019/20.

The Trust Board has reflected on the outcome of the process of producing the Quality Report for 2018/19 and steps have been put in place to ensure that sufficient time is afforded to all stakeholders, internal and external to the Trust. The Quality and Safety and the Audit and Risk committees are scheduled to review drafts of the Quality Report for 2019/20 with a view to have final version ready for consultation with stakeholders in April 2020.

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 2019 (the 'quality report') and certain performance indicators contained therein.

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 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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 Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter;

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50: 50 breach allocation rules.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the '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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 May 2019;
- the national patient survey, dated 13 June 2018;
- the national staff survey, dated 26 February 2019;
- Care Quality Commission inspection report, dated 24 July 2018;
- the Draft Head of Internal Audit's annual opinion over the trust's control environment, dated 31 March 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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 ('!SAE 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 documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Hillingdon Hospitals NHS Foundation Trust.

Basis for qualified conclusion

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 total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator requires that the NHS Foundation Trust accurately record the start and end times of each patient's wait in A&E, in accordance with detailed requirements set out in the 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, transfer or discharge as an inpatient.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

In 1 case of our sample of patients' records tested we found that the attendance fell outside the indicator definition and should not have been included in the calculation of the published indicator.

In respect of the start time, we found that:

- In 3 cases of our sample of patients' records tested, the start of the wait time was not accurately recorded; and
- In 1 case of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence necessary to test the start time of the wait.

In respect of the end time, we found that:

- In 5 cases of our sample of patients' records tested, the end time was not consistent with other Trust records; and
- In 2 cases of our sample of patients' records tested, the end time was not accurately recorded.

Overall, for 7 cases of our sample of patients' records tested, the errors identified above affected the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

In addition there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2019.

Review the content of the quality report against the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance.

Due to a delay in sending a draft quality report to external stakeholders, at the time of the signing of this report the Trust has not received:

- feedback from commissioners
- feedback from governors
- feedback from local Healthwatch organisations feedback from the overview and scrutiny committee.

As a result we are unable to confirm that the quality report is materially compliant with the requirements set out in the 'NHS foundation trust annual reporting manual' and Annex 1 of the detailed guidance.

Pages 181 to 183 and page 186 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 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 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

Deloitte LLP St Albans
28 May 2019

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 2018/19 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 2018 to May 2019
  - Papers relating to quality reported to the board over the period April 2018 to May 2019
  - the Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 May 2019
  - the CQC Inpatient Survey dated 13 June 2018
  - the national staff survey dated 26 February 2019
  - the Draft Head of Internal Audit's annual opinion over the trust's control environment, dated 31 March 2019
  - CQC Inspection Report dated 24 July 2018
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review 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.

Professor Elisabeth Paice OBE FRCP
Interim Chair
The Hillingdon Hospitals NHS Foundation Trust

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24th May 2018

Appendix 1

The table below shows 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 2018/19. The number of cases submitted to each audit or enquiry are shown 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	1st April 2018 to 31st March 2019. 407 cases (100%)
Adult Community Acquired Pneumonia	Yes	Minimum of 60 cases to be submitted. Submission deadline is 31st May 2019.
BAUS Urology Audit – Female Stress Incontinence Audit	No	Unable to participate due to resources
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	No	Unable to participate due to resources
Case Mix Programme Adult Critical Care (ICNRC)	Yes	1st April 2018 to 31st March 2019. 444 cases (100%)
National Paediatric Diabetes Audit (Royal College of Paediatric and Child Health)	Yes	184 cases (100%) 1st April 2018 to 31st March 2019. Not yet verified
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	Yes	1st April 2018 to 31st March 2019. 279-Hip replacement 428-Knee replacement
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	Yes	222 cases (100%) Jan to Dec 2018 57 cases (100%) Jan to March 2019
Falls and Fragility Fractures Audit Programme: Fracture Liaison Service Database	Yes	1st April 2018 to 31st March 2019. 245 cases (100%)
Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls	Yes	2/ 2 (100%) January to March 2019
Feverish Children (care in emergency departments)	Yes	1st Aug 2018 and 31st Jan 2019 96 cases submitted
Inflammatory Bowel Disease (IBD) programme	Yes	1st April 2018 to 31st March 2019. Just the Biologic patients reported, 26 (100 %.)
Learning Disability Mortality Review Programme (LeDeR)	Yes	1st April 2018 to 31st March 2019 16 cases submitted (100%)
Major Trauma Audit (TARN)	Yes	1st April 2018 to 31st March 2019 178 cases submitted Q1-34, Q2-57, Q3-52, Q4-35

Audit	Participated	Cases submitted
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	1st April 2018 to 31st March 2019 16 cases C diff 2 cases MRSA blood stream 2 cases MSSA blood stream 35 cases E coli Bloodstream 7 cases Klebsiella Bloodstream Infection 3 cases P.aeruginosa Bloodstream Infection
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	1st April 2018 to 31st March 2019 0 maternal deaths. Babies 38
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	NABCOP does not directly 'collect' patient data and so there is no submission of cases.
National Audit of Cardiac Rehabilitation	Yes	1st April 2018 to 31st March 2019 467 cases submitted (100%)
National Audit of Dementia Care	Yes	54 cases submitted (100%)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	July 2018.- March 31st 2019 38 cases submitted (100%)
National Bowel Cancer Audit Programme (NBOCAP)	Yes	1st April 2018 to 31st March 2019 127 cases submitted data yet to be validated.
National Cardiac Arrest Audit	Yes	57 cases (100%) April 2018 to Dec 2018 Q4 waiting validation
National Chronic Obstructive Pulmonary Disease Audit Programme	Yes	209 cases (100%) April to December 2018 Q4 waiting validation
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	No	Unable to participate due to resources
National Comparative Audit of Blood Transfusion programme: Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	No	Did not participate as too few cases
National Comparative Audit of Blood Transfusion programme: Management of massive haemorrhage	Yes	Sept 18 – Feb 19 38 cases submitted
National Adult Diabetes Audit : National Foot Ulcer audit	Yes	April 1st 2018 – March 31st 2019 18 cases submitted
National Diabetes Audit – Adults NaDIA-Harms	Yes	April 1st 2018 – March 31st 2019 10 cases submitted (100%)
National Adult Diabetes Audit: National In-patient Diabetes Audit	Yes	N/A – Audit did not take place in 2018 withdrawn by organisation

Audit	Participated	Cases submitted
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	Jan 1st – Dec 31st 2018 77 cases - (100%)
National Core Diabetes Audit	No	Unable to participate due to IT issues
National Emergency Laparotomy Audit	Yes	1st Dec 2017 – 30th Nov 2018 96 cases submitted and verified
National Audit of Care at the End of Life (NACEL)	Yes	April – May 2018 55 cases submitted=100%
National Heart Failure Audit	Yes	April 1st 2018 – March 31st 2019 280 cases submitted, however data entry still open and yet to be validated.
National Joint Registry	Yes	1st April 2018-31st March 2019 Knees- 299 cases submitted Hips-273 cases submitted Shoulders- 8 cases submitted
National Lung Cancer Audit	Yes	1st April 2018-31st March 2019. 256 cases submitted (100%)
National Maternity and Perinatal Audit	Yes	Jan 2017 – Dec 2018 4674 Birth Records submitted (100%)
National Mortality Case Record Review Programme (previously Retrospective Case Record Review, funded by NHSI)	Yes	1st April 2018-31st March 2019. 793 patients died 779 received level 1 reviews (98%) 88 sent for SJR review (11%)
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	01/01/18 to 31/12/18 430 cases submitted but not yet verified.
National Ophthalmology Audit	Yes	01 September 2017 to 31 August 2018 1770 Cataract Cases submitted
National Prostate Cancer Audit	Yes	1st April 2018-31st March 2019. 189 cases, all known cases submitted.
National Oesophago-gastric Cancer Audit	Yes	1st April 2018-31st March 2019. 64 cases, all known cases submitted.
Non Invasive Ventilation	Yes	Deadline for submission is 30th June 2019
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption CQUIN	Yes	All 4 quarters fully submitted
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antimicrobial Stewardship CQUIN	Yes	30 submissions required for each quarter and fully submitted
Sentinel Stroke National Audit Programme	Yes	April 2018 to March 2019 190 cases submitted (99%)

Audit	Participated	Cases submitted
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	4 cases submitted (100%)
Seven Day Hospital Services Self-Assessment Survey	Yes	April 2018 Total number cases submitted = 181 (represents 100% of sample size requested)
Surgical Site Infection Surveillance Service	Yes	Only 1 quarter is required for data submission Jan- March 2019 **Hillingdon Hospital** – Total 68 cases submitted, Hip replacement =27 cases NoF = 41 **Mount Vernon Hospital** –Total 84 cases submitted all Hip replacement
UK Cystic Fibrosis	Yes	Data submitted from the Brompton Hospital , THH not required to submit
Vital Signs in Adults (care in emergency departments)	Yes	1st Aug 2018 and 31st Jan 2019 128 cases submitted
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	1st Aug 2018 and 31st Jan 2019 42 cases submitted
National Confidential Enquiries		
Child Health Clinical Outcome Review Programme: **Chronic Neuro-disability**	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%
Child Health Clinical Outcome Review Programme Non-invasive ventilation		100% Submission rate all completed
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): **Acute Heart Failure**	Yes	4 cases included 2 excluded Clinical questionnaires submitted 4/4 = 100% Case notes submitted 4/4 = 100% 1/1 organisational 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% 1/1 organisational questionnaire 100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): **Cancer in Children, Teens and Young Adults**	Yes	1/1 organisational questionnaire submitted = 100%

Audit	Participated	Cases submitted
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): **Pulmonary embolism**	Yes	4/4 case notes and 4/4 clinical questionnaires submitted 100% 3 excluded patients 1/1 organisational questionnaire submitted 100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): **Acute Bowel Obstruction**	Yes	6/6 case notes submitted 100% 1/1 organisational questionnaire submitted 100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): **Long-term ventilation in children, young people and young adults**	Yes	2/2 organisational questionnaires submitted 100%

Appendix 1.1

Audit	Key Findings
National Lung Cancer Audit annual report 2017 Published: 24 Jan 2018	Results show a lower proportion of patients with Non Squamous cell lung cancer (NSCLC) referred for surgery (9.2% v 17.5%) compared to the National average. This may be because THH have a local cyberknife facility to which some patients are referred in preference to surgery which affects the proportion referred for surgery. There is also a lower than National average NSCLC with advanced stage 3b/4 and performance status 0-1 and referred for chemotherapy (47% v 62.5%) and lower than National average of Small cell carcinoma (SCLC) referred for chemotherapy (16.6%v68%). In addition there are lower national survival rates (31.5%v 37%). Results have been reviewed and the poorer survival for the previous year is due to the poorer stage at presentation than nationally, for reasons not entirely clear but outside our control. Issues with administrative support have now been addressed and another consultant appointed who will have some responsibility for lung cancer. This will allow current standards to be improved in the future.
NCEPOD Chronic Neurodisability Each and Every Need 2018 Published: 08 Mar 2018	This NCEPOD study was a national study to review of the quality of care provided to patients aged 0-25 years old with chronic neurodisability, using the cerebral palsies as examples of chronic neurodisabling conditions. There were 35 recommendations of which 5 were principal recommendations. ● Improving clinical coding and the quality of routine data ● Diagnosis and management ● Clinical leads and care planning ● Transition and age appropriate care ● Communication ● The organisation of care The Trust is in the process of reviewing our practice against these recommendations. We cannot currently meet all recommendations for over 16s because of capacity- only one neuro rehabilitation consultant employed by the Trust supported in part by neurologist who would only deal with specific neurological issues. There are also IT issues with information sharing and the development of the electronic record.

Audit	Key Findings
National Diabetes Inpatient Audit, England and Wales 2017 Published: 14 Mar 2018	The Published report from March 2018 shows that the prevalence of Diabetes is increasing. Hillingdon Hospital has higher than national average (NA). 27.3% vs 17.5%. However the staffing ratio for the diabetes inpatient nursing hours is 0.74 vs 0.85 which is lower than the NA . There are no dedicated Diabetes pharmacists or Dietician posts in comparison to other hospital. The majority of the patients admitted have Type 2 Diabetes similar to NA of 74.4%. Due to limited hours of DISN there is no time, to provide diabetes support for preoperative clinics to help patients optimise the Diabetes care, to improve surgical outcomes and Length of stay OS. Funding is being sought to support this service . Currently there is limited inpatient Diabetes outreach consultant support. The insulin , prescribing errors have reduced and are below the national average due to various interventions that have been put in place including establishment of Link Diabetes Specialist Nurse group, development of Trusts own e-learning module for insulin safety available through I develop and regular education for nurses
National Diabetes Footcare Audit: Third Annual Report 2014-2017 Published: 14 Mar 2018	The Hillingdon hospital participated in NDFA 2016-2017and the baseline characteristics were similar to national figures. NDFA ulcer severity- The Sinbad score was higher than national average (64.7% vs 45.2). As hospital see more severe cases seen in comparison to community. The cohort numbers is small and likely reason is due to bias in entering only severe cases. NDFA time to assessment – We had, as this pathway is available and known to patients. NDFA 12 weeks and 24 weeks outcomes similar to national average. Action: - Circular has been set and Podiatry and wound care team aware to recruit all cases.
National Prostate Cancer Audit (NPCA) – Fourth year annual report – patient summary Published: 29 Mar 2018	The results of the 2017 National Prostate Cancer Audit, which relate to patients newly diagnosed with prostate cancer for the period 1st April 2015 - 31st 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 to continue with the live collection of data during MDT via the Somerset Cancer Register to improve data. completeness even further. Statement has already been submitted as part of the 16/17 quality accounts report.

Audit	Key Findings
National Maternity and Perinatal Audit: Clinical report 2017 Published: 05 Apr 2018	The Maternity Unit has a Maternity dashboard that is benchmarked against other Trusts within the North West London Sector as well as monitoring local needs e.g. skin to skin contact; this is reviewed monthly at the Maternity Governance Group where actions are taken as required e.g. auditing caesarean section rates. This information is shared with the Maternity Voices Partnership and Commissioners via the CQRG. The electronic database system has been reviewed and changes have been made to improve external reporting. This has been done through improving documentation by midwives, working with information analysts to ensure that the information documented is captured by the questions asked to providers of the service, and ensuring that the relevant question has been asked. Some of the NMPA data requires a change by NHS Digital which we await. Currently the unit is in the process of upgrading the Euroking system to further improve our electronic data capture. The unit has implemented the Saving Babies Lives care bundle and Perinatal Mortality Review Tool.
COPD National Audit Programme: Resources and organisation of Care in hospitals: Time to integrate care Published: 12 Apr 2018	This is a snapshot audit of the organisation and resourcing of COPD care undertaken in the spring of 2017. It recommended a number of key improvements:-. 1 30% of Trusts including Hillingdon hospital have no oxygen therapy training programme in place and this needs to be developed. 2 At THH the COPD admission rate This is most likely to reflect the provision of admission avoidance services by Hillingdon Integrated Respiratory Services (HIRS) – (>400 patients 18/19, 75% to not admit within subsequent 30 days). 3 Most COPD patients being treated on non-respiratory wards. At Hillingdon respiratory have 18 beds versus the national median of 28 beds. To ensure more COPD patients are cared for by respiratory, bed allocation and resource requires review. 4 HIRS provides 6 day services. A business case is required to deliver 7 day a week specialist respiratory care. 5 Access to high value interventions such as smoking cessation and pulmonary rehabilitation are offered as part of the COPD discharge bundles routinely. 6 The report highlighted no changes in respiratory staffing despite increasing workloads and assessment burden.

Audit	Key Findings
Chronic Obstructive Pulmonary Disease: Secondary care clinical audit 2017: Working together Published: 12 Apr 2018	This report captures the process and clinical outcomes of patients admitted to hospital with acute COPD exacerbations (Feb-Sep 2017). The report showed COPD care remained variable across England and Wales. The report highlighted three quality improvement priorities. 1. Ensure a spirometry result is available for all admissions with an acute exacerbation of COPD. Hillingdon Hospital was commended by the National COPD Audit program for its excellent availability of spirometry results. Access to general practice spirometry records are available Hillingdon Care Records (HCR). and Hillingdon Integrated Respiratory Services (HIRS) worked with the IT department to make departmental spirometry results available electronically. 2. Ensure all current smokers are identified, offered, and prescribed smoking cessation pharmacotherapy. Smoking cessation and nicotine replacement is offered as part of the COPD discharge bundle. Hillingdon Hospital is participating in the national CQUIN on preventing ill-health by risky behaviours. HIRS has developed an electronic smoking cessation referral form on HCR. There is no formal smoking cessation service at THH. 3. Ensure all patients requiring NIV receive it in a timely manner. Variation in NIV care has been noted locally. The Trust is working towards compliance with the current BTS NIV guidelines and NCEPOD report and has drafted a new Trust policy which is currently being approved. HIRS has worked hard to deliver the National COPD Audit and has achieved the best practice tariff since the audit commenced.
COPD National report 2018: Pulmonary rehabilitation, an exercise in improvement Published: 12 Apr 2018	Pulmonary rehabilitation services for Hillingdon CCG are provided by Harefield hospital who co-delivers Integrated Respiratory Services in Hillingdon. This report reiterates the benefits of pulmonary rehabilitation. It identified three national quality improvement targets. All three areas are achieved by the Harefield pulmonary rehabilitation service. 100% of patients are enrolled within 90 days from referral, all exercise assessments are performed to the recommended technical standards and completion rates achieved are greater than 70%. At Hillingdon hospital, the Hillingdon Integrated Respiratory Service (HIRS) offers all patients reviewed by them when admitted to Hillingdon hospital pulmonary rehabilitation at Harefield hospital as a component of the COPD discharge bundle. All patients reviewed in community COPD clinics who are eligible for pulmonary rehabilitation are also offered referral. There is good cross site/joined up working between the two organisations to deliver integrated respiratory care to patients in Hillingdon

Audit	Key Findings
The Learning Disabilities Mortality Review Annual Report 2017 Published: 04 May 2018	This LeDeR review has key information in relation to people with a learning disability who deaths were notified to the LeDeR programme. Just over a quarter (27%) had a mild learning disability, 33% had moderate and 29% a severe learning disability. About 64% of patients passed away in hospital with a learning disability as opposed to 47% of the general population. A summary of recommendations in relation to providers include the identification of people that require reasonable adjustments and to audit their provision. It is recommended that there is mandated learning disability awareness training. Finally a focus on the application of the Mental Capacity Act 2005 (MCA) and to provide training and audit of compliance. The Trust is continuously providing training awareness training about the use of the Mental Capacity Act and continual promotion of reasonable adjustments for patients with a learning disability. A Learning Disability all day awareness event was held in October 2018 at the Trust in which over 80 staff attended. The Trust has recently participated in a nationwide audit commissioned by NHSI in relation to the care of patients with a learning disability. The results are due in March 2019.
MBRRACE-UK Perinatal Mortality Surveillance Report 2018	**.MBRRACE – UK Perinatal Mortality report: 2016 births** 1) The maternity unit are providing quarterly reports to the Board in relation to Perinatal Mortality to the Board from March 2019 and this is monitored within the division to ensure that the reports meet the required standards.
National Audit of Breast Cancer in Older Patients: Annual report published June 2018	*The second annual report from the National Audit of Breast Cancer in Older Patients was reviewed and discussed at the breast MDT meeting soon after publication; the two areas of discussion included the Charlson co morbidity score and the electronic version of the frailty index.* *The breast team adheres to the WHO (World Health Organisation) - performance status score, which includes the Charlson co morbidity score and the frailty index, of which both are reordered in the patient notes and on the Somerset database. The Anaesthetists also apply the American Society of Anaesthesiologists classification (ASA) score to establish if there are any risks to patients prior to breast surgery. The Trust are reliant on both grading score systems to ensure women are offered treatments in line with the recommended guidelines thus to ensure that the highest quality of care pathway is being provided to older patients using the services".*

Audit	Key Findings
National Paediatric Diabetes Audit Report 2016-17: Care processes and outcomes Published: 12 Jul 2018	The National Paediatric Diabetes Audit looks at data for all patients under our care, specifically HbA1c (a measure of overall blood glucose levels) and the completion of 7 key care processes (7 annual health checks that each patient should receive). The audit shows our results compared to other local services and national results. We currently perform above the national average in completion of the 7 key care processes and when compared to other London diabetes services. Although we are performing well in this area, there are still improvements to be made. The introduction of annual review clinics will continue to increase completion of the 7 key processes. Our average HbA1c is above the national average, although it is improving yearly. To continue to reduce our average HbA1c we have introduced patient education workshops, changed blood glucose targets and have an ongoing quality improvement program for patients on insulin pumps.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme 2017 Annual SHOT Published 12 July 2018	The purpose of this audit was to summarise all of the SHOT (Serious Hazards of Transfusion) reports from 2017 and implement changes in the transfusion practice in Hillingdon Hospital. From the 2017 SHOT reports, 4 key messages were highlighted which were important to look at and implement possible changes within the Trust. Each of the SHOT recommendation resulted in different learning outcomes and preventative actions. The ongoing transfusion audits are based every year on the SHOT recommendations to improve transfusion practice. The latest most innovative professional approach to transfusion across the Trust based on the audit findings which in turn helping clinical and laboratory staff to review and make changes in their performance every year.
College of Emergency Medicine (CEM) Procedural Sedation in Adults 2017 Published:31st July 2018	As a result of the audit a new procedural sedation policy was initiated. No induction agent is to be given in resus without a sedation proforma being filled out. The aim is to reduce the risk of anaesthetic complications during procedural sedation. A sedation day teaching session was arranged for all Health professionals for on the use of the sedation proforma
National Ophthalmology Database Audit Report 2018 Published: 09 Aug 2018	Data for cataract surgeries performed at Hillingdon during the audited period show that the posterior capsule rupture rate was in line with the national average; however the rate of vision loss following cataract surgery was higher than the national average and a statistical outlier. Further work is required to understand whether this finding represents the reality on the ground or whether it was due to incomplete data being available. This will be followed up with an audit of each patient who suffered visual loss after cataract surgery during the audited period. Learning from the follow up audit will be directed towards the cause of the problem, whether it be incomplete record keeping or a genuine effect.
National Audit of Dementia Benchmarking (HQIP) Published: 22 Aug 2018	Since the audit in 2016 there has been a dedicated education programme for dementia and delirium targeting medical, nursing and therapy colleagues to ensure a focus on mental state assessment. Since March 2017 our specialist dementia nursing team has expanded which has allowed dedicated support on the wards for staff and patients to ensure mental state assessment is a priority and the diagnosis of delirium considered proactively. We are hopeful that the most recent audit will reflect the improvements made.

Audit	Key Findings
National Oesophago-Gastric Cancer Audit: Annual report 2018 Published: 13 Sep 2018	The National Oesophago-Gastric Cancer Audit reviews management of people with Oesophago-Gastric Cancer, largely by tertiary centres with limited application to the THH service. Trust 2017/18 data for upper GI cancers, including oesophago-gastric, pancreatic and liver cancers, indicate 2ww achievement of 91.5% (target 93%). Main delays related to straight to test referrals to endoscopy and radiology. Radiology now have funding to run their second CT scanner and are outsourcing reporting while Gastroenterology has appointed 3 new consultants increasing capacity in both services. Achievement of the 62 day target was 65.3% (target 85%). 2 delays were due to unavoidable complexities in diagnostics and 2 related to CT delays. The other delays were at the tertiary centre although 4 were referred within the 38 day timeframe and 1 within 41 days. In line with Recommendation 13 the Trust will explore the comparatively low use of active cancer management among palliative patients to confirm our view, in line with individual patient reviews, that patients are offered
Sentinel Stroke (SSNAP): SSNAP quarterly report Royal College of Physicians 2018	The Sentinel Stroke National Audit Programme (SSNAP) looks at data for all patients who have a primary diagnosis of an acute stroke. The audit commences at The Hyper acute Stroke Units (HASU) and continues when the patient is repatriated to their local stroke unit until discharged. The audit looks at the whole stroke pathway from thrombolysis right through to discharge planning and aftercare. There are 10 main domains which capture activity from all disciplines, including how much time the patient has received therapy. THH currently performs in line with other Pan London Rehabilitation Units; however we do not achieve our standard for Psychology assessments, only achieving 20% of all patients receiving an assessment. This has been acknowledged by the Trust, is on the Governance Risk Register and is factored for consideration of creating a part time psychology post in this year's financial business plan for stroke services.
Patient Reported Outcome Measures (PROMS)	(PROMs) measure health gain in patients undergoing hip replacement, knee replacement surgery in England, based on responses to questionnaires before and after surgery, which is then used as an indication of the outcomes or quality of care delivered to patients. The annual PROMs data for April 2016-March 2017 suggested the need to concentrate on the adjusted health gains, however was difficult to fully analyse given the low response rates. The main learning and areas identified for quality improvement included the need to improve the rates of uptake of PROMS Hip and knee forms, which included exploring and adopting new methods for both the distribution and collection of the Knee and Hip forms, to help encourage patients to engaging Proms. A higher response rate would provide a better representation of the Trusts data and stats, with the intention of further improving the health gains for patients".

Audit	Key Findings
National Emergency Laparotomy Audit (NELA): annual report Royal College of Anaesthetists Published Sept 18	The report from Year 4 shows slight improvement in all areas achieving the national average for most standards but there are still areas that need improvement.:- The early risk scoring is required when booking Laparotomies in theatre however recording needs to improve, and a Laparotomy Pathway Document maybe a solution. With regard to the standard dual Consultant presence in theatre, the data in the report is from 2016-2017 and does not reflect the current status of the availability of an all-day emergency theatre list which we anticipate will give considerable improvement to the figures next year also, it does not take into account Consultant involvements in decision making and awareness of the case. At THH Consultant presence may not be required due to the training and experience of a strong Staff Grade Team. Risk adjusted Mortality has increased the reasons for this are unclear. Reviewing some of the measures recorded in NELA for post-operative care (Critical care and Elderly care support) we are comparable to the national average, along with below national average for unplanned return to theatre and Unplanned admissions to Critical care which is under review. There is little evidence as to why this has not improved and it is not clear when these deaths occur, i.e., within a few days post operatively or later in their admission from complications.
National Joint Registry 15th Annual Report 2018 Published: 25 Sep 2018	The NJR data entry has been regularly discussed during the audit meeting days; discussions have included the importance of completing the correct MDS form for all eligible NJR procedures. The Trust specific report for the year 2016/2017 suggests further improvement is required to the number of eligible cases being submitted. The current report indicated 93% of records were submitted to the audit which was below the expected standard. To further increase the update of the NJR eligible records the Trust registrars have been given access to data entry if required. Furthermore, since consultants have started to independently input their own data, this has led to an improvement/ reduction in the numbers of the mismatched data for the Hillingdon and Mount Vernon sites, for the data matching audit 2017-2018. As a result of the consultants taking ownership for their own data entry, further improvements/reductions in mismatched data are likely, which will assist the Trust in meeting the expected level of submission standard

Audit	Key Findings
National Neonatal Audit Programme (NNAP) – 2018 Annual Report on 2017 data Published 28 Sep 2018	*NNAP is a national audit contributed to by all neonatal units in the country through routine data entry across all aspects of care. Audit criteria include admission temperatures for very preterm babies, update of parents by a senior doctor within 24 hours of admission, administration of antenatal steroids / magnesium sulphate to mothers who deliver prematurely (shown to reduce morbidity in babies) and frequency of follow-up of preterm babies at 2 years corrected age. Hillingdon Neonatal Unit performed above the national average for all quality indicators in the 2017 and 2018 reports. Although the team are naturally proud of these results, we continue to work hard on improving our compliance further. Interventions include the purchase and use of a new incubator that can be used for delivery room resuscitation, transport and incubation on the neonatal unit thereby improving admission temperatures*
National Mortality Case Record Review – Annual Report 2018 Published: 04 Oct 2018	The NMCRR report is not designed to generate data to compare Trusts' performance or to contribute to a national measure of the number of avoidable deaths but to be used by Trusts to support their own learning and improvement. The new structured judgemental review process was introduced in this Trust in April 2018 and is reported in the learning from deaths section of the Quality Accounts.
NCEPOD Common Themes and Recommendations Published: 11 Oct 2018	The first Confidential Enquiry into Perioperative Deaths (CEPOD) was published in 1987 in response to professional concern about perioperative deaths. Since then NCEPOD have published another 45 reports and extracted a set of common themes that are relevant to the care of all patients admitted to hospital. These themes are:- 1. Consultant review 2. Supervision of trainee doctors 3.Multidisciplinary review 4. Documentation 5. Monitoring and early warning scores 6. Morbidity and mortality reviews 7. Critical care review 8. Networks 9. Consent 10. Policies, protocols, proformas, guidelines & standard operating procedures (SOPs) 11. Common clinical conditions As NCEPOD undertakes more studies further evidence will be added to the chapters. THH has self assessed itself against the recommendations and is making progress in looking at improvements that can be made as a result of the report
Maternal, Newborn and Infant Programme: Saving Lives, Improving Mothers' Care Published: 01 Nov 2018	**MBRRACE – UK Maternal Report on maternal deaths 2014-2016** The maternity unit has recognised the needs of women with complex social needs and there is a complex needs team (Topaz) who ensure that the women are referred to the appropriate team for continuity of care. The team provides training to midwives and doctors on Perinatal Mental Health, Domestic Abuse and the process for providing support to these women and this meets the requirement from the report, to improve care to these groups of women

Audit	Key Findings
National Hip Fracture Database (NHFD) Annual Report 2018 Published: 15 Nov 2018	The report highlights that the Trust performs excellently on KPI 1 (Prompt Orthogeriatric review) and significantly above national average on KPI 2 (Prompt surgery) through prioritising hip fractures with dedicated theatre time for surgery.THH have set up a monthly hip fracture meeting and review all patients with missed target cases and disseminate findings on those patients. We meet the average for KPI3 (NICE compliant surgery). This KPI is subject to regular Trust audit and we are working to improve practice by identifying appropriate surgery for hip fracture patients at the earliest opportunity. KPI 4 (Prompt mobilisation) is below the national average. We are aware this relates to clinical and therapy factors in addition to bed pressures within the Trust. We are working towards ensuring all hip fracture patients are cared for on a single ward. Performance on KPI 5 (Not delirious post op) & KPI 6 (Return to original residence) is above the national average. A Trust wide improvement programme focussed on frailty care is currently underway to improve identification and management of delirium and all care for this patient group.
National Cardiac Audit Programme (NCAP) Annual Report 2018 Published: 22 Nov 2018	The Myocardial Infarction National Audit Project (MINAP) looks at the data for all patients presented to Hillingdon Hospital in myocardial infarction be it an ST elevation myocardial infarction (STEMI) or non-ST elevation myocardial infarction (NSTEMI). The audit compares our results to other services, locally and nationally. We are coding significantly higher numbers than to be expected. The proportion of patients who received all appropriate secondary prevention measures were in line with national average. Additionally, the number of patients with an NSTEMI who are treated with inpatient angiography is around national average. As the Trust does not have a catheter laboratory on site, this significantly skews some of the date. We have lower levels of reperfusion, inpatient echocardiography and review of patients presenting with NSTEMI than national average. This is to be expected as the patients are transferred offsite, sometimes very soon after admission for further investigation and treatment.
Acute Heart Failure: Failure to Function NCEPOD Date of publication: 22nd November 2018	The Acute Heart Failure NCEPOD report along with the recommendations has triggered a review process of our hospital heart failure services and we meet almost all of the recommendations. More specifically, there is very good practice in our hospital regarding: a) prompt Cardiology Consultant review or heart failure specialist nurse review within 14 hours of admission, b) follow-up of discharged patients by the heart failure nurses, c) heart failure management plan included in the discharge summary of HF patients, d) regular MDTs to discuss about the management plan of the patients. The NCEPOD recommendations however also allowed us to identify some areas where we can improve our heart failure services. We are now looking at including the palliative care team to our MDTs, updating the Trust's acute heart failure guidelines and increase our echocardiography department staff to achieve the 48h waiting time target for an inpatient echocardiogram. We are optimistic that we will be fully compliant with the NCEPOD recommendations very soon."

Audit	Key Findings
National Vascular Registry: Annual Report 2018 Published: 28 Nov 2018	The NVR is being maintained at Northwick Park Hospital (NWP). It involves registering all activities related to AAA, Carotids, Bypass operations, Angioplasties and Amputations. All these activities are done at NWP hospital excepting for the few Angioplasties that are done in the Radiology department at the HH
Fracture Liaison Service Database (FLS-DB) Annual Report 2018 Published: 03 Dec 2018	The fracture liaison service database (FLS-DB) annual report makes a number of recommendations to improve the effectiveness in post-fracture care delivery, to reduce the number of preventable subsequent fragility fractures. The report highlights that we are meeting targets for time to FLS assessment, time to DEXA scanning, falls assessment and recommendations for bone therapy. We have also made improvements in monitoring adherence to treatment within the first 12-16 weeks. There are however significant gaps in the identification of all fragility fractures - particularly spinal fractures, inpatient non hip fractures and hip fractures (currently entered onto NHFD but not FLSDB), as well as adherence to treatment at 12 months. To address these gaps we will be recruiting an additional FLS nurse and administrator. 0.5PA Consultant time has also been allocated for FLS service development with the initial aim of developing a pathway for the identification of vertebral fractures (in conjunction with radiology), followed by developing our current service for bone health assessment for non-hip fractures.
National Bowel Cancer 2018 Annual report	Findings not yet available at time of publication
Medical and Surgical Clinical Outcome Review Programme: Perioperative Diabetes Report 2018 (NCEPOD) Published: 13 Dec 2018	The report is a review of the quality of care provided to patients over the age of 16 who had diabetes and underwent a surgical procedure The overarching theme of the findings was that that was a lack of clinical continuity of diabetes management across the different specialties in the perioperative pathway (from referral to discharge). Absence of joint ownership of the diabetes management and multiple guidelines targeted at specific specialties, rather than a joint multidisciplinary approach, meant that the diabetes management of the patient was falling between gaps in the surgical pathway. Improvements in both clinical and organisational systems of care are required. THH has carried out a self assessment and is in the process of addressing recommendations not fully met. An action plan has been drawn up to take forward but the main issue is the lack of resources which need to be addressed with a business plan.

Audit	Key Findings
Medical & Surgical Review Programme: Cancer in Children, Teens and Young Adults Report (NCEPOD) Published: 13 Dec 2018	The aims of this study were to examine the process of care of children, teenagers and young adults aged 24 years and under who died and/or had an unplanned admission to critical care within 60 days of receiving systemic anti-cancer therapy (SACT) in order to: • Review the decision making and consent process around the prescription of SACT in this group of patients • Explore remediable factors in the quality of care provided to patients during the final protocol of SACT • Explore preventable causes of treatment-related mortality in young peoples' cancers • Examine the configuration of the service and organisational structures in place for the safe delivery of SACT to children, teenagers and young adults. A self assessment has been carried out against these recommendations and the Trust met the majority that were applicable. Actions taken include: 1) a performance score has been introduced to our chemotherapy proforma 2) a network-wide solution to audit of complications of SACT is being explored 3) we have been in the process of introducing e-prescribing for SACT for some time and limiting factors to complete this have been escalated to our executive team
Blood Transfusion management of patients at risk of Transfusion Associated Circulatory Overload (TACO) National Comparative Audit 18/19	Transfusion associated circulatory overload (TACO) is the most common cause of transfusion associated mortality reported to Serious Hazards of Transfusion (SHOT, 2017) and in many cases is thought to be preventable. The aim for audit was to establish if we needed to make adjustments in our hospital guidelines to reflect the latest advancements of the management of TACO. The new TACO guideline will give a clear pathway how to treat patients who develop respiratory distress during or up to 24 hours after transfusion. Where transfusion is suspected to be the cause will need to be reported on Datix followed up by a SHOT report. As a pre-emptive measure patient undergoing transfusion should have a well devised transfusion plan in the medical notes prior administration. Following the national guideline recommendations in absence of active bleeding clinical staff need to use the minimum number of red cells unit to achieve a target haemoglobin level and single unit transfusion needs to be considered if possible.

Audit	Key Findings
Trauma Audit and Research Network (TARN)	Significant progress has been made in both level 1 and 2 trauma training for nurses and an ongoing programme of training for junior and middle grade doctors often using our simulation suite on various trauma protocols and pathways which are also readily available both electronically and in hard copy. New pathways have been incorporated and current pathways amended in keeping with current evidence. The TARN data has been used for an audit on head injury (which has been re-audited showing improvement in our performance in NICE criteria based CT head scanning) and an audit on chest injury management which is due to be re-audited. The ED triage and streaming process has improved and we are optimistic that this will lead to early identification of trauma patients and trauma-call being put out which will improve our patient care and performance over the next year
Case Mix Programme Adult Critical Care (ICNRC)	The following actions have been taken to improve patient care:-NWLCCN 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 4 hours of the decision. The CSP is notified as soon as the decision is made and time documented. There is now a 'step down' option on Nerve centre that informs the CSP's of ITU/HDU patients ready for the ward. It had been planned that priority is given to critical care discharges over elective and ED admissions to ensure a critical care bed is available immediately for emergency admissions. Bed pressures have meant this does not always happen. Patients are ideally discharged as early as possible in the working day between the hours of 07.00hrs and 21.59hrs. Single sex breech reporting has also been utilised to ensure patients who are delayed discharges are transferred as soon as possible. This reporting is now more robust

Appendix 1.3

Audit	Actions
Local rib fracture pathway	The Trust is committed to providing the highest quality of care to all patients using its services. As a result of the audit there were a number of areas identified for quality improvement. There was a low awareness of the optimal pathway in the management of rib fractures and poor monitoring of patient parameters via the NEWS charts. As a result the local Trust guidelines for the management of rib fractures has been modified to include:- • Monitoring patient parameters to optimise patient pathway. • Discharge process to reduce readmission numbers. • Lower threshold for imaging in suspected rib fracture. • Involvement of Physiotherapy team earlier in patient pathway. • Explicit direction to contact MTC in event of thoracic injury requiring chest drain. • Scope for anaesthetic team to use discretion in determining best invasive anaesthesia. • New breathing exercise leaflet for all patients to optimise recovery. • Education teaching which includes, nurses monthly teaching, SHO monthly teaching, Middle Grade monthly teaching, Anaesthetic audit day.
Sensitivity of axillary ultrasound in diagnosing axillary metastases compared to histology from sentinel lymph node biopsy	This audit looked at the sensitivity targets outlined by the Royal College of Radiologists for two different aspects, both of which we were above the standards. 1. Ultrasound should identify nodes with metastatic involvement Target 50% Sensitivity, Result 53% 2. Ultrasound guided FNAC/biopsy should be accurate in the identification of metastatic disease in nodes which appear abnormal on ultrasound: Target – equal to prevalence of axillary nodal metastatic disease in first time presenters to the local symptomatic breast service (43%) Result 88% The one stop clinic ensures a patient's first encounter is with the full multi-speciality team preventing multiple trips during an emotionally challenging journey. When compared to the past, the team work between the specialities allows good forward planning along with scheduling of appointments and procedures. This in turn allows for appropriate timings of SLNB as mentioned above.
Hypoglycaemia Audit	Following the audit, inpatient diabetes specialist nurses have been doing regular teaching sessions on appropriate documentation and management of hypoglycaemia. This should help reduce the frequency of hypoglycaemic episodes and their mismanagement.

Audit	Actions
Bone protection in hip fracture patients (re-audit)	As a result of the audit a new clerking proforma for hip fracture patients with more specific questions and flow diagram for management of osteoporosis has been produced This will enable consistent approach to investigation and management, information on discharge and follow-up and will improve patient care.
Acute paediatric asthma management re-audit	A new wheeze booklet was introduced and the acute team have been engaging with it very well. Medical management is appropriate, in particular use of inhalers vs nebulisers. Key areas to work on are documentation related – in particular inhaler technique and severity, as these are often done but not formally documented. With each new set of trainees, there needs to be an emphasis on teaching around wheeze/asthma and education on how to use the proforma. Inhaler technique is often checked by the nurses but they do not feel empowered to complete the booklet. However with education nursing staff now feel more confident to do this and the shift is already happening. One area highlighted was lack of smoking cessation advice given. On discussion this was due to a lack of knowledge, confidence and resources available to do this.
Venous Thromboembolism (VTE), including to assess VTE appropriateness in General Surgery-DVT risk assessment and prophylaxis prescription for the patients on emergency admission.	The audit results were promising and suggested compliance with the Trusts VTE prophylaxis guideline, within the division of Surgery. Doctors were reminded to ensure that they continue to work in line with the VTE guideline requirements. The audit focused on the assessment/prescription of VTE prophylaxis, however did not include the implementation of patients actually wearing the ted stockings, which is an important factor to support the prevention of VTE. It would be beneficial to the Trust, when carrying out a future VTE audit to take this in to consideration.
Feverish illness in children (Re-audit with A&E) 2017/18	The audit showed that the team is very good at managing the very sick children and all the relevant steps of management are completed. It was noted that the team is not good at collecting urine sample in children under age of 5 with fever. Collecting urine is important especially if there is no clear focus of infection. It is now part of 6 weekly teaching of nursing staff that all children under 5 are given urine pot to collect urine at the time of triage. The team also did not do well in documenting observations in the doctors' clerking notes and justifying the reasons if NICE guidance was not followed for children in amber and green categories. Junior doctors are now taught at the time of induction and also reminded by the consultants to document the initial observations and clearly document the management plan and reasons of their decisions.

Audit	Actions
Management of Ankle Fractures	The Audit highlighted that 84% of patients had good documentation about skin condition and neurovascular status. The Importance of documenting this in each and every patient's notes was highlighted to all doctors present in audit meetings. It was also highlighted that ankle fractures should be prioritised on trauma list if the swelling is operable. This however might not be always possible if there are more urgent cases on trauma list like Neck of Femur Fracture. All junior doctors also educated to inform all patients about post-operative rehabilitation and expected time to recovery.
Management of febrile neutropenia in paediatric oncology patients at THH 2017-2018 Re-Audit	The audit has shown that there have been some improvements in patient care – good use of the febrile neutropenia proforma, thorough clinical examination, timely initial investigations and senior review. Antibiotic choice and review appropriate. Improvements include ensuring that ALL patients with febrile neutropenia are commenced on iv antibiotics within an hour of presentation, completion of risk stratification on admission and documentation of blood culture results in the notes – especially if informing the decision to stop antibiotics.
Paediatric Transfusion 18/19 Re-audit	Transfusion is a regular practice on our wards. This audit was to ensure that children are receiving transfusion in keeping with Local Guidelines: For the correct reason – Are being consented – In a safe manner. The audit highlighted that documentation of consent, indication for transfusion and checking patient ID prior to transfusion is poor. It is felt that this could be much improved by incorporating these into a new transfusion chart and this is in progress. A re-audit in August 2020 will show whether the new chart and further training has been successful in improving these elements.
Petechial Rash Guidelines in Paediatrics Re-audit	• The audit emphasised the importance of observations including BP at triage for nursing colleagues to help make a thorough assessment of sepsis. • Safety netting to the parents and documentation in the notes or Parent Information Leaflet on discharge is a key part of the management plan. • Awareness about coding to Paediatric doctors is not only important for payment by results and also for future audit purposes
Diabetic Ketoacidosis (DKA) in Paediatrics 2017/18 re-audit	The re-audit was looking at the reasons for Children and Young people with diabetes (CYPD) admissions and comparing over time the numbers presenting in DKA including whether these were known CYPD (preventable) together with the management of CYPD in DKA during the audit period compared to BSPED standards and previous audit findings. A retrospective audit over a period of time was carried out, identifying patients from the CYPD database. The DKA re-audit has shown improvement in almost all areas of practice especially a notable decrease in readmissions due to other quality improvements in the CYPD service. As a general audit finding not specific to DKA, medical and nursing documentation needs to improve to document 4hourly reviews which are happening but not documented well.

Audit	Actions
Newborn and Infant Physical Screening 16/17 (NIPE) Audit	*This audit examined the Trust's performance in completing the Newborn & Infant Physical Examination (NIPE) within 72 hours of birth. The NIPE is offered to all babies born in the care of the Trust (both in hospital, or at home) and is designed to diagnose important congenital problems, in particular abnormalities of the heart, eyes, testes or hips. The national target of 95% of NIPE examinations completed by 72 hours of life was met (98.4%). Following the audit 4 actions to improve performance have been developed, including improved induction training for junior doctors and updating a checklist for preterm babies.*
Term Baby Admissions to NNU	Infants born at term ($\geq 37+^{0}$) form the largest proportion of all babies admitted to neonatal care (60%). Most admissions are unexpected, causing extra stress to parents. Identifying and addressing those factors which lead to avoidable admissions would avoid separation of mother and infant, prevent unnecessary exposure to infection, and potentially result in significant cost savings to the health service through avoidable expenditure on cot days and treatment. The objective of the audit was to determine the term babies admitted to NNU relative to total term deliveries, to determine the proportion of term babies admitted to NNU relative to total NNU admissions and to identify the most common reasons for term baby admissions to NNU. We have evidenced that local data is comparable to national data and identified a number of areas of good practice: there is detailed online data available to facilitate data collection (Badgernet, Euroking); we have a number of guidelines available to doctors/midwives and these are adhered to e.g. BM monitoring for babies; availability of beds in TCU allows mother and baby to stay together; we accommodate skin-to-skin contact where possible. The following were identified as areas for improvement: there are inconsistencies between different resources (e.g. Badgernet versus maternal notes); breast feeding support could be improved and antenatal breast milk expression encouraged; further promotion of immediate skin-to-skin. Following our audit, there has been wider encouragement of breastfeeding clinics, especially among high-risk mothers, and improved feeding support postnatally. A joint NNU-Maternity audit has been started and new hypoglycaemia and RDS guidelines will be implemented to reduce number of RDS and hypoglycaemia-related NNU admissions.
Local Audit of CEM Severe Sepsis and Septic Shock (2018/19)	The Severe Sepsis and Septic Shock Audit looks at data for all patients under our care, specifically those diagnosed with sepsis and the initiation of sepsis-6 protocol for them. This audit shows our results compared to our previous audit cycle and national results. Our current results suggest that we have improved significantly on early initiation of sepsis-6 protocol, although there is still improvement to be made in various elements of the protocol. To continue delivering effective and timely patient care in septic patients, we have introduced regular teaching sessions for doctors and nurses, and as a quality improvement project we propose introducing patient information sheet from resources provided by The Sepsis Trust UK and re-audit after 6 months.

Audit	Actions
To improve the appropriateness of prescribing oral vs intravenous paracetamol in the ED setting, for acute pain relief	Data collected by hospital pharmacy highlighted that our use of IV (intravenous) paracetamol in Hillingdon Hospital significantly exceeds that in other Trusts nationally. ED's most recent financial plan has also highlighted our overuse of IV paracetamol with regards to it's per unit cost when compared to oral paracetamol. The aim of the audit was to quantify our prescribing practice of IV paracetamol for acute pain relief in ED, and ascertain if our 'pain management in adults' ED guideline is being adhered to. Our data collection over a week showed that over 80% of the paracetamol used in ED is intravenous, and in most instances it is inappropriately prescribed and not clinically indicated. By educating ED doctors and nurses through teaching sessions, as well as putting up easy to read posters across ED, we hope to reduce the inappropriate use of intravenous paracetamol which will act as a significant cost saving measure, as well as improve our prescribing practices.
Paediatric Eczema Management 2017/18 re-audit	Eczema is a common Paediatric condition. The audit was conducted to ensure we have a unified approach to the Management of Paediatric Eczema and that current management for inpatients and outpatients is in line with NICE guideline recommendations. Results were also compared to an audit carried out in 2012. Data was collected from clinic letters, inpatient notes and discharge summaries of children coded with eczema. The audit showed that evidence based treatment and treatment plans to manage flare ups had improved in all 9 areas of the standard since 2012. Results showed that patients/parents/carers understanding of eczema and recommended management/treatment could be improved. The Eczema leaflet is now being updated to reflect this and to ensure all patients receive a copy, will be included in all clinic letters where Eczema is named as a problem. In the future the community nursing team may be included in the management of Eczema and support in the community.
Domestic Violence Processes in Maternity Dept	The audit aim was to assess if maternity staff were asking pregnant women if they were suffering domestic abuse, recording and responding appropriately and to assess if midwives were asking and recording the partner / father of the baby details. The audit showed an area for improvement in asking the question and ensuring the answer is recorded and actions taken. This has been an area of focus at the mandatory training for midwives to ensure all midwives are confident and feel equipped to ask women about domestic abuse and signpost to services. The hospital Independent Domestic Violence advocate is also attending mandatory training in order to ensure staff, are aware of the referral process and service. A re-audit will be carried out at a later date to review compliance.

Audit	Actions
Adherence to local guidelines in management of bronchiolitis 17/18 Re-audit	The audit 'adherence to local guidelines in the management of bronchiolitis' outlined that as a paediatric department, we are already doing fewer unnecessary investigations and treatments for children presenting with bronchiolitis, when compared with previous years. To maintain this, and hopefully improve further, there will be teaching sessions about bronchiolitis and its management, with the aim to also increase awareness of the local guidelines that exist. This will be done during the induction period for new junior doctors starting in the paediatric department. This will hopefully help minimise investigations and treatments that are not necessary in a child with bronchiolitis, thus improving patient care.

Appendix 2.1
Seven Day Services

Clinical Standard	Self Assessment of Performance	Weekday	Weekend	Overall Score
Standard 2: Time from admission to Consultant Review	The evidence to demonstrate compliance is taken from the clinical audit undertaken in April 2018 - this shows the Trust met this standard for the first time, with overall compliance of 92%. • Compliance was significantly aided by the additional medical staff supported by resource from the Winter Bid (NB: temporary resource). • Consultant job plans include agreed consultant lead ward rounds, but not 7 days a week in all areas (see below) Compliance at the weekend was 87% overall. • Main specialties failing the target are surgical due to on call patterns and timing of daily post-take ward rounds (gynaecology, surgery, T&O). • Ongoing actions to strengthen targeted, timely consultant review include board rounds, changes to medical and surgical admission pathways via SAU/RAMU/AMU. Patient experience data (FFT/National Patient Survey), Complaints/PALS data available but does not differentiate between weekdays and weekends or specific to consultant presence/ availability.	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Not met
Standard 5: Access to Diagnostics	Standards met in all areas except Echocardiography and MRI at weekends. Mitigation: • Weekend in-patient MRI slots considered as a business case, but not thought to be cost effective. • Pathways in place for transfer to another unit for the investigation if CT is unsuitable. Further actions: • strengthened monitoring of incidents related to delays in MRI/ECHO • regular risk assessments of pathways falling short of standards.	Yes available on site	Mostly met	Met

Clinical Standard	Self Assessment of Performance	Weekday	Weekend	Overall Score
Standard 6: Access to Consultant-directed Interventions	Fully compliant either on site or off site via formal arrangement. • Formal arrangements mapped in NWL for cross-site interventional & diagnostics Further action: • strengthened monitoring of these arrangements required, including review of incidents and complaints.	Yes available on/off site by formal arrangement	Yes available on/off site by formal arrangement	Met
Standard 8: On-going Review	April 2018 clinical audit findings • once daily reviews non-compliance at weekends • increased workload out of hours • poor documentation in notes. Ongoing assurance provided to Trust Board via Safer medical staffing paper at Trust Board and Workforce Transformation Steering Board. Mortality - HSMR continues to improve and is below expected for all admissions, weekend only admissions remains within the expected range. ICNARC mortality is as expected. Actions: • Deteriorating Patient Policy updated • SBAR refresher training underway. • Electronic observations system (hObs) which includes NEWS2 and sepsis in use in inpatient areas • Progress regularly reported to QSC.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Partially met (Once Daily: No the standard is not met for over 90% of patients admitted in an emergency)	Not Met

Appendix 2.2
Clinical standards for continuous improvement

Standard 1: Patient experience	Data is collected on patient experience and reviewed in the Trust, but is not scrutinised to determine quality of care/consultant presence on weekdays versus weekends. This is the same for complaints and PALS comments. • This will be reviewed going forward to improve the use of patient experience data for 7DS compliance.
Standard 3: Multidisciplinary team review	The Trust is addressing the 7 day service provision and workforce gaps as part of its emergency care improvement plan. Weekly MADE with the system partners, demonstrated positive effect. Areas to focus on include: • MDT therapies weekend cover is variable. • Respiratory and orthopaedic physio cover in place at weekends and bank holidays, • No dietetics or speech and language therapy cover. • Rota of Occupational Therapy, Physiotherapy and Therapy Assistant covering weekends on the Acute Medical Unit on bank. – Longer term solutions being evaluated via business planning route. • Pharmacy is funded to increase their service from March 2019 to ensure better weekend cover for medicines reconciliation and a transcribing pharmacist for peak demand times and areas. – For pharmacy there is an approved business case to help achievement of this standard to support medicines reconciliation at weekends/public holidays which we do not currently provide.
Standard 4: Shift handovers	Shift Handovers are in place. Nervecentre is improving the handover process in ensuring consistent information is being shared. This will continue to be embedded across the Trust
Standard 9: Transfer to community, primary and social care	The Trust is addressing the 7 day service provision and workforce gaps as part of its emergency care improvement plan. Weekly MADE with the system partners, demonstrated positive effect. • Integrated Discharge team reflective of the partner agencies within Hillingdon. – 7 day service including a discharge co-ordinator over the weekend, currently being fully recruited to.

Glossary

A	
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.
Always Events	An Always Event® is a clear, action-oriented, and pervasive practice or set of behaviors that provides the following: • A foundation for partnering with patients and their families; • Actions that will ensure optimal patient experience and improved outcomes; and • A unifying force for all that demonstrates an ongoing commitment to person- and family-centered care.
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	
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	
Datix	An information system that provides a portal for staff to report incidents. It also acts as a database and repository for all reported incidents providing analytical tools for staff to review themes and trends of reported incidents.
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	
ECIST	A clinically led national NHS team that has been designed by clinicians to help health and care systems deliver high quality emergency care.
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	
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 % 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.
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.
HObs	The short name given to the electronic observations system used at the Trust to replace the paper forms traditionally used to plot observations of clinical parameters such as temperature and heart beats. It is short for Hillingdon Observations.
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	
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.
Lived Experience	The term used to describe the experience of a patient and/or their carers as they engage in the co-design of health care services.

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.
MBI	A consultancy company (MBI Health Group) that provides support to organisations on the subjects of Operations, Finance and Access (A&E, Cancer and Elective care standards).
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)	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	
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	
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.
People Committee	This is the Trust Board committee responsible for monitoring and gaining assurance on indicators relating to the workforce.

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.
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.
SORT	A mnemonic used to prompt clinicians to review patients in a standardised order. It stands for S –Sickest first; O - Out of the hospital, R – Rest of the patients and T – To come in.
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 تہانوں اے اطلاع کسے 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.

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 .

4

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 2018/19 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.

5

Independent Auditors Report

5

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 2019 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 Equity for the year ended 31 March 2019;
- the Statement of Cash Flows and
- the related notes 1 to 30.

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.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Recognition of NHS Revenue • Going Concern (see 'material uncertainty related to going concern' section) • Arrangements to secure value for money (see 'matters on which we are required to report by exception – use of resources' section)
Materiality	The materiality that we used for the current year was £5.1m, 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.

Material uncertainty relating to going concern

We draw attention to note 1.2 in the financial statements and the disclosures in the Annual Governance Statement, which indicate that the foundation trust incurred a net deficit of £25.9m during the year ended 31 March 2019 (31 March 2018: deficit of £8.0m) and has net current liabilities at 31 March 2019 of £13.9m (31 March 2018: £7.8m). The operational plan for 2019/20 forecasts a £2.7m deficit however this position is only achieved after recognition of £19.5m income from Provider Sustainability Fund ("PSF") and the Financial Recoverability Fund ("FRF"). In addition, the foundation trust has existing loans of £76.2m (31 March 2018: £38m) of which £2.8m is due in the 2019/20 financial period (31 March 2018: £3.1m).

The foundation trust has identified additional funding is required before the end of 2019/20 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 did not receive the full amount of the PSF and FRF income forecast, it would have to apply for alternative funding from the Department of Health and Social Care ("DHSC"). The outcome of this application is currently uncertain with a month-to-month mechanism being used by DHSC to evaluate and agree additional cash support.

In response to this, we:

- reviewed the foundation trust's financial performance in 2018/19 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, the financing required and the related funding arrangements that have been agreed. Where funding has been agreed, we have confirmed this to signed loan agreements.
- 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 1.2 and summarised above, these events or conditions indicate that material uncertainties exist 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.

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.

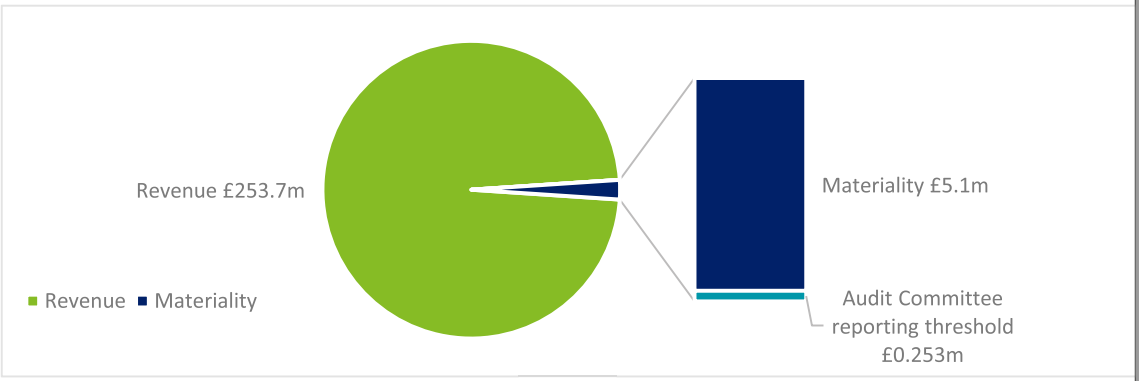
Recognition of NHS Revenue	
Key audit matter description 	As described in note 1, Accounting policies and other information, there are significant judgements in recognition of revenue from care of NHS patients and in accounting for disputes with commissioners due to the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. Details of the foundation trust's income, including £168.1m (2017/18: £165.3m) of Commissioner Requested Services, are shown in note 5 to the financial statements. Receivables from NHS and DHSC group bodies of £17.6m (2017/18: £18.8m) are shown in note 18 to the financial statements. The majority of the foundation trust's income comes from three commissioners, NHS Hillingdon (£151.7m), NHS Ealing (£26.1m) and NHS England (£16.7m), increasing the significance of associated judgements. 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 recognition of NHS income. 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. 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 accounting for disputes.

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	£5.1m (2017/18: £5.0m)
Basis for determining materiality	2% of revenue (2017/18: 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 £253k (2017/18: £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.

Basis for adverse conclusion

- In June 2018, the Trust undertook enforcement actions issued by NHS Improvement ("NHSI") under section 106 of the Health and Social Care Act 2012. NHSI stated that it had reasonable grounds to suspect that the Trust has provided and is providing health services for the purpose of the health service in England while failing to comply with the following conditions of its Licence: FT4 (5) (c) (d) (f) (g) and FT4 (7). These breaches demonstrate shortcomings in corporate governance arrangements and financial management standards. Key areas flagged in particular include, but are not limited to: A&E performance, delivery of cost improvement plans and weaknesses in the Project Management Office team.
- The Trust was inspected by the CQC in March 2018, with its report being issued in July 2018. The report indicated that overall the Trust was rated 'Requires improvement' with the same rating being given across all five indicators with the exception of 'Are services safe' – rated 'Inadequate' and 'Are services caring' - rated 'Good'. The same report rated the principal Hillingdon Hospital site as overall 'Inadequate' with the same ratings as the overall Trust given across all five indicators with the exception of 'Are services well-led' which was rated 'Inadequate'.
- Following release of the CQC report, further enforcement actions were issued by NHSI in relation to the delivery of quality. Undertakings include, but are not limited to: a required review to determine reasons why lack of progress against CQC targets was not identified, development of an assurance framework, deploying a framework to ensure patient safety issues are escalated, a review of risk management policies, and improvements to medical engagement.
- In May 2018, the Trust agreed enforcement undertakings in relation to governance including undertaking an externally commissioned governance review to inform the strengthening of governance arrangements. The final outcomes of this report are expected in August 2019, however interim improvement measures from that review indicate that improvements are required, which reflect weaknesses in arrangements in 2018/19, with regards to: capacity and capability within the Trust's leadership team and project management office, development of Trust strategy, governance structures and membership of groups within those structures, the Board Assurance Framework, arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management.

These issues are evidence of weaknesses in proper arrangements for acting in the public interest, through demonstrating and applying the principles and values of sound governance.

- There are weaknesses in the Trust's risk management arrangements and Board Assurance Framework, which have been identified through an external governance review and the Trust's CQC report. These weaknesses included, but are not limited to: the way in which key risks and actions are articulated to the Board and impact on the Board and committee agendas; the process for capturing and considering emerging risks and reviewing the risk register; the way in which risks are linked to strategy; the process for escalation and moderation of risks; and the timely completion of actions to address risks.
- There are weaknesses in the internal control environment of the Trust that have been identified by the Trust's internal auditor including arrangements in respect of: consultant job planning; the retention programme; core financial systems; the Trust's outsourced contact management; business continuity; discharge planning; and the governance of the CQC Action Plan.

These issues are evidence of weaknesses in proper arrangements for managing risks effectively and maintaining a sound system of internal control

- There are weaknesses in the Trust's arrangements to ensure the quality of performance data as evidenced by our limited assurance report on the content of the quality report and mandated performance indicators which contains a qualified conclusion because of errors identified which affected the calculation of the 18 week Referral-to-Treatment and Accident and Emergency 4 hour wait performance indicators in 2016/17 and 2017/18. Our limited assurance report for 2018/19 contains a qualified conclusion because of errors identified which affected the calculation of the Accident and Emergency 4 hour wait indicator. Recommendations raised as part of previous assurance work in this area have not been effectively implemented.

This issue is evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable performance information to support informed decision making and performance management.

The Trust has described in its Annual Governance Statement the financial challenges it faces and the pressures on financial sustainability including matters which are not wholly within the control of the Trust. Particular indicators of pressure on sustainable finances include the following:

- The Trust incurred a deficit of £25.9m for the year ended 31 March 2019, against an originally planned deficit of £7.5m. Due to poorer than expected financial performance, the Trust has not been able to claim any Provider Sustainability Funding ("PSF"). PSF of £5.5m was included in the plan based on achieving a deficit control total of £7.6m. The Trust's 2019/20 plan submission in February showed a forecast deficit of £23.7m for 2019/20. In order to fund these deficits, the Trust received financial support in the form of new loans from

the Department of Health in 2018/19 of £22.9m and is seeking further financial support in 2019/20.

- The Trust has estimated its backlog maintenance to be £236m across the estate but, due to limitations in available funding, has allocated only limited funding to capital developments. The Trust had capital expenditure in 2018/19 of £5m and plans capital expenditure of £15.6m in the 2019/20 year. The Trust is exposed to risks related to the age and condition of the estate that could impact levels of service provision. The CQC noted in their July 2018 report that, since their 2015 reports highlighting the poor condition of the Trust's buildings and estate, there had been "little or slow progress in addressing this issue."
- There are weaknesses in the Trust's arrangements for developing budgets and monitoring costs and cashflows against budgets, including in relation to a significant variance to planned pay and non-pay costs.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, we are not satisfied that, in all significant respects, The Hillingdon Hospitals NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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;
- 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

We have nothing to report in respect of these matters.

made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

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
28 May 2019

6 Forward to the Accounts

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Forward to the Accounts

The accounts for the year ended 31 March 2019 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.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
28 May 2019

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The 2018/19 Accounts

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	NOTES	31 March 2019 £000	31 March 2018 £000
Operating Income from patient care operations	3	**222,968**	225,808
Other operating income	4	**30,803**	28,422
Operating expenses	6, 7, 8	**(275,789)**	(266,158)
Operating deficit from continuing operations		**(22,018)**	(11,928)
Finance income	11	**54**	20
Finance expense	12	**(3,171)**	(2,648)
PDC dividends payable		**(3,528)**	(4,130)
Net finance costs		**(6,645)**	(6,758)
Other gains	13	**2,769**	10,670
Deficit for the year from continuing operations		**(25,894)**	(8,016)
Deficit on discontinued operations and the result on disposal of discontinued operations		**-**	-
Deficit for the year		**(25,894)**	(8,016)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019	NOTES	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible Assets	14	**3,902**	2,476
Property, plant and equipment	15	**139,710**	140,118
Investment property	16	**45,856**	43,087
Receivables	18	**1,821**	1,950
Total non-current assets		**191,289**	187,631
Current assets			
Inventories	17	**2,964**	3,243
Receivables	18	**25,695**	27,117
Cash and cash equivalents	19	**1,032**	1,099
Total current assets		**29,691**	31,459
Current liabilities			
Trade and other payables	20	**(40,719)**	(35,998)
Borrowings	21	**(2,932)**	(3,129)
Provisions	23	**-**	(171)
Total Current Liabilities		**(43,651)**	(39,298)
Total assets less current liabilities		**177,329**	179,792
Non-current liabilities			
Borrowings	21	**(73,233)**	(51,053)
Provisions	23	**(1,967)**	(2,150)
Total non-current liabilities		**(75,200)**	(53,203)
Total assets employed		**102,129**	126,589
Financed by:			
Public dividend capital		**74,860**	73,426
Revaluation reserve		**48,579**	49,837
Income and expenditure reserve		**(21,310)**	3,326
Total taxpayers' equity		**102,129**	126,589

The notes 1 to 30 form part of these accounts.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
28 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2019	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**73,426**	**49,837**	**3,326**	**126,589**
Deficit for the year	-	-	(25,894)	(25,894)
Other transfers between reserves	-	(1,258)	1,258	-
Public dividend capital received	1,434	-	-	1,434
Taxpayers' equity at 31 March 2019	**74,860**	**48,579**	**(21,310)**	**102,129**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2018	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**71,479**	**51,129**	**10,050**	**132,658**
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**71,479**	**51,129**	**10,050**	**132,658**
Deficit for the year	-	-	(8,016)	(8,016)
Other transfers between reserves	-	(1,292)	1,292	-
Public dividend capital received	1,947	-	-	1,947
Taxpayers' equity at 31 March 2018	**73,426**	**49,837**	**3,326**	**126,589**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

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

Income and expenditure reserve

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	NOTES	For the Year Ended 31 March 2019	For the Year Ended 31 March 2018
		£000	£000
Cash flows from operating activities			
Operating deficit		**(22,018)**	(11,928)
Non-cash income and expense			
Depreciation and amortisation	6	**9,337**	9,302
Income recognised in respect of capital donations	4	**(77)**	(137)
Increase / (decrease) in receivables and other assets		**1,642**	(6,195)
Increase / (decrease) in inventories		**279**	(346)
Increase in payables and other liabilities		**1,748**	4,160
Decrease in provisions		**(414)**	(140)
Net cash generated used in operating activities		**(9,503)**	(5,284)
Cash flows from investing activities			
Interest received		**54**	20
Purchase of intangible assets		**(1,510)**	(233)
Purchase of property, plant, equipment and investment property		**(5,587)**	(5,568)
Net cash generated used in investing activities		**(7,043)**	(5,781)
Cash flows from financing activities			
Public dividend capital received		**1,434**	1,947
Movement on loans from the Department of Health and Social Care		**23,150**	18,054
Capital element of finance lease rental payments		**(1,262)**	(1,877)
Capital element of PFI, LIFT and other service concession payments		**(230)**	(226)
Interest on loans		**(1,297)**	(734)
Other interest		**(11)**	-
Interest paid on finance lease liabilities		**(166)**	(273)
Interest paid on PFI, LIFT and other service concession obligations		**(1,520)**	(1,457)
PDC dividend paid		**(3,619)**	(4,330)
Net cash generated from financing activities		**16,479**	11,104
(Decrease) / increase in cash and cash equivalents		**(67)**	39
Cash and cash equivalents at 1 April - brought forward		**1,099**	1,060
Prior period adjustments		**-**	-
Cash and cash equivalents at 1 April		**1,099**	1,060
Cash and cash equivalents at 31 March	19	**1,032**	1,099

Note 1 Accounting policies and other information

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 2018/19 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 the accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 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.

Note 1.2 Going concern

DHSC group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

The Trust's annual report and accounts have therefore been prepared on a going concern basis.

In considering the Trust's circumstances, 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 in the foreseeable future. The term 'foreseeable future' is defined in International Accounting Standard 1 as being a period of at least 12 months from the entity's reporting date. For this reason, they have continued to adopt the going concern basis in preparing the accounts.

Given the deteriorating financial context within the Trust, the local healthcare economy and the wider NHS, the Directors have also given serious consideration to broader financial sustainability and note that:

The recurrent underlying position of the Trust is in deficit. The final reported deficit in 2018/19 was £25.9m, and the Operational Plan for 2019/20 currently shows a £2.7m deficit. This position is only achieved by the Trust receiving non-recurrent support of £19.5m from the Provider Sustainability/Financial Recovery Fund

The Trust has an agreed financial plan for 2019/20. Signed contracts with both the local commissioners (North West London CCGs) and NHS England amount to £198.8m. This provides certainty and underpins 88.7% of the Trust's clinical income in 2019/20

This plan assumes delivery of £11.7m of back-loaded Financial Improvement Schemes, of which £5.4m have been identified to date

The Trust's Statement of Financial Position shows net liabilities. In 2018/19 the Trust received £24.5m of central cash support in order to continue operations. Financing support is provided by HM Treasury in order to ensure that essential services continue to be delivered. This financial support is not risk-assessed in relation to the Trust's ability to repay. There is no indication that this support is not likely to continue.

The Directors acknowledge that, given the mechanism the Department of Heath and Social Care (DHSC) is using for agreeing cash support is on a month-on-month basis, there is 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 it's assets and discharge it's liabilities in the normal course of business.

The Trust has been in receipt of financial support throughout 2018/19, and the plan for 2019/20 also includes significant non-recurrent support. 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 this financial support. The Directors continue to work with partners across Hillingdon and the wider North West London Sustainability and Transformation Partnership footprint to develop and implement a strategy consistent with the resources available.

There is significant uncertainty surrounding the Brexit issue. The Trust made preparations through 2018/19 for the potential impact of the UK's exit from the European Union, including planning for the case of a 'no deal' EU Exit, including following recommendations in the Department of Health and Social Care's EU Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

In terms of governance, the Director of People and Organisational Development has been the Trust's EU Exit Senior Responsible Officer, reporting to the Board.

Note 1.3 Interests in other entities

The Trust is a consortium partner with Chelsea and Westminster Hospital NHS Foundation Trust and Imperial College Healthcare NHS Trust for the provision of Pathology Services. The Trust includes within its financial statements its share of the Assets, Liabilities, Income and Expenses.

Joint Ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint Ventures are accounted for using the equity method.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The effect of readmissions is not material, or is reflected in the contract baseline and thus in the transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Research income that falls under IFRS 15 is not material.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

"Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit."

Note 1.4.3 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

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. Asset 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 March 2019. The surveyors are MRICS qualified and registered valuers and are experienced in the healthcare sector.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

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.

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Note 1.7.3 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs."

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.5 Private Finance Initiative (PFI) and 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.

Note 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	60
Dwellings	5	5
Plant & machinery	2	20
Transport equipment	-	-
Information technology	2	15
Furniture & fittings	5	15

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Expenditure on research is not capitalised.

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

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- The Trust intends to complete the asset and sell or use it
- The Trust has the ability to sell or use the asset
- How the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- The Trust can measure reliably the expenses attributable to the asset during development."

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Software licences	5	15
Licences & trademarks	15	15

Note 1.9 Inventories

Inventories are stated at the lower of cost or net realisable value. Cost is calculated on a FIFO basis (First In First Out).

Note 1.10 Investment properties

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.

Note 1.11 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.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement
Financial assets are categorised as loans and receivables or available for sale as financial assets. 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.

Financial liabilities are classified as other financial liabilities.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.1.14

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at fair value through income and expenditure

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

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.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition

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

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

Note 1.14 Leases

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

Note 1.14.1 The trust as lessee

Finance leases

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

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

The annual rental charge 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, is 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.

Note 1.14.2 The trust as lessor

Finance leases

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

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

Note 1.15 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.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 30.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 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.

Note 1.17 Public dividend capital

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

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

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

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

Note 1.18 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.

Note 1.19 Foreign exchange

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.

Note 1.20 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.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.22 Gifts

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

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.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.24 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 2019 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.

1.25 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.

1.26 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.

IFRS 14 Regulatory Deferral Accounts	Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
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. See Note 29.2.
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 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely availableand the cost to develop this information would be significant.

Significant amounts of income are received from transactions with the Department of Health and other NHS bodies. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	31 March 2019 £000	31 March 2018 £000
Elective income	**31,322**	29,595
Non elective income	**65,454**	63,776
First outpatient income	**15,898**	15,606
Follow up outpatient income	**19,320**	22,998
A & E income	**12,753**	12,451
High cost drugs income from commissioners (excluding pass-through costs)	**12,583**	11,112
Other NHS clinical income	**56,527**	63,042
Patient transport services income	**1,150**	1,063
Community services income from CCGs and NHS England	**2,419**	2,803
Private patient income	**191**	208
Agenda for Change pay award central funding	**2,745**	-
Other clinical income	**2,606**	3,154
Total income from activities	**222,968**	225,808

Note 3.2 Operating Income (by source)	31 March 2018 £000	31 March 2017 £000
Income from activities		
NHS England	**14,023**	15,074
Clinical commissioning groups	**202,888**	201,217
Department of Health and Social Care	**2,745**	-
Other NHS providers	**515**	642
NHS other	**-**	106
Local authorities	**-**	383
Non-NHS: private patients	**191**	172
Non-NHS: overseas patients (chargeable to patient)	**1,440**	1,503
Injury cost recovery scheme	**1,053**	1,182
Non NHS: other	**113**	5,529
Total income from activities	**222,968**	225,808
Of which:		
Related to continuing operations	**222,968**	225,808
Related to discontinued operations	**-**	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	31 March 2019	31 March 2018
	£000	£000
Income recognised this year	**1,440**	1,503
Cash payments received in-year	**740**	340
Amounts added to provision for impairment of receivables	**(231)**	(119)
Amounts written off in-year	**175**	371

Note 4 Other operating income

	31 March 2019	31 March 2018
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	**345**	465
Education and training (excluding notional apprenticeship levy income)	**9,415**	10,094
Non-patient care services to other bodies	**8,790**	8,431
Provider sustainability / sustainability and transformation fund income (PSF / STF)	**2,062**	-
Income in respect of employee benefits accounted on a gross basis	**576**	587
Other contract income	**6,072**	5,268
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	**49**	10
Receipt of capital grants and donations	**77**	137
Rental revenue from operating leases	**3,417**	3,430
Total other operating income	**30,803**	28,422
Of which:		
Related to continuing operations	**30,803**	28,422
Related to discontinued operations	**-**	-

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	31 March 2019	31 March 2018
	£000	£000
Income from services designated as commissioner requested services	**168,124**	165,309
Income from services not designated as commissioner requested services	**54,844**	60,499
Total	**222,968**	225,808

Note 6 Operating expenses

	31 March 2019 £000	31 March 2018 £000
Staff and executive directors costs	**176,739**	169,555
Remuneration of non-executive directors	**134**	141
Supplies and services - clinical (excluding drugs costs)	**34,758**	34,747
Supplies and services - general	**3,975**	3,936
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**18,156**	19,474
Inventories written down	**60**	82
Consultancy costs	**2,025**	1,643
Establishment	**5,242**	4,905
Premises	**7,884**	7,409
Transport (including patient travel)	**1,837**	1,860
Depreciation of property, plant and equipment	**8,752**	8,734
Amortisation of intangible assets	**585**	568
Movement in credit loss allowance: contract receivables / contract assets	**758**	
Movement in credit loss allowance: all other receivables and investments	**13**	642
Increase/(decrease) in other provisions	**(262)**	30
Audit fees payable to the external auditor		
audit services- statutory audit	**101**	86
other services: audit-related assurance services	**19**	15
other auditor remuneration (external auditor only)	**71**	-
Internal audit costs	**111**	119
Clinical negligence	**8,326**	6,571
Legal fees	**179**	207
Insurance	**258**	233
Research and development	**363**	360
Education and training	**1,727**	1,722
Rentals under operating leases	**508**	373
Redundancy	**73**	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	**550**	521
Car parking & security	**376**	314
Hospitality	**41**	36
Losses, ex gratia & special payments	**110**	5
Other services, eg external payroll	**2,303**	1,869
Other	**16**	1
Total	**275,789**	266,158
Of which:		
Related to continuing operations	**275,789**	266,158
Related to discontinued operations	**-**	-

Note 7.1 Other auditor remuneration

	31 March 2019	31 March 2018
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. All assurance services	**71**	-
Total	**71**	-

This relates to a governance review carried out by external auditors

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Employee benefits

	31 March 2019	31 March 2018
	£000	£000
Salaries and wages	**139,501**	131,448
Social security costs	**14,685**	13,868
Apprenticeship levy	**690**	644
Employer's contributions to NHS pensions	**15,521**	14,658
Pension cost - other	**26**	-
Termination benefits	**102**	22
Temporary staff (including agency)	**10,453**	12,645
Total gross staff costs	**180,978**	173,285
Recoveries in respect of seconded staff	**(1,709)**	(1,519)
Total staff costs	**179,269**	171,766
Of which		
Costs capitalised as part of assets	**842**	757

Note 8.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the PY year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £14k (£1k in 2017/18).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

	31 March 2019	31 March 2018
	£000	£000
Operating lease revenue		
Minimum lease receipts	**2,760**	2,760
Contingent rent	**657**	670
Other	**-**	-
Total	**3,417**	3,430

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**2,455**	2,075
- later than one year and not later than five years;	**8,772**	7,218
- later than five years.	**100,057**	98,656
Total	**111,284**	107,949

Note 10.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Hillingdon Hospitals NHS Foundation Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Operating lease revenue		
Minimum lease receipts	**474**	351
Contingent rent	**34**	22
Contingent rent	**-**	-
Total	**508**	373

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**508**	408
- later than one year and not later than five years;	**1,727**	1,583
- later than five years.	**72**	166
Total	**2,307**	2,157
Future minimum sublease payments to be received	**-**	-

Note 11 Finance income

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

	31 March 2019	31 March 2018
	£000	£000
Interest on bank accounts	54	20
Total finance income	54	20

Note 12.1 Finance expenditure

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

	31 March 2019	31 March 2018
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,439	812
Finance leases	140	272
Interest on late payment of commercial debt	12	34
Main finance costs on PFI and LIFT schemes obligations	1,520	1,458
Total interest expense	3,111	2,576
Unwinding of discount on provisions	60	72
Other finance costs	-	-
Total finance costs	3,171	2,648

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	31 March 2019	31 March 2018
	£000	£000
Amounts included within interest payable arising from claims under this legislation	12	34

Note 13 Other gains / (losses)

	31 March 2019	31 March 2018
	£000	£000
Fair value gains on investment properties	2,769	10,670
Total other gains	2,769	10,670

Note 14 Intangible assets – 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**7,294**	**-**	**7,294**
Additions	542	968	1,510
Reclassifications	501	-	501
Valuation / gross cost at 31 March 2019	**8,337**	**968**	**9,305**
Amortisation at 1 April 2018 - brought forward	**4,818**	**-**	**4,818**
Provided during the year	585	-	585
Amortisation at 31 March 2019	**5,403**	**-**	**5,403**
Net book value at 31 March 2019	**2,934**	**968**	**3,902**
Net book value at 1 April 2018	**2,476**	**-**	**2,476**

Note 14.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017	**6,598**	**-**	**6,598**
Transfers by absorption	-	-	-
Additions	233	-	233
Reclassifications	463	-	463
Valuation / gross cost at 31 March 2018	**7,294**	**-**	**7,294**
Amortisation at 1 April 2017	**4,250**	**-**	**4,250**
Provided during the year	568	-	568
Amortisation at 31 March 2018	**4,818**	**-**	**4,818**
Net book value at 31 March 2018	**2,476**	**-**	**2,476**
Net book value at 1 April 2017	**2,348**	**-**	**2,348**

Note 15 Property, plant and equipment – 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**50,792**	**77,321**	**1,700**	**2,658**	**31,170**	**18**	**16,883**	**93**	**180,635**
Additions	-	4,702	31	2,712	1,162	-	238	-	8,845
Reclassifications	-	800	-	(1,783)	-	-	482	-	(501)
Valuation/gross cost at 31 March 2019	**50,792**	**82,823**	**1,731**	**3,587**	**32,332**	**18**	**17,603**	**93**	**188,979**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**4,515**	**390**	**-**	**21,701**	**18**	**13,824**	**69**	**40,517**
Provided during the year	-	4,951	390	-	2,248	-	1,158	5	8,752
Accumulated depreciation at 31 March 2019	**-**	**9,466**	**780**	**-**	**23,949**	**18**	**14,982**	**74**	**49,269**
Net book value at 31 March 2019	**50,792**	**73,357**	**951**	**3,587**	**8,383**	**-**	**2,621**	**19**	**139,710**
Net book value at 1 April 2018	**50,792**	**72,806**	**1,310**	**2,658**	**9,469**	**-**	**3,059**	**24**	**140,118**

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**50,792**	**73,822**	**1,700**	**1,070**	**30,181**	**18**	**16,420**	**93**	**174,096**
Additions	-	3,472	-	2,297	989	-	244	-	7,002
Reclassifications	-	27	-	(709)	-	-	219	-	(463)
Valuation/gross cost at 31 March 2018	**50,792**	**77,321**	**1,700**	**2,658**	**31,170**	**18**	**16,883**	**93**	**180,635**
Accumulated depreciation at 1 April 2017	**-**	**84**	**-**	**-**	**19,354**	**18**	**12,262**	**65**	**31,783**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	**-**	**4,431**	**390**	**-**	**2,347**	**-**	**1,562**	**4**	**8,734**
Accumulated depreciation at 31 March 2018	**-**	**4,515**	**390**	**-**	**21,701**	**18**	**13,824**	**69**	**40,517**
Net book value at 31 March 2018	**50,792**	**72,806**	**1,310**	**2,658**	**9,469**	**-**	**3,059**	**24**	**140,118**
Net book value at 1 April 2017	**50,792**	**73,738**	**1,700**	**1,070**	**10,827**	**-**	**4,158**	**28**	**142,313**

Note 15.2 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	50,192	62,257	951	3,587	5,062	2,419	19	124,487	8,845
Finance leased	-	-	-	-	2,780	202	-	2,982	(501)
On-SoFP PFI contracts and other service concession arrangements	600	9,255	-	-	-	-	-	9,855	188,979
Owned - donated	-	1,845	-	-	541	-	-	2,386	40,517
NBV total at 31 March 2019	**50,792**	**73,357**	**951**	**3,587**	**8,383**	**2,621**	**19**	**139,710**	**8,752**

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	50,192	61,195	1,310	2,658	5,387	2,443	24	123,209	7,002
Finance leased	-	-	-	-	3,516	616	-	4,132	(463)
On-SoFP PFI contracts and other service concession arrangements	600	9,529	-	-	-	-	-	10,129	180,635
Owned - donated	-	2,082	-	-	566	-	-	2,648	31,783
NBV total at 31 March 2018	**50,792**	**72,806**	**1,310**	**2,658**	**9,469**	**3,059**	**24**	**140,118**	**-**

Note 16 Investment Property

	31 March 2019	31 March 2018
	£000	£000
Carrying value at 1 April - brought forward	**43,087**	**32,417**
Carrying value at 1 April	**43,087**	**32,417**
At start of period for new FTs	**-**	**-**
Movement in fair value	2,769	10,670
Carrying value at 31 March	**45,856**	**43,087**

Note 16.1 Investment property income and expenses

	31 March 2019	31 March 2018
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(1,753)	(1,729)
Direct operating expense arising from investment property which did not generate rental income in the period	(194)	(177)
Total investment property expenses	**(1,947)**	**(1,906)**
Investment property income	3,026	3,337

Note 17 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	1,334	1,199
Consumables	1,470	1,884
Energy	20	20
Other	140	140
Total inventories	**2,964**	**3,243**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £28,706k (2017/18 PY: £33,778k). Write-down of inventories recognised as expenses for the year were £60k (2017/18 PY: £82k).

Note 18 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	22,812	-
Trade receivables*	-	22,073
Accrued income*	-	3,750
Allowance for impaired contract receivables / assets*	(1,518)	-
Allowance for other impaired receivables	(688)	(1,566)
Prepayments (non-PFI)	2,180	2,017
PDC dividend receivable	148	57
VAT receivable	836	786
Other receivables	1,925	-
Total current trade and other receivables	**25,695**	**27,117**
Non-current		
Contract receivables*	1,294	-
Allowance for impaired contract receivables / assets*	(283)	-
Allowance for other impaired receivables	-	(338)
Prepayments (non-PFI)	810	810
Other receivables	-	1,478
Total non-current trade and other receivables	**1,821**	**1,950**
Of which receivables from NHS and DHSC group bodies:		
Current	17,610	18,763
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2018 - brought forward		-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,229	(1,229)
New allowances arising	771	13
Reversals of allowances	(13)	-
Utilisation of allowances (write offs)	(186)	-
Allowances as at 31 March 2019	**1,801**	**(1,216)**

Note 19 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**1,099**	**1,060**
At 1 April (restated)	**1,099**	**1,060**
At start of period for new FTs	**-**	**-**
Net change in year	(67)	39
At 31 March	**1,032**	**1,099**
Broken down into:		
Cash at commercial banks and in hand	266	342
Cash with the Government Banking Service	766	757
Total cash and cash equivalents as in SoFP	**1,032**	**1,099**
Total cash and cash equivalents as in SoCF	**1,032**	**1,099**

Note 20 Trade and other payables

	2018/19	2017/18
	£000	£000
Current		
Trade payables	19,266	14,846
Capital payables	4,257	1,429
Accruals	8,959	11,268
Receipts in advance (including payments on account)	1,394	1,691
Other taxes payable	4,174	4,072
Accrued interest on loans*	-	180
Other payables	2,669	2,512
Total current trade and other payables	**40,719**	**35,998**
Of which payables from NHS and DHSC group bodies:		
Current	12,435	10,927
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan, £325k has been added to the carryiing value of the loan. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 21 Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from the Department of Health and Social Care	1,715	1,390
Obligations under finance leases	964	1,509
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	253	230
Total current borrowings	**2,932**	**3,129**
Non-current		
Loans from the Department of Health and Social Care	59,719	36,569
Obligations under finance leases	2,049	2,766
Obligations under PFI, LIFT or other service concession contracts	11,465	11,718
Total non-current borrowings	**73,233**	**51,053**

Note 21.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**37,959**	**4,275**	**11,948**	**54,182**
Cash movements:				
Financing cash flows - payments and receipts of principal	23,150	(1,262)	(230)	21,658
Financing cash flows - payments of interest	(1,297)	(166)	(1,520)	(2,983)
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	180	-	0	180
Application of effective interest rate	1,442	166	1,520	3,128
Carrying value at 31 March 2019	**61,434**	**3,013**	**11,718**	**76,165**

Note 22 The Hillingdon Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where The Hillingdon Hospitals NHS Foundation Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**3,328**	**4,722**
of which liabilities are due:		
- not later than one year;	1,087	1,677
- later than one year and not later than five years;	1,884	2,691
- later than five years.	357	354
Finance charges allocated to future periods	(315)	(447)
Net lease liabilities	**3,013**	**4,275**
of which payable:		
- not later than one year;	964	1,509
- later than one year and not later than five years;	1,710	2,431
- later than five years.	339	335

Note 23 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Total
	£000	£000	£000
At 1 April 2018	**1,683**	**638**	**2,321**
Arising during the year	50	62	112
Utilised during the year	(132)	(20)	(152)
Reclassified to liabilities held in disposal groups	-	-	-
Reversed unused	(56)	(318)	(374)
Unwinding of discount	50	10	60
At 31 March 2019	**1,595**	**372**	**1,967**
Expected timing of cash flows:			
- not later than one year;	-	-	-
- later than one year and not later than five years;	-	-	-
- later than five years.	1,595	372	1,967
Total	**1,595**	**372**	**1,967**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions / early departure costs

Note 23.1 Clinical negligence liabilities

At 31 March 2019, £169,497 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust (31 March 2018: £138,918).

Note 24 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
Other	-	(46)
Gross value of contingent liabilities	**-**	**(46)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**(46)**
Net value of contingent assets	**-**	**-**

Note 25 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	4,258	1,395
Total	**4,258**	**1,395**

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

Note 26.1 Imputed finance lease obligations

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

	31 March 2019	31 March 2018
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**21,228**	**22,300**
Of which liabilities are due		
- not later than one year;	1,076	1,071
- later than one year and not later than five years;	4,287	4,289
- later than five years.	15,865	16,940
Finance charges allocated to future periods	(9,510)	(10,352)
Net PFI, LIFT or other service concession arrangement obligation	**11,718**	**11,948**
- not later than one year;	253	230
- later than one year and not later than five years;	1,182	1,105
- later than five years.	10,283	10,613

Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2019	31 March 2018
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**27,774**	**29,331**
Of which liabilities are due:		
- not later than one year;	1,557	2,158
- later than one year and not later than five years;	6,228	5,627
- later than five years.	19,989	21,546

Note 26.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**2,236**	**2,158**
Consisting of:		
- Interest charge	1,520	1,458
- Repayment of finance lease liability	230	226
- Service element and other charges to operating expenditure	486	474
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	64	47
Total amount paid to service concession operator	**2,300**	**2,205**

Note 27 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current ywear analyses.

At 31 March 2019, £169,497 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust (31 March 2018: £138,918).

Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**		**£000**	**£000**
Trade and other receivables excluding non financial assets	23,515	-	-	23,515
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	1,032	-	-	1,032
Total at 31 March 2019	**24,547**	**-**	**-**	**24,547**

Carrying values of financial assets as at 31 March 2018 under IAS 39	**Loans and receivables £000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	25,100	-	-	-	25,100
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,099	-	-	-	1,099
Total at 31 March 2018	**26,199**	**-**	**-**	**-**	**26,199**

Note 27.1 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	61,434	-	61,434
Obligations under finance leases	3,013	-	3,013
Obligations under PFI, LIFT and other service concession contracts	11,718	-	11,718
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	35,151	-	35,151
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	**111,316**	**-**	**111,316**

	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	37,959	-	37,959
Obligations under finance leases	4,275	-	4,275
Obligations under PFI, LIFT and other service concession contracts	11,948	-	11,948
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	35,806	-	35,806
Other financial liabilities	-	-	-
Provisions under contract	2,321	-	2,321
Total at 31 March 2018	**92,309**	**-**	**92,309**

Note 27.2 Fair values of financial assets and liabilities

For Current financial instrument (less than one year), fair values are assumed to be equal to book values. Notes 27 & 27.1 include only non-current financial assets and financial liabilities.

Note 27.3 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	37,990	39,106
In more than one year but not more than two years	28,009	2,767
In more than two years but not more than five years	30,627	32,143
In more than five years	14,690	18,293
Total	**111,316**	**92,309**

Note 28 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total number of cases £000	Total number of cases Number	Total number of cases £000
Losses				
Cash losses	5	1	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	111	189	88	376
Stores losses and damage to property	-	-	4	82
Total losses	**116**	**190**	**92**	**458**
Special payments				
Compensation under court order or legally binding arbitration award	8	68	9	43
Extra-contractual payments	-	-	-	-
Ex-gratia payments	8	4	10	4
Special severance payments	-	-	1	4
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**16**	**72**	**20**	**51**
Total losses and special payments	**132**	**262**	**112**	**509**
Compensation payments received		-		-

Note 29 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £180k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 29.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018. Application of the standard had no material impact on recognition and measurement of revenue for the Trust in either period stated. In line with guidance, disclosure has been changed to matched the requirements of the standard for the 2018/19 period only.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 29.2 IFRS 16

IFRS 16 Leases – This standard has been issued. Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted. The Trust is continuing to assess the potential impact on application of the standard in 2020/2021. The implications are therefore not yet known and are therefore not quantifiable.

Note 30 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 transactions in excess of £5m in the year are shown below:

Income
East & North Herts NHS Trust
Health Education England
Imperial College Healthcare NHS Trust
NHS Ealing CCG
NHS East Berkshire CCG
NHS England
NHS Harrow CCG
NHS Herts Valley CCG
NHS Hillingdon CCG

Expenditure
Imperial College Healthcare NHS Trust
HMRC
NHS Pension Scheme
The NHS Litigation Authority

Hosted Charity
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

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.

Note 31 Staff costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	**£000**	£000
Salaries and wages	119,996	19,505	**139,501**	131,448
Social security costs	13,062	1,623	**14,685**	13,868
Apprenticeship levy	601	89	**690**	644
Employer's contributions to NHS pensions	14,863	658	**15,521**	14,658
Pension cost - other	17	9	**26**	-
Termination benefits	102	-	**102**	22
Temporary staff	-	10,453	**10,453**	12,645
Total gross staff costs	**148,641**	**32,337**	**180,978**	**173,285**
Recoveries in respect of seconded staff	(1,709)	-	**(1,709)**	(1,519)
Total staff costs	**146,932**	**32,337**	**179,269**	**171,766**
Of which				
Costs capitalised as part of assets	842	-	**842**	757

Average number of employees (WTE basis)	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	465	58	**523**	508
Ambulance staff	-	-	**-**	-
Administration and estates	718	72	**790**	815
Healthcare assistants and other support staff	579	155	**734**	721
Nursing, midwifery and health visiting staff	856	203	**1,059**	1,045
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	351	33	**384**	334
Healthcare science staff	18	6	**24**	155
Total average numbers	**2,987**	**527**	**3,514**	**3,578**
Of which:				
Number of employees (WTE) engaged on capital projects	13	-	**13**	13

Reporting of compensation schemes - exit packages 2018/19	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	1
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	1	1	2
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**2**	**3**
Total cost (£)	£73,000	£102,000	£175,000

In the period there were 3 Exit Packages; one compulsory redundancy, one Payment in Lieu of Notice and one Compensatory Payment.

Reporting of compensation schemes - exit packages 2017/18	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	2	2
£10,000 - £25,000	-	2	2
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**4**	**4**
Total cost (£)	£0	£45,000	£45,000

In the comparative period there were four Exit Packages; two payments in Lieu of Notice and two Compensatory Payments.

	2018/19		2017/18	
Exit packages: other (non-compulsory) departure payments	**Payments agreed Number**	**£000**	**Payments agreed Number**	**£000**
Contractual payments in lieu of notice	1	6	2	23
Exit payments following Employment Tribunals or court orders	1	96	1	18
Non-contractual payments requiring HMT approval	-	-	1	4
Total	**2**	**102**	**4**	**45**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Languages/ Alternative Formats

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