Our Values

PERSONAL
SAFE
EFFECTIVE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton University Hospital
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2017/18

Incorporating hospital and community health services, teaching and research

Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2017/18

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

Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2017/18

ANNUAL REPORT

QUALITY ACCOUNT

demonstrating our commitment to providing quality care for all patients and reporting back on our performance against priorities for quality improvement agreed by the Board of Directors, and identifying our priorities for 2018/19.

FINANCE

including the consolidated Annual Accounts for the financial year 2017/18.

ANNUAL REPORT

Our Values

PERSONAL
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Chair and Chief Executive's Report

Welcome to our 2017/18 Annual Report.

The continuing high level of public interest in the challenges, especially financial, affecting the NHS hides an underlying picture of very large numbers of talented and committed people working incredibly hard to continue delivering high quality care to patients.

In the case of Homerton, we said at this time last year that it would be extremely challenging to achieve a surplus in the current year. So it proved, but thanks to great efforts by our staff, and with the support of our patients, our Clinical Commissioning Group and the wider community, we were able to do this. In the event, the surplus was larger than forecast because of the additional funding provided centrally to NHS trusts which achieved certain financial and other targets. This is obviously welcome, because it will go towards much needed investment in the services we provide.

We believe this positive financial outcome was achieved without impacting adversely on the services we provide. Rather, we have continued to make progress in improving our services. We mentioned last year that we had achieved good Care Quality Commission (CQC) ratings for each of the five key lines of enquiry and overall for both our adult and children and young people's community services following the inspection visit in early 2017. This was followed by another good rating for the Mary Seacole Nursing Home following the inspection visit in June 2017. In April of this year, the CQC carried out one of its regular unannounced inspections of our acute services, the report on which will most likely be published later in the summer.

The Trust has also been scrutinised through a variety of other external review processes including the Children & Young People's (CYP) Peer Review, April 2017; Joint Advisory Group for GI Endoscopy, October 2017; Paediatric Critical Peer Review, October 2017; and the NHS England Review of Neonatal services, February 2018. The Trust received positive reports through each of these processes.

The quality of our services is also well illustrated by the performance of the Trust against access targets such as the Emergency Care 4 hour target and the wait for elective treatment (RTT) with the Trust being amongst the very best performers nationally throughout the year.

Recognition of individual services through specific awards is also important. The Emergency Department is well recognised for its performance against national targets. Two administrative members of staff received awards from the London Mayor's Office for their contribution to an ongoing programme targeted at reducing violent crime through accurate and complete data submissions. In addition, the Locomotor Service won the HSJ Value in Healthcare Award 2017 for Improving the Value of Diagnostic Services. The award was for extended scope practitioners (ESPs) in the service being trained to be musculoskeletal sonographers resulting, in an improvement to each patient's journey.

All that said, we are very conscious of the need to seek continually to improve our services. The Board takes very seriously reports of incidents where we have not achieved the standards which we and patients expect, and ensures that lessons from these incidents are well learnt. In addition, there will be much scope to improve yet further the quality and range of what we offer through the integration programmes currently under way in this part of London.

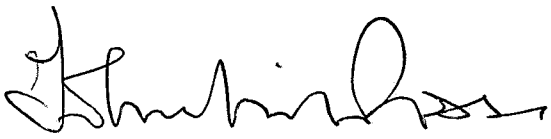
Considerable progress has been made in moving towards what is called an Integrated Care System within Hackney and the City, and the Trust is a key contributor to this work. The transformation work has the potential to involve a range of the Trust services, both acute services as well as those provided within the community. In outline, this work is leading to much closer cooperation between different parts of the health sector, GP surgeries, community health centres and hospitals; and also involves social care delivered by the London Borough of Hackney and the Corporation of London. One of the aims is that clinicians, other health and care workers and patients, by working together, can form pathways that better serve individual patients. This in turn leads to less uncertainty for patients, and more efficient delivery of care.

Over a larger area encompassing what is now called the East London Health and Care Partnership (ELHCP), we are working with other acute hospitals and mental health trusts, as well as the wider health economy and local authorities, to try to achieve similar improvements in health care and efficiency over a wider geographical area. Recent discussions have included consideration of pathways for the smaller surgical pathways such as ENT and urology as well as options around future provision of pathology services.

The complexities involved in developing these strategic opportunities, together with continuing to deliver high quality care within an increasingly constrained financial envelope, put an enormous strain on all our staff. We owe them a great debt of gratitude, and we would like to thank every single individual who contributes to the great work that Homerton does.

The Trust ended the year with the recognition by NHS Improvement (NHSI) of the Trust's performance resulting in becoming a segment 1 (high performance) Trust under the Single Oversight Framework (SOF). NHS Improvement segments providers based on an assessment of the level of support each provider needs across five themes; quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. Segment 1 recognises the Trusts ability to operate autonomously and without the need for NHSI support.

Finally, we would also like to thank our Board colleagues for their hard work and commitment during the year. Our Medical Director, Dr Martin Kuper, left the Trust on 31 March to take on a similar role at London North West University Healthcare NHS Trust, and our Chief Nurse Sheila Adam will be retiring soon after the year end. We thank them for their considerable service to Homerton, and wish them both much success in their future endeavours.



Sir Tim Melville-Ross

Chair

25 May 2018

Tracey Fletcher

Chief Executive

25 May 2018

Performance Report

Overview

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

Our principal activities

Homerton University Hospital NHS Foundation Trust provides hospital and community health services for Hackney, the City and surrounding communities, as well as a range of specialist services for a wider population. The Trust comprises Homerton Hospital, Mary Seacole Continuing Care Nursing Home, and community and homecare services across Hackney and the City.

The hospital has almost 500 beds spread across 11 wards, a nine bed intensive care unit, maternity, paediatric and neonatal wards, and the Mary Seacole Nursing Home. We have three day surgery theatres and six main operating theatres for a number of types of surgery, including general surgery, trauma and orthopaedics, gynaecology, maxillofacial, urology, ENT, bariatric surgery and obstetrics. We also have a surgical treatment room within the main theatres complex. The community service provision operates from over 60 sites of varying sizes and levels of occupancy across the London Borough of Hackney and the City of London, and includes sexual health, Locomotor services, school nursing and diabetes eye screening.

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

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

The Trust's Strategic Vision in 2017/18

Since becoming a foundation trust in 2004, the Trust has maintained its reputation as a high performing NHS provider, delivering quality patient and service user care, whilst maintaining compliance with all key performance and regulatory requirements.

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

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

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

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

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

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

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

The Trust continued to support the work of the East London Health and Care Partnership which brings together the area’s eight councils and 12 NHS organisations, who are combining their expertise and resources to ensure health and care services meet the needs of local people, now and in the future. The Trust has also worked with the local authority and commissioners in the development of the Hackney Devolution Pilot, which aims to deliver an integrated, effective and financially sustainable system at the local level.

The Trust’s Strategic Objectives in 2018/19

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

The strategic priorities were established within the context of a five year strategic plan, 2014 – 2019 and are: Quality, Integration, and Growth which continue to be supported by the following objectives:

Quality

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

Integration

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

Growth

- Scale – Ensure core services are of a sufficient scale for long term sustainability and effectiveness.
- Reputation – Develop a national reputation and profile for leading the way in the provision of high quality and innovative health care services.

- Turnover – Establish an ability to respond to the financial and quality challenges facing health care providers by increasing turnover to £400m by 2020.

Key risks to delivering our strategic objectives

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

- failure to develop an engaged and motivated workforce may undermine the Trust's ability to deliver its services in accordance with its values and desired staff behaviours, resulting in a poor experience for the patient;

- the patient receives avoidable harm from poor practice as a result of a failure to comply with required Trust safety policies and lessons learned;

- if the culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust falling short in the quality of care delivered to patients;

- a lack of adherence to latest research, or practice which is not compliant with the best evidence could lead to a less effective service provision;

- failure to achieve financial targets may result in difficulties in funding future investment plans and threaten the organisation's financial autonomy;

- poor reviews and performance outcomes by regulators, other bodies, the press and public may result in a damaged reputation that diminishes the Trust's ability to grow;

- failure to expand and retain sufficient activity through a failure to adapt and engage in local collaborative healthcare arrangements may limit the Trust's ability to increase turnover and maintain clinically sustainable services.

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

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

Going concern disclosure

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

Performance against strategic priorities 2017/18

We have recorded a number of achievements during the year:

- We remain one of the best performers for A&E services in London and nationally; consistently delivering over 90% for the 4-hour wait target and achieving 94.73% against the 95% target in 2017/18
- Good compliance against the key operational and quality requirements with a particular strong performance against the 18 week referral to treatment standard and Improving Access to Psychological Therapies (IAPT)
- Band 5 nurses have the opportunity to apply for a series of post-graduate modules which could lead to either a post graduate certificate in nursing (PG Cert); or for those already with a PG Diploma, the opportunity to obtain a Masters level degree.
- Homerton Hospital has become the first NHS Trust in the country to be accredited with a Planet Mark™ sustainability certificate in recognition of its ongoing environmental commitment.
- A satisfactory rating for the Information Governance Toolkit with all standards achieving level 2 or higher
- Staff sickness continues to remain stable and below 3%
- We continue to support high quality research with 3017 of our patients taking part in clinical trials throughout the year
- The risk-adjusted 30-day mortality rate is 4.4%, less than half the national average of 10.6%
- Scored ‘above average’ for 60% of the key questions in the national staff survey for our peer group. Achieved a response rate of 50% with particularly positive comments on the quality of staff appraisals and training from respondents
- Delivered harm free care to 96.5% of Homerton patients
- Mary Seacole Nursing Home was rated ‘good’ by the CQC
- Ranked within the top 20% of all NHS Trusts for all PLACE domains. Patient-Led Assessments of the Care Environment (PLACE) involve local people and help drive improvements in the care environment

Performance Analysis

Review of financial performance

The Trust had an Income & Expenditure (I&E) surplus of £11.7m for the financial year 2017/18, compared to the planned surplus of £5.8m. The main source of income for the Trust is contracts with commissioners in respect of health care services, the Trust's main commissioner being City and Hackney Clinical Commissioning Group.

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

2017/18	Plan £m	Actual £m	Variance £m
Income			
Clinical contracts	268.8	285.6	16.8
Other income	33.5	23.5	(10.0)
STF Funding	6.4	10.9	4.5
Total income	308.7	320.0	11.3
Expenses			
Pay	(199.1)	(202.5)	(3.4)
Non-pay	(91.3)	(94.4)	(3.1)
Total expenses	(290.4)	(296.9)	(6.5)
EBITDA*	18.3	23.1	4.8
Depreciation and amortisation	(7.9)	(7.5)	0.4
PDC dividends	(4.4)	(3.9)	0.6
Net interest	(0.2)	(0.1)	0.1
Sub-total	(12.5)	(11.5)	1.0
Net Surplus/(Deficit)	5.8	11.7	5.9

*Earnings Before Interest, Tax, Depreciation and Amortisation

Income was £6.8m (2.2%) above plan and was driven by significant increases in activity above plan in accident and emergency, daycase, outpatient and non-elective activity as set out below. Sustainability and Transformation Funding (STF) income totalled £10.9m for the year and was higher than plan by £4.5m.

The Trust achieved £10.0m of savings during the year as part of its Quality, Innovation, Productivity and Prevention (QIPP) agenda. Projects included staffing and skill mix reviews, reduction in premium rates for additional clinical workload, service reconfiguration, negotiation with suppliers and more efficient use of our capacity.

Capital expenditure & liquidity

Capital expenditure for the year totalled £8.8m, including: £2.8m on new and replacement medical equipment, £1.6m on IT projects and £4.5m on estates projects including a centrally funded project to improve patient streaming in the Emergency Department.

The Trust's liquidity position improved in-year due to the income and expenditure surplus and improved performance on the collection of aged debt. The Trust ended the year with debtors £3.3m lower than at the last year-end and the closing cash balance £6.4m higher.

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

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

Counter fraud policies and procedures

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

Review of non-financial performance

Patient activity

In 2017/18, the Trust experienced increased activity in a number of its service areas – both planned and unplanned, whilst also experiencing reductions – again, both planned and unplanned – in other service areas. The table below provides a summary of observed activity levels against the Trust's 2017/18 activity plan, as well as providing activity data from the previous year for hospital-based services.

Category	2016/17 Activity	2017/18 Plan	2017/18 Activity	% Variance from Plan
A&E attendances (inc Primary and Urgent Care Centre)	121,310	122,790	123,611	0.7%
Hospital (acute) non-elective spells (including deliveries)	29,257	28,834	29,402	2.0%
Hospital outpatient attendances & maternity pathways*	240,087	237,842	235,966	-0.8%
Hospital (acute) elective spells	23,546	23,686	25,077	2.1%
Adult critical care and rehabilitation - occupied bed days	30,754	31,723	28,588	-9.9%
Neonatal critical care – occupied bed days	14,132	14,354	14,163	-1.3%
Direct access diagnostics	1,281,553	1,266,233	1,289,684	1.9%
Other attendances (fertility, regular attenders, therapies and podiatry)	41,039	38,135	43,612	14.4%

**It is worth noting that due to the implementation of a new sexual health contract, the figures above exclude attendances for this service to ensure consistent reporting. Maternity is also excluded from this figure.*

The table below identifies activity against plan for the Trust's CCG commissioned community services:

Adult Services		TOTAL			
ServiceLine	Currency	Plan	Actual	Variance	% Variance
ACERS	Attendances	10489	11545	1056	10.1%
Adult Community Rehabilitation Team	Attendances	15252	12796	-2456	-16.1%
Dermatology	Attendances	1560	1490	-70	-4.5%
Dietetics	Attendances	3740	4022	282	7.5%
Foot Health	Attendances	29088	27512	-1576	-5.4%
Locomotor	New Attendances	14028	14238	210	1.5%
Locomotor Pain Service	New Attendances	924	920	-4	-0.4%
Community Gynaecology	Attendances	276	203	-73	-26.4%
Sickle Cell and Thalassaemia	Attendances and Group Contacts	2431	1290	-1141	-46.9%
Adult Community Nursing	Attendances	138655	146430	7775	5.6%
Primary Care Psychology	Patients Entering Treatment	26818	22826	-3992	-14.9%
Wheelchair Services	Attendances	1920	1811	-109	-5.7%
Children's Services		TOTAL			
ServiceLine	Currency	Plan	Actual	Variance	% Variance
Audiology	Attendances	1587	1579	-8	-0.5%
Children's Occupational Therapy	Attendances	4234	4275	41	1.0%
Children's Physiotherapy	Attendances	4788	4388	-400	-8.3%
Community Paediatrics	Attendances	3864	3440	-424	-11.0%
Disability CAMHS	Attendances	2544	3418	874	34.4%
First Steps	Attendances	4992	6461	1469	29.4%
Speech and Language Therapy	Attendances and Group Contacts	29798	30854	1056	3.5%
Newborn Hearing Screening	Screens Completed	5601	5546	-55	-1.0%
Community Children's Nursing	Attendances and Group Contacts	5489	5532	43	0.8%

For the Trust's main Local Authority commissioned services, the activity numbers for 2017/18 were:

- Health Visiting
  - 105,311 face-to-face contacts
  - 9,034 non-face-to-face contacts
- Sexual Health
  - 34,255 Clifden Centre contacts (11.4% up from 16/17)
  - 20,836 community contacts (3.8% down from 16/17)

Further breakdown of hospital-based activity performance

Non-elective activity

The Trust experienced a level of A&E activity 0.7% above its 2017/18 plan and 1.9% above the 2016/17 activity level.

Elsewhere, the non-elective activity position can be further broken down by performance against plan as follows:

- Adult admissions +6.6%
- Paediatric and neonatal admissions +4.1%
- Surgical and gynaecology admissions -6.4%
- Maternity delivery admissions -5.8%

Planned care activity

With regard to the Trust's planned care activity (outpatients, day case and elective), activity was over-plan in several areas but other services outturned under plan as detailed in the following sections.

Outpatients

The Trust experienced significant (+5% or more) activity over and above its activity plan in the following specialties (excluding maternity and only including where the annual activity exceeds 1,000 attendances):

- Endocrinology
- Neurology
- Ophthalmology
- Paediatrics (General)
- Paediatric Dermatology
- Paediatric ENT
- Urology

However, outpatient first attendance activity has been significantly (-5% or more) under plan in the following specialties (excluding maternity and only including where the annual activity exceeds 1,000 attendances):

- Accident & Emergency
- Allergy
- Cardiology
- General Medicine
- Geriatric Medicine
- Haematology
- Respiratory Medicine
- Rheumatology

Day case

Day case activity was 7.2% above the Trust's activity plan in 2017/18. The specialties that were significantly above plan (5% or more and more than 250 cases undertaken in total) were:

- Cardiology
- Gastroenterology
- General Medicine
- General Surgery
- Gynaecology
- Trauma & Orthopaedics

Whereas, the specialties that were significantly below plan (5% or more and more than 250 cases planned in total) were:

- Allergy
- Haematology
- Paediatric ENT
- Pain management

Elective

The activity in 2017/18 in relation to elective procedures was 1.3% under plan. Specialties that were above plan (5% or more and more than 200 cases undertaken in total) were:

- Gastroenterology
- Maxillo-Facial Surgery
- Sleep studies
- Urology

Specialties below plan (5% or more and more than 200 cases planned in total) were:

- Bariatric surgery
- Gynaecology
- Trauma and Orthopaedics

Adult rehabilitation

The breakdown of the Trust's three rehabilitation services activity variances (General Adult Rehabilitation, Stroke Rehabilitation and Neuro-rehabilitation) was:

- General rehabilitation +7.0%
- Stroke rehabilitation -47.5%
- Neuro-rehabilitation +.07%

Adult Critical Care

Adult critical care activity was 3.0% below plan in 2017/18.

Neonatal critical care

Neonatal critical care activity was 1.3% under plan in 2017/18; however, there were variances within the levels of care:

- Intensive care – 1.6% under plan
- High dependency care – 0.4% above plan
- Special care – 2.3% under plan.

Direct access diagnostics

As in previous years, the demand for a number of direct services increased compared to the previous year, with the overall activity 1.9% over plan.

The key areas over plan (more than 5%) were:

- Direct Access Echo
- Direct Access Pathology (taken in-house)
- Direct Access Radiology (X-rays)

The key areas under plan (more than 10%) were:

- Direct Access Phlebotomy
- Direct Access Pathology (outsourced)
- Direct Access Sexual Health Tests
- Direct Access Radiology (non-X-rays)

Operational performance

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

The following table sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all foundation trusts, were required to report to NHS on a range of measures quarterly. Further information and narrative on performance against quality standards are included in the Quality Account.

Key Performance Indicators	2017/18 Target	2017/18 Performance
A&E patients discharged < 4hrs	95%	94.73%
Cancer		
2 Week Wait	93%	96.41%
31 Day Target	96%	99.75%
62 Day Target	85%	81.70%
Infection Control		
MRSA	0	1
Clostridium difficile (*C.diff*)	7	9
18 Week RTT Indicator		
Incomplete Pathways	92%	96.18%
IAPT Indicators		
6 week target	75%	93.87%
18 week target	95%	99.42%

With regard to the delivery of key operational milestones, the Trust has performed strongly throughout the year in relation to the Incomplete RTT standard (for patients who have been referred on to consultant-led referral to treatment pathways), and strong performance is expected to continue in to 2018/19.

In 2017/18, the Trust has again performed comparatively strongly against the 4-hour Accident and Emergency standard but, as in 2016/17, has found maintaining compliance throughout all four quarters challenging and unfortunately did not deliver the annual 95% performance. During periods of under-performance the following variables in particular prove challenging: available staffing particularly, although not exclusively, associated with medical posts, increasing patient acuity and rising activity volumes –

particularly in relation to surges within ED attendances. The challenge in relation to hitting this standard has again been flagged as a risk in the Trust's 2018/19 Operating Plan.

Similarly, the Trust generally performs well against the suite of cancer standards. Nevertheless, and in line with historical trends, Trust performance with regard to the 62-day standard has frequently oscillated. In this context, the Trust only delivers a limited number of treatments on-site and is therefore disproportionately reliant on partner organisations to achieve compliance with the standard. This also extends critically to diagnostic support and in particular, although not exclusively, histopathology where the Trust has experienced long-standing challenges with its local supplier. The challenge in relation to hitting this standard has again been flagged as a risk in the Trust's 2018/19 Operating Plan.

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

The Trust also reports its performance against two IAPT indicators, and has performed strongly in this area.

Quality metrics

Details of performance against key quality indicators that were prioritised throughout 2017/18 are presented in the Quality Account.

Sustainability Report 2017/18

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

The NHS carbon footprint comprises three key areas: travel, building energy use and procurement, and it is crucial that NHS organisations support the agenda for driving down carbon emissions in these areas. With an increasing population the demand for healthcare services continues to grow; the challenge is to continue to support carbon reduction within this growing context.

The Trust is progressing towards its carbon reduction target via a number of strategic energy efficiency infrastructure improvements in the estate, and is looking to expand activities to support wider sustainable outcomes over the next year.

Resource	2015-16	2016-17	2017-18 Usage *
Electricity (kWh)	10,647,532	10,373,536	**10,012,291**
Gas (kWh)	18,141,712	17,936,638	**17,744,378**
Water (m3)	75,086	92,264	**81,182**

* Estimated usage

The Trust has implemented its Board approved Sustainable Development Management Plan (SDMP) during 2017/18 which incorporating Climate Change Adaptation Planning. The SDMP details carbon reduction through energy efficiency, as well as looking at other environmental aspects such as waste, water, community engagement, CSR and travel and will seek to integrate and embed sustainability through functions such as governance, workforce and procurement.

Homerton shows its green credentials in...

A world's first

Homerton became the first hospital in the world to be officially presented with The Planet Mark™ Certificate in recognition of its commitment to year-on-year progress in sustainability.

Homerton has been working with environmental consultancy Low Carbon Europe (LCE), an Associate Partner of The Planet Mark™, since 2013 to manage its environmental impacts. However, The Planet Mark™ award marks the first time the NHS Trust has measured and reported its carbon footprint.

Analysis of the hospital's environmental impacts show the relative carbon footprint in year ending March 2017 was 1.7 tCO2e per employee and the total carbon footprint was 5,885 tCO2e.

The report included emissions from energy use in the building (natural gas and purchased electricity), water and fleet. Electricity emissions accounted for 72.6% of total emissions followed by natural gas, which accounted for 25.7%.

As an Associate Partner of The Planet Mark™ programme, LCE was responsible for measuring Homerton Hospital's carbon footprint and delivering The Planet Mark™ carbon footprint report.

The Planet Mark™ founder Steve Malkin said: "The Trust should be congratulated for what it has achieved in recent years to reduce its carbon footprint. It continues to look at new ways to become more sustainable and to reduce carbon emissions further. We are delighted to recognise Homerton as the first hospital to receive our accreditation."

The Homerton sustainability team (LtoR) Thrina Fenech – Senior Estates & Facilities Administrator, Michal Huk – Facilities Manager, Akacan Agir – Facilities Monitoring Officer, Liam Triggs - Facilities General Manager, Deanna Bisnar - Facilities Monitoring Officer

Planet Mark's Steve Malkin hands over a certificate to Trust Non-Executive Director Jude Williams

Homerton Director of Estates Chris Forster said: "Working with our partners Low Carbon Europe, and with the full support of our Trust Board, we have been developing our sustainable management plan and action plan to reduce emissions in the hospital and our community units. We have just appointed a new environment and sustainability manager to take this work forward as we seek other new initiatives to enable us to become energy efficient."

Achieving The Planet Mark™ Certification means Homerton has shown good practice in sustainability including:

- measuring its carbon emissions from electricity gas, water and fleet
- setting a 5% carbon reduction target for its 2017-18 reporting period
- investing in the Eden Project to support education on climate change
- storing 260 tCO2e by protecting one acre of endangered rainforest through the charity Cool Earth
- committing to engage employees and suppliers to drive improvements.

Homerton University Hospital has become the first NHS Trust in the country to be accredited with a Planet Mark™ sustainability certificate in recognition of its ongoing environmental commitment. The hospital was given the prestigious award, which is also backed by the Eden Project to recognise its commitment to year-on-year progress in carbon footprint reduction.

Holders of the certificate have a minimum requirement to reduce their carbon emissions by 2.5 per cent every year. The Trust met these requirements by April 2017, reporting a carbon footprint of 1.7 tonnes carbon dioxide equivalent (tCO2e) per employee, totalling in 5,885 tCO2e overall.

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

The Trust has integrated a new green travel plan which supports sustainable travel modes by staff, patients and visitors to and from Homerton Hospital partially including the reduction of car parking, renewable travel options and a corporate move to reusable energy sources such as additional bicycle storage and removal of petrol cars in favour of electric bicycles and cars. The Trust is also promoting to all staff, visitors and patients how they can better access the Trust sites via public transport in partnership with Hackney Council.

In August 2017 the Trust was awarded £120,000 of additional grant funding to introduce the Homerton Hospital's 'Low Emission Neighbourhood' or LEN, in working partnership with Hackney Council and the Greater London Assembly. The Trust is the first to be awarded this grant and centre itself at heart of the local community's plan to reduce emissions. The award of the grant is to improve and reduce the community neighbourhood carbon footprint via environmentally beneficial projects such as planting news trees, the creation of green sustainable rest stations, promoting electric car parking and improving charging facilities, improving green travel information and providing bicycle storage facilities on site.

In November 2017 the Trust became a supporting partner with 'Why pledge an Acre of Rainforest'. The 'Homerton's Acre' goes directly towards supporting the Asháninka community in Central Peru, whose livelihoods depend on the Amazon rainforest's existence. Deforestation contributes up to 20% global CO2 emissions and the Trust is directly supporting the fight against this.

The Trust has rolled out a new on-site parking policy in April 2018 which puts the environmental factors, green travel and appropriate travel at the centre, to drive cultural change and supports the commitment to reducing the hospital's carbon footprint and low emission neighbourhood.

Sustainability makes both good environmental sense and good business sense. By improving resource efficiency and reducing wastage, we can make a huge contribution towards achieving cost savings, as well as reducing the Trust's carbon footprint.

To succeed this work relies on the support of all staff to ensure the best possible environmental working practices at Homerton Hospital. There are 2.8 million staff in the health and care sector as a whole, which means that potentially the sector can make a vast contribution to sustainability. Simple interventions like switching off lights and equipment when not in use, and closing doors and windows can help to reduce the carbon footprint, save money and improve the patient care environment.

Social Community and human rights Issues

The Trust is committed to ensuring that services meet the needs of people regardless of their age, disability, ethnicity, gender, race, pregnancy and maternity, religion or belief, sexual orientation and gender reassignment. This is in accordance with the Equality Act (2010) and the Trust's public sector equality duties under the NHS Constitution. The Trust recognises the importance of respecting and protecting the human rights of patients, staff and members, in line with Equality and Human Rights Commission guidance.

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

The Trust is committed to safeguarding all patients and works with partners through local multi-agency Safeguarding Boards to safeguard vulnerable adults and children. All staff receive safeguarding training as part of their mandatory training requirements.

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

Tracey Fletcher

Chief Executive

25 May 2018

Accountability Report

Directors' report

The following disclosures relate to the Trust's governance arrangements and illustrate the application of the main and supporting principles of the NHS Foundation Trust Code of Governance (the Code).

It is the responsibility of the Board of Directors to ensure that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code in the particular circumstances.

The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, the regulator and stakeholders to assess the NHS foundation trust's performance, business model and strategy. The Directors confirm their responsibility for preparing the Annual Report and Accounts.

Board of Directors

Composition of the Board

The Board of Directors had six Executive and seven Non-Executive Directors, including the Chair, on 31 March 2018. The Chairman and Non-Executive Directors are held to account by the Council of Governors. The Board provides leadership to the Trust and sets the strategic direction of the organisation. The Board decides upon matters of operational performance, risk, quality assurance and governance and monitors the delivery of objectives and targets. Board members are invited to attend Council of Governors meetings and joint Board and Council of Governors meetings are also held periodically.

In 2017/18 the Board had the following members:

Non-Executive Directors:

Chair, Tim Melville-Ross; Deputy Chair and Senior Independent Director, Sir John Gieve; Vanni Treves; Jude Williams; Susan Osborne; Polly Weitzman; and Martin Smith.

Executive Directors:

Tracey Fletcher, Chief Executive; Dr Martin Kuper, Medical Director; Dylan Jones, Chief Operating Officer; Sheila Adam, Chief Nurse & Director of Governance; Jonathan Wilson, Director of Finance and Daniel Waldron, Director of Organisational Transformation.

The term of office for Non-Executive Directors is three years. Following this term, and subject to satisfactory appraisal, a Non-Executive Director is eligible for consideration by the Council of Governors for a further uncontested term of three years. All Non-Executive Director appointments are made in accordance with the Trust's Constitution. Sir John Gieve was reappointed as a Non-Executive Director in September 2017 for an additional one year term.

The Chairman and Non-Executive Directors can also be removed by the Council of Governors. The removal of a Non-Executive Director requires the approval of three-quarters of all the members of the Council of Governors. Details of disqualification from holding office as a Director of the Trust are set out in section 13 of the Trust's Constitution.

The Executive Directors hold permanent NHS contracts subject to NHS terms and conditions and are appointed by a nominations committee.

Members of the Board of Directors

Non-Executive Directors

Sir Tim Melville-Ross, Chair

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

Sir John Gieve

Sir John Gieve was first appointed by the Council of Governors in 2011. He was a career civil servant, which included appointments as Managing Director of the Treasury for three years and Permanent Secretary to the Home Office between 2001 and 2005. Sir John was Deputy Governor of the Bank of England from 2006 to 2009. He is also Chair of Nesta, the innovation charity, and of Vocalink, the payments company. Sir John is a member of the Audit Committee and is the Trust's Senior Independent Director and Deputy Chair.

Vanni Treves CBE

Mr Treves was first appointed by the Council of Governors in 2012. He was for many years Senior Partner of Macfarlanes, a leading firm of Solicitors, and also has a broad experience of industry and education. He is a former Chairman of London Business School, the National College for School Leadership and Channel Four Television. Mr Treves was awarded the CBE in 2012. He chairs the Risk Committee.

Jude Williams

Ms Williams was formerly Lead Governor on the Council of Governors at Homerton. She has a career in public health strategy/policy development with a particular focus on health inequalities, staff health and public and patient involvement. She worked in east London throughout the 90's as a director within the Health Authority followed by national level work in the Department of Health and as Head of Public Health in the Healthcare Commission. She currently undertakes executive level coaching and some anti-gang violence work with the Home Office. She is a member of the Audit Committee.

She was reappointed for a further three-year term in March 2017.

Polly Weitzman

Ms Weitzman has been with Ofcom since 2004, initially as Director of Regulatory and Competition Law (2004 – 2006) and since 2006 as their General Counsel. Polly has a strong track record in change management. From 1986 – 2004, Polly was a partner and then Head of EC and UK Competition Law with city law firm Denton Wilde Sapte. Ms Weitzman is a member of the Audit Committee.

She was reappointed for a further three-year term in March 2017.

Susan Osborne CBE

Miss Osborne was a registered nurse qualifying in 1974 and registered as a midwife in 1976 (now lapsed). She worked at Homerton when it first opened in 1986 as the Deputy Director of Nursing. Her last permanent NHS role, which concluded in 2009, was as Chief Nurse NHS East of England, and before that she was the Director of Nursing (DNS) at St Mary's Hospital, Paddinton and Interim DNS for the merged Imperial College Healthcare NHS Trust. She has held senior director posts in the NHS, which include CEO for the Royal London Homoeopathic Hospital. She established her own company in 2009 and worked as an independent management and nursing consultant undertaking interim director posts in challenged trusts until 2017. She was awarded a CBE in 2005 for her contribution to nursing services. Currently, she is a Trustee of Cavell Nurses' Trust and Chair of the Safe Staffing Alliance. Miss Osborne is a member of the Risk Committee.

She was reappointed for a further three-year term in March 2017.

Martin Smith

Mr Smith was the Chief Executive of the London Borough of Ealing from 2009 until he retired from this role in April 2016. He led Ealing through a period of rapid change accelerated by an unprecedented financial challenge. Previously he was the Chief Executive of the London Borough of Tower Hamlets and his local government career, primarily in finance roles, began in 1977. He also led on the health agenda on behalf the chief executives of all 33 London councils and was Chair of the London Health Chief Officers' Group. He is a qualified Chartered Public Finance Accountant and is Chair of the Audit Committee.

Executive Directors

Tracey Fletcher, Chief Executive

Ms Fletcher re-joined the Trust in 2010 as Chief Operating Officer, having previously been with Homerton Hospital for many years. She has extensive experience in health care management. Ms Fletcher was appointed as Chief Executive Officer in January 2013. Ms Fletcher is a member of the Charitable Funds Committee and Risk Committee.

Dr Martin Kuper, Medical Director

Dr Kuper joined the Trust as Medical Director in June 2014. He was previously the Medical Director at Whittington Health NHS Trust where he helped achieve the best national SHMI (summary level hospital mortality indicator) for the past three years. Dr Kuper's clinical background is in anaesthesia and critical care medicine. He was appointed a National Clinical Adviser (anaesthesia) in 2009 and won regional innovation funding to lead the implementation of enhanced recovery pathways across London. Dr Kuper left the Trust in early April 2018 to take up a new medical director post.

Sheila Adam, Chief Nurse and Director of Governance

Ms Adam joined the Trust in July 2013. She previously held the post of Deputy Chief Nurse and Head of Nursing for Surgery and Cancer at UCLH Foundation Trust where she also set up the Centre for Nurse and Midwife-led Research. She is an Honorary Professor in nursing leadership at City University and the author of a number of books on Critical Care Nursing. Ms Adam sits on the Infection Control Committee and the Risk Committee. Ms Adam will leave the Trust in May 2018 due to retirement.

Jonathan Wilson, Director of Finance

Mr Wilson joined the Trust in August 2016. He was previously director of finance at The Royal National Orthopaedic Hospital NHS Trust in Stanmore. His career in the NHS started in 1998 when he joined the NHS Graduate Financial Management Training Scheme. He has also worked at Moorfields Hospital.

Dylan Jones, Chief Operating Officer

Mr Jones was appointed Chief Operating Officer in January 2013. Previous roles at Homerton include Divisional Director of the Integrated Medical and Rehabilitation Services Division (2011 to January 2013) and General Manager for the General and Emergency Medicine Division (2008-11).

Daniel Waldron, Director of Organisational Transformation

Mr Waldron was appointed Director of Organisational Transformation in May 2013 and the post was made a Board level position in August 2014. Daniel joined the Trust in December 2008 and has held the posts of General Manager for Children Women's and Sexual Health and Divisional Operations Director for Surgery Women and Sexual Health. He oversaw the introduction of the £10m women's and children's wing at Homerton in 2010.

Board meetings

The Board has regular scheduled meetings and can also, when necessary, convene special meetings. Eleven meetings were held in public during 2017/18.

Attendance

The Directors' record of attendance at Board meetings is shown below.

Name	Attendance
Sir Tim Melville-Ross	11/11
Sir John Gieve	11/11
Vanni Treves CBE	11/11
Polly Weitzman	10/11
Jude Williams	11/11
Susan Osborne CBE	10/11
Martin Smith	11/11
Tracey Fletcher	11/11
Martin Kuper	10/11
Sheila Adam	11/11
Dylan Jones	9/11
Daniel Waldron	10/11
Jonathan Wilson	11/11

Register of Directors' interests

Some of the Trust's Directors hold interests that may be relevant or material to NHS business matters. All our Directors declare those interests in the Register of Directors' Interests which is published annually in the Board papers and is available for inspection by members of the public via the Trust's Company Secretary.

Contacting the Board

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

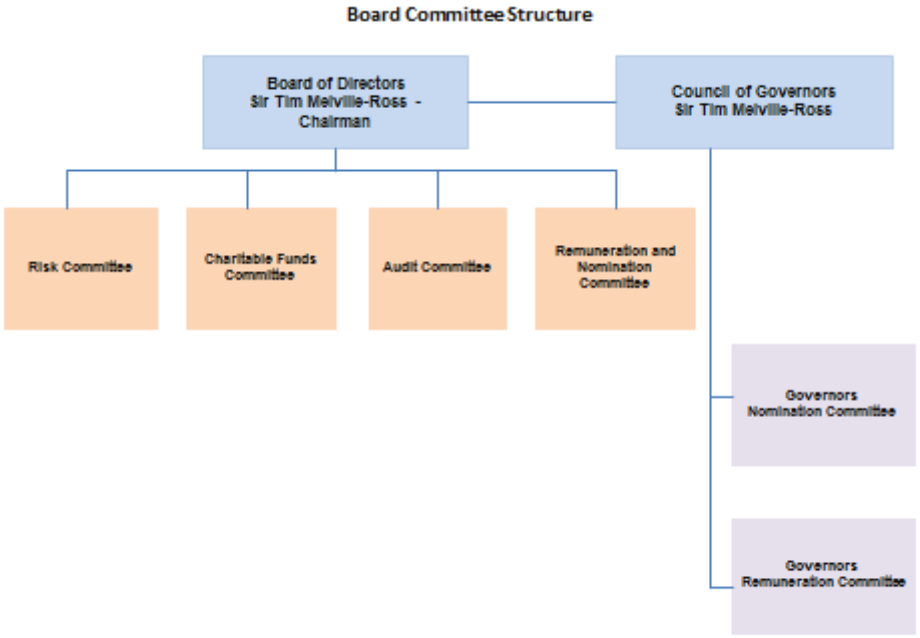
Telephone: 020 8510 5555
Email: huh-tr.Enquiries@nhs.net
Write: Trust Offices, Homerton University Hospital NHS Foundation Trust,
Homerton Row, London, E9 6SR.

Directors' indemnity

The Trust is a member of the NHS Litigation Authority Scheme. Membership of this scheme provides Directors with indemnity under the Liability for Third Party Scheme (LTPS). This covers Directors where they are acting within the "Relevant Function" as defined by LTPS.

Board committees

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



Audit Committee

Membership and attendance

The Audit Committee is chaired by Martin Smith, a Non-Executive Director, and includes three other Non-Executive Directors – Sir John Gieve, Jude Williams and Polly Weitzman. It met seven times in 2017/18.

Name	Attendance
Martin Smith (chair)	7/7
Sir John Gieve	5/7
Polly Weitzman	5/7
Jude Williams	6/7

How the Audit Committee discharges its responsibilities

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

Significant issues considered

During the year the Committee considered 11 reports from the internal auditors that sought to provide assurance to the Trust on the overall adequacy and effectiveness of the risk management, control and governance processes.

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

For all reports, management provides an action plan to address any issues identified. Progress against these action plans is reviewed at each Audit Committee and further testing is undertaken by internal audit to ensure their recommendations are embedded in the organisation. The Committee has also reviewed key policy documents and discharged its duties by reviewing the schedule of tender waivers to ensure any such waivers are in line with the Trust's policy. Other areas of the Committee's work include: reviewing the Trust's progress on budget setting and business planning; considering the Trust's medium term financial strategy; reviewing arrangements for Clinical Audit; and reviewing the Trust's plan for submission of its annual reference costs.

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

Declaration on health care income

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

	£'000
Health care income	285,675
Non-health care income	34,408
Total income	320,083

The Trust has included within "health care income": all income from contracts for patient services; Sustainability & Transformation Fund income; and income for the use of the Trust's buildings and facilities where it is from another NHS body engaged in the provision of health care. During the year the Trust received a total of £10.9m funding in relation to Sustainability & Transformation funding.

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

Better payment practice

During the financial year to 31 March 2018, the Trust paid 73.7% by volume and 84.1% by value of all non-NHS suppliers within 30 days.

Cost allocations

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

Auditors

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

The external auditors for Homerton are KPMG LLP appointed by the Council of Governors in December 2016. Their fees for audit services undertaken in 2017/18 were £69,825. KPMG's accompanying report on the financial statements is based on their audit conducted in accordance with International Financial Reporting Standards and the Financial Reporting Manual issued by NHS Improvement. Their work includes a review of the organisation's system of internal control which is used to inform the nature and scope of their audit procedures.

The Trust's external auditors may perform non-audit work where the work is clearly audit related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded. There was no non-audit work carried out during 2017/18.

As far as the Directors are aware, there is no information relevant to the audit which has not been disclosed to the auditors. The Directors have taken all the steps that they ought to have taken as a director 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.

Remuneration Committee

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

The Committee is chaired by Sir Tim Melville-Ross, Chairman of the Board and all of the Non-Executive Directors are members. The Committee met on one occasion in 2017/18. Details of salary and pension entitlements for the Board of Directors are set out in the Remuneration Report on page 34.

Risk Committee

The Risk Committee was established by the Board to support the development of the Trust's risk management systems and processes. It ensures that the Trust Risk Register is fit for purpose and that risks are subject to robust scrutiny to achieve the Trust's principal objectives and deliver its core business. The Committee receives annual compliance reports from key areas of the business to provide assurance to the Board that quality and risk management arrangements are at an appropriate level.
The Risk Committee is chaired by Vanni Treves and met four times in 2017/18.

Homerton Hope - Homerton Hospital Charitable Fund

Homerton Hope Charity was established in March 1997 and the Corporate Trustee is Homerton University Hospital NHS Foundation Trust. The Executive Directors and the Non- Executive Directors of the Trust share the responsibility for ensuring that the NHS body fulfills its duties as Corporate Trustee in managing the charitable fund.

The Trust Board has delegated the responsibility of managing the charitable fund to the Charitable Funds Committee. The Director of Finance is responsible for the day-to-day management and control of the administration of the charitable fund and is the chair of the Charitable Funds Committee. The Director of Finance has particular responsibility to ensure that spending is in accordance with the objectives and priorities agreed by the Charitable Funds Committee and the Board; the criteria for spending the charitable fund are fully met; full accounting records are maintained; and that devolved decision-making or delegated arrangements are in accordance with the policies and procedures set out by the Board on behalf of the Corporate Trustee.

The Charitable Funds Committee reviews the performance of the external investment manager and ensures that the investment of funds is in accordance with the Charity's policy on ethical investment. The Committee approves the appointment and the terms of business of the investment manager and approves items of expenditure above the delegated limits of the fund holders. The Committee receives regular reports on financial activity and fundraising programmes.

A number of funds are earmarked for certain wards and departments and these are managed on a day-to-day basis by fund holders within the relevant directorate. The fund holders are required to adhere to the Standing Financial Instructions, Standing Orders and Delegated Limits set by the Corporate Trustee. The members of the Charitable Funds Committee oversee the work of the fund holders and have the power to withdraw a fund holder's delegated authority and to direct the use of funds (subject to any specific donor restrictions).

The Trust recognises that a well governed Charitable Funds Committee is essential if the Charity is to be effective in achieving its objectives. The Committee seeks to represent the people with whom the Charity works and its members have the knowledge and skills required to run the Charity.

Charitable Funds strategic objectives

The main objective of the Charitable Fund is to ensure that the funds are used:

"*For any charitable purpose or purposes relating to the National Health Services provided by Homerton University Hospital NHS Foundation Trust".*

The Charity is funded by donations and legacies received from patients, their relatives, and the general public and other organisations. In order to meet the Charity's overall objective the trustees ensure that all spend relates to one of the following three areas:

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

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

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

Review of achievements and performance

During 2017/18, the Charity continued to support a wide range of charitable and health related activities, benefiting patients and staff. The areas of benefits are varied, but generally relate to the provision of specialist staff, goods and services which would not have been possible using NHS funding. Some of the activities continued over the past year are explained below.

HIV support services co-ordinator

As a result of the successful Positive Lives fundraising campaign the Charity has been able to support the appointment of an HIV Support Services Co-ordinator. The post-holder has been in post for a number of years and facilitates the provision of comprehensive health and social care for people living with HIV attending the unit. The team also received funding to introduce a Social Care Co-ordinator post which has had a positive impact on both patients and clinicians.

Peer navigators project

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

Art programme

The therapeutic value of art in health and in speeding recovery is well documented. Homerton Hospital has always displayed art work in its wards, corridors and courtyards. Based in the heart of Hackney, the hospital provides an excellent blank canvas for artists to display their work to patients, staff and visitors. Art therapy sessions are now held in RNRU, the Elderly Care Unit and the Graham Ward Stroke Unit.

We held an art auction in November 2017 facilitated by Christie's auctioneers and sold nearly £2200 worth of art.

Christmas presents for inpatients

The Charity was able to provide small gifts to patients who were staying in hospital during Christmas 2017.

Staff Welfare

The Charity provided funding for a number of courses and conferences attended by staff and also funded food and entertainment for the summer staff barbeque. Contributions were also made to the work of the Healthy Homerton Project, for example funding the rental of a "life check" machine for three months.

Equipment purchased for patient benefit

Over the last year Charitable Funds were used to purchase a number of items of equipment and to provide additional services to benefit patients. Some of the items funded are listed below:

- Welcome packs providing information for patients
- Christmas decorations for wards
- Sofas for ITU and Starlight
- Large toys for Children's Emergency Assessment (CEA) and Starlight Ward
- Plants and whiteboards for ITU
- Accuvein and stand for CEA
- Bereavement information bags

Other fundraising activities

During the year a number of fund raising activities were held as outlined below:

Trading stands

The Charity has continued to receive contributions from these stalls amounting to nearly £4000 during the year. The variety of stalls has increased to include jewellery, bags, books and beauty products.

Collection boxes and money spinner

The Charity continued to receive income via a range of other initiatives including collection boxes and a money spinner located around the hospital. Total funds received in the year were in excess of £1,500.

Donations received

The Charity received a number of donations from various donors through the Justgiving and Virgingiving websites and cheques. Total funds received were in excess of £23,000 (excluding fees). The Charity also received £55,000 from the Monument Trust to fund a social care post and £39,500 from MAC Aids for the peer navigator role.

The Charity received £4000 from Tesco Groundworks which will go towards the Mary Seacole Nursing Home garden redevelopment project, along with the money raised from the wheelchair walk. It also received £950 from the John Lewis Stratford community matters and £500 from the Asda Leyton Mills community matters.

The Trust did not make any political donations during the year.

Board, committee and Directors' evaluation

The Board of Directors is satisfied that its balance of knowledge, skills, and experience is appropriate to the Board and its committees. The Board collectively considers that it is appropriately composed in order to fulfil its function and remain within its Terms of Authorisation. Non-Executive Directors meet the independence criteria laid down within the NHS Foundation Code of Governance.

The annual appraisal of the Chairman involves collaboration between the senior independent Director and the lead Governor from the Council of Governors to seek the views of both Directors and Governors. The performance of Non-Executive Directors is evaluated annually by the Chairman.

The Chief Executive reviews the performance of the Executive Directors. The outcome of these appraisals is reported to the Remuneration Committee. Executive Directors have an annual appraisal with the Chief Executive.

Well-led framework

Last year, in order to fulfil the requirements of NHS Improvement's well-led framework, the Board commissioned an external well-led governance review which was carried out by Grant Thornton UK LLP[1]. The actions from the review were implemented in 2017/18. Further details on how the Trust meets the requirements of the well-led framework are documented in the Annual Governance Statement on page 65.

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

Council of Governors

As a Foundation Trust Homerton is accountable to the local population and members of the public may become members and Governors of the Trust. Members are represented by a Council of Governors comprising elected public and staff members, together with representatives of partner organisations, local authorities and Commissioners.

The Council of Governors is responsible for representing the interests of the local community in the management and stewardship of the NHS Foundation Trust, and for sharing information about key decisions with other NHS Foundation Trust members.

There are 25 Governors under the leadership of the Trust Chairman including:

- 14 Public Governors (elected)

10 representing Hackney, 2 representing the City of London and 2 representing adjoining boroughs;

- 6 Staff Governors (elected)

4 representing clinical staff and 2 representing other, and

- 5 Appointed Governors nominated from partnership organisations.

The opinion of the Council of Governors is sought by the Board of Directors on key strategic issues. The Council of Governors is invited to review issues of importance at its meetings and advise the Chairman of their views. The Chairman ensures that these views are considered at the Board of Directors meeting as part of the decision-making process.

The Council of Governors and the Board of Directors hold regular joint meetings during the year. Executive Directors and Non-Executive Directors regularly attend Council of Governors meetings to gain an understanding of the views of Governors and the membership constituencies they represent and to provide the Governors with an opportunity to ask questions. The Governors held five meetings in 2017/18 including two joint meetings of the Council of Governors and the Board of Directors. The Trust's Constitution requires the Council of Governors to meet at least three times a year. The Council of Governors, after each of their meetings, provide a report to the Board to ensure all key issues discussed are brought to the Board's attention.

Director Attendance

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

Sir Tim Melville-Ross	5/5
Sir John Gieve	4/5
Vanni Treves CBE	3/5
Polly Weitzman	3/5
Jude Williams	4/5
Susan Osborne CBE	3/5
Martin Smith	4/5
Tracey Fletcher	4/5

Martin Kuper	3/5
Sheila Adam	4/5
Dylan Jones	0/5
Daniel Waldron	4/5
Jonathan Wilson	4/5

Governor Attendance

The following table summarises Governor attendance at Council of Governors' meetings held in 2017/18.

Name	Constituency	Date elected or appointed	Attendance
Tim Melville-Ross	Chairman	N/A	5/5
Shuja Shaikh	Public (Hackney)	Sept 2015 (1st term)	4/5
Saleem Siddiqui	Public (Hackney)	Sept 2016 (1st term)	4/5
Stuart Maxwell	Public (Hackney)	Sept 2012 (2nd term)	5/5
Julia Bennett	Public (Hackney)	Sept 2012 (2nd term)	5/5
Dr Coral Jones	Public (Hackney)	Sept 2016 (1st term)	3/5
Paul Ashton	Public (Hackney)	Sept 2013 (2nd term)	4/5
Danny Turton	Public (Hackney)	Sept 2014 (2nd term)	1/5
Ayse Ahmet	Public (Hackney)	Sept 2015 (1st term)	4/5
Ruth Martin	Public (Hackney)	Sept 2016 (1st term)	5/5
Eric Cato	Public (Hackney)	Sept 2017 (1st term)	3/3
John Bootes*	Public (City)	March 2010 (3rd term)	5/5
Hazel Mckenzie	Public (Outer)	Sept 2015 (1st term)	2/5
Mary Rose Thomson	Public (Outer)	Sept 2017 (1st term)	1/3
Siva Anandaciva	Public (Outer)	Sept 2014 (1st term)	2/2
Hilda Walsh	Staff (Clinical)	Sept 2013 (2nd term)	5/5
Suzanne Levy	Staff (Clinical)	Sept 2014 (2nd term)	4/5
Helen Cognoni	Staff (Clinical)	Sept 2015 (1st term)	2/5
Alun Myers	Staff (Clinical)	Sept 2016 (1st term)	3/5
Chris Mullett	Staff (Other)	Sept 2016 (1st term)	5/5
Ibrahim Hafeji	Staff (Other)	Sept 2017 (1st term)	2/3
Dr Mark Rickets	NHS City and Hackney CCG	Appointed 2015	5/5
Ben Hayhurst	Hackney Council	Appointed 2014	5/5
Dr Lisa Reynolds	City University	Appointed 2015	4/4
Judith Sunderland	City University	Appointed 2018	1/1

*Lead Governor

The following Governors stepped down during the year, either through resignation or their terms of office expiring: Siva Anandaciva, Caroline Bowring, Helena Charles, Wayne Head and Lisa Reynolds.

Following elections, Governors that commenced either their first term or an additional term of office during the year were: Eric Cato, Ibrahim Hafeji, Mary Rose Thomson and Danny Turton.

If there is a dispute between the Council of Governors and Board of Directors, the Chairman, in the first instance, will endeavour to resolve it. If the Chairman is unable to find a resolution, the Senior Independent Director and the Lead Governor will together attempt to resolve the issue. Should the Senior Independent Director and the Lead Governor fail to resolve the conflict, the Board of Directors, pursuant to section15(2) of Schedule 7 of the Act, will decide the disputed matter.

Register of Governors' interests

A register of interests is maintained in relation to the Governors. This is available for viewing from the Trust Company Secretary.

Elections

Public and staff Governors are elected by the Trust's membership. Elections are held in accordance with the election rules, as stated in the Trust's Constitution, using a single transferable vote system. Elections for vacancies in four constituencies (Hackney, City and Staff (other) were held this year to replace those Governors who had resigned or completed their term of office in accordance with the transition schedule. The elections were administered on behalf of the Trust by Electoral Reform Services Limited. Governors may be removed from the Council of Governors, if needed, in accordance the grounds set out in the Constitution.

Foundation Trust membership

The Trust is committed to recruiting a diverse membership which is reflective of the community that Homerton serves. There is no set limit on the number of people who can register as members within the eligibility criteria.

The overall public and staff membership has decreased over the past year with 825 fewer members overall, than at the beginning of the year. The Trust ended the year with 5,189 public members and 3,356 staff members. Figures were updated following the annual data cleanse carried out by Membership Engagement Services, who the Trust engages to administer the membership database.

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

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

The public membership continues to be broadly representative of the local population in terms of ethnicity and gender but is under represented in the 16-39 age category. The Hackney 2011 Census data has been used for comparison of the local population, as the majority of Trust's patients live in the borough and the Hackney constituency has the majority of public members.

The Trust is able to monitor its membership through the membership database using the information supplied by the members on their application forms. The application form is available online via the Trust website and at public areas across the Trust. Ongoing analysis and review of membership enables the Trust to undertake detailed demographic analysis of the membership, and identify where gaps exist in recruitment.

During the year, membership recruitment sessions, supported by governors, were held at the hospital and health centres across the borough. Membership engagement events, hosted by Governors, and featuring a lecture from a member of staff on a health topic of interest were also held. Memberlink newsletters were sent to all public members providing information, election details and news about the Trust's services. The Lead Governor also holds regular informal meetings with Governors to keep in touch with opinion and further enhance communication between the Council and Board members.

In 2016/17 the Trust established a Membership and Engagement Committee of the Council of Governors. This new group has reviewed the membership strategy and is actively looking at opportunities to increase membership, with particular emphasis on recruiting younger people.

Membership strategy

The Trust's Membership strategy outlines the eligibility requirements for becoming a member and describes the boundaries for public membership. It also provides an assessment of the membership and describes recruitment priorities. Copies are available on request via the Company Secretary.

Contacting the Governors

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

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

Statutory responsibilities

The Council has a number of statutory responsibilities, which include but are not limited to:

- holding the non-executive directors to account for the performance of the Board,
- appointing or removing the chairman and non-executive directors
- deciding the remuneration of non-executive directors
- appointing or removing UCLH's auditors.

The Council also has the final decision on significant transactions, receives the Annual Report, Quality Report, Accounts and auditors report; approves changes to the Constitution; and gives its views on the development of a forward plan.

Committees of the Council

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

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

Nominations Committee of the Council of Governors

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

The Committee met on two occasions during the year and recommended to the Council of Governors, the reappointing of Sir John Gieve and Martin Smith as Non-Executive Directors.

Remuneration Committee of the Council of Governors

The Remuneration Committee of the Council of Governors comprises public and staff Governors and is chaired by the Lead Governor. Its purpose is to review and recommend salary and related conditions of the Non-Executive Directors and the Chairman. No meetings of the Committee were held in 2017/18.

Remuneration report

For the purposes of this report the disclosure of remuneration to senior managers is limited to Executive and Non-Executive Directors of the Trust.

In accordance with the Constitution the remuneration of the Executive Directors is determined by a Nomination and Remuneration Committee of the Board, comprising the Chairman and all Non-Executive Directors. The remuneration of the Chairman and Non-Executive Directors is determined by the Remuneration Committee of the Council of Governors.

Both Committees work to common principles and procedures. Remuneration levels are set taking into account the requirements of the role, market rates, the performance of the Trust, internal comparability and affordability. No individual is involved in any decision that affects his or her own remuneration. Both Committees adopt the principles of good governance in setting remuneration, and take into account a wide range of pay guidance across other public sector and relevant independent organisations to inform the process.

The Nomination and Remuneration Committee of the Board advises on any major changes in employee benefit structure in the Trust and ensures that contractual terms on termination and any payments made are fair to the individual and the organisation. Both Committees are authorised to obtain external or other professional advice on any matters within their terms of reference, with due regard to probity and cost. The Trust does not award performance bonuses.

The Nomination and Remuneration Committee meets at least annually to review the Board structure, size and composition, and to give consideration to succession planning and identify the skills and knowledge of the Board. The committee must also meet as part of the process of appointment for Executive Directors and decide on their remuneration.

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

The Trust currently carries a provision of £0.336m for early retirements relating to ex-members of staff.

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce. The remuneration of the highest paid Director in Homerton University Hospital NHS Foundation Trust in 2017/18 was £167,407 (2016/17 £164,307). This was 5.3 times (2016/17 5.0 times) the median remuneration of the workforce, which was £31,754 (2016/17 £32,631).

The remuneration of two Executive Directors is greater than £150,000.[2] In consideration of benchmarking information compared with peer trusts, the scope of the job roles and their responsibilities and the continued probity of the Remuneration Committee the Trust is satisfied that the remuneration is fair and reasonable.

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

Audited Analysis of Staff Costs 2017/18				
			2017/18	**2016/17**
	Permanently Employed	**Other**	**Total**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	155,108	1,290	156,398	152,398
Social Security costs	15,679		15,679	15,043
Employer contributions to NHS Pensions Agency	17,960		17,960	17,701
Pension Cost - Other	5		5	5
Termination Benefits	255		255	-
Agency staff		12,187	12,187	11,707
	189,007	**13,477**	**202,484**	196,854

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

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

Treves V – Non-executive Director	10-15	-	-	-	-	**10-15**
Williams J – Non-executive Director	10-15	-	-	-	-	**10-15**
Weitzman P – Non-executive Director	10-15	-	-	-	-	**10-15**
Osborne S – Non-executive Director	10-15	-	-	-	-	**10-15**
Smith M – Non-executive Director	10-15	-	-	-	-	**10-15**

In 2017/18 the Trust paid £433 (2016/17 - £114) as expenses to Executive and Non-Executive Directors and there were no payments to Governors (2016/17 - nil). The Trust is well served by its Governors and volunteers who are not paid for their services.

The element of the Medical Director's salary that related to their clinical role in 2017/18 was approximately £0.009m.

The following table provides information on the remuneration of senior managers in the Trust in 2016/17.

Audited Remuneration of Senior Managers 2016/17 (restated)						
	Salary	**Taxable Benefits**	**Annual Performance related Bonus**	**Long Term Performance Related Bonus**	**Pension-related Benefits**	**Total**
	(bands of £5,000)	**(to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £2,500)**
Executive Director	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Fletcher T – Chief Executive	160-165	-	-	-	32.5-35.0	**195-200**
Jones D – Chief Operating Officer	120-125	-	-	-	25.0-27.5	**145-150**
Metcalfe M - Interim Director of Finance (from 1st to 30th April 2016)	10-15	-	-	-	17.5-20.0	**30-35**
Yarnold J – Interim Director of Finance (from 1st May to 31st July 2016)	60-65	-	-	-	-	**60-65**
Wilson J – Director of Finance (from 1st August 2016)	85-90	-	-	-	-	**85-90**
Adam S - Chief Nurse and Director of Governance	110-115	-	-	-	12.5-15.0	**125-130**
Kuper M - Medical Director	145-150	-	-	-	-	**145-150**
Waldron D - Director of Organisation Transformation	100-105	-	-	-	15.0-17.5	**115-120**
Melville-Ross T - Chairman	40-45	-	-	-	-	**40-45**

Gieve Sir J – Non-Executive Director	10-15	-	-	-	-	**10-15**
Treves V – Non-Executive Director	10-15	-	-	-	-	**10-15**
Williams J – Non-Executive Director	10-15	-	-	-	-	**10-15**
Weitzman P – Non-Executive Director	10-15	-	-	-	-	**10-15**
Osborne S – Non-Executive Director	10-15	-	-	-	-	**10-15**
Smith M – Non-Executive Director	10-15	-	-	-	-	**10-15**

Pensions

Normal Retirement age is dependent upon NHS Pension scheme, for the 1995 scheme normal retirement age is 60, for the 2008 scheme normal retirement age is 65. Five of the Trust's Directors during 2017/18 are members of the 1995 scheme and their normal retirement age is 60. The Director of Finance opted out of the NHS Pension scheme on commencing employment with the Trust in August 2016.There are no additional benefits receivable in the event of early retirement and no rights under more than one pension scheme arising for the Directors.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown below relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV amounts, and from 2004/05 the other pension amounts, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pensionable service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The CETV at 31March 2017 is discounted by the HM treasury discount rate. A common market valuation factor is then applied to the difference between this and the CETV as at 31 March 2018 to calculate the real increase in CETV. If a director or senior manager started during the year, the opening pension or cash equivalent transfer value (CETV) values will not normally be available and therefore the opening value or increase in year will be set to nil. Jonathan Wilson, Director of Finance, left the NHS Pension scheme on commencing employment with the Trust in August 2016 therefore the pension figures in the table below have been set to nil.

Audited Pension Benefits of Senior Managers

Name and title	Real increase in pension at Pension Age	Real increase in pension lump sum at Pension Age	Total accrued pension at pension age at 31 March 2018	Lump Sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Fletcher T - Chief Executive	2.5-5.0	0.0-2.5	50-55	120-125	811	727	77
Jones D - Chief Operating Officer	0.0-2.5	0.0-2.5	20-25	50-55	279	239	37
Adam S - Chief Nurse and Director of Governance	0.0-2.5	2.5-5.0	50-55	155-160	-	-	-
Wilson J – Director of Finance	-	-	-	-	-	-	-
Kuper M - Medical Director	5.0-7.5	10.0-12.5	55-60	140-145	953	820	125
Waldron D - Director of Organisation Transformation	0.0-2.5	-	15-20	-	173	144	28

Chairman of Nomination and Remuneration Committee Report

The Nomination and Remuneration Committee of the Board of Directors met in April 2017 to consider Executive Director Performance and Remuneration. The meeting was chaired by Sir Tim Melville-Ross and also present were Sir John Gieve; Polly Weitzman; Vanni Treves; Jude Williams; and Martin Smith. The meeting was also part attended by the Chief Executive and fully attended by the Company Secretary and Associate Director of Workforce for the purpose of providing advice or services that materially assisted the Committee with the matters before them.

The Committee reviewed the financial pressures, external context and wider salary and workforce situation at the Trust as well as current director salaries and benchmarking information. Following discussion, the Committee agreed to increase the Chief Executive's salary by 2% and to increase Director salaries by 1% or 2% depending on performance and benchmarking salary information received for executive posts.

The Committee also met in November 2017 to consider two Executive Director resignations and approve the appointment process for the Medical Director and Chief Nurse.

Components of Senior Management Remuneration

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

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

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

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

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

Policy on payment for loss of office

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

Tracey Fletcher

Chief Executive

25 May 2018

Staff report

The number of staff directly employed by the Trust increased by 67.99 full-time equivalent (FTE) from 3467.50 FTE in 2016/17 to 3535.49 FTE in 2017/18. Excluded from these figures are most pre and postgraduate health care practitioners who were placed with us for training, bank and agency employees, staff holding honorary contracts and catering and domestic personnel.

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

Average number of employees (WTE basis, including bank and agency staff)	Total 31 Mar 2018 2017/18	Permanent 31 Mar 2018 2017/18	Other 31 Mar 2018 2017/18
Medical and dental	519	458	61
Ambulance staff	0	0	0
Administration and estates	804	638	166
Healthcare assistants and other support staff	740	625	115
Nursing, midwifery and health visiting staff	1,357	1,158	199
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	552	528	24
Healthcare science staff	98	83	15
Total average numbers	4,070	3,490	580

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

The consultancy figure for 2017/18 was £1.0m (2016/17 £1.441m) and this included the cost of consultancy work to identify savings opportunities together with professional fees for negotiating utilities rebates.

Staff performance indicators

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

Vacancy rates have steadily decreased over the last financial year from 9.61% at April 2017 to 8.89% at March 2018. The staff turnover rate has decreased over the last financial year by 0.4 percentage points and 597 staff joined the Trust over the course of the year. The highest increase in the turnover rate has

been within the staff groups Additional Clinical Services, Administrative and Clerical and Estates and Ancillary.

Staff support and wellbeing

The sickness rate has held steady at an average of 2.91% based on a 12 month year to date figure. This compares favourably with other medium sized acute trusts with an average of 4.2%. This performance can in part be attributed to a rigorous application of the sickness policy and audits to ensure the low sickness rate isn't a result of under reporting. Support has also been provided by the Employee Health Management Service which has proven particularly effective at supporting staff to remain in or return to the workplace where ill health is a feature.

The Trust's staff influenza vaccination campaign resulted in 3,289 (70.71%) of front line health care workers being vaccinated, an increase of 19 percentage points on the previous year's campaign. As part of the Trust's health and well-being effort and building on the achievement of being awarded Greater London Authority Excellence, a broad range of activities were supported by the Trust including health fairs, promotion events around the health calendar, mindfulness sessions, subsidised gym membership as well as the participation in the Healthy London Partnership's Health and Well Being Ambassador programme resulting in around 40 staff becoming trained and actively operating in respect of this agenda.

The health, safety and wellbeing of staff, patients and visitors continues to be a key priority for the organisation and it is well recognised that improving staff health and safety has a direct impact on the Trust's ability to provide high quality care for patients. The health & safety related work conducted by the Trust also serves to comply with its legal duties and ensure that staff, patients and visitors are protected and safe. The Trust has an onsite Occupational Health Team and all new employees complete a health check before commencing with the Trust. An annual report is made to the Risk Committee, a board sub-committee chaired by a Non-Executive Director, and includes information on non-clinical incidents, training and risks. The Trust also has a Health and Safety Committee, chaired by the Chief Nurse and Director of Governance, which reports to the Workforce Committee. The Occupational Health Team regularly review core employee health metrics, including reason for referral, referral by staff group and division, and service users seen within the key performance indicator of 10 working days.

Staff involvement and engagement

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

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

The Trust's staff engagement group oversees the development and delivery of the annual staff engagement improvement plan. The plan is informed by the annual staff survey, the quarterly staff friends and family survey, exit interview data and other local research. In 2017 the Trust commenced an organisational development project, in partnership with ICE Creates, aimed at developing staff

engagement and improving retention. The programme will continue into 2017/18 and is focused on four key areas:

- Reviewing the Trust values and developing a staff engagement tool kit
- Developing a Trust wide leadership strategy and set of behaviours
- Introducing a more systematic approach to talent identification and development
- Establishing a structured and consistent approach to staff recognition

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

Staff survey

Between September and November all staff were asked 88 questions about their working life and these were then distilled into 32 key findings which in turn have been presented under nine broader groupings.

Based on a whole Trust sample (3402 staff mailed) the Trust received a 50.4% response rate which was a minor decrease on the previous year (54.78%).

The results of the survey were positive when compared to many peers; however, the Trust did see reductions in scores in some areas.

The ranking profile against the 32 Key findings was as follows:

Homerton Key Findings Compared to Acute and Community Trusts (39)		
Number	**Ranking***	**%**
19	Better than average	59%
3	Average	9%
10	Worse than average	31%

There were two areas (detailed below) where the Trust scores were identified as having statistically significantly declined since 2016 and no areas where a significant improvement was indicated.

Key Finding	2016 Score	2017 Score	16/17 Diff.
KF14. Staff satisfaction with resourcing and support	3.45	3.39	0.06
KF29. % reporting errors, near misses or incidents witnessed in last month	93%	87%	6 pts

Results of the top 5 and bottom 5 ranking score are set out below, the results are derived from benchmarking against 208 provider Trusts.

Top 5 Ranking Scores								
Key Finding (KF)	**Higher or Lower better**	**2016 Score**	**2017 Score**	**16/17 Diff**	**Significant**	**Average**	**%ile**	**Rank (out of 208)**
KF 12. Quality of appraisals	Higher	3.46	3.46	0	Not Significant	3.12	99%	3
KF 3. Percentage of staff agreeing that their role makes a difference to patients / service users	Higher	93%	93%	0	Not significant	90%	99%	3
Key Finding 13. Quality of non-mandatory training, learning or development	Higher	4.13	4.17	0.04	Not Significant	4.06	97.5%	6
Key Finding 32. Effective use of patient / service user feedback	Higher	3.89	3.90	0.01	Not Significant	3.69	97.1%	7
KF 6. Percentage of staff reporting good communication between senior management and staff	Higher	45%	43%	-2%	Not Significant	34%	93.7%	14
Bottom 5 Ranking Scores								
Key Finding (KF)	**Higher or Lower better**	**2016 Score**	**2017 Score**	**16/17 Diff**	**Significant**	**Average**	**%ile**	**Rank (out of 208)**
KF 11. Percentage of staff appraised in last 12 months	Higher	74%	76%	2%	Not Significant	87%	0.90%	202
KF 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Higher	76%	76%	0%	Not Significant	85%	6.7%	194
Key Finding 20. Percentage of staff experiencing discrimination at work in the last 12 months	Lower	18%	20%	2%	Not significant	12%	95.1%	188
KF 17. Percentage of staff feeling unwell due to work related stress in last 12 months	Lower	39%	41%	2%	Not significant	38%	78.3%	163
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Lower	27%	30%	3%	Not Significant	28%	74.5%	155

The Staff Engagement Group is currently developing the Trust's action plan to ensure the Trust can positively respond to the findings and act on the feedback staff have provided. Delivery of the plan is overseen by the staff engagement group which reports into the Workforce Committee. The plan is built around a number of key themes and the actions are informed by feedback from a range of sources including an engagement project being delivered in partnership with ICE Creates. The table below summarises they key actions against each theme.

Improvement Themes	Key Actions	
Theme 1: Career Progression, Development and Retention	1.1	Establish a programme of career development training
	1.2	Establish a nursing transfer process
	1.3	Set up 'Career Clinics' for nursing staff
	1.4	Develop career ladder work for nursing and admin staff
	1.5	Establish a programme of support and development for preceptorship nurses
	1.6	Develop a senior staff nurse role to attract and retain experienced band 5 nurses
	1.7	Develop rotational programme for experienced band 5 nurses
	1.8	Deliver Post Grad training programme for band 5 nurses
	1.9	Pilot settling in conversations for new staff
	1.10	Establish development programme for admin staff
	1.11	PDR process to be transferred on to ESR
	1.12	Develop talent management strategy
Theme 2: Leadership Strategy	2.1	Develop a managers induction programme
	2.2	Establish leadership competency framework and tools
	2.3	Review leadership development programmes to ensure consistent approach, quality and access
Theme 3: Staff Health and Wellbeing	3.1	Develop MSK strategy and action plan
	3.2	Develop stress and mental health strategy and action plan
	3.3	Establish a violence and aggression sub group of the H and S committee.
	3.4	Develop and implement improvement plan for violence and aggression
	3.5	Develop programme of work for the Health Ambassadors
Theme 4: Reward and Recognition	4.1	Review staff benefit offer
	4.2	Develop a Staff recognition strategy
Theme 5: Diversity, Inclusion and Opportunity	5.1	Review process for managing performance and conduct to include Executive Director level review of cases prior to decision to take formal action
	5.3	Develop best practice guidance on recruitment and selection
	5.4	All staff managers involved in recruitment to attend 'unconscious bias' training
	5.5	Deliver 'Inclusion Lab' project run in partnership with BRAP
	5.6	Review and recommission career development and leadership programmes for BAME staff
	5.8	Develop actions plan in response to Workforce Disability Scheme Commitments
Theme 6: Division and service level interventions	Provide targeted team development support as part of the wider staff engagement programme	

Theme 7: Communication	Ensure interventions are widely publicised and accessed.

Education and related activities

Core mandatory training

The Trust ended the year with an overall compliance of 88% against all core mandatory training with a minimum compliance of 80% in seven out of nine areas. The biggest gains in compliance from 2017 to 2018 were in fire safety (77% to 81%), and safeguarding adults level 2 (74% to 80%).

Formal monitoring of paediatric life support was introduced during the year, which has achieved 78% compliance (from 30% in 2017). Work will continue to achieve a minimum of 80% compliance in this area.

In the coming year it is anticipated that there will be an increase in range of core mandatory training subjects which will require formal monitoring, the first of which is WRAP training (Workshop to Raise Awareness about PREVENT) which is part of the government's approach to tackling radicalisation.

Leadership development

The Trust has continued to review and refresh multidisciplinary leadership programmes for staff new to management, and those more experienced managers wanting to develop their leadership skills. In addition, the Trust has commissioned an introduction to leadership programme aimed at Black, Asian and Ethnic Minority (BAME) staff in response to the staff survey which indicated that BAME staff are disproportionately represented in lower bands, the majority being in Bands 2 - 4.

A total of 53 staff completed the programmes in 2017, and a further 50 will complete the programmes during 2018.

In addition, a targeted team leadership skills programme was developed and commissioned for community nurse managers; and a number of stand-alone leadership workshops are offered in-house to provide staff with key business and personal-effectiveness skills to succeed in their roles.

The organization is continuing to expand a pool of mentors to provide ongoing support and development for aspiring leaders and talented staff within the organisation.

Apprenticeships

Through an expanding apprenticeship programme Homerton is creating career development opportunities for existing staff at all bands, as well as developing a work experience programme in partnership with local schools and colleges.

The Trust continues to promote apprenticeships in business administration, management, and health care support training for existing staff, as well as recruiting apprentices to vacant posts. 2017 saw a change in how the Trust recruits entry level roles; all Band 2 and Band 3 roles are now considered for apprenticeships. This has led to an expansion of training including the senior health care support worker apprenticeship for allied health professional roles. Nationally there has been a reduction in new apprenticeship starts as employers have been anticipating the next wave of apprenticeship standards to

be approved; these include the nursing degree apprenticeship, the nursing associate apprenticeship and the advanced clinical practitioner apprenticeship amongst others.

Following a tendering process, the Trust will be working with a new training provider for the business administration apprenticeship; and will be participating in the tendering process with partners in east London, for the nursing associate apprenticeship.

The Trust aims to continue expanding the training opportunities for staff as new apprenticeship standards are approved nationally and mapped to career pathways.

Workforce education and development

Homerton provides a programme of workforce education and training to support staff in the delivery of safe, effective care and a positive patient experience. This includes providing training in customer care, communication skills, and managing violence and aggression - supporting staff in managing challenging conversations in highly charged situations. A bespoke workshop on working effectively with patients and/or their carers with mental health conditions was developed with the simulation team and an in-house training programme to improve the awareness of mental health needs in physical heath settings is being developed with our mental health colleagues.

Inter-professional learning opportunities continue to improve effective team working, and our bespoke dementia simulation programme is targeted to specific multi-disciplinary teams.

The Trust is developing and promoting a range of online educational resources, particularly in leadership, including Virtual Ashridge, and the NHS Leadership Academy resources.

The Trust is also continuing to use simulation and e-learning as part of a blended approach to education and development, and is working with service user trainers to ensure that the experience of patients and their carers is integrated into care programmes.

A bespoke education programme was commissioned to enable staff to develop skills to implement shared decision-making, and adopt a health-coaching model for working with patients.

As part of the recruitment and retention strategy, the Trust is developing structured career pathways for staff:

- offering band 5 nurses the opportunity to apply for a series of post-graduate modules which could lead to either a post graduate certificate in nursing (PG Cert); or for those already with a PG Diploma, the opportunity to obtain a Masters level degree. Modules studied include personal and professional development, professional leadership, change management, and a work-based Quality Improvement project.
- combining with a rotation scheme for junior staff, radiography managers commission a range of PG Certificate and PG Diploma courses (e.g.: radiographer reporting; medical ultrasound; neonatal cranial, and hip ultrasound) which extend the knowledge and skills of staff, equipping them to carry out extended scope roles by providing essential and extended specialist clinical practice necessary for the development of an improved and responsive service.

- pharmacy managers similarly commission PG certificate and PG diploma in specialisms and advance practice for staff, combined with a rotational programme, and are considering adding an Independent Prescribing course to their education portfolio.
- aligning to Capital Nurse initiatives, a formal band 6 / 7 career development pathway for nurses and Allied Health Professionals is in development; this will include offering specific specialist training and education programmes leading to an Advanced Practice qualification and Advanced Nurse/Midwife/AHP Practitioner role. In addition, we are reviewing preceptorship and graduate development for AHP staff, with the aim of supporting the retention of staff, promoting career development to more senior roles and planning for succession.
- providing targeted support to staff where standards of numeracy and literacy are prerequisites for further academic programmes (such as the Trainee Nursing Associate programme).
- Taking up opportunities for HEE funded programmes, and have seven staff successfully recruited to the 18 month overseas nurses programme at Middlesex University, which support existing health care assistants into registered professional roles.

Medical education

In 2017/18 the Trust continued to demonstrate its commitment to the delivery of undergraduate and postgraduate education.

The results from the National GMC Survey of Doctors in Training were positive. All supervisors have now completed the seven domains of the Professional Development Framework and attended an educational appraisal. The Trust delivered regional teaching days for core medicine, gastroenterology, general internal medicine (GIM) and obstetrics and gynaecology trainees. Three Grand Rounds also took place during the course of the year and were well received.

Feedback from the Barts and the London School of Medicine and Dentistry quality visit was also very positive. The Trust has increased the numbers of medical students on placements and also placed physicians' associate students. Initial feedback from students is good. Homerton continues to see a good number of medical students who have undertaken placements at the Trust and who choose to return to us for foundation programme or specialty training.

The simulation centre was again successful in securing bids and delivering numerous courses, many in collaboration with other centres across the region and pan London. In situ simulation has also been embedded across the Trust. The seventh Homerton Simulation Conference 'novel thinking and new technologies in healthcare' was well received.

The Newcomb Library continues to offer a much appreciated service to Homerton staff and students on placement. Work continues to develop library services in line with Health Education England's national framework for NHS library and knowledge services, Knowledge for Healthcare. The library continues to provide literature searches to support quality improvement and service development throughout the Trust.

Research and development

Research and Development (R&D) at Homerton continues to offer patients the opportunity to become a participant in high quality research. The department received a grant of £625,076 from the North Thames Clinical Research Network to support research activity within the Trust in the year 2017/18. This included

planned funding and *ad hoc* approved requests. This funding, along with earned income, has enabled the Trust to support 22 research nurses and clinical trials coordinators, along with a full time pharmacist. R&D also contributes to the radiology and pathology departments to support practitioners involved in research activity.

The research department also supports two specialty leads, namely Simona Cicero Lead for Reproductive Health and Childbirth, and Paul Fleming, Specialty Lead for Children. These high profile roles assist in raising the profile of Homerton, confirming it as a high quality research site.

As of 31 March 2017, 139 studies were either recruiting or in follow up across the Trust with 38 new studies being approved during the course of the year, of which five were commercial studies. In 2017/18, 3017 patients agreed to be included in clinical trials taking place at Homerton.

The department keeps a balanced portfolio of study recruitment, offering both interventional and observational research from commercial and non-commercial sponsors alike as illustrated in Table 1 below.

Type of study	Number	Recruitment
Commercial	10	176
Academic	8	
Non-Commercial/ Non portfolio	32	
Portfolio	79	2652
Service Evaluation	2	N/A
Total	121	3017

Table 1: Numbers of each study type with recruitment. [1]

Examples of research carried out at Homerton in 2017

Prostate cancer has been at the forefront of press coverage in recent months. Homerton is conducting the PROVENT TRIAL (Together Preventing Prostate Cancer) which is a chemoprevention study in men enrolled on an active surveillance programme for prostate cancer, aiming to examine the clinical effectiveness of Aspirin and/or Vitamin D3 to prevent disease progression in men on active surveillance. It may benefit patients with prostate cancer by preventing the development of more aggressive disease. This study is funded by Barts Health. Please visit the PROVENT study website https://www.provent.org.uk/ for more information.

Another area of public concern is the treatment and prevention of HIV**.**

The PrEP Impact trial is a three year study run by NHS England providing pre-exposure prophylaxis (PrEP) to those at risk of HIV. In 2017, a significant decline in new diagnoses of HIV in the UK in gay and bisexual men was announced, with access to PrEP identified as a contributory factor in the downturn in new diagnoses. The impact trial is an implementation study, looking at large-scale use of PrEP with 10,000 places across England. Recruitment spaces for gay and bisexual men were taken up quickly: however, protected trial places for women and other groups at risk of HIV are still to be filled. Homerton's unique patient population means that the Trust has the potential to be at the forefront of research in these population groups.

Research also continues to pioneer new treatments for frequently encountered diseases such as rheumatoid arthritis (RA). The APIPPRA trial is designed to find out if and how Abatacept (a “Biologic” therapy currently used in practice to treat severe, active RA) helps to prevent a future diagnosis of RA in patients who do not have a current diagnosis of RA (although have some joint pain) but are at risk of developing the disease. The three monthly follow up visits appear to help patients understand their disease in more detail. Patients are more closely monitored for their disease progression and any adverse event is dealt with immediately to ensure patients feel more supported in their disease journey. The treatment with Abatacept itself is so far proving to ease the joint pain, so there may be an innovative pathway to treat patients with “pre-clinical” RA (i.e. before diagnosis) in future.

Patient receiving study drug

All clinical research studies being performed by the Trust are subject to performance benchmarks in initiation and delivery time. The Trust submits quarterly reports to the National Institute of Health Research (NIHR) setting out the performance against these metrics. All reports are available on the Trust website.

The annual R&D conference was held on 10 November 2017 and continues to be a huge draw for Trust staff with over 170 attendees.

Judging for the poster competition

The winning poster (RESPITE: A Multicentre Randomised Controlled Trial of IV Remifentanil Patient Controlled Analgesia vs Pethidine for Labour Analgesia by Dr Winston Ng, Dr Tabitha Tanqueray & Dr Sebastian Murray) won both the judges’ vote and the ever popular viewers’ vote. The remaining 56 posters were submitted from a broad range of specialties demonstrating the high quality of research being carried out across the Trust. Prizes were presented to the winning teams by Sir Tim Melville-Ross, Trust Chairman.

Oral presentations featured both internal speakers who discussed their current research and the effect on our patients, and external speakers (including patients) who spoke about how their engagement with research also impacts on patients.

The R&D team looks forward to continued success in 2018/19.

Equality and diversity

The Trust lead for equality and diversity is the Director of Organisation Transformation. The Equalities Report 2016, our Equality Objectives and Workforce Race Equality Standard (WRES) are available from the Trust website at www.homerton.nhs.uk All publication duties have been met.

Delivery of the Trust equality objectives, which were first published in 2012, is overseen by the Trust Equality and Diversity Group. In 2016 the objectives were reviewed by the Group to take account of the progress made. The objectives for 2016-2018 are as follows:

OBJECTIVE	SUCCESS MEASURES
EDSII Goals 1 and 2: Implement Goal 1 (Better Health Outcomes) and Goal 2 (Improved Patient Experience) of EDSII, helping us to foster an organisation which understands the cultural needs of our patients and encourages an inclusive environment.	The success measures for this objective are: • Continued improvement in the collection of patient data relating to the 9 protected characteristics and hard to reach groups and communities • Patients from all communities and protected groups have a consistent and positive experience • An inclusive environment of equality and diversity at the Trust
Workforce Race Equality Standard: develop and implement a programme of work to enhance the experience of staff at the Trust in line with the 9 indicators of the WRES.	The success measures for this objective are: • Personal and leadership development programmes developed and implement • Through analysis of disciplinary processes develop an understanding of why BME staff are more likely to enter disciplinary processes • Through analysis develop an understanding of why BME staff are more likely to report they are subject to discrimination from their manager/team leader
Workforce diversity: Improve and deepen our knowledge and understanding of the diversity of our workforce to consistently show improving levels of satisfaction and engagement for all staff groups	The success measures for this objective are: • Up-to-date and accurate records held on ESR so staff can improve and understand the diversity of our workforce • Able to respond to the Workforce Disability Equality Scheme in a meaningful way • Introduction of a Disability Forum or group

Summary of Trust Workforce Diversity Data

Age	2016/17	%	2017/18	%
16-25	270	7%	263	7%
26-35	1219	32%	1221	32%
36-45	993	26%	989	26%
46-55	833	22%	864	22%
56-65	405	11%	446	12%
66+	50	1%	53	1%
75+	4	0.11%	5	0.13%
Total	**3,774**		**3,841**	

Ethnicity	2016/17	%	2017/18	%
White	1687	45%	1737	45%
Mixed	134	4%	142	4%
Asian or Asian British	562	15%	594	15%
Black or Black British	1092	29%	1110	29%
Other Specified	146	4%	164	4%
Not Stated	146	4%	78	2%
Undefined	7	0.19%	16	0.42%
Total	**3,774**		**3,841**	

Gender	2016/17	%	2017/18	%
Male	836	22%	846	22%
Female	2938	78%	2995	78%
Total	**3,774**		**3,841**	
Recorded Disability	121	3%	140	3%

At the end of the year there were eight male and five female members of the Board of Directors, and there were three male and six female other senior management staff (including non-board level directors, directors of divisions, associate medical directors, and director of medical education).

Policies in relation to disabled employees and equal opportunities

The Trust's services and employment practices must be accessible and fair to all; employees and service users must be treated with respect and not subject to any form of discrimination, harassment or victimisation on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race (this includes ethnic or national origins, colour or nationality), religion or belief (including lack of belief), sex and sexual orientation. These are known as the nine protected characteristics of the Equalities Act 2010. The Trust is committed to promoting equality of opportunity and eliminating discriminatory practice. For staff with disabilities, whether they became disabled during the last year, or otherwise, the Trust's current workforce policies, such as related to training, and career development, manage for this, including dealing with reasonable adjustment requests.

Stakeholder relations

The Trust continues to have strong relationships with NHS, local authority and education partners as well as community and patient representative groups. In particular the Trust is actively engaged in the Health and Wellbeing Board for Hackney and represented within its formal sub-structures. The Trust is also working jointly with local commissioners and providers within the Hackney Health and Social Care Transformation Board which oversees the strategy for integrating health and social care services across Hackney and the City. The Trust maintains good representation at each of the four associated workstreams, including the Unplanned Care Board which is chaired by the Trust Chief Executive. At a sub-regional level the Trust continues to work with NHS and Local Authority partners as part of the East London Health and Care Partnership.

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

Key stakeholders have nominated representatives on the Council of Governors which also includes elected representatives of members of the public living in local boroughs and Trust staff.

The Trust has a statutory duty to collaborate with partners in health and social care. We have representation at the monthly Hackney HealthWatch and are also represented at Overview and Scrutiny Commission meetings, which are held in public, providing members with regular service and performance updates.

Exit Packages

Exit Packages awarded in 2017/18 were as follows:

	Reason	Redundancy	PILON	Other	A/L	Total
1	Agreed Termination	£0	£5,095	£0	£1,152	£6,247
2	Agreed Termination	£0	£5,000	£0	£0	£5,000
3	Agreed Termination	£0	£11,136	£0	£2,221	£13,357
4	Agreed Termination	£0	£11,303	£1,023	£411	£12,737
5	Agreed Termination	£0	£12,652	£0	£679	£13,331
6	Agreed Termination	£0	£14,739	£0	£0	£14,739
7	Agreed Termination	£19,427	£0	£0	£0	£19,427
8	Compulsory Redundancy	£3,024				
9	Compulsory Redundancy	£8,710				
10	Compulsory Redundancy	£21,156				
11	Compulsory Redundancy	£27,639				
12	Compulsory Redundancy	£30,952				
13	Compulsory Redundancy	£39,241				
14	Compulsory Redundancy	£40,510				
15	Compulsory Redundancy	£40,561				
16	Compulsory Redundancy	£43,045				
Totals		**£274,265**	**£59,925**	**£1,023**	**£4,463**	**£339,676**

Salary and pension entitlements of senior managers

Tax arrangements of public sector appointees

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

- All off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018	2

Of which:

Number that have existed for less than one year at time of reporting.	2
Number that have existed for between one and two years at time of reporting.	-
Number that have existed for between two and three years at time of reporting.	-
Number that have existed for between three and four years at time of reporting.	-
Number that have existed for four or more years at time of reporting.	-

For the two existing engagements the Trust has undertaken a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

- For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which: Number assessed as within the scope of IR35	-
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	-
Number of engagements reassessed for consistency / assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

- For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on- payroll engagements.	- 6

Disclosures set out in the NHS Foundation Trust Code of Governance

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

For the year ending 31 March 2018 the Trust complied with all the provisions of the Code as set out in NHSI's Annual Reporting Manual 2017/18.

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

Code Reference	Annual Report Section	Page
A.1.1	Board of Directors and Council of Governors	18
A.1.2	Directors Report and Board Committees	18
A.5.3	Council of Governors	30
Additional requirement	Council of Governors	29 and 30
B.1.1	Board Composition	18
B.1.4	Board Composition and Directors' Evaluation	18
Additional requirement	Board Composition	18
B.2.10	Nominations Committee	38
Additional requirement	Not applicable - no appointments made in year	-
B.3.1	Sir Tim Melville-Ross' biography	19
B.5.6	Foundation Trust Membership	32
B.6.1/B.6.2	Directors' Evaluation and Well-led Framework	28 and 65
C.1.1	Statement of Accounting Officer's Responsibilities	59
C.2.1	Annual Governance Statement	60
C.2.2	Audit Committee	23
C.3.5	Not applicable – Accepted by the Council	-
C.3.9	Audit Committee	23
D.1.3	Remuneration Report	34
E.1.4	Contacting the Board/Contacting the Governors	22 and 32
E.1.5	Council of Governors	29
E.1.6	Foundation Trust Membership	31
Additional requirement	Membership Strategy	32
Additional requirement	Register of Directors'/Governors' Interests	22 and 31

NHS Improvement's Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

As of March 2018 Homerton moved from segment 2 to segment 1, with no support needs identified across the five themes.

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 Q3 score**	**2017/18 Q4 Score**
Financial sustainability	Capital Service Cover	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	2	2
Overall scoring		**1**	**1**

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

Statement of Accounting Officer's Responsibilities

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Homerton University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Homerton University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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

Tracey Fletcher

Chief Executive

25 May 2018

Annual Governance Statement

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.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Homerton University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has ensured that its risk management system receives the appropriate leadership and management. The Chief Nurse and Director of Governance is the executive lead for risk management at Board level and the Director of Finance has delegated responsibility for managing financial risk. All Executive Directors take responsibility for risk identification, management and mitigation within their designated areas of work.

The Board of Directors has established a Risk Committee to provide assurance to the Board that the Trust has an effective and appropriate risk management system. The Risk Committee has been in operation for a number of years and is chaired by a non-executive director (NED) and its membership includes another non-executive director and the Chairman, as well as Trust executive directors. Meetings are held on a quarterly basis.

The Risk Committee:

a) ensures that the Trust Risk Register is fit for purpose and that an appropriate structure is in place for the regular scrutiny and monitoring of risks;
b) is kept informed about all aspects of risk management through a variety of reports from sub-committees and working groups on clinical and other organisational risks;
c) receives scrutiny reports from both internal and external sources including the Care Quality Commission;
d) receives annual compliance reports from the Improving Patient Safety Committee, Information Governance Committee, Policy Group, Improving Clinical Effective

Committee, Improving Patient Experience Committee, Resilience Committee (for emergency planning and business continuity) and the Health & Safety Committee;

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

The Board Assurance Framework (BAF) is the mechanism which is used to record the Trust's strategic objectives and manage the associated risks that threaten their achievement. The BAF is reviewed on a monthly basis by the Executive Directors and formally reviewed by the Risk Committee and Board of Directors to ensure that appropriate mitigating action is being taken against the key risks. Operational and other corporate risks are reviewed by the Board as part of its regular monitoring of performance through reports received, or in the context of specific issues that arise.

The divisional Quality and Patient Safety Managers report regularly via the Head of Quality and the Head of Patient Safety & Risk to the Chief Nurse and Director of Governance. The Non-Clinical Risk Manager also reports to the Chief Nurse and Director of Governance.

As set out in the Trust's Risk Management Policy, associate medical directors, divisional operations directors, senior nurses, and other relevant senior managers are responsible for the management of risk within the workplace. Together they foster a culture of risk awareness throughout their divisions and ensure that risk assessments for all work-based activity are conducted. The Trust continues to develop a comprehensive risk register, identifying risks at both the Trust and divisional and directorate level. The Head of Patient Safety and Risk is responsible for the maintenance of this register. Risk registers are held at divisional level and they are subject to regular scrutiny.

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

The Trust is committed to continuous improvement and learning; from incidents and complaints, outcomes from audits and the experiences of patients, clients and staff. The quality of performance information is assessed through data quality reports to divisions and regular audit.

The corporate induction programme ensures that all new staff are provided with details of the Trust's risk management systems and processes. This includes the comprehensive induction of all junior doctors with regard to key policies, standards and practice prior to commencement in clinical areas. Mandatory training reflects essential training needs for various staff members, and includes risk management processes such as health and safety, manual handling, resuscitation, infection control, safeguarding patients, blood transfusion and information governance. In addition tailored training for individual roles is identified by managers and agreed with staff through personal development plans. The Board of Directors received risk management training in 2017/18. The programme of risk training is subject to internal audit review.

The Audit Committee reports on the adequacy and effective operation of the Trust's overall control system. in particular it reviews, monitors and evaluates all aspects of financial risk management and oversees the policies and procedures for all work related to fraud and

corruption, as well as overseeing the internal audit programme. Its work is detailed from page 23 of the Annual Report.

The risk and control framework

The Risk Management Policy is reviewed by the Risk Committee, approved by the Board of Directors and is available to all staff through the Trust's intranet. The Risk Management Policy describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process and the Trust's risk identification, assessment and control system, as well as the Trust's risk appetite.

It includes guidance on the risk assessment matrix used to evaluate risks for inclusion in the Trust's risk registers.

Risk management is embedded in the activities of the organisation in a number of ways:

- Corporate and divisional objectives are risk assessed as part of the annual business planning and performance management process
- Structured processes are used for the completion of local risk assessments to populate the Trust's risk register
- The Quality Innovation Productivity and Prevention (QIPP) process includes a risk assessment for its schemes
- There are structured processes in place for incident reporting, the investigation of Serious Incidents (SIs), complaints and litigation cases
- All Executive Directors regularly review the BAF to ensure that appropriate action is being taken against key risks to the Trust strategic objectives
- The Trust continues to carry out on-going exercises to capture both clinical and non-clinical risk data at divisional and departmental levels through local risk assessments.

The Trust continues to abide with key elements of the quality governance arrangements set out in the Quality Governance Framework; strategy, capabilities and culture, processes and structure and measurement. The Trust ensures compliance with the Quality Governance Framework as follows:

• The quality governance arrangements are organised through the divisional structure with each division headed by an operational and clinical lead, and with a governance structure in place that supports the achievement of all quality priorities. This structure and approach to governance has recently been reviewed in light of an audit report by the Trusts Internal Auditors, with changes made to enhance the standardisation of the approach. The divisions review quality governance and performance information on a regular basis, including: incidents and serious incidents; patient experience feedback including Friends and Family Test; survey reports; complaints; Patient Advice and Liaison Service (PALS) enquiries; litigation; clinical audit data and NICE compliance. Divisional performance is also monitored and reviewed each month against a range of performance measures including quality and safety at Clinical Division Performance Review meetings.

• The Trust Management Board (Quality and Operational Assurance), chaired by the Chief Executive, meets monthly and reviews and monitors quality issues for the whole Trust.

• The Risk Committee and the Improving Quality Board, Improving Patient Safety Committee and the Clinical Effectiveness Committee and supporting groups are used as conduits for the dissemination of information to and from wards, departments and divisions

to the Board and feeding back. This approach supports the process for enabling that improvement responses are made as close to the delivery of care as possible and also provides a route for escalation of concerns and monitoring of mitigating actions to the Trust Board.

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

In summary the Board of Directors receives the following monthly information:

- performance against national targets, including infection control targets, A&E wait times and Referral to Treatment (RTT), which will be accompanied by plans for improvement if there are concerns in relation to any particular targets

- key performance indicators related to patient safety and clinical effectiveness, such as patient safety thermometer results, achievement of harm free care, number of hospital acquired pressure ulcers, number of cardiac arrests and standardised hospital mortality ratios

- exception report from the maternity services dashboard

- patient experience data, including Friends and Family Test, PALs and complaints data

- key workforce metrics, such as agency spend, vacancy rates, turnover and sickness absence

- key financial performance data, including income and expenditure and a summary of QIPP performance

- progress reports on the Trust's financial plan

- the Board also reviews serious incidents in detail at its meeting in private and the details of actions that are being taken to address any areas of concern.

The year-end key performance indicators are confirmed on page 14 of the Annual Report. The Trust did not achieve the A&E 4-hour wait target in quarters one and four and the 62 day cancer wait target in quarters, one, two and four.

Care Quality Registration

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

In May, the CQC rated both the Trust's adult community services and children & young people's community services as 'Good' in every domain, further to their inspection visit in February 2017.

An inspection of the Mary Seacole Nursing Home in August 2017 resulted in an overall "good" rating and with good in all five key lines of enquiry. An earlier inspection in August 2016 had resulted in an overall "requires improvement" rating. The action plan in place to

address the issues raised has now been closed following the successful outcome of the inspection.

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

The implications for the Trust registration with CQC are included in the assessment of each bid or tender application made and also when changes are being planned to the scope or other arrangements of services currently provided.

Board Oversight

The Trust reported a year-end surplus of £11.7m for the financial year 2017/18 before impairments and including all sustainability and transformation funding. A review of the 2017/18 financial position has been incorporated within the 2018/19 planning process. Cost pressures have been reviewed and the governance around cost control and cost savings is being strengthened to meet the in-year efficiency savings target.

Further assurance is provided by the Audit Committee who commission specific reviews by the Trust's internal auditors and counter fraud services. Any areas of concern are risk assessed and managed via the Trust Risk Register and assurance has been provided through the scrutiny, at Trust Board level.

A Board Assurance Framework (BAF) detailing the principal risks to the achievement of the Trust's strategic objectives was in place for the financial year. As mentioned earlier, the BAF has been reviewed regularly by the Trust's executive team and Board of Directors throughout the year. All of the principal risks identified are monitored and reviewed by the Risk Committee at each of its meetings.

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

- failure to develop an engaged and motivated workforce may undermine the Trust's ability to deliver its services in accordance with its values and desired staff behaviours, resulting in a poor experience for the patient;

- the patient receives avoidable harm from poor practice as a result of a failure to comply with required Trust safety policies and lessons learned;

- if the culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust falling short in the quality of care delivered to patients;

- a lack of adherence to latest research, or practice which is not compliant with the best evidence could lead to a less effective service provision;

- failure to achieve financial targets may result in difficulties in funding future investment plans and threaten the organisation's financial autonomy;

- poor reviews and performance outcomes by regulators, other bodies, the press and public may result in a damaged reputation that diminishes the Trust's ability to grow;

- failure to expand and retain sufficient activity through a failure to adapt and engage in local collaborative healthcare arrangements may limit the Trust's ability to increase turnover and maintain clinically sustainable services.

The Trust has comprehensive plans in place to mitigate the above risks which are monitored by the Risk Committee and Trust Board. The efficacy of these plans is assessed regularly by the executive team and reviewed monthly by the Trust Board. The Trust recognises its risk management approach will not eliminate risks totally, but it will provide the organisation with a means to identify, prioritise and manage the risks. This will provide a balance between the cost of managing and treating risk, and the anticipated benefits that will be derived.

Incident reporting is openly encouraged through staff training and further embedded by the Trust's adoption of a just culture. Risks identified from serious incidents that impact upon public stakeholders are managed by involving the relevant patient and/or their family. The Trust has an established process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed, policies have an equality impact assessment completed, which is considered by the approving group and the Trust's Policy Group. The Equality and Diversity Group reports to the Training, Education and Leadership Committee, which reports to the Workforce Committee, and its work centres on progressing actions to advance equality in the Trust and meet the standards set out in the NHS Equality Delivery Systems (EDS2).

Well-led Framework

In June 2017, the Trust Board formally accepted an externally commissioned 'Well-led' governance review report and the recommendations that were made. The report concluded that the Trust was well-led with a strong board but was facing significant challenges, in particular, financially and strategically.

The independent review was carried out against the well-led governance framework published by Monitor in May 2014 with an assessment made in relation to the four well-led domains:

1) Strategy and Planning
2) Capability and culture
3) Process and structures
4) Measurement

Of the 10 questions asked as part of the well-led framework, three were rated as 'green' (meets or exceeds expectations) and seven were 'amber-green' (partially meets expectations but confident in the management's capacity to deliver).

The high performing areas were:

a) The Board's skill and capacity to lead the organisation.
b) The Board's ability to shape an open, transparent and quality-focused culture.
c) The active engagement of stakeholders on quality, financial and operational performance.

The outcome of the well-led governance review was shared with NHS Improvement and action plan was drawn up to address the recommendations identified in the report. Key areas for improvement highlighted were:

a) A need for a greater focus on strategy.
b) A lack of diversity on the Trust Board.
c) A thinly spread resource in quality governance.

The Board has received regular updates on the identified actions and has paid particular attention to the improvement areas mentioned above. Of the 22 actions raised, 14 had been completed at the end of February 2018.

In March, the Trust was notified of a CQC well-led inspection visit in May 2018.

Stakeholder Involvement

The Trust has arrangements in place for working with stakeholders and partner organisations, including close working with the Trust Commissioners, local General Practitioners, the Council of Governors, Healthwatch, NHS England (London), the City of London Corporation, and the London Borough of Hackney. Stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including:

- public and stakeholder representation on the Council of Governors
- involvement from the members of the Foundation Trust
- the National Patient Survey Programme
- Healthwatch Hackney and Healthwatch City of London
- Health in Hackney Scrutiny Commission
- Hackney Health and Wellbeing Board.

Pensions

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

Carbon reduction

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

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

In addition to the financial review of resources and the quarterly monitoring returns to NHS Improvement (NHSI), all budget holders are provided with monthly financial information to help them ensure resources are used economically, efficiently and effectively. Monthly finance and performance reports are provided for the Board. Internal Audit also has an important role to challenge how resources are used. The Trust has an internal performance management review process which provides evidence of performance at divisional level and the actions being taken to ensure resources are being used effectively and efficiently. In addition the annual business planning process, including the requirement to identify productivity and efficiency opportunities, that provides another mechanism to achieve this

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

In March, the Trust was notified of a Use of Resources Assessment, led by NHS Improvement to take place in May 2018. This assessment will generate a report and rating which will be published by the CQC.

Information governance

The Trust has an established process for managing the Information Governance agenda, led by the Medical Director, as Caldicott Guardian. The Chief Operating officer is the Trust Senior Information Responsible Officer. Systems and processes have been reviewed, including the submission of the Information Governance Toolkit, which, after internal audit review, met all requirements at level 2 or above, with an overall score of 74% and a rating of satisfactory. The Trust declared that it has complied with information governance guidelines and the Data Protection Act 1998. The Information Governance Committee is responsible for monitoring and controlling risks relating to data security and oversees an Information Governance risk register. The Information Governance Committee reports to the Risk Committee on a quarterly basis, which in turn reports to the Board.

All Information Governance security related incidents were reported via NHS Digital's incident reporting tool during the financial year 2017/18 and there were no level two incidents during this period.

Annual Quality Report

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

The Annual Quality Account 2017/18 has been developed in line with relevant national guidance and legislative requirements. The Quality Account meets the NHSI requirement to produce a Quality Report. Assurance over the content and quality of the information in the report is achieved as follows:

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

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

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

and sent for internal and external consultation, including the Council of Governors. The Trust Management Board approves the final content of the report before it is presented to the Trust Board.

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

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

Internally generated information is produced by the specialist Information Services team and is used both in the Quality Account and for operational performance management, including the management of elective waiting lists which are formally reviewed in operational meetings. All core information is subject to review and approved by appropriate Trust senior management before distribution internally or national return submission. The HSCIC indicator portal is also used in the preparation of accounts to ensure that nationally reported figures align with those being reported internally. In addition the Trust has a dedicated data quality team whose remit is to operate the Trust's data quality assurance framework. Finally, the Trust's internal audit function is also actively engaged in the validation of the data used in the preparation of the Accounts. Further details of the Trust's data quality processes can be found in the Quality Account.

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 that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- reports from the internal and external auditors and the local counter fraud specialist
- patient and staff surveys
- outcomes of Care Quality Commission reviews.

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

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

- The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing reports from the Risk Committee and Audit Committee. The Board has also reviewed the Board Assurance Framework as well as monitoring performance objectives via the integrated Board report.

- The Risk Committee has overseen the effectiveness of all the Trust's risk management arrangements including review and endorsement of the Risk Management Policy and the on-going development of the risk register including all key clinical and non-clinical risks highlighted by other committees.

- The Audit Committee has been a directing force in relation to reviewing the system of internal control particularly with regard to corporate risk and counter fraud. The Audit Committee also has a key role in the oversight of the Trust's key financial challenges. Internal Audit has reviewed and reported upon financial reporting, clinical audit and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

- Executive Directors have ensured that key risks have been highlighted, monitored and the necessary action taken to address them. Executive Directors were also directly involved in producing and reviewing the BAF.

- Internal Audit provided consistent support and advice with regard to the system of internal control including the on-going development of the Trust's risk management processes. The head of internal audit opinion did not, based only on the work they undertook during the year, highlight any issues that required flagging as significant control issues and stated the Trust had an adequate and effective framework for risk management, governance and internal control. They did, however, identify some weaknesses in the application of some internal controls and management actions to address these weaknesses were agreed and are progressing.

Conclusion

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

Tracey Fletcher

Chief Executive

Date: 25 May 2018

QUALITY ACCOUNT

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

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Homerton University Hospital NHS Foundation Trust

Quality Account Report 2017/18

Our commitment to quality

CONTENTS

Part 1: Statement on quality

1.1 Statement on quality from the Chief Executive

I am delighted to present our Quality Account for 2017/18, which details Homerton University Hospital NHS Foundation Trust's position on quality over the last year, and which provides assurance that we continue to strive to provide the highest quality clinical care. We are proud to continue to perform well against our key performance and regulatory requirements while delivering high quality care for our patients and service users. The focus given to the quality improvement work is key to these achievements.

Our improving quality programme has continued to lead and support improvement projects throughout the year. Overall our approach to quality improvement includes key areas of partnership working across Hackney to deliver system-wide change and increase the impact of this. The Trust has been aligned with the work of the Transformation Board in developing pathways of care and supporting the development of the neighbourhood approach, enhancing the opportunity for multi-disciplinary working. The programme has also continued to focus on reducing avoidable falls in hospital wards resulting in: the falls with harm rate continuing to reduce year on year; identification and response to acutely deteriorating patients; and further work on understanding what 'trust and confidence in nurses' means to patients, families and staff, the results of which now form the basis of nursing study days.

The internal quality transformation work has once again explored the benefits of technological and system advancements, and considered how these could improve the way we are able to offer care and share information effectively. This has resulted in the introduction of mobile working for community staff to provide access to patients' records on the move. In addition, the initiation of the implementation programme for a paperless outpatients service through the use of system enhancements and improved digital dictation is enabling easier access to patient records for all clinical staff plus faster, more effective communication to GPs.

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

- A&E 4 hr waits – one of the best performing NHS trusts nationally;
- SHMI – recorded as 13th lowest nationally
- National Cardiac arrest audit – lowest rate of inpatient cardiac arrests nationally
- RTT (waiting times) – 96% of patients wait <18 weeks
- Diagnostic waiting times - 99.97% of patients wait < 6 weeks for diagnostic procedures
- Clinical pathways - 21 optimised clinical pathways developed in partnership with primary care designed to improve patient care
- Personalised care - 170 staff have been trained in shared decision making to enable personalised care and support for patients with long-term conditions

We have also welcomed the Care Quality Commission (CQC) during the past year when they carried out inspection visits to adult and children & young people community services and Mary Seacole Nursing Home. Both inspections led to overall ratings of Good and each of the key lines of enquiry also receive Good ratings. A range of other services have been peer reviewed during the course of the year including pathology, who gained United Kingdom Accreditation Service (UKAS) accreditation, to international standard ISO 15189:2012, for each of the three pathology departments – biochemistry; microbiology; and haematology & blood transfusion.

We continue to share our examples of good practice both within Homerton at our Quality Sharing Days, Simulation Training Day and the annual Research & Development Day, all with attendance from local stakeholders and partner organisations. Additionally, recognition has been given to our Locomotor Service who won the 2017 Health Service Journal Value Award for improving the value of diagnostics. The HSJ Value Awards seek to recognise and reward outstanding efficiency and improvement by the NHS. These national awards recognise the work of our extended scope practitioners for developing and incorporating ultrasound imaging into their clinical practice as musculoskeletal specialist practitioners.

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

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

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgment about individual cases, where another clinician might have reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

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

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

Tracey Fletcher
Chief Executive
Homerton University Hospital NHS Foundation Trust

1.2 Introduction to the Quality Account 2017/18

Homerton University Hospital NHS Foundation Trust has always placed the quality of services uppermost in the strategic aims of the organisation and at the heart of decisions taken by the Board.

As an NHS health care provider we are required to produce an Annual Account to describe the quality of services we deliver to our patients (as part of our Annual Report). Foundation trusts must also publish quality accounts each year, as required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010.

Quality accounts help NHS trusts to improve public accountability for the quality of care they provide. The Quality Account is a key mechanism to provide demonstrable evidence of measures undertaken in improving the quality of the Trust's services. The Quality Account also describes the organisation's quality priorities and aims for the coming year.

The Quality Account incorporates all the requirements of the Quality Accounts Regulations as well as those of NHS Improvement's (NHSI) additional reporting requirements. The purpose of the Account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review its services
- demonstrate what improvements are planned by the Trust
- respond and involve external stakeholders' feedback including patients and the public.

Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2017/18.

The Trust Management Board takes responsibility for overseeing the development and delivery of the Quality Account and quality priorities. Underpinned by the three key drivers for quality and the Care Quality Commission's (CQC) five domains, the Trust's 'Quality Structure' creates a robust arrangement for driving improvement and providing a clear and accountable process for scrutiny and assurance for delivery of the Quality Account.

Glossary symbol:

This symbol * indicates a term's inclusion in the Glossary, Appendix C.

1.3 Homerton s approach to improving quality

Quality is at the heart of Homerton University Hospital NHS Foundation Trust's organisational strategy and values set out in 'Achieving Together: Working towards 2020'.

The Trust's approach to quality improvement supports the delivery of this strategy and is aligned with the organisation's values.

The Trust launched its first Improving Quality Strategy in autumn 2015. The strategy introduced the Institute for Healthcare Improvement (IHI) model for improvement in recognition that organisations need a repeatable method to underpin their improving quality activity. In spring 2017 the Trust reviewed and refreshed the Improving Quality Strategy. This puts renewed emphasis on the fact that improvements in quality of care are more likely to occur when staff are equipped with the skills needed to bring about changes and are supported by leaders at all levels.

During 2017/18 the Quality Improvement (QI) team has worked with a wide variety of services. Examples include:

- reducing harm from avoidable falls in hospital wards
- working with home care agencies and primary care staff to improve carer's ability to recognise and respond to pressure ulcers
- building patient centred care capability and capacity through advanced communication skills training. The QI* team organised a Person Centred Care showcase in January 2018. This enabled patients, service users and clinical staff caring for adults, young people, children or babies working in hospital and community settings to network and share ideas and experiences.

The QI team has brought quality improvement methods to:

- identify and respond to acutely deteriorating patients by examining relevant data and information
- build and modify clinical service and topic focussed dashboards to support and drive improvements in care
- find out what 'Trust and confidence in nurses' means to patients, families and staff through facilitated focus groups, interviews and telephone surveys. Themes identified have formed the basis for nursing study days and small scale QI projects.

Partnerships

Working in partnership is a key component of the Trust's Improving Quality approach and Homerton has benefitted from being part of UCL Partners (Academic Health Science Network). The QI team ran a quality improvement workshop jointly with UCL Partners showcasing the LIFE system for data analysis and project management at the Trust's seventh Annual Simulation Conference.

Homerton is an active participant in the QUEST network of 14 NHS trusts which are committed to focussing on improving quality and patient safety. In 2017/18 the Trust participated in the launch of the 'Best Employer' brand initiative and is helping to develop and test the standards that will be used to judge compliance. The aim is to be in the top 20% NHS trusts to work by 2020.

Homerton's Transformation Programme includes projects that harness technologies and develop new ways of working. The aim is to develop and embed best practice in delivering safe, effective and efficient care. Projects include three projects.

- Developing electronic patient records, introducing kiosks and use of voice recognition systems to ensure that outpatient clinic appointments run smoothly and information is communicated securely between patients and health professionals.
- Increasing the proportion of patients undergoing the laparoscopic cholecystectomy procedure that return home the same day. The team have benefitted greatly from participating in the Improvement Science for Leaders programme run by Haelo at QUEST.
- Introducing mobile working to community based health care workers so that they are able to care for clients close to their homes more effectively.

The Improving Quality Strategy 2017 will continue to shape QI priorities and ways of working in 2018/19. In particular there will be a focus on harnessing the creativity and ideas of teams working in partnership with patients to improve care by providing coaching in QI methods and tools.

1.4 Quality achievements in 2017/18

The Trust is located in the London Borough of Hackney and is an integrated provider of acute and community based services across parts of the City of London and the London Borough of Hackney. As a Foundation Trust, Homerton continues to maintain its reputation as a high performing provider; and strives to work in partnership with commissioners, local GPs*, Healthwatch Hackney and other voluntary and statutory groups to ensure that the care we deliver is safe, effective and a positive experience for service users.

During 2017/18, the Trust has accomplished a number of achievements that it is proud of, and which support the organisation's drive and commitment to provide quality services to its local community. The following is a snapshot of these (detailed information on each will follow in future pages).

- Homerton Hospital classified 13th for the lowest Summary Hospital-level Mortality Indicator (SHMI) score
- Homerton Hospital has the lowest rate of cardiac arrests in patients on wards nationally.
- Rapid access to services for patients
- Emergency Department (ED) continues to be amongst the top performers in achieving 4 hour targets
- Discharge team recognised as Hackney stars
- Pathology department gains United Kingdom Accreditation Service (UKAS) accreditation, to international standard ISO 15189:2012
- Research study recruitment performance at Homerton Hospital is one of the highest in London
- Homerton is one of the top performers in data submission, standards of care and outcomes
- the Trust is placed high against all London acute trusts for participation in patient-led assessments of the care environment (PLACE).
- Community mobile working and community transformation
- SkyGuard devices offer reassurance for all 'lone' community staff
- Locomotor Service won the 2017 Health Service Journal (HSJ) Value Award for improving the value of diagnostics
- Providing training and support for overseas nurses
- Homerton has committed to being baby friendly
- The quality teaching over coffee (QTc) bulletin, is a successful tool for sharing learning
- Homerton Hospital site has become a no go zone for smoking

Homerton Hospital is classified 13th for the lowest SHMI score out of 134 acute trusts

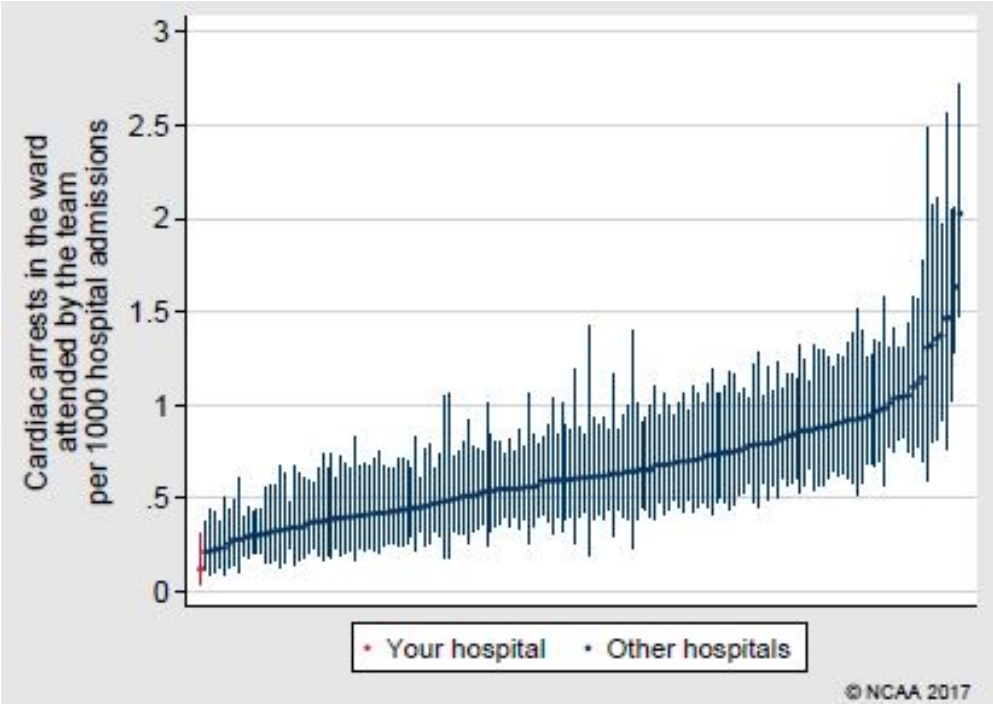
The latest data available for SHMI is for the period from July 2016-June 2017 released in December 2017. Overall Homerton Hospital has had the 13th lowest Standardised Hospital Mortality Indicator in the last two periods released nationally.

For further information please refer to section 2.3 (Core Performance Indicators) of the Quality Account.

Homerton Hospital has the lowest rate of ward cardiac arrest in the Country

We are very proud that, in the most recent National Cardiac Arrest Audit, Homerton had the lowest rate of cardiac arrest on our wards of any hospital in the country.

FIGURE 1: TRUST position in the NCAA 2017 report



Rapid access to our services for patients

Endoscopy is now providing a direct access and straight to test service to allow GPs to refer patients straight in to an endoscopy procedure. Dermatology and respiratory services deliver a one stop pathway for suspected cancer patients, providing same day biopsy/excisions or lung function test directly following first appointment. These pathways shorten patient waiting times allowing earlier diagnosis and faster treatment.

ED* continues to perform well nationally

The Emergency Department performance against the 4 hour wait target has been challenging nationally, but despite this our ED and Urgent Care Centre continue to deliver excellent care and remain one of the top performers in relation to the 4 hour target.

The aim of the team is to consistently deliver high quality care to all patients and to help people when they are at their most vulnerable including relatives and family members.

There is a continued focus to reduce the number of patients who breach the 4-hour standard, whether the 95% target has been achieved or not. It is accepted that this can be challenging at times, and is reviewed regularly at operational and strategic levels.

At an operational level interventions include:

- structured feedback every 12 hours from the Emergency Department senior staff which included challenges to the shift in order for these to be acted on as soon as possible and to identify early trends or concerns
- daily review of the past 24 hour breaches by an emergency medicine consultant
- weekly multi-disciplinary meetings to review performance, ensure adequate staffing in all streams, identify any areas of potential concern, review incidents and complaints to ensure a high level of quality of care is continued to be delivered
- meetings with supporting services such as pathology and radiology to review the entire patient pathway and improve flow.

There is a weekly ED meeting chaired by the Chief Operating Officer where performance is reviewed in detail. This allows a thorough break down and review of multiple aspects of the performance, gives an opportunity to question events and challenges and helps support the department by providing any additional resources and senior executive support where required.

There was one specific day (5 March 2018) when there was an unusually high number of breaches which was an unexpected situation. This resulted in a significant reduction in performance against the 4-hour standard for the 24-hour period. This was unprecedented and in order to understand and reduce the probability of this recurring, it was fully investigated internally, lessons learnt and action taken.

At a Trust level, the 4-hour standard is accepted as a hospital target rather than the Emergency Department alone, and hence a lot of work has been done within the medical productivity programme to ensure flow through the hospital is as optimal as possible.

Discharge team are Hackney Stars

Homerton Hospital's integrated discharge team were awarded the 2016 'Team of the Year' by the Hackney Stars awards programme run by the borough council. The multi-disciplinary team of five who plan and coordinate patient discharges back into the community were selected for their hard work, enthusiasm and knowledge. Manager Vicky Greig said: "I only joined the team this summer so it's all credit to the team members who won the award last year. They do a tremendous job. We now hope to maintain our service and perhaps win the award again."

FIGURE 2: HUHFT Discharge team

Pathology department gained UKAS accreditation

Paula Wilks, Pathology Quality Manager, tells of the effort that went into ensuring accreditation.

In 2017 pathology at Homerton Hospital gained United Kingdom Accreditation Service (UKAS) accreditation, to international standard ISO 15189:2012, for each of the three pathology departments – biochemistry, microbiology and haematology & blood transfusion.
The accreditation is for a diverse and complex range of tests, developed in response to the needs of the local population. As far back as 2014 we embarked on an improvement schedule to ensure that we were compliant with the higher level ISO standard. We were inspected by UKAS* between June 2015 and January 2016, with each lab inspection lasting two to three days and with several UKAS inspectors on site each time. The inspections were in a lot of depth, looking at all the processes in each laboratory and the quality management systems in place. It was a lot of pressure for everyone in pathology, but the outcome was the best possible – an offer of UKAS accreditation for each lab! After each visit we had a number of findings to clear, and so we worked hard to clear them as quickly as possible.

Staff put in a lot of effort to get the laboratories ready for inspection by UKAS, on the inspection days and to clear the findings. This was recognised by the UKAS inspectors in their feedback comments:

"The assessors were impressed with the overall atmosphere in the laboratory. All staff were friendly and open with, and gave full cooperation to the assessors."

"Staff were clearly enthusiastic about the services offered by the laboratory, and their individual part in that service. The staff were prepared for the visit, and though many activities were witnessed being performed by different members of staff, all of them seemed quite happy to be witnessed performing the different activities".

"The service was well managed and efficiently run by very enthusiastic and Knowledgeable staff".

"Overall quality management processes are good".

I would like to thank the pathology staff once again for all their hard work.
We are now accredited for the individual tests we perform in-house.

Please refer to our web page:
(http://www.homerton.nhs.uk/our-services/services-a-z/p/pathology/qualitydepartment/pathology-accreditation/)

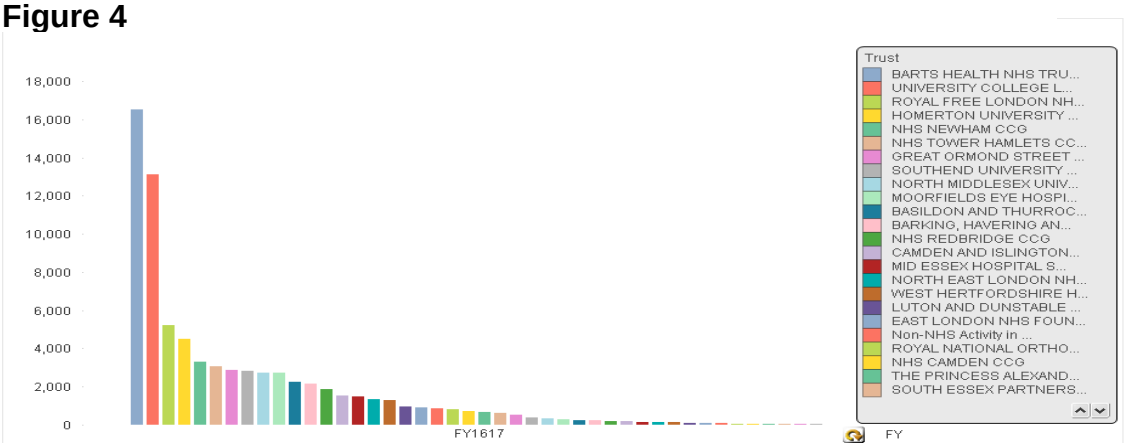
Figure 3: Trust Pathology team

Research study Recruitment performance at Homerton University Hospital Foundation Trust

Homerton was the fourth highest recruiting Trust in the North Thames Clinical Research Network (NT-CRN) for 2016/17 (see **Figure 4**) which is an increase on 11 positions in 2014/15 where the Trust was 15th in the table. There is also improved communication of research in the Trust and enhanced collaboration with the clinical support services such as pathology, radiology and pharmacy as they are all integral to the successful delivery of the vast majority of interventional studies and as such the R&D team works very closely with these departments when setting up any new study. This reflects in different ways as Homerton Hospital was awarded NT-CRN* R&D team of the month to the fertility team for recruiting the first patient within 18 days. Also recruiting the first patient in the country in a

commercial study raises Homerton Hospital's profile as an excellent research site for further pharmaceutical research studies.

Figure 4



Homerton is one of the top performers in data submission, standards of care and outcomes

The Year 3 National Emergency Laparotomy Audit demonstrates that Homerton is one of the top performers in terms of data submission, standards of care and outcomes. Standards of care in terms of consultant presence in theatre and critical care admission post-operatively are currently at 100% for patients with >5% predicted risk of mortality (See attached HUH Year 4, Q3 report). P-POSSUM* scoring is over 90%. The risk-adjusted 30-day mortality is 4.4%, less than half the national average of 10.6%.

Homerton is placed high against all London acute trusts for participation in Patient-Led Assessments of the Care Environment (PLACE)

Ever since 2013 and the introduction of a new assessment formula Homerton Hospital has participated in PLACE*. The assessments involve local people (known as Patient Assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and the extent to which the environment is able to support the care of those with dementia. The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services.

There are separate assessments and scores issued for Homerton Hospital and Mary Seacole Nursing Home, likewise combined Trust-wide scores. Homerton Hospital performed extremely well in 2017 and demonstrated continuous efforts to drive improvements in the patient environment. Both qualitative feedback of the assessors and quantified comparison to other NHS organisations highlighted recognition of the combined focus set by the Trust. The

organisation scored high across all PLACE domains, ranking within the 20% best of all NHS trusts. Homerton placed equally high against other acute London trusts.

Community mobile working and transformation

The community teams have been using laptops to undertake clinical work whilst working in the community as part of the transformation agenda. The benefits have been to:

- access to Rio in the clients home allows access to all clinical information, e.g. open referrals for other HCP, progress notes, assessments etc
- have the patient history available at their staff's fingertips
- access Health Information Exchange portal with consent of the patients to see GP records
- allows staff using mobile working laptops to do their clinical recording while out and about, which allows staff to work more efficiently by reducing travel time.

A time and motion study was conducted with a 50% roll-out of RiO software and WiFi enabled laptops. This study showed a decrease in travel time and increased patient face to face contact.

Due to the success of this study, laptops have been issued for the Acute Community Rehabilitation Team (ACRT) which enables 100% roll-out of mobile working for clinical staff.

Further evaluation will help us to understand the team-wide impact.

ACRT* has taken a system-wide approach following the introduction of self-management models. The service works with clients to develop and deliver a high quality rehabilitation programme in order to empower them to live with their health condition. Rehabilitation with ACRT aims to build on clients' skills, knowledge and confidence by focusing on each individual's values and goals.

Having undergone training and updated the mission statement, the team is now implementing service-wide changes to support staff, clients and ensure sustainable change across all aspects of service delivery which includes reviewing all client correspondence, team leaflets and creating client-therapist videos as a teaching resource for staff. ACRT has created its own PROM (patient reported outcome measure) to start piloting and is looking to digitise this in line with the paperless and transformation agenda. One of ACRT's occupational therapists is currently on a part-time placement with 'Bridges Self-Management' and is evaluating the impact of these service changes as part of their pre-MReS project.

The team was a finalist in the GP Awards for 'Long Term Conditions of the Year' for its work reviewing the Parkinson's Disease Pathway, joining community and inpatients teams to optimise client care and introduced the inter-disciplinary assessment in line with NICE Parkinson's Disease guidelines.

Patricia Griffin and Kira Rowsell, ACRT physiotherapists, were invited to the Houses of Parliament in October to represent and promote community physiotherapy for City & Hackney with the launch of the Chartered Society of Physiotherapy's #RehabMatters campaign (see **Figure 5**).

Figure 5

SkyGuard offers reassurance for community staff

The Trust has provided all 'lone' community workers with new higher specification personal alert devices.

The SkyGuard Lone Worker Devices (LWDs) provide an important support function ensuring that staff working in the community can get help and support immediately in an emergency situation.

Davie Ore, the Trust's Interim Security manager said: "As part of our recent work on improving the way we respond to violence and aggression, the Trust is making available to all lone workers a new and upgraded SkyGuard device.

Figure 6

"The devices can pinpoint the location of staff in an emergency or if they are unaccounted for whilst on duty via GPS and staff can use an SOS emergency button if they feel threatened in any way. All staff will also be asked to use the devices to 'check in and out' at the beginning and end of the day so that the Trust is aware they are working in the community and also that they have safely completed their work".

Community Midwifery Matron Muna Ward said: "It's very reassuring to be able to keep in contact with base and also to know that if needed staff can alert us of any threat to them immediately.

Community staff are being asked to watch a short video, which is a useful refresher for staff members on how to use their new devices: https://www.youtube.com/watch?v=YSqrAHPnCWg

Homerton's Locomotor Service won the 2017 HSJ* Value Award for improving the value of diagnostics

Homerton's Locomotor service is a community based musculoskeletal interface service. Its team of extended scope physiotherapists (ESPs) manage complex conditions referred from primary care. To improve each patients' journey and avoid delay in secondary care diagnostics, ESPs* have trained to become musculoskeletal sonographers to provide diagnostic ultrasound as well as ultrasound guided injections for the MSK* conditions they encounter in their clinics in a primary care setting.

These national awards recognise the work of the ESPs for developing and incorporating ultrasound imaging into their clinical practice as musculoskeletal specialist practitioners.

Winning an HSJ value award and being shortlisted in two other categories is a huge achievement and demonstrates the range of value that locomotor service ESPs (who are also trained musculoskeletal ultra-sonographers) bring to Hackney and the wider NHS. The HSJ Value Awards seek to recognise and reward outstanding efficiency and improvement by the NHS.

https://www.hsj.co.uk/topics/finance-and-efficiency/hsj-value-in-healthcare-awards-2017-improving-the-value-of-diagnostic-services/7017781.article

The Locomotor service was a finalist in two other HSJ Value award categories: Specialist Service and Training and Development (**see Figure 7**).

Figure 7

Providing training and support for overseas nurses

A training programme has been devised at Homerton Hospital to enable overseas nurses to become fully accredited to work in one of the most specialised and high pressure environments of any hospital – the Intensive Care Unit. Homerton Hospital's ICU recently began recruiting from overseas and successfully employed four nurses from the Philippines: Rochelle So, Alfred Batalla, Jeremiah Lopez and Czarmaine Piluden.

Figure 8

Emma Gumbleton, ICU Clinical Nurse Educator, and the ICU Nursing team

The four were involved in a pilot scheme at the hospital to prepare nurses for the national Objective Structure Clinical Examination (OSCE). This test was introduced in October 2014 and is a requirement for all overseas nurses to undertake to gain part 2 of the Nursing and Midwifery Council (NMC) register.

The exam is designed to test the nurse's ability to apply professional standards and to ensure that they are safe to practise; meet the requirements set out by the NMC* Code; and are competent to enter the register. The exam is made up of written and practical challenges which test each individual's skills, experience and knowledge. ICU* Clinical Nurse Educator Emma Gumbleton (provided the nurses with a structured approach to their learning and development, and they were allocated one day a week to practise and prepare for the exam.

Emma said: "During this time, the nurses practised the written tests" (as this account for approximately 67% of the OSCE*). Patient-centred assessment was practised using questions to identify patient's needs to be able to formulate a nursing plan of care, implementation of care through administering medications and completion of a transfer of care document for nursing evaluation. These procedures were practised multiple times including the clinical skills stations and simulating scenarios.

"The exam is a challenge for the nurses as the average pass rate is 50%. The nurse is only allowed to take it twice and if unsuccessful is required to wait a minimum of six months before they are able to re-sit the exam. The time and effort we are putting into this preparation work appears to be paying off as we currently have a 100% success rate in the exam with the first four applicants all passing first time.

"We are delighted to have such dedicated and caring professionals working with us. We are soon to have four more nurses join the team from the Philippines and are looking forward to their arrival - and to begin preparing them for full accreditation to enable them to be part of the ICU team."

The work to recruit and develop overseas nurses will is now being rolled out across the Trust with 19 nurses arriving over the next few months who will work in different parts of the hospital.

Homerton Hospital committed to being baby friendly

Homerton's Health Visiting Service and City and Hackney Children's Centres, have been awarded a "certificate of commitment" from the UNICEF Baby Friendly Initiative.

Figure 8

This is the first step towards gaining international recognition for great work supporting mothers and their partners.

The Baby Friendly Initiative is a programme created by UNICEF and the World Health Organisation and was designed to support, protect and promote breastfeeding and close, loving parent - infant relationships. The Baby Friendly Initiative is a tiered accreditation. By achieving a certificate of commitment, it demonstrates that the Trust is ready to work towards gaining stage 1 accreditation within the next year.

Bahar Ghodsian, Baby Friendly Initiative Project Lead Dietitian said: "To achieve stage 1 we will carry out a review of staff training and update the infant feeding policy. Staff will also be audited around their knowledge of responsive parenting and infant feeding. Once fully implemented, the accreditation has been proven to result in cost savings, an increase in breastfeeding rates and hence better health outcomes for mothers and infants across the borough. It will also improve support for parent-infant bonding and relationships."

This certificate was preceded by a visit from Anne Woods, Deputy Programme Director of the UNICEF Baby Friendly Initiative. Anne's team spoke to 50 health visitors, midwives, dietitians, children's centre staff and neonatal nurses, providing an introductory presentation about breastfeeding and the Baby Friendly Initiative. With the support of UNICEF, an action plan was then developed to enable achieving the certificate of commitment and to work towards Stage 1 accreditation.

Bahar explained: "The Baby Friendly Initiative is much needed as, despite strong evidence behind the benefits of breastfeeding, the UK has some of the lowest breastfeeding rates in the world. At 6-8 weeks of age, a large number of infants in Hackney receive breastmilk but fewer than half are exclusively breastfed.

"The World Health Organisation recommends exclusive breastfeeding for the fi rst six months of life and with continued breastfeeding alongside solids for two years and beyond; currently less than 1% of UK infants receive this.

"However, internationally, the breastfeeding picture is very different with children, on average, receiving breastmilk until an estimated 4-5 years.

"We are delighted that City and Hackney Children's Centres and Health Visiting services have received this award," said Baby Friendly Initiative Programme Director Sue Ashmore. "Surveys show us that most mothers want to breastfeed but don't always get the support they need. Mothers in City and Hackney have the satisfaction of knowing that their health visitors and children's centres are aiming to provide the highest standard of care."

For more information on the Baby Friendly Initiative, please see - https://www.unicef.org.uk/babyfriendly / or contact Baby Friendly Initiative Project Lead Dietitian bahar.ghodsian@nhs.net

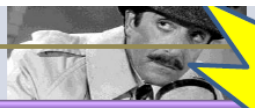
Sharing learning through QTc*

The QTc is a Trust-wide newsletter with a focus on quality and safety in a fun, friendly and easy to read format. It follows on from the success of the AED, the Emergency Department Newsletter and alternates with the QTc Bullets.

The QTc is aimed towards all Trust staff members, at all levels to include clinical and non-clinical staff. The QTc covers information from all areas and includes data regarding incidents and reporting, never events, risk alerts and also 'learning from others' where departments can be open to all and share their data and governance information so that other areas can learn. This aims to highlight that many of the issues faced within one area are similar to those faced in other areas and working as one, and information sharing can reduce incidents and errors occurring. It also aims to highlight areas where processes are working well and support those areas where governance processes might be weaker by providing direction, information and people or areas to contact for further support.

The QTc Bullets is produced alternative months with the QTc and is more direct and punchy. The QTc Bullets reports two or three real serious incidents from the Trust that have been signed off from the Patient Safety Committee (PSC) with specific lessons that all staff would benefit from. This aims to make incidents and the surrounding learning real and relevant to all. It also links to themes within the serious incidents and also with the QTc.

Edition 12 May 2018



Rigor Mortis sets in between 3-4 hours after death. It disappears again within 36 hours.

The QTc

Mortality Reviews and the Story so far

In 2017 the National Guidance on Learning from Deaths was published which aims to create a standardised approach to reporting and investigating deaths that occur in hospitals, so that lessons can be learnt and processes improved. This does not replace other processes such as the Serious Incident process or the Child Death Overview Panel but works alongside them. All hospital deaths are reviewed and provided with a 'CESDI score' between 0 (no suboptimal care) to 3 (suboptimal care – where different care would reasonably be expected to have made a difference and hence considered a potentially 'avoidable' death'.) This score determines the degree of 'suboptimal care' if any, and whether this contributed to the death or not. The aim is very much about making improvements and what lessons can be learnt, especially towards optimising end of life care. So where are we at so far? April – September 2017 data shows that there were 203 deaths of which 181 were reviewed.
Of the 181, there were CESDI 3 x2, CESDI 2 x3, CESDI 1 x44 and CESDI 0 x102. Full Data Dashboards for April – September 2017 are as follows....

Total Number of Deaths and Deaths Reviewed

No. Deaths			No. Reviews undertaken		
April	May	June	April	May	June
33	47	38	29	43	36
Quarter 1			Quarter 1		
118			108		

Total Deaths Reviewed by CESDI Score

Score 0 No suboptimal care			Score 1 Suboptimal care, but different management would have made no difference to the outcome			Score 2 Suboptimal care - different care might have made a difference (possibly avoidable death)			Score 3 Suboptimal care - different care would reasonably be expected to have made a difference (probably avoidable death)		
April	14	48.3%	April	6	20.7%	April	1	3.4%	April	0	0.0%
May	25	58.1%	May	7	16.3%	May	0	0.0%	May	0	0.0%
June	18	50.0%	June	11	30.6%	June	0	0.0%	June	2	5.6%
Q1 total	57	52.8%	Q1 total	24	22.2%	Q1 total	1	0.9%	Q1 total	2	1.9%

The table above shows that 84 deaths (out of 108 cases reviewed) were CESDI scored during Q1.
These 2 deaths followed the SI process: 1 was closed with a final CESDI of 3 and 1 is still under the SI investigation.
(Please bear in mind that these numbers can change following investigations).

Table 1: Total Number of Deaths and Deaths Reviewed

No. Deaths			No. Reviews undertaken			No. CESDI reviews undertaken		
July	August	September	July	August	September	July	August	September
25	31	29	23	24	26	23	19	25
Quarter 2			Quarter 2			Quarter 2		
85			73 (86%)			67 (79%)		

Total number of Learning Disability deaths in 6 months = 0.
Total number of severe Mental Health deaths in 6 months = 4.

Table 2: Number of CESDI Reviews, by CESDI Score

Score 0 No suboptimal care		Score 1 Suboptimal care, but different management would have made no difference to the outcome		Score 2 Suboptimal care - different care might have made a difference (possibly avoidable death)		Score 3 Suboptimal care - different care would reasonably be expected to have made a difference (probably avoidable death)	
Jul	10	Jul	13	Jul	0	Jul	0
Aug	14	Aug	4	Aug	1	Aug	0
Sep	21	Sep	3	Sep	1	Sep	0
Q2	45	Q2	20	Q2	2	Q2	0

One CESDI score of 0 has been investigated through the SI process with a final CESDI score of 1. There is currently one case still in the process with an initial CESDI score of 2.

So what can we learn from 'Dr Death'?

Of 203 deaths, 181 were reviewed. The majority of cases were considered as no suboptimal care, but there are always lessons to learn.

- ✓ Good communication with the family is paramount and in many cases this was done very well.
- ✓ Consider organ donation where appropriate. In the sad case of death, we may be able to provide life for another person.
- ✓ Use Treatment Escalation Plans (TEP) and record the discussions.
- ✓ Consider carefully when best to discuss and commence End of Life (EoL) pathways.

Lessons Learned

RISK ALERT

The April Risk Alert is 'Communication'.

Poor, or communication breakdown, is one of the most common reasons for incidents and or complaints. Communication comes in lots of forms and errors can happen between staff, between patients and staff or relatives and staff. Remember - Not written down = not done; Handover is a 'danger zone'; Escalate early; An apology goes a long way; High risk patients groups (alcohol, learning difficulties, dementia, non-English speakers); Non-verbal communication is very important.

Don't forget to Feedback

What do you think of the QTc and has it helped you? Please take 2-3 minutes to answer this very quick survey to see how the QTc can be improved. Scan the QR code with your mobile device and tick the boxes!

Quick Quiz – The Answers!

So how did you get on? No cheating I hope?!

1. How many milligrams are there in 0.6 grams? 600mg
2. How many mls are in 0.3 litre? 300mls
3. What is the largest - 150 micrograms or 0.1 milligram? 150 micrograms
4. You need to administer 600 milligrams and you have 1.5 grams in 10mls. How much of this solution do you give? 4mls
5. You need to give 4mg and you have 1000 microgram tablets. How many do you give? 4
6. Which is the largest dose – 0.5ml of 1:1000 or 1ml of 1:10,000? 0.5ml of 1:1000
7. You have worked out that you need to draw up 5.1 mls. What size syringe(s) would you use? 5 or 10ml and a 1 or 2ml syringe. Do not round off!
8. A patient requires a blood transfusion. The bag contains 320 mls and it needs to go over 3 hours. What do you set the drip rate at (Drops per minute)? 106mls per hour = 26.5 drops per minute
9. You need to give 180 mgs and have 500mgs in 6mls. How many mls do you administer? 2.16mls
10. What is the correct dose and route of administration of the first dose of adrenaline in anaphylaxis? 0.5mg i.m.

Use KnowledgeShare - e-mail updates with links to the latest guidelines and evidence. http://tinyurl.com/knowledgeshareHOM

Anything to add to the QTc? Email Emma – erowland@nhs.net

Homerton Hospital is a no go zone for smoking

In line with NHS national policy, plans were put in place to ensure that Homerton Hospital became completely smoke free in January 2018.

Smoking was previously banned in all public buildings, including hospitals, in 2007. Now, 10 years on, the NHS aims to ban smoking anywhere on the hospital site.

Andreena Walton, the Trust's smoking adviser said: "In October 2017 we asked all staff to cease smoking on the hospital site. At the end of 2017, the remaining smoking shelters came down and anyone wishing to smoke now have to do so off site. We are currently liaising with the local authority and local residents. We will continue to encourage people – staff and patients – to give up smoking".

Trust Chief nurse, Sheila Adam said: "Smoke free public buildings and services have now been the norm for 10 years following the introduction of the Smoke Free England law. Many NHS organisations are already totally smoke free and have been so for several years and there is now a national drive to ban smoking completely on all NHS sites.

"Smoking remains the number one health risk to people in this country and is the cause of many diseases and conditions which cost the NHS millions of pounds a year to treat.

"It is right and proper that we should be discouraging smoking on NHS sites but at the same time we offer nicotine patches and continue to support to patients who are smokers whilst in hospital.

"We are also liaising closely with colleagues at the local authority and have been engaging with local residents living near to the hospital and major clinics so that they are aware of our proposals".

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

2.1 Priorities for improvement during 2017/18

This year the Trust set ambitious priorities to drive high quality care and respond to the challenge of meeting the health needs of our diverse community. An initial list of proposed priorities was drawn up. This was based on the progress against 2016/17 priorities, external drivers such as national improvement initiatives and identified key areas as part of our regulatory inspections. Building on the progress that Homerton has made during 2017/18, the Quality Account priorities and Quality Plan for 2017/18 formed the foundation for the Trust's strategy to deliver improvements in patient and service user care and achieving compliance with key performance and regulatory requirements.

As part of an ongoing consultation process, a forum was arranged at the beginning of December 2016 with external stakeholders including patient representatives to discuss possible priorities for 2017/18. This forum was a very successful meeting with good attendance from the majority of Trust external stakeholders including representatives from: Healthwatch, CCG*, patient public involvement, City & Hackney Older People's Reference Group, Adult Community Rehabilitation Team, Sickle Cell Group, Safeguarding Adult and Children Board, Charitable Foundations, Patient User Experience Group including Youth Provider Network, local Jewish community, Hackney Dementia Action Alliance, Alzheimer Society, Age UK, Maternity Matters (Maternity Services Liaison Committee), and a representative from the Trust's Council of Governors.

The group were informed that our priorities for 2017/18 will not only need to be achievable and based on data that the Trust has access to but at the same time they should be ambitious with a drive on improving quality of care within the Trust.

Following initial feedback from our external stakeholders, a list of potential priorities was drawn up. These were discussed with divisional management teams and a 'Survey Monkey' of staff was carried out. The list of potential priorities was also presented to the wheelchair service users and their opinion sought. The proposed priorities were then approved by the Trust's Improving Quality Board and Trust Management Board. In addition, the priority proposals were presented to the Council of Governors and finally signed off by the Board of Directors.

The identified eight priorities were based on three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience. The final priority proposals were also presented to the Council of Governors and their opinion sought.

Having set ambitious aims in 2017/18 the Trust has demonstrated progress against all targets although full achievement has not always been possible.

Detailed description of the work and the progress against each of the priorities are in Part 3 of this report.

Summary of the Trust quality improvement priorities for 2017/18

Table 1: Summary of the eight priorities agreed

Domain	Priority No.	Priority Title	Carried forward (2016/17)	New Priority (2017/18)	2017/18 Progress
Safe	1	To prevent and reduce harm to patients caused by avoidable falls with harm in hospital		✓	✪
	2	To ensure learning is shared across the trust following patients' deaths		✓	◐
Effective	3	To improve identification and response to acutely deteriorating patients	✓		✓
	4	To embed patient centred care (through improved effectiveness of joint clinical pathways between community and acute settings and training for key skills such as shared decision making and health coaching)		✓	✪
Caring / Patient Experience	5	To improve our end of life care and advanced care planning	✓		◐
	6	To improve nurse communication to positively impact on in-patient's reporting having trust and confidence in nursing		✓	◐
Responsive / Effective	7	To improve the effectiveness of discharge from our care		✓	◐
Well Led / Patient Experience	8	To improve health and wellbeing of NHS staff		✓	◐

✪ **Target exceeded** ✓ **Target fully achieved** ◐ **Progress towards target achieved**

2.1.1 Priorities for improvement for 2018/19

Building on the progress that Homerton Hospital has made during 2017/18, the Quality Account priorities and Quality Plan for 2018/19 formed the foundation for the Trust's strategy to deliver improvements in patient and service user care and achieving compliance with key performance and regulatory requirements.

As part of the ongoing consultation process, a forum was arranged at the beginning of December 2017 with external stakeholders including patient representatives to discuss possible priorities for 2018/19. This forum was a good meeting with attendance from some of our main external stakeholders including representatives from: Healthwatch, CCG*, and local Jewish community.

The group were informed that the priorities for 2018/19 will not only need to be based on data that the Trust has access to and achievable but at the same time ambitious with a drive on improving quality of care within the Trust.

Following initial feedback from our external stakeholders, a list of potential priorities was drawn up; these were discussed with our divisional management teams and a 'Survey Monkey' of staff was carried out. The list of potential priorities was also presented to the various patient user groups and their opinion sought. The proposed priorities were then approved by the Trust's Improving Quality Board and Trust Management Board. In addition, the priority proposals were presented to the Council of Governors and finally signed off by the Board of Directors.

Table 2: Quality Account priorities 2018/19

Domain	Priority No.	Priority Title	Carried forward (2017/18)	Underpinning drivers				
				Links to CQC Inspection	Links to 2017/18 CQUIN*	Links to national initiative	Linked to Patient and staff survey	Links to incidents/ Sis/ PALs/Complaints
Safety	1	To reduce the number of community and hospital attributed pressure ulcers	X	✓	X	✓	X	X
	2	Improve patients wellbeing by appropriate management of their nutritional needs	X	✓	✓	X	✓	X

Domain	Priority No.	Priority Title	Carried forward (2017/18)	Underpinning drivers				
				Links to CQC Inspection	Links to 2017/18 CQUIN*	Links to national initiative	Linked to Patient and staff survey	Links to incidents/ Sis/ PALs/Complaints
Safety	3	Appropriate identification and management of Deteriorating patients	✓	✓	✓	✓	X	✓
Effectiveness	4	To achieve the Quest Best Employer accreditation	✓	✓	X	✓	✓	X
	5	Improving services for adults and adolescents with mental health needs	X	✓	✓	✓	X	X
	6	Improving management of end of life patients for adults	✓	X	X	X	X	✓
Patients Experience	7	Ensuring staff are actively hearing the Voice of the Child and this is integral to care	✓	✓	X	X	✓	✓
	8	Improving the first impression and experience of the Trust for all patients and visitors	X	X	X	X	✓	✓

Domain	Priority No.	Priority Title	Carried forward (2017/18)	Underpinning drivers				
				Links to CQC Inspection	Links to 2017/18 CQUIN*	Links to national initiative	Linked to Patient and staff survey	Links to incidents/ Sis/ PALs/Complaints
Patients Experience	9a	For patients who on discharge are receiving 1 or more community services to have a seamless discharge with communication between all services enhanced	✓	✓	X	✓	✓	X
	9b	To implement a complete electronic postnatal discharge process with a failsafe element to ensure timely and appropriate delivery of postnatal care to mothers and babies once transferred from hospital into the community setting	X	X	X	X	X	✓

2.2 Statements of assurance from the Board

Review of Trust services

During 2017/18 Homerton provided and/or sub-contracted 68 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2017/18.

National Clinical Audit

The Trust participates in relevant national audits and confidential enquiries programmes as listed through the Healthcare Quality Improvement Partnership (HQIP). All the programmes listed are assessed for relevance in 2017/18.

During 2017/18, 34 national clinical audits and three national confidential enquiries covered relevant health services that the Trust provides.

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

The national clinical audits and confidential enquiries that the Trust was eligible to participate in during 2017/18 are listed in **Table 3** alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 3: List of national audits and confidential enquiries required for the Quality Account report 2017/18 that the trust participated in

Audit Title	Eligible for partecipation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	261	261	100%
Bowel Cancer (NBOCAP)	✓	✓	86	86	100%
Case Mix Programme (CMP)	✓	✓	593	593	100%
NCEPOD-Child Health Clinical Outcome Review Programme (Young People's Mental Health)	✓	✓	3	2	100%

Audit Title	Eligible for partecipation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
Elective Surgery (National PROMs Programme)	✓	✓	382	391	98%
Endocrine and Thyroid National Audit	✓	✓	39	39	100%
Falls and Fragility Fractures Audit programme (FFFAP)	✓	✓	102	102	100%
Fractured Neck of Femur	✓	✓	48	48	100%
Head and Neck Cancer Audit (HANA) (TBC)	✓	✓	23	23	100%
Inflammatory Bowel Disease (IBD) programme	✓	✓	0	173	0%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	1	3	0.33%
Major Trauma Audit	✓	✓			
Maternal, Newborn and Infant Clinical Outcome Review Programme(MBRRACE)	✓	✓	67	67	100%
NCEPOD- Medical and Surgical Clinical Outcome Review Programme – Heart Failure	✓	✓	5	2	100%
NCEPOD- Medical and Surgical Clinical Outcome Review Programme – Preoperative Diabetes	✓	✓	4	4	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	✓	N/A	N/A	Completed
National Audit of Dementia	✓	✓			
National Audit of Intermediate Care (NAIC)	✓	✓	143	143	100%
National Bariatric Surgery Registry (NBSR)	✓	✓			
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	✓	✓	33	38	87%
National Cardiac Arrest Audit (NCAA)	✓	✓	21	21	100%
National Comparative Audit of Blood Transfusion programme	✓	✓	22	22	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	✓	✓	25	25	100%
National Diabetes Audit – Adults	✓	✓	12940	12940	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	91	91	100%
National Heart Failure Audit	✓	✓	5	6	83%

Audit Title	Eligible for partecipation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
National Joint Registry (NJR)	✓	✓	198	198	100%
National Lung Cancer Audit (NLCA)	✓	✓	127	135	94%
National Maternity and Perinatal Audit (NMPA)	✓	✓	5748	5748	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	709	858	83%
National Prostate Cancer Audit	✓	✓	150	150	100%
Oesophago-gastric Cancer (NAOGC)	✓	✓	53	53	100%
Pain in Children (care in emergency department)	✓	✓	50	50	100
Procedural Sedation in Adults (care in emergency departments)	✓	✓	36	36	100
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	109	122	89%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	✓	✓	10	10	100%
UK Parkinson's Audit	✓	✓	10	10	100

Please note that data is not being collected for NCEPOD Chronic Neurodisability in 2017/18.
We do not participate in the Fracture Liaison Service data base as part of the Falls and Fragility fractures National Audit but participate in the other 2 audits including Inpatient Falls and National Hip Fracture Database.

The reports of **34** National Clinical Audits were reviewed by us in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 4: Examples of changes from a national audit

Audit	Changes made
National Audit of Intermediate Care (NAIC)	We regularly review our data having been involved in the NAIC audit since 2012 and following this we have built quality initiatives (e.g. around MDT timely responsiveness to assessing patient's needs), graphically the improvement in patients receiving MDT care sooner in the IIT episode of care has been demonstrated

Audit	Changes made
National Audit of Intermediate Care (NAIC) Sentinel Stroke National Audit programme (SSNAP)	Our data has shown our balance of MDT skills has favoured therapy over social work and nursing and over the past 2 years we have consequently changed the balance to increase our nursing and social work provision.
	The NAIC data highlight how City and Hackney are a national outlier for lacking an Intermediate Care bed base and the data is being used to support a commissioning business case.
	We have successfully shown that our responsiveness is number one nationally for our rapid response (crises response) in the 2017 data and our home treatment and reenablemenent has improved responsiveness progressively over the last 3x audit cycles.
	Access to timely therapy interventions were commended
Sentinel Stroke National Audit programme (SSNAP) UK Parkinson's Audit	• Length of Stay • Management of incontinence Recording of the 6 month post discharge follow-up appointment
	• Improvement on management of incontinence • Review discharge protocols - and management of MDTs and white board rounds • Data issue around 6 month follow up appointments are being addressed.
	• Plan to add OP screening onto new initial assessment form for movement disorder clinics.
UK Parkinson's Audit PROMS	• To work closely with neuropsychiatric service and consider further funding for this area in the future.
	• A Parkinson's disease nurse specialist recruited as an accessible point of contact for patients with Parkinson's disease.

Audit	Changes made
UK Parkinson's Audit PROMS	• Expanding our orthopaedic department, including the appointment of a specialist hip surgeon (started July 2017) and specialist knee surgeons (from 2016). • Developing further areas of specialisation within the department to ensure high quality care from a dedicated expert. • Encouraging patients to return the questionnaires and also asking for local completion of satisfaction indicators. • Developing new surgical pathways which better engage patients. • Reviewing PROMs data and findings are discussed within relevant departments. • Reviewing PROMS data on a bimonthly basis through Improving Clinical Effectiveness Committee.

Local clinical audit

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

The reports of **94** local clinical audits were reviewed by us in 2017/18 and the Trust intends to take the following actions to improve the quality of health care provided.

Table 5: Examples of actions that the Trust intends to take or has taken following national recommendations

Audit title	Key actions following the audit
Procedural sedation	Form generated on EPR which has increased documentation in line with RCEM best practice.
Sickle cell analgesia	Significant improvement in time to analgesia for sickle cell patients. Improved time to administration of Patient Controlled Analgesia (PCA) on wards. Patients attending outside pathway and protocol are flagged up via frequent attenders group with primary care to ensure there is additional support.

Audit title	Key actions following the audit
JAG Audit - 30 day mortality and 8 day re admission	Overall no evidence of significance re admissions following endoscopy procedures in this period. Ensure that referrers list diabetes in special considerations to ensure morning appointments and close monitoring
Acute Neurotherapy Service (ANTS)	Standard Operating Procedure (SOP) completed Quarterly stakeholder meetings to be arranged Improvement on management of incontinence in patients Review discharge protocols - and management of Multi Disciplinary team (MDT) meetings and white board rounds
Intensive Therapy Unit (ITU)admission Powerplan. Improving ePrescribing on ITU	e-powerplan has been initiated in ITU* in order to improve ePrescribing
Management of Perinatal Substance and Alcohol Use Guideline Audit	Egroup was created for 80% of women (Egroup consists of other healthcare professionals involved in clients care). Guideline updated to include and identify appropriate measures for subsequent audit, including reference guideline and (Standard Operating Procedure) SOP for morphine positive UDS.
MEOWS Audit - Community Postnatal	List to be completed of people to contact for advice while in community. New starter pack commenced with guidance for new midwives including escalation of deteriorating patients pathways. Standardised Team leader Agenda to include Modified early obstetric Warning System (MEOWS).
Maternal and Newborn wristband audit (whether electronic wristbands were being used)	Inform midwives that electronic wristbands need to be applied to babies and document if unable to use electronic wrist band
Stabilisation of preterm babies on labour suite	• Improve documentation • Increase number of babies that have in-out surfactant • Improve appropriate length insertion of ETT • Improve thermal management of pre-term babies on labour ward

Participation in clinical research

Homerton believes that clinical research is of major strategic and reputational importance to the Trust. The R&D department continues to uphold its commitment to ensuring that National Institute for Health Research (NIHR) portfolio adopted studies are accessible for patients, relatives and staff to participate, ensuring there is ongoing clinical research in all clinical divisions. An increase in educational research undertaken by staff has also been observed and this highlights the Trust's commitment to improving the quality, relevance, and focus of research, as well as encouraging and supporting research studies in areas of relevance to local health needs. At any given time, approximately 120 – 130 research studies are open to recruitment in Homerton Hospital (**Table 6**). This is achieved by sourcing trials that are suitable for Homerton Hospital patients and in line with clinical preference: ensuring all governance and regulatory processes are adhered to; recruiting patients who are eligible for the trial; data collection and maintenance of accurate records and accurate and secure archiving of all trial related documentation.

Table 6: Open studies at Homerton Hospital

Specialty	No. of Studies
Anaesthesia, perioperative medicine and pain management	2
Cancer	11
Cardiovascular disease	2
Children	6
Critical care	1
Dementias and neurodegeneration	1
Dermatology	1
Gastroenterology	5
General Health Relevance	12
Genetics	1
Haematology	3
Health services and delivery research	5
Hepatology	2
Infectious diseases and microbiology	9
Mental Health	2
Metabolic and endocrine disorders	1
Musculoskeletal disorders	12
Neurological disorders	3
Primary Care	4
Public health	2
Reproductive health and childbirth	24
Respiratory disorders	3
Stroke	5
Surgery	2
Grand Total	**121**

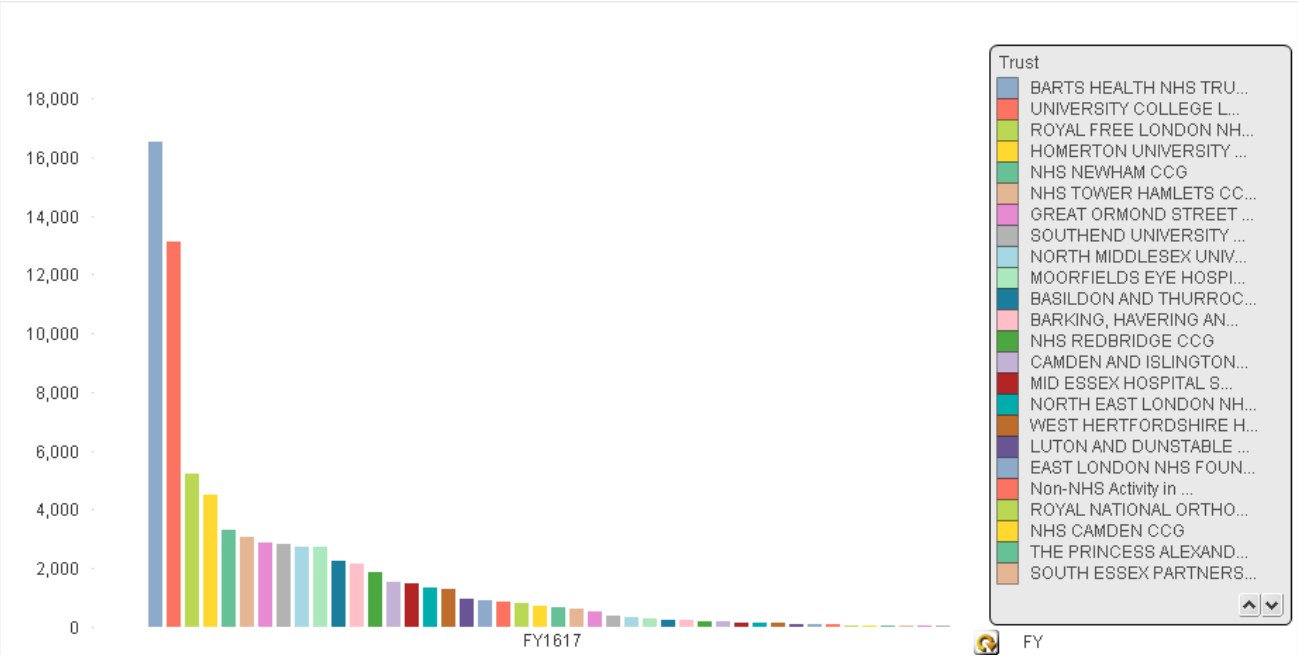
Patient Involvement in Research

A current focus of the NIHR encourages us to seek the views of patients in various aspects of study design and their experiences of participating in clinical research. Recently, the Trust was pleased that a patient could describe her experiences of taking part in research in the form of a presentation at the annual R&D conference held on the 16 November 2017 at Homerton Hospital. The patient participated in an NIHR-funded, pragmatic randomised controlled trial called TITRATE with the objective to achieve disappearance of signs and symptoms of RA, e.g. pain, fatigue, mobility, measured at 12 months. The patient elaborated on the quality of direct personalised care that she received as a result of participating in the trial, also the consistency of seeing the same clinical trial practitioner each time making it easy to share her medical issues with the practitioner in comparison with post trial issues.

Research study recruitment performance at Homerton Hospital

Homerton was the fourth highest recruiting Trust in the North Thames Clinical Research Network (NT-CRN) for 2016/17 (see **Figure 9**), an increase on 11 positions from 2014/15. There was also improved communication of research performance priorities in the Trust and enhanced collaboration with the clinical support services such as Pathology, Radiology and Pharmacy as they are all integral to the successful delivery of the vast majority of interventional studies. Thus, the R&D team works very closely with these departments when setting up any new study. This reflects in different ways as Homerton was awarded NT-CRN* R&D team of the month to the fertility team for recruiting the first patient within 18 days. Also recruiting the first patient in the country in a commercial trial, a study to determine the effect of the drug GBT440 compared to placebo in increasing red blood cell counts and reducing the severity of sickle cell disease raises Homerton's profile as an excellent research centre for more pharmaceutical research studies.

Figure 9: Recruitment of trusts in the NT-CRN



Example research studies

RESPITE study

Traditionally, Pethidine (Meperidine) has been the commonest opioid used for analgesia during labour. However, the efficacy of the drug is questionable and it has a number of undesirable side effects including sedation, nausea, placental transfer and risk of neonatal respiratory depression. An epidural is often requested following inadequate pain relief with Pethidine treatment. However, epidural analgesia is not without its own set of risks and side effects and it has been shown to increase the risk of instrumental delivery. The RESPITE study was undertaken to elicit the facts

Remifentanil Patient-Controlled Analgesia (PCA) is a technique that recent evidence suggests may provide a safer, more effective alternative to Pethidine. There is also evidence that Remifentanil PCA reduces epidural conversion rates compared to pethidine; however, no trial has yet investigated this as a primary endpoint.

This trial opened at Homerton Hospital in May 2015 for recruitment and completed in September 2016. This study aimed to determine whether labour analgesia with Remifentanil PCA*, reduces the requirement for progression to epidural analgesia compared to IM injection with Pethidine. Secondary outcomes included the relative efficacy, maternal and neonatal indices of wellbeing and maternal satisfaction.

The study indicated that Remifentanil PCA has been shown to reduce progression to epidural compared to Pethidine, allowing risks of epidural analgesia to be avoided, whilst there is minimal difference in incidence of respiratory depression and sedation. This study provided promising results advocating the choice of Remifentanil PCA as a superior alternative to IM Pethidine although its main area of caution is the requirement of monitoring for desaturation and the need for subsequent oxygen supplementation which necessitated 1-1 midwifery care.

POPPY study

Although pain has previously been identified as a prevalent and burdensome problem, little recent research into pain and its affect has been generated alongside new treatments in the population of patients living with HIV. The POPPY Study described the prevalence of pain, associated factors and impact on quality-of-life.

Current pain and pain-related healthcare use was collected via a self-reported questionnaire. It assessed group differences in the prevalence of pain after controlling for demographic covariates (gender, race, HIV acquisition, educational attainment, body mass index). The associations between current pain and quality-of-life and depression scores were assessed as well.
The results found that older people living with HIV (PLWH) continue to experience higher rates of pain than younger PLWH and similarly-aged HIV-negative participants, with strong associations with depression and poorer quality-of-life.

PROVENT trial

Prostate cancer has been at the forefront of press coverage in recent months. At Homerton Hospital, the team is conducting the PROVENT TRIAL (Together Preventing Prostate Cancer): this is a chemoprevention study in men enrolled on an active surveillance programme for prostate cancer, aiming to examine the clinical effectiveness of Aspirin and/or Vitamin D3 to prevent disease progression in men on active surveillance. It may benefit patients with prostate cancer by preventing the development of more aggressive disease. This study is funded by Barts Health. Please visit the PROVENT study website https://www.provent.org.uk/ for more information.

Another area of public concern is the treatment and prevention of HIV.

PrEP impact trial

The Pre-Exposure Prophylaxis (PrEP) Impact trial is a three year study run by NHS England providing PrEP* to those at risk of HIV. In 2017, a significant decline in new diagnoses of HIV in the UK in gay and bisexual men was announced, with access to PrEP identified as a contributory factor in the downturn in new diagnoses. The impact trial is an implementation study, looking at large-scale use of PrEP with 10,000 places across England. Recruitment spaces for gay and bisexual men were taken up quickly: however, protected trial places for women and other groups at risk of HIV are still to be filled. Homerton's unique patient population means that we have the potential to be at the forefront of research in these population groups.

CQUIN* payment framework

During 2017/18 the Trust continued to work with the Commissioning for Quality and Innovation (CQUIN) scheme to drive quality improvements across the organisation.

A proportion of the Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: NHS England » 2017/19 NHS Standard Contract: November 2016

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

All of the CQUINS linked to the Acute and Community contracts for 2017-19 are National CQUINS, unlike previous years, where a proportion of the schemes have been locally agreed with C&H CCG. This is still set at 2.5% of the annual contract value. The breakdown is as follows for the acute and community contracts:

- 1.5% of this attached to national CQUIN
- 0.5% is risk reserve linked to control total
- 0.5% is linked to STP engagement and commitment.

For the NHSE contract, CQUINs are treated as follows:

For the public health and dental services element:

- 2.5% is attached to specific Public Health and Dental schemes

For the specialised services element of the NHSE contract;

- a maximum of 2% is available and is attached to specific specialised CQUIN schemes

Appendix B provides details of Trust 2017/19 CQUINs*.

Care Quality Commission (CQC)

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

The CQC has not taken any new enforcement actions against the Trust during the reporting period 2017/18.

The Trust has not participated in any special CQC reviews or investigations during the reporting period.

Inspection of community health services

Homerton provides integrated acute and community based health services. Community health services are provided for adults and children, young people and families.

An inspection of community health services was carried out by the CQC in January and February 2017. Both adults and children's community health services received an overall rating of 'Good', as well a 'Good' rating for each of the five Key Lines of Enquiry (KLoE). The five KLOEs* are: Safe, Effective, Caring, Responsive and Well-led.

Several areas of good practice were highlighted in the adult community health services report which included "highly effective internal and external multidisciplinary working", and "extended scope practitioners in physiotherapy" who "displayed skills beyond the expected

level of competency" and "one stop diagnostic interventions within the community, reducing the need for referrals to hospital-based services".

The CQC also made a number of recommendations on areas for improvement that community health services for adults must or should undertake. These related to improving:

- compliance with completion of mandatory safeguarding adults level 2 training
- accurate and timely recording of completed staff appraisals
- timely and accurate sharing of information between acute and community practitioners working on separate computer networks
- the Friends and Family test response rate in community adult services
- the trust should review demand and investigate options for expanded out of hours community nursing provision.

In the CQC inspection of community health services for children, young people and families, good practice areas highlighted included a safeguarding children screening team. The team screen information about vulnerable children and identify for example, high-risk children who attended accident and emergency. The team passes information on to the health visiting or school nursing team.

The Trust was asked to improve the following areas:

- the completion rate for infection control level two training
- the completion rate for paediatric basic life support training
- staff familiarity with the term 'duty of candour'
- the response rate for the Friends and Family test
- staff awareness of the major incident plan and how to access emergency information when needed.

Robust action plans have been developed to address the CQC's recommendations as well as actions identified by staff as part of reflections on the inspection process. All actions are monitored and reported on, through divisional and trust-wide committees.

Figure 10: Homerton Community Health Services CQC ratings for 2017: adults and children, young people and families

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Inspection of Mary Seacole Nursing Home

Homerton is also registered with CQC to provide care at Mary Seacole Nursing Home - a purpose built 50 bedded residential nursing home. The CQC inspection of the nursing home in June 2017 was followed by the publication of the inspection report in August 2017 in which the service was rated as 'Good' overall, and 'Good' for each of the five key lines of enquiry. This is an improvement on the previous inspection in April 2016, which rated the service as 'Requires Improvement'. At the 2017 inspection, the CQC found that Mary Seacole Nursing Home had taken effective and appropriate actions to fully address all recommendations from the 2016 inspection. The Trust is therefore pleased to report a marked improvement in the CQC ratings from the previous reporting period.

Data quality

Homerton submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data for April 17 – Mar 18:

- which included the patient's valid NHS number was:
  - 98.9% for admitted patient care
  - 99.7% for outpatient care
  - 94.4% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:
  - 100.0% for admitted patient care
  - 100.0% for outpatient care
  - 100.0% for accident and emergency care

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

To improve facilitation of this a Data Quality Committee chaired by the Chief Operating officer has been newly re-established. The committee will meet monthly, within the week prior to the monthly Informatics Committee, and shall be quorate. This committee will be a vehicle for data quality improvement and awareness within the Trust. It will promote and maintain robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality. Twelve key data quality indicators and four contractual indicators will be monitored through this committee. New data quality indicators will be monitored as and when identified and deemed necessary by the committee. It will be the vehicle through which new issues are raised, analysed to identify cause, impact and manage resolution.

This will continue to be the platform through which strategies, policies and standards are monitored to ensure they align with operational requirements.

Information Governance (IG)

The Trust recognises that information is an important asset, supporting both clinical and management needs and ensures that information is respected, held securely and used professionally. The Trust also makes sure personal information is dealt with legally, securely, efficiently and effectively, in order to help achieve the best possible care for our patients.

To measure compliance across a broad spectrum of information handling initiatives, NHS organisations are required to complete an annual self-assessment, which is supported by relevant evidence, using the Information Governance Toolkit (IGT). The IGT* is used to address any gaps relating to confidentiality, information security, clinical information, corporate information and secondary uses of patient information. An IG improvement plan is refreshed and implemented on an annual basis. Throughout 2017/18 there has been continuing progress in improving the effectiveness and raising awareness of the organisational Information Governance mechanisms. The Trust has achieved 100% level 2 or higher on all requirements of the IG Toolkit.

Table 7: Trust's Information Governance toolkit assessment report in 2017/18, overall score

IGT* Assessment	2017/18	2016/17
Level 0	0	0
Level 1	0	0
Level 2	36	32
Level 3	9	13
Total Requirements	45	45
Overall score	74%	76%
Self-assessed grade	Satisfactory	Satisfactory

Information governance incidents

All serious information security related incidents are reported directly to the Department of Health and the Information Commissioners Office (ICO), via the NHS Digital incident reporting tool. In 2017/18 there were no serious information security incidents reportable to the ICO. Serious Incidents are investigated and reported to the Trust's Serious Incident Panel, relevant Executive, Clinical or Operational Director, the Caldicott Guardian and the

Senior Information Risk Owner. All such investigations follow the Root Cause Analysis methodology in line with best practice.

Information Governance Toolkit

The error rates correspond overall to Level 2 of the Information Governance (IG) toolkit requirement 505. The percentage coding requirements for this attainment level are shown below, together with those required for Level 3.

Table 8: percentage of coding required for level 2 and 3 compared with HUHFT's achievements

	Requirements		Homerton Achieved
	Level 2	Level 3	
Primary diagnosis	>=90%	>=95%	>=93% (Level 2)
Secondary diagnosis	>=80%	>=90%	>=83% (Level 2)
Primary Procedures	>=90%	>=95%	>=93% (Level 2)
Secondary Procedures	>=80%	>=90%	>=94% (Level 3)

Clinical coding error rates

Homerton was not subject to the Payment by Results (PbR) clinical coding audit during 2017/18 by the Audit Commission.

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

The Clinical Coding department supports patients' care by providing ICD-10 DIAGNOSTIC codes and OPCS procedure codes that are used for a variety of purposes, including payment and Hospital Standardised Mortality Ratios.

A full time audit programme is in operation to further enhance the accuracy of the clinical coding across all specialities.

As part of our commitment to driving up the quality of coding at Homerton, the coding department has undertaking several audit projects throughout 2017-2018

The aims of these audits were to focus on improving the quality of our data and focus on providing a high quality, accurate coding service.

The department codes around 74,000 episodes a year across a wide range of specialities.

The Trust will be taking the following actions to improve data quality in 2018/19.

- On-going assessment and development of training programmes to support colleagues in the maintenance of high quality data, including the introduction of mandatory data quality training for specific staff groups.
- To continue to develop current audit programme and broaden scope to provide information assurance.
- Proactive use of benchmarking to ensure the Trust meets best practice standards.
- On-going training and development of the clinical coding team members to enhance their skills, knowledge and data management.
- On-going work with the EPR team to improve the process of capturing information for better data.

A recent information governance report concluded that the Trust codes to a very high standard, adhering to the rules and conventions of the national clinical coding framework set by NHS Digital.

Table 9: Clinical coding audit results

Speciality	Primary diagnosis correct %	Secondary diagnosis correct %	Primary procedure correct %	Secondary procedure correct %	HRG Changes %
Obstetric	82%	77%	98%	91%	17%
General Medicine	94%	88%	91%	100%	10%
Paediatric	98%	80%	100%	100%	14%
Gynaecology	90%	89%	91%	92%	10%
Trauma	97%	71%	87%	88%	10%
Urology	97%	84%	88%	100%	10%
General Surgery	96%	94%	100%	88%	8%

Learning from deaths (new addition)

During 2017/18, 452 patients died at Homerton Hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period: 115 in the first quarter; 85 in the second quarter; 103 in the third quarter; 149 in the fourth quarter (see Table 10).

Table 10: Total number of deaths in 2017/18

Quarter 1	Quarter 2	Quarter 3	Quarter 4
115	85	103	149

By 31 March 2018, 321 case record reviews and 11 investigations have been carried out in relation to 452 of the deaths included in **Table 11**

In 11 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

115 in the first quarter; 80 in the second quarter; 96 in the third quarter; 36 in the fourth quarter.

Table 11: Total number of reviews undertaken in 2017/18

Quarter 1	Quarter 2	Quarter 3	Quarter 4
115	80	96	36

Four of the 452 patient deaths i.e. 1% of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 2 of the 115 patient deaths (2%) reviewed for the first quarter; 0 of the 80 deaths (0%) reviewed for the second quarter; 1 of the 96 deaths (1%) for the third quarter; 1 of the 36 deaths (0.36%) for the fourth quarter. The number of reviews for quarter 4 will increase as they are completed. These numbers have been achieved using the CESDI score methodology (see **Table 12**).

Table 12

CESDI score	
CESDI 0	No suboptimal care
CESDI 1	Suboptimal care, but different management would not have made any difference to the outcome
CESDI 2	Suboptimal care; different management may have made a difference to outcome (**possibly avoidable death**)
CESDI 3	Suboptimal care; different care would reasonably be expected to have made a difference (**probably avoidable death**)

Please see below a list of learning identified following case record reviews and serious incident investigations for 2017/18:

- Discussing TEP plan as necessary and appropriate ITU escalation
- Appropriate and timely start of End of Life pathway
- Appropriate and timely start of palliative care
- Clearer and consistent information between family of dying patient and different teams
- Clearer headline notes

- Delay to starting package of care
- Good management of potential organ donor and early referral to SNOD
- Need appropriate neurosurgical advice
- Need better communication between Royal London Hospital and Homerton Hospital
- Need review of End of Life Care documentation
- Identification and management of the deteriorating patient
- Identification and management of bowel obstruction

Outline of actions taken in and following the reporting period as a result of learning from the review of deaths

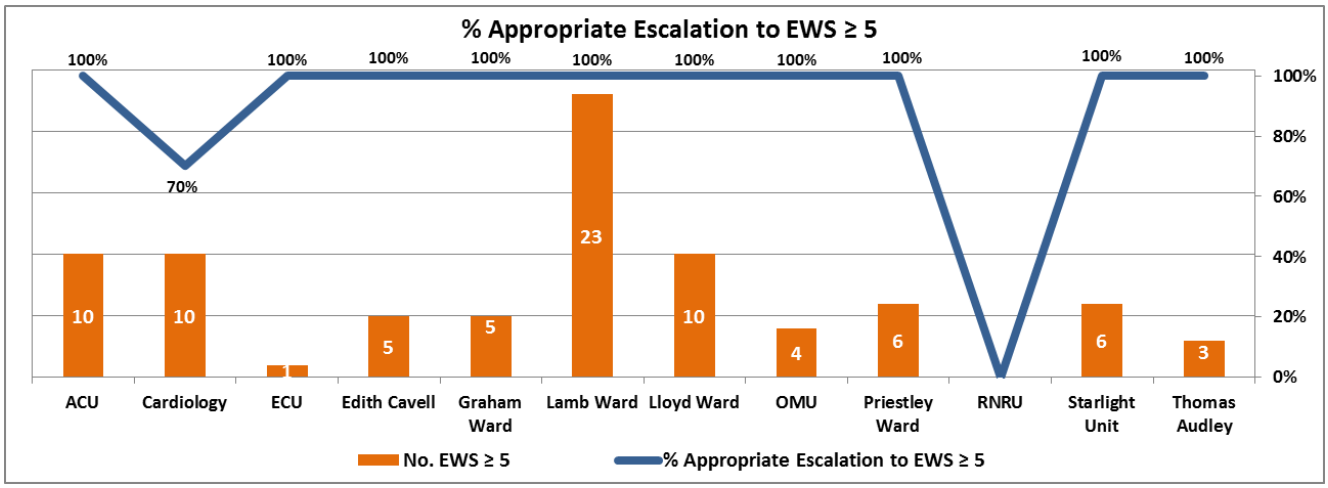
- Radiographs requested for the indication of possible bowel obstruction should be escalated to on call radiologist for urgent reporting.
- General physicians should seek a formal report and discussion with on call radiologist regarding diagnosis and further imaging for all patients with dilated bowel on radiographs.
- The ACU nursing and nursing support staff need a formal reminder and if necessary refresher training on recording, documenting and acting upon NEWS scores.
- ACU in situ session to run on identification and management of bowel obstruction.
- To perform a spot check audit on surgical patient notes to check if blood results are noted and acted on in a timely manner. Clear guidelines are needed on who is responsible for review and escalation of results.
- For this case to be brought to the attention of the deteriorating patient group so that education on the deteriorating, very elderly patient can be promoted in both medical and nursing refresher training. Recognising that signs are subtle.
- Training for consultants and senior middle grade doctors regarding filling out treatment escalation plans on the Electronic Patient Record including surgical plan and wishes. Consider whether these should be mandatory for all surgical admissions. Improvement in record keeping by all clinicians across the Trust is recommended as we have identified failures in record keeping.
- To create an SOP whereby any patient admitted with a perforation following a scope should be immediately reported to the endoscopist concerned by the admitting team. Endoscopy users group to decide method: consider nhs.net email to endoscopist plus phone call to on call “GI bleed” rostered endoscopist.

Impact of the actions described above

Although it is early days for understanding the impact of some of the actions, it is apparent that ACU nurses have improved their escalation of deteriorating patients exhibiting a NEWS score of 5 or above over the last few months.

- ACU have 100% appropriate escalation of NEWS score of 5 or above.

Figure 11: % of appropriate escalation to EWS of 5 or above by ward



- In addition, following the learning around failures in record keeping regarding patients' end of life wishes, 83% of patients referred to palliative care at End of Life have a treatment escalation plan in place.

The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period (but were not included) will not be relevant to the 2017/18 Quality Account report and will be published in 2018/19. These are deaths that were subject to an investigation but were not completed in the 2017/18 financial year.

The estimated number of deaths included in the previous paragraph which as a result of the review or investigation were more likely than not to have been due to problems in the care, will not be relevant to the 2017/18 Quality Account report and will be published in 2018/19.

2.5 Reporting against core indicators

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

Table 13: National core indicators

No.	Prescribed information	NHS Outcomes Framework Domain
1	a. Summary Hospital-level Mortality Indicator (SHMI) b. Patient deaths with palliative care coded	1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions
2	Patient Reported Outcome Measures Scores (PROMS) for: i. Groin hernia surgery iii. Hip replacement surgery iv. Knee replacement surgery	3. Helping people to recover from episodes of ill health or following injury
3	Readmission rate (within 28 days) for patients aged: i. 0-15; and ii. 16 and over	3. Helping people to recover from episodes of ill health or following injury
4	Responsiveness to the personal needs of patients	4. Ensuring that people have a positive experience of care
5	Percentage of staff who would recommend the Trust as a provider of care to their family or friends	4. Ensuring that people have a positive experience of care
6	Friends and Family Test covering: i. Accident and Emergency ii. Inpatients	4. Ensuring that people have a positive experience of care
7	Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)	5. Treating and caring for people in a safe environment and protecting them from avoidable harm
8	*C-difficile* infection rate per 100,000 bed days	5. Treating and caring for people in a safe environment and protecting them from avoidable harm
9	Rate of patient safety incidents; and number and percentage that resulted in severe harm or death	5. Treating and caring for people in a safe environment and protecting them from avoidable harm

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

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

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

SHMI* has three bandings: Higher than expected, as expected and lower than expected. If the number of deaths falls outside the 'as expected' range, then the Trust will be considered to have either a higher or lower SHMI* than expected. If you would like to know more about how these ranges are calculated, then please refer to the NHS Digital website at: http://content.digital.nhs.uk/article/6963. A 'higher than expected' SHMI* should not automatically be viewed as bad performance, but rather should be viewed as a 'smoke alarm', which requires further investigation. Conversely, a 'lower than expected' SHMI* does not necessarily indicate good performance.

On the most recently published national figures, for the period July 2016 – June 2017, Homerton Hospital's SHMI was 0.847, which places Homerton Hospital in the 'lower than expected' band. Homerton Hospital ranks number 13 for the lowest mortality indicator, out of 134 trusts.

Since SHMI includes deaths both in hospital and within 30 days of discharge, this low mortality is a tribute to our care delivered both within the hospital and by our community services following discharge.

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

The Summary Hospital-Level Mortality Indicator or SHMI* has been consistently below predicted since November 2015. Homerton Hospital has improved recognition of impending death and end of life care through a variety of processes. This has resulted in an increasing proportion of deaths being coded as 'palliative'. This would tend to lower the Hospital Standardised Mortality Ratio or HSMR. However, in practice, the HSMR has been below expected since March 2016, and is compatible with the below expected SHMI so we do not believe this is artefactual since patients who are receiving palliative care are not excluded from the SHMI calculation.

Data is reported to the Board of Directors as part of the Performance Report and any variations or anomalies are investigated and findings fed back through the Improving Clinical Effectiveness Committee. The Trust mortality rates are also reviewed quarterly at the joint Clinical Quality Review Meeting (CQRM) with City & Hackney CCG and NHS England. There are currently no areas of concern in relation to mortality at Homerton Hospital.

Palliative care coding is reported in the quality account, particularly because it used to affect the mortality as assessed by the Hospital Standardised Mortality Indicator or HSMR. Homerton Hospital's palliative care coding has increased, which our End of Life Board has reviewed and assesses as appropriate. Of note, the newer indicator SHMI is not affected by whether or not a death is coded as palliative.

Table 14: Summary Hospital-level Mortality Indicator (SHMI) rate

	Reporting Period		
	2015/16	2016/17	Oct 16 - Sep 17
Homerton Hospital	**0.930 (Band 2) as expected**	**0.8103 (Band 3) - lower than expected**	**0.8473* (Band 3) - lower than expected**
National Average	1.00	1.00	1.00
Lowest Performing Trust	1.178	1.212	1.247
Highest Performing Trust	0.678	0.708	0.727

***Latest figures available on NHS Digital**

Table 15: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

	Reporting Period		
	2015/16	2016/17	Oct 16 - Sep 17
Homerton Hospital	**23.6%**	**37.4%**	**45.4%***
National Average	28.5%	30.7%	31.5%
Lowest Performing Trust	0.6%	11.1%	11.5%
Highest Performing Trust	54.6%	56.9%	59.8%

***Latest figures available on NHS Digital**

Avoidable deaths

The Trust has adopted a robust system for reviewing mortality following recommendations made in the 'CQC learning from death document' and the National Quality Board (NQB). All departments have adapted the mortality review process to ensure deaths are appropriately reviewed and lessons and themes are captured. The Trust uses the CESDI scoring system which is very well validated (see **Table 12** in Part 2, Learning from Deaths paragraph). Certain services, including maternity (including still births), neonates, paediatrics and learning disability follow specific pathways and review mortalities according to relevant national recommendations. A live Mortality Review Tool (MRT) to support the review process is in development. The mortality review policy is available on the Trust intranet.

The Quality and Risk team gather the results of all death reviews undertaken across the Trust and ensure the Board receives a quarterly report on the total number of deaths, total numbers of reviews undertaken and the themes and lessons identified as a result of such reviews. Themes are then shared with the Trust's End of Life Board to ensure lessons are learned and issues addressed. The Trust has been sharing the learning and the themes from these reviews through the board and divisional reports and via other communication tools. Mortality reviews is a standard agenda item on the Improving Clinical Effectiveness Committee (ICEC) which meets bimonthly. Each division have also ensured that their governance approach to mortality reviews is robust and have this as a standard agenda item on their clinical governance meeting.

Table 16: The results for the financial year 2017/18 are shown below

	Reporting Period			
	Q1	Q2	Q3	Q4
CESDI 0	68	48	49	17
CESDI 1	25	23	25	7
CESDI 2	2	2	2	1
CESDI 3	2	0	1	1

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

- Refining the process of Trust-wide mortality review and meeting national requirements in relation to mortality review as these become defined.
- Ongoing work aims to improve the recognition and management of deteriorating patients, with a particular focus on patients with sepsis. Actions include review and updating of our electronic NEWS alert system, which flags possible deteriorating patients, who are then screened for sepsis or other causes of deterioration and treated when appropriate. This will be amended to reflect the revised National Early Warning Score edition 2.0.
- Patient Group Directives are in development to reduce delays to antibiotic delivery by allowing ED nurses to prescribe antibiotics.
- An extensive programme in relation to recognition and management of the deteriorating patient and in particular sepsis is underway; on band 6 and band 5 study days, on SHO teaching sessions, and on monthly Trust induction.
- Interactive simulated sepsis teaching on wards delivers combined multidisciplinary teaching for nurses, doctors, HCAs.

- We also deliver daily 'flash' teaching on wards and in ED. In ED all new staff since October have been specifically orientated on sepsis, including system alerts, policies, guidelines, and roles & obligations.
- We also deliver sepsis scenarios within our multidisciplinary simulation centre teaching, throughout the year. All sepsis training is logged on a dedicated log, available on the Trust wide S drive and shared with the sepsis steering group. Action Card prompts for all clinical staff, developed in response to incidents and SI's, are being printed and distributed.

Patient Reported Outcome Measures (PROMS)

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

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

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

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

For each procedure, there are two generic PROM measures of health status:

1. EQ-5D index score which is derived from responses to question within the following five areas:

1. Mobility
2. Self-Care
3. Usual Activities
4. Pain/Discomfort
5. Anxiety/Depression

For each of these areas, the patient has to choose the level of their perceived problem from the options available.

2. EQ-VAS score is the measure against one question: How good or bad is your health today on a scale of 0 to 100, with 100 being the best health you can imagine and 0 being the worst health you can imagine.

In addition, there are also condition specific PROMs, the Oxford Hip and Knee Score, and Aberdeen Varicose Vein Questionnaire. These measures have been developed to identify

the differences in the health status directly associated with the specific condition, and are therefore more sensitive to the outcome when compared against the generic health measures.

PROMS outcomes are published 15 months after the year of interest. The most recent finalised report is the 2015/16 report which was released in August 2017. There is also provisional data available for 2016/17. The parameters included in this report are the Oxford Scores – which measure the functional and symptom changes between pre- and 6 months post-operatively, and the health-related quality of life score, measured with the EQ5D, again measured pre- and post-operatively. Patients may not have filled both parts to the questionnaire in completely – therefore there can be a different number of completed records for each parameter.

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

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre and postoperative questionnaires. However, we have no control over response rates and relatively low numbers of patients returned the questionnaires. In addition, there is not necessarily a direct relationship between quality of life enquired about six months after a surgical procedure, and the quality of that procedure.
- The patient reported outcomes measures scores (PROMS): adjusted average health gain (based on EQ-5D index).
-

Table 17: Average adjusted health gain for groin hernia at Homerton Hospital compared with the national average, in addition to the lowest and highest performing trusts over three different periods of time

	Groin hernia surgery		
	2014/15	2015/16	2016/17
Homerton Hospital	*	**0.099**	*
National Average	0.084	0.088	0.087~
Lowest Performing Trust	0.000	0.021	0.042
Highest Performing Trust	0.154	0.157	0.163

Latest figures available on NHS Digital

**denotes either a small number of records (less than 30) or no procedures and therefore figures have been suppressed.*

PROM for groin hernias is being discontinued centrally and locally. However, the Trust is still committed to improve its service and to meet commissioning and local guidelines and act on patient feedback.

Homerton Hospital has an "adjusted average health gain" index of 0.099 which is above the national average but below the best performing trust. Therefore, there is room for improvement.
As part of our routine Clinical Governance practice we monitor our practice against standards set by Royal College of Surgeons/ British Hernia Society standards (https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/groin-hernia-commissioning-guide_published-2016.pdf?la=en)

We have recently detected a decline on the numbers of laparoscopic hernia repair and have fallen short of compliance with these standards when it comes to proportion of operations being done laparoscopically.

Laparoscopic hernia repair have been associated with several outcomes which may influence PROMs, in particular a reduction in chronic pain following groin hernia surgery. Therefore, it makes sense to promote laparoscopic groin hernia surgery in our department.

We are also assessing our department surgical consent practice. Surgical consenting is important, in particular relation to PROMs, as it is an opportunity to manage patent's expectations with outcome after surgery. A better informed patient will probably be a more content patient after surgery and are less likely to feel surgery wasn't helpful.

Table 18: Average adjusted health gain for hip replacement at Homerton Hospital compared with the national average, in additional to the lowest and highest performing trusts over three different periods of time

	Hip Replacement Surgery (primary)			Hip Replacement Surgery (secondary)		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
Homerton Hospital	**0.347**	**0.391**	**0.466**	*	**No data**	**No data**
National Average	0.436	0.438	0.442	0.277	0.284	0.288
Lowest Performing Trust	0.331	0.320	0.345	0.185	0.224	0.215
Highest Performing Trust	0.524	0.512	0.538	0.376	0.373	0.362

Latest figures available on NHS Digital
**denotes either a small number of records (less than 30) or no procedures and therefore figures have been suppressed.*

Table 19: Average adjusted health gain for knee replacement at Homerton Hospital compared with the national average, in additional to the lowest and highest performing trusts over three different periods of time

	Knee Replacement Surgery (primary)			Knee Replacement Surgery (secondary)		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
Homerton Hospital	**0.229**	**0.198**	**0.333**	*	*	**No data**
National Average	0.315	0.320	0.325	0.257	0.258	0.266
Lowest Performing Trust	0.204	0.198	0.235	0.184	0.190	0.218
Highest Performing Trust	0.418	0.398	0.413	0.331	0.335	0.266

Latest figures available on NHS Digital

**denotes either a small number of records (less than 30) or no procedures and therefore figures have been suppressed.*

The PROMS scores for elective hip and knee replacement have shown considerable improvement in 2016/17. We are now above the national average for average health gain scores for both hip and knee replacements (primary). The introduction of several new orthopaedic consultants and a new elective orthopaedic ward are factors that have contributed to this.

We predict that score will continue to improve over the next year as we continue to implement service developments. We are working with the pre-operative assessment team to improve the pathway and assessment of patients prior to their operation. We are also reviewing the processes around the day of surgery, aiming to align our processes with other high performing trusts, to reduce the time it takes for patients to recover from their surgery.

The implementation of the enhanced recovery programme at the Trust which forms part of the surgical productivity program should also have a positive effect on our surgical outcomes.

The Trust intends/or has taken the following actions to improve this indicator, and so the quality of its services, expanding our orthopaedic department, including the appointment of a specialist hip surgeon (started July 2017) and specialist knee surgeons (from 2016).

- Developing further areas of specialisation within the department to ensure high quality care from a dedicated expert.
- Encouraging patients to return the questionnaires and also asking for local completion of satisfaction indicators.
- Developing new surgical pathways which better engage patients.

- Reviewing PROMs data and findings are discussed within relevant departments.
- Reviewing PROMS data on a bimonthly basis through Improving Clinical Effectiveness Committee.

28 day emergency readmission rate

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

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

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

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

Table 20: Readmission rates from local data

	2015/16	2016/17	2017/18
Readmission Rate (Adult: 16+)	12.60%	12.70%	11.95%
Readmission Rate (Child: 0-15)	3.83%	3.63%	4.66%

The Trust intends to/or has taken the following actions to improve this indicator, and thus the quality of its services.

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

Responsiveness to personal needs of patients

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

Homerton considers that this data is as described because it forms part of the annual national inpatient survey which is conducted independently of the Trust. However, the Trust follows the guidance and methodology as set out by the CQC in provision of data to Picker Institute, an approved contractor.

The enhancement is due to the five key areas for improvement, driven by the Trust's five year plan, our Patient Experience Strategy and our Improving Patient Experience Committee, which meets monthly. The committee monitors improvement through the patient experience action plan. The key themes and five main objectives in the action plan were developed from patient feedback from a variety of resources including the National Survey Programme, Healthwatch and the Friends and Family Test, and our local survey programme.

Table 21: Responsiveness the personal needs of patients

	Reporting Period:		
	2014/15	2015/16	2016/17
Homerton Hospital	**64.3**	**65.0**	**66.3**
National Average	68.9	69.6	68.1
Lowest Performing Trust	59.1	58.9	60.0
Highest Performing Trust	86.1	86.2	85.2

Hospital stay: 01/06/2014 to 31/08/2014; Survey collected 01/09/2014 to 31/01/2015
Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016
Hospital stay: 01/07/2016 to 31/07/2016; Survey collected 01/08/2016 to 31/01/2017

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

- Reviewing and updating our Patient Experience and Engagement Strategy based on feedback from a workshop attended by key stakeholders from the Trust, CCG*, Healthwatch and local community.
- Engaging with key stakeholders through our Improving Patient Experience Committees, User Engagement Committee, Health watch and the CCG.
- Monitoring our overall performance through our Improving Quality Board and the Trust Management Board.
- Improving our Patient Led Assessment of the Care Environment (PLACE)* national scores to 4% better than national average and in the top ten out of 23 London trusts.

- Trained 49 members of staff in 'Advanced communication skills to support shared decision making'.
- Trained 118 staff in how to work with patients in a way that increases 'Self-Management'.
- Carried out a project on the Elderly Care Unit to find out what patients believe they need to achieve to go home and make sure this is discussed during the ward round.
- Improving patient experience and information on discharge. The permanent ward based discharge planners introduced by the Trust have resulted in improvements to patient's successful discharge.

There are also a number of ongoing initiatives across the hospital:

- 'Hearing the Voice of the Child' – 11 staff from Starlight Ward have been given training in 'Child Centred Communication'. The children are now being given the opportunity to note down questions for the doctor prior to the ward rounds and staff are acting as 'Communication Champions', to assist the children to give information during the ward round.
- On ITU, systems are being set up to enable patients who are unable to speak to communicate their wants and needs.
- In orthopaedic clinics, some doctors are noting all the treatment options in their clinic letters and giving the patient time to decide their preferred option.
- In the Locomotor Service, patients attend educational groups before they see individual clinical staff, so they are made aware of all the treatment options available to them.
- The consent policy has been revised, to emphasise shared decision making between patient and clinician.
- Parents are actively engaged in the ward rounds on NICU.

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

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

The Picker Institute conducted the survey on behalf of the Trust and all full and part time staff employed by the organisation on the 1 September 2017 (with certain specific exclusions) had the opportunity to complete the survey electronically between September to December 2017. The Trust achieved a return rate of 50%, which represented a 5.1% decrease from 2016 (55.1%).

In terms of the specific question related to the Trust's Quality Account i.e.
'If friends/relatives needed treatment would you be happy with standard of care provided by organisation?' the results can be seen in **Table 22**.

Table 22: Staff recommending the Trust to family and friends

	Reporting Period		
	2015	2016	2017
Homerton Hospital	**73.8**	**76.18**	**74.76**
National Average*	68.18	68.33	68.37
Lowest Performing Trust	45.73	47.87	48.08
Highest Performing Trust	88.98	90.92	89.29

Latest figures available on NHS Digital

**average of 'Combined Acute and Community trusts*

Homerton intends to take the following action to improve this indicator, and so the quality of its services:

- Ensuring the organisation acts fairly: career progression.
- The Trust has reviewed its Staff Engagement Action Plan in light of the 2017 Staff Survey results (key features of the plan including those areas where results were not so positive when benchmarked against comparator).
- Responding to our latest staff survey by themes (see **Table 23**).

Table 23: Actions that the Trust intends to take to improve for this indicator

Theme	Key Action
Equality and Diversity	Review process for managing performance and conduct to include Director level review of cases prior to decision to take formal action
	Develop best practice guidance on recruitment and selection of managers including use of various assessment tools and interview panel composition
	All staff managers involved in recruitment to attend Unconscious bias training
	Inclusion Lab project run in partnership with BRAP
	Targeted development programme(s) for BAME Staff
Theme	**Key Action**

Career progression and recognition	Establish a programme of career development training
	Develop Talent Management Strategy
	Develop career ladder work for nursing and admin staff
	Review and improvement of on boarding process
	Settling in conversations for new staff
Leadership Strategy	Develop a managers induction programme
	Establish leadership competency framework and tools
	Review leadership development programmes to ensure consistent approach, quality and access
Staff health and Well Being	Develop MSK strategy and action plan
	Develop stress and mental health strategy and action plan
	Develop and implement improvement plan for violence and aggression
	Develop programme of work for Health Ambassadors
Reward and Recognition	Review staff benefit offer
	Develop Staff recognition strategy
General – Values	Further work on the Trust Values and develop a programme to review and refresh their application in the workplace
Divisions/Units	Work more closely with managers to develop action plans to address negative outliers

Patients recommending the Trust to Family and Friends

The Trust follows the guidance and methodology as set out by the Department of Health (DOH) in provision of data to Optimum HealthCare. A robust data quality assurance process is in place to ensure data that is uploaded to the national reporting system UNIFY is accurate. We have a CQC rating of outstanding for A&E which reflects commitment and high standards of clinical care hence our consistent score.

The Trust's national adult inpatient surveys 2016 scores improved from 2015. The Trust made a statistically significant improvement in one question 'Did you have trust and confidence in doctors treating you?' This change reflected the work started on shared decision making and building trusted relationships which included education, simulation scenarios and Trust intranet site to share learning and resources.

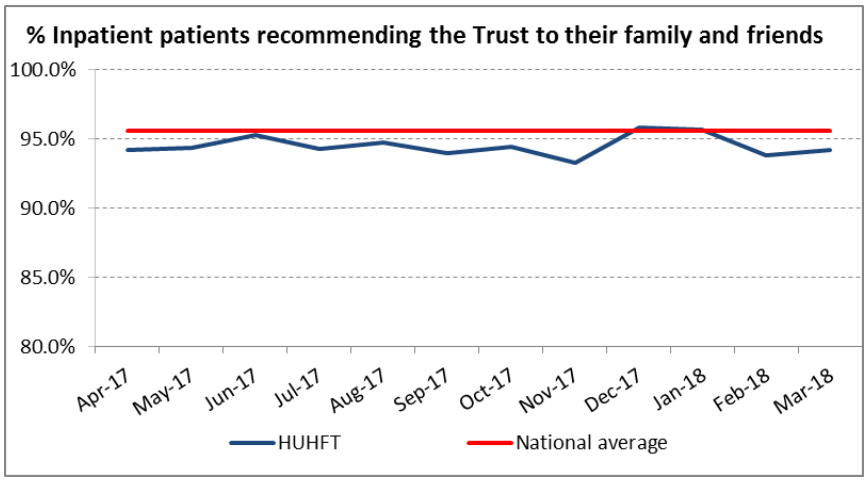
The local survey programme shows improvements in adult inpatient wards with patients feeling they were treated with dignity and respect, having confidence and trust in staff and cleanliness. 93% of our patients would recommend A&E to their family and friends. Patient praise A&E for their high professional standards, the caring and friendly attitude of staff and their listening skills. There are still some concerns over waiting times but patients comment that, once seen, they are very impressed with the service.

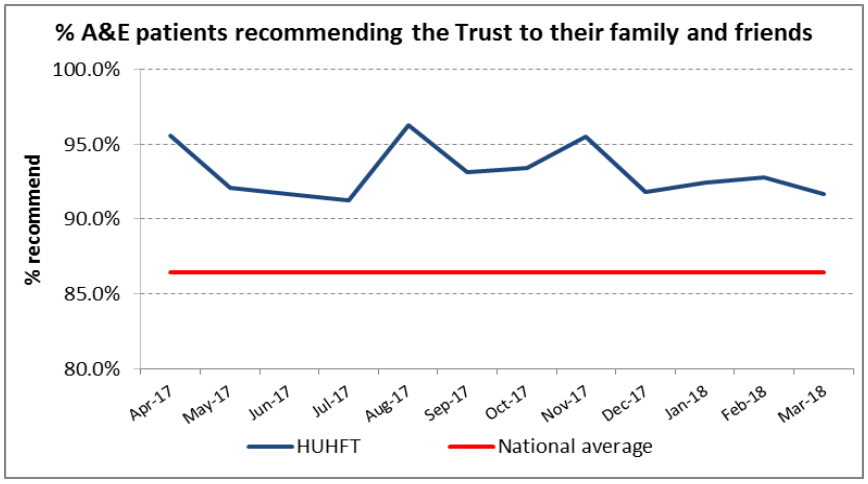
Table 24: Percentage of patients who would recommend the Trust to their family and friends

	A&E		Inpatient	
	2016/17	2017/18	2016/17	2017/18
Homerton	**93.0%**	**93.0%**	**93.6%**	**94.5%**
National Average	86.2%	86.4%	95.4%	95.6%
Lowest Performing Trust	47.1%	59.2%	74.8%	54.5%
Highest Performing Trust	99.1%	98.3%	100.0%	100.0%

Latest figures available on NHS Digital

Figure 12: A&E and inpatient patients recommending the Trust to family and friends Homerton Hospital vs National average





Homerton has taken the following actions to improve this indicator, and so the quality of its services.

- Revising and updating the Patient Experience Strategy to reflect input from the Trust, CCG , Healthwatch and our local community groups.
- Implementing shared decision making project to enhance patient/ clinician communication.
- Quality Improvement approach to improving Trust and Confidence in Nurses with a dedicated Quality Improvement lead.
- Commissioned a training programme from London South Bank University to support empathy and good communication skills.
- A focus on improving patient enjoyment of food through dietetics, catering and patient experience working together with patients.
- Working with new technologies to improve services for patients.

Rate of admissions assessed for VTE

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

Table 25: Percentage of patients admitted to hospital and who were risk assessed for VTE

	Reporting Period		
	2014/15	2015/16	2016/17
Homerton Hospital	**96.8**	**96.2**	**96.2**
National Average*	96.1	95.7	95.6
Lowest Performing Trust*	88.6	79.9	79.1
Highest Performing Trust*	100.0	100.0	100.0

Latest figures available on NHS Digital

*based on the average of "Acute Trusts"

Homerton intends to take the following actions to improve this indicator, and so the quality of its services.

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

Clostridium Difficile rate (C-Difficile)

Acute hospitals in England are required to report all *Clostridium difficile (C.difficile)* toxin positive stool samples in those patients over two years of age. During the 2017/18 reporting period, our national threshold not to be exceeded for patients developing *C-difficile* at Homerton Hospital, was no more than seven cases. There have been ten Homerton Hospital attributable cases to date this year, in addition to which the hospital have admitted patients with *C.difficile*. This is more than the four Homerton Hospital attributable cases last year. The Trust continues to report low number of cases when compared to other trusts across England. Review of these cases by the Trust's clinical commissioning group found that only four of the ten cases were associated with lapses in care. These were attributable to patient management issues which included time to isolation, commencement of appropriate precautions and the timely sending of stool samples. The Trust continues to work hard to reduce the risk of patients developing *C.difficile*.

The *C.difficile* rate per 100,000 days as shown in **Table 26** is sourced from the NHS Digital website and is up to end December 17. The 2017/18 data shows a slight increase in our rates from the previous year, we are still at a good level compared to the National average. In addition, when compared against our peer group, we have the third lowest rate per 100,000 bed days. However Moorfields Hospital would not expect to report any cases as a small specialist trust.

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

The Trust continues to work hard at reducing the risk of *C-difficile* infection to patients and marinating the low rates. This includes continuously improving on already embedded processes for reducing risk of infection by antimicrobial stewardship, prompt identification of

possible cases and laboratory testing processes. This work and patient safety remains a priority which is demonstrated in the continued low rates in the Trust.

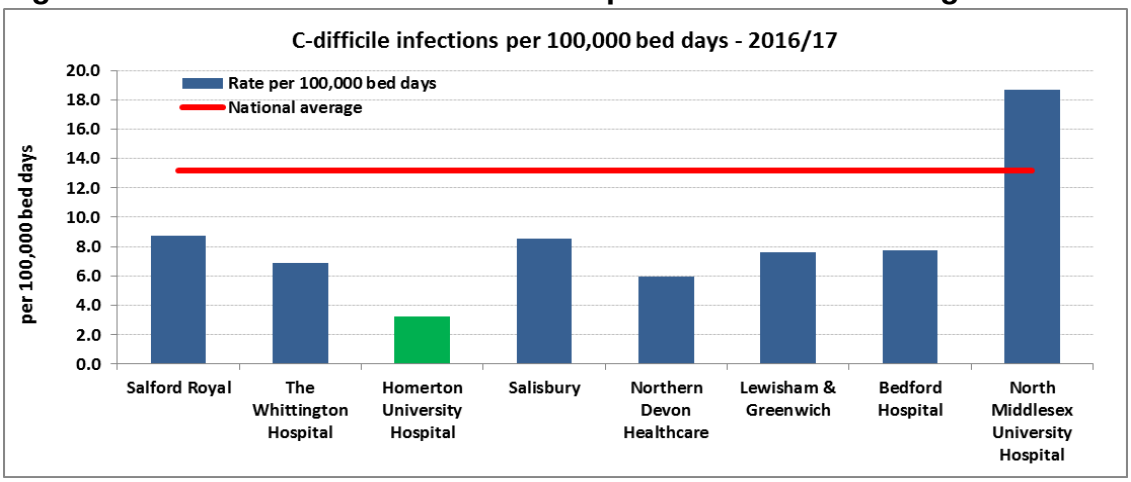
Table 26: Rate per 100,000 bed days of cases of *C-difficile* infection

	Reporting Period		
	2014/15	2015/16	2016/17
Homerton Hospital	**5.2**	**7.8**	**3.3**
National Average*	15.0	14.9	13.2
Lowest Performing Trust	62.6	66.0	82.7
Highest Performing Trust	0.0	0.0	0.0

Latest figures available on NHS Digital

**based on the average of "Acute Trusts"*

Figure 13: *C.difficile* rate Homerton Hospital vs national average



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

- ward focused training following RCA findings;
- emphasis placed on patients with diarrhoea at ward level;
- raised profile of C.difficile mandatory training;
- focus on timely isolation of all patients with diarrhoea whilst awaiting results;
- focus of sample testing of all diarrhoeal stools in a timely manner;
- prompt identification of possible cases by Infection prevention and control team and liaison with clinical staff;
- environmental decontamination and audit of the environment to reduce clutter which can prevent high standards of cleaning;
- education and training of staff at mandatory training, online training, posters newsletters and audit reports;
- regular audits to ensure compliance with national and local guidelines;
- investigation of every case to identify lessons to be learnt and feedback to the multidisciplinary teams.

Patient safety incidents

Homerton treats and cares for thousands of patients each year and places the safety of its patients at the heart of its care delivery strategy. Whilst the vast majority of patients are treated safely and effectively, very occasionally adverse incidents do occur regardless of how dedicated, caring and competent our staff are.

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

The Trust has effective systems in place to ensure that all incidents reported are reviewed locally within divisions and escalated for consideration of formal investigation as per criteria outlined in the NHS England incident management framework. All formal investigations of incidents undertaken are conducted using both Root Cause Analysis (RCA) and review of human factors to identify care and service delivery problems and develop informed, practical recommendations for improvement. This ensures that both lessons learnt and actions taken are robust and will prevent similar incidents in the future. To support this work this current financial year the Trust has continued to train staff in root cause analysis by commissioning formal training in RCA* and human factors to support staff in the undertaking of investigation and ensure investigations are robust.
NHS Improvement has recently published a new league to encourage openness and transparency. Data for the 2017/18 league table is drawn from the 2016 NHS Staff Survey and from the National Reporting and Learning System (NRLS). It is worth noting that while the number of incidents reported at the Trust has witnessed a slight drop we are still placed in the top 25% high reporting NHS organisations. This underlines two important aspects of the Trust`s incident reporting culture:-

- That the Trust has a high reporting culture which is a marker of its strong commitment to patient safety. "High reporting is a mark of `high reliability` organisations" (NPSA 2008).
- The Trust constantly encourages staff to report incidents as these can facilitate learning and improvement in patient care. Learning from incidents through theming and trends so as to prevent recurrence is a great feature of the Trust`s incident management agenda.
- The Trust is committed to strengthening identification, reporting and learning from incidents especially in areas where there are low levels of reporting and ensuring there are feedback mechanisms in place to ensure lessons learned are feedback to staff and incident reporters so identifying what changes and improvements to patient care as a result of their report.

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

- The Trust uses an electronic incident reporting system (DATIX) which enables all incidents to be reported, monitored, reviewed and investigated.
- The Trust has a robust process to ensure rigorous incident management.
- All incidents are reviewed at weekly divisional or corporate CLIP (Complaints, Litigation, Incidents and PALS) meetings and themes and trends reviewed at monthly divisional governance meetings. Trust Management Board receive quarterly updates from the Divisions.
- Where incidents are graded as moderate harm and above further scrutiny is applied.
- Where appropriate a Serious Incident (SI) investigation or an internal root cause analysis (RCA) investigation is undertaken and reported through the Patient Safety Committee (PSC) and subsequently the Quality and Improving Patient Safety Board, Trust Management Board (TMB) and the Trust Board.
- Incident reports and investigations are scrutinised and validated through PSC before submission to the NRLS*.

Table 27: Rate of reported patient safety incidents per 1,000 bed days

	Reporting Period			
	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 - Mar 17
Homerton	**46.92**	**47.30**	**47.64**	**49.3~**
National Average*	38.11	38.58	39.89	41.1
Lowest Performing Trust	18.07	14.77	21.15	23.1
Highest Performing Trust	74.67	75.91	71.81	69.0

~Latest figures available on NHS Digital

** based on the average of 'Acute (non specialist) Trusts'*

Table 28: Number of reported patient safety incidents

	Reporting Period			
	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 - Mar 17
Homerton	**2,966**	**2,856**	**2,915**	**2,987~**
National Average*	4,647	4,818	4,955	5,122
Lowest Performing Trust	12,080	11,998	13,485	14,506
Highest Performing Trust	1,559	1,499	1,485	1,301

~Latest figures available on NHS Digital

** based on the average of 'Acute (non specialist) trusts'*

Table 29 presents a summary update of the total number of patient safety incidents which resulted in severe harm or death that were reported at Homerton Hospital from April to September 2016.

Table 29: Number of patient safety incidents resulting in severe harm or death

	Reporting Period			
	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 - Mar 17
Homerton	**8**	**13**	**11**	**7~**
National Average*	20	19	19	19
Lowest Performing Trust	89	94	98	92
Highest Performing Trust	2	0	1	1

~Latest figures available on NHS Digital

** based on the average of 'Acute (non specialist) trusts'*

Table 30: Percentage of patient safety incidents resulting in severe harm or death

	Reporting Period			
	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 - Mar 17
Homerton	**0.27%**	**0.46%**	**0.38%**	**0.23%~**
National Average*	0.43%	0.40%	0.37%	0.40%
Lowest Performing Trust	2.92%	2.04%	1.73%	0.53%
Highest Performing Trust	0.07%	0.00%	0.02%	0.01%

~Latest figures available on NHS Digital

** based on the average of 'Acute (non specialist) trusts'*

Table 27 shows that Homerton Hospital is a high reporting Trust which is a marker of high reliability as we consistently report a higher number of patient safety incidents per 1000 bed days than the national average. The number of patient safety incidents reported as per **Table 28** is stable while the number of incidents resulting in severe harm or death to patient remains steady and is intermittently below the national average.

Homerton has taken the following actions to improve this indicator, and so the quality of its services.

- In addition to induction training for new starters on incident reporting, the Quality and Patient Safety team has been delivering training on Datix and incident reporting to staff in both the acute and community settings. The aim is to develop staff capacity and capability as well as confidence in reporting patient safety-related incidents.
- The Trust `Incident Reporting Policy` has been refreshed and is available on the Trust intranet. This new version is more detailed and user-friendly.
- There has been a great deal of focus on providing feedback to staff who report incidents, so that they can realise the benefits or improvements to patient safety and care that have resulted from the incident(s) they reported.
- The quality and patient safety managers are more visible in the divisions and community, thus ensuring that there is greater awareness and knowledge of patient safety incidents.
- The list of incident handlers from Datix is being refreshed to take off those who have left the Trust in order to ensure timely provision of feedback to those who report patient safety incidents.

Duty of Candour

When a patient dies or suffers harm, staff also suffers considerable distress. The statutory Duty of Candour (DoC) requires the Trust to inform and apologise to patients or their families if there have been mistakes in a patient's care that led to death or significant harm". Homerton is committed to delivering safe and effective care to all those who access its services. When things go wrong the effects of harming a patient can have devastating emotional and physical consequence for patients, their families and carers. It can also be distressing for the professionals involved. DoC* aligns with the Trust's "Being Open" Policy as it provides a framework which supports the Trust`s safer culture and wider organisational learning. This policy also acknowledges the legal duties the Trust is under to be open to patients and/or their relatives/carers/representatives especially those contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – regulation 20.

The Trust ensures that DoC is implemented whenever an incident occurs by:

- encouraging staff to be open and often apologise to patients when they have been errors in the provision of their care that resulted or would have led to harm as soon as possible
- ensuring staff to complete DoC prior to every Serious Incident Review (SIR) meeting. The template used at the SIR meeting provides an opportunity for the Chair to audit or interrogate if DoC has been done
- ensuring that DoC is discussed as a standing item on the agenda for SIR meetings
- the Quality and Safety Team are currently delivering bespoke training on DoC both to staff in the Community and Acute setting
- use of tools such as global emails, newsletters and dedicated training sessions to encourage the implementation of DoC

- implementing a DoC tracking tool for use in the Quality of Risk department to ensure completion of all DoC steps
- launching updated report templates for formal investigations with sections devoted to DoC* to ensure that the three parts of it are robustly and appropriately fulfilled.

By undertaking each of these steps the Trust ensures it is open and honest with patients and their relatives when adverse incidents occur; provide timely and appropriate communication and ensure that we share and disseminate our learning. Our process can be found in **Figure 14.**

Figure 14: Duty of Candour algorithm

Seven day hospital services

Please note that following the release of 2017/18 Quality Account guidance, providers of acute services have been asked to include a statement regarding how they are implementing the priority clinical standards for seven day services.

The national target is that the 4 priority clinical standards below are fully met by 2020:

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

Homerton made good progress, ranking third in London and 36th nationally (varying slightly by standard) on the last full audit in March 2017. The performance in September 2017, when only standard 2 was audited, was similar. Providing consistent cover seven days is particularly challenging in the smaller surgical specialities such as ear, nose and throat surgery, oromaxillofacial surgery, breast surgery and urology. In 2018, Homerton is working with Barts Health to develop a partnership agreement covering these specialities so that we jointly provide consistent, safe and effective care to our patients, seven days a week.

Part 3: Quality performance indicators

3.1. National/NHS Improvement performance indicators (from the Single Oversight Framework (SOF)

Homerton endeavours to meet all national targets and priorities. Below is a summary of the national targets and indicators (including those set out in NHS Improvement's Risk Assessment Framework) in **Table 31**.

Other national/local priorities are detailed in Part 2 of this publication**.**

Table 31

NHS Improvement targets / indicators	Indicator Description	Target 2017/18	2017/18	2016/17	2015/16
Infection Control	Clostridium Difficile (C-diff): variance from plan	7	10	4	10
Access	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate- patients on an incomplete pathway	92%	96.18%	95.3%	N/A
	A&E - total time in A&E under 4 hours (from arrival to admission/transfer/discharge)	95%	94.73%	94.1%	95.1%
	*Cancer: 62 day wait for first treatment (from urgent GP referral for suspected cancer)	85%	81.70%	83.9%	87.3%
	Cancer: 62-day wait for first treatment (from NHS Cancer Screening Service referral)	90%	100.00%	100.0%	100.0%
	Maximum 6 week wait for diagnostic procedures	99%	99.97%	N/A	N/A
	Proportion of people completing treatment who move to recovery (from IAPT* database)	50%	56.65%	N/A	N/A
	Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	75%	93.87%	84.4%	79.0%
	Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	95%	99.42%	99.1%	98.0%

***Cancer: 62 day wait:**

Trust performance with regard to the 62-day standard does frequently oscillate. In this context, the Trust only delivers a limited number of treatments on-site and is therefore disproportionately reliant on partner organisation to achieve compliance with the standard. This also extends critically to diagnostic support and in particular, although not exclusively, histopathology where the Trust experienced long-standing challenges with its local supplier. Nevertheless, the Trust identified areas where internal processes can be refined in order to ensure that patients are diagnosed as quickly as possible. The Trust continues to review its tumour site timed pathways alongside its demand and capacity modelling to ensure they are in line with the revised treatment reallocation rules to be introduced in 2018/19 and further forward the 28 day faster diagnosis standard in 2020.

For information purposes, NHS foundation trusts providing acute services should select two indicators that are relevant for the Trust. These should be selected from the following list in order (i.e. if 1 and 2 below are both reportable then those should be selected:

1. Percentage of patients with a total waiting time in A&E for 4 hours or less from arrival to admission, transfer or discharge.
2. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.
3. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
4. Emergency re-admissions within 28 days of discharge from hospital.

   If there are not two indicators in the above list that are relevant for your trust, the foundation trust should select an additional indicator(s).

3.2 Review of 2017/18 priorities

The following section provides a detailed description of progress made against the 8 improvement priorities we selected in 2017/18. Additionally, we will provide details of future work to continue our improvements in 2018/19. Although several priorities will not be continued, we will ensure these will be monitored through the most appropriate channels.

PRIORITY ONE

Safe: To prevent and reduce harm to patients caused by avoidable falls with harm in hospital

Background:

Falls are one of the main causes of harm that occur in hospital. Following an audit of all falls with harm that occurred in 2015 there were consistent themes throughout – poor communication and handover, impaired cognition or incontinence, mobilising to or in the toilet, and they often occurred out of hours.

The Falls Working Group is working to raise awareness on falls and enable better communication resources and procedures available to staff to help prevent inpatient falls.

Our success measures have been to:

1.1 Reduce the number of avoidable falls with harm
1.2 Continuous improvement in recording lying and standing blood pressure: all patients over 65 have a recorded lying and standing blood pressure within 72 hours of admission
1.3 An improvement of 20% on patients over 75 able to have an appropriate cognitive assessment. This is a pilot starting on ECU for 2017

Data source: DATIX, EPR

What did we achieve to date?

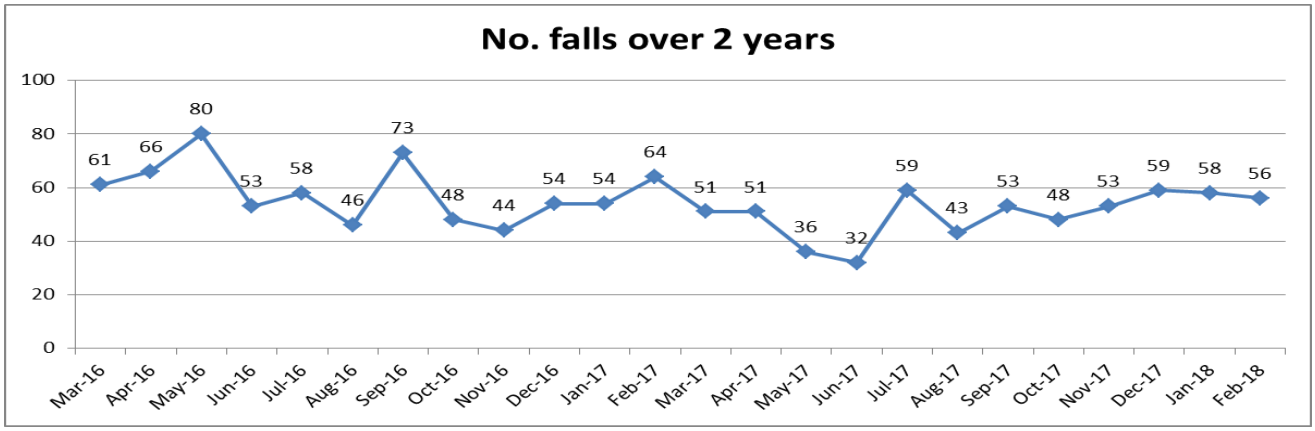
	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
1.1	Reduce the number of avoidable falls with harm	13	12	2	2	0	2
1.2	Continuous improvement in lying and standing blood pressure: all patients over 65 have a recorded lying and standing blood pressure within 72 hours of admission	10.5%	24%	16.07%	20.07%	20.95%	17.00%
1.3	An improvement of 20% on patients over 75 able to have an appropriate cognitive assessment. This is a pilot starting on ECU for 2017	48%	55%*	61%	64%	63%	59%

There were two confirmed avoidable falls with moderate or major harm in Quarter 1 and four inpatient falls with severe harm in Q2, however on investigation, one was deemed to be unavoidable and one is still in the final stages of the investigation period.

In Q3 there have been again three inpatient falls with severe harm which have already been deemed unavoidable.

This year to date there has currently been six avoidable falls with harm. If this trend continues we are on track to meet our target to retain the number of falls with harm at less than 12.

.**Figure 15**: Number of inpatient falls per month at Homerton Hospital (all levels of harm)



Number of falls overall has remained statistically unchanged across the last two years (data drawn from Falls Dashboard), however the figure appears to be overall trending down. A new report was created by IT which assesses the compliance rate of lying/standing BP assessments being completed by drawing the data directly from EPR. This created a much more accurate figure, and demonstrated that the true compliance rate across the hospital was only 10.5% for 2016/17. The previous figure of 22% came from the 2015 National Audit for Inpatient Falls, which consisted of only 12 patients; therefore the sample size was too small to be accurately representative. The baseline was therefore set based on the EPR data. We have been able to track our progress showing good improvement over time by using the new report, to a high of 24.3% in October, achieving the originally chosen target of 24%. This progress dropped off over November/December and we could relate this to additional strain and a drop in results on ECU where improvement work had been carried out. The dementia and delirium team pilot ran in Quarter1, which was focused on ensuring that AMTs were consistently completed. The dementia team has been focusing on engaging junior doctors to be completing the assessment which has continued to yield good results. The improvement in compliance rates of AMTS completion has been sustained in Q3. This was due to a large drive by dementia and delirium lead consultants and nurses working with the junior doctors to ensure timely completion on admission.

In March 2018 the team identified a technical error with the completion of AMT forms which has since been worked on and mitigated. This problem led the team to record higher than expected numbers of AMTs completed in error. The AMTS form on EPR is being further tweaked to allow for an additional delirium screen, aiming to further address recommendations by the National Audit of Inpatient Falls.

The new changes to the form will also include the loading of the 4A-T screen for delirium, should the clinician suspect delirium.

We can evidence progress through:

1. Improving the falls with harm rate per 1000 bed days year on year:

	Falls with harm (moderate and above) rate per 1,000 bed days		
	2015/16	2016/17	2017/18
FY Total	0.11	0.10	0.09

2. Increasing dashboard access figures.
3. Month-on-month improvement of lying/standing BP assessment and AMT compliance rates.
4. Development of RCA/SI investigation timeframes and quality.
5. Scoping completed for the Integrated Falls & Bone Health Dashboard.

6. Clinical Leadership Programme supported (redevelopment of borough-wide falls pathway and guidance for GPs).
7. Results of National Audit for Inpatient Falls received in November2017/January 2018.
8. Falls Week held October 2017.
9. Planning commenced to incorporate Falls training into annual Nursing Update in 2018 to improve efficiency and consistency of training across wards.
10. Local QI projects ongoing.

What will we do in 2018/19 to continue improvements?

- Roll out of successful strategies to improve lying/standing BP assessments, environmental set up and moving and handling communication drawn from QI projects running on ECU to other wards.
- Ongoing review of the data by ward, as well as thematic reviews of falls to target recurring areas for change.
- Ongoing links with community to ensure falls pathway is consistent and seamless across both primary and secondary care.
- Ongoing development of dashboards from RiO to get feedback on functioning of falls pathway and target areas for improvement.
- Ongoing development of falls training available within the trust.

PRIORITY TWO

Safe: To ensure learning is shared across the Trust following patient deaths

Background:

In March 2017 the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the new framework has been to introduce a standardised approach to the way NHS Trusts report, investigate and learn from patient deaths.

The framework focuses on:

- improving governance processes around patient deaths
- new board leadership roles
- a new system of case record reviews
- quarterly reporting of specific information about deaths in care
- new policy and data set
- Trusts to publish details of their policy and approach via public board meetings by the end of Quarter 2 and to start publishing the data (plus learning points) from Q3 onwards

- involving at every stage the families/carers of patients who have died in care.

Our success measures have been to:

2.1 Percentage of mortality case note reviews undertaken
2.2 Percentage/Number of mortality case note reviews undertaken for patients with learning disability
2.3 All mortality case note reviews shared through a suitable channel

What did we achieve to date?

From 2015/16, the majority of inpatient services had already started reviewing patient deaths through multi-disciplinary meetings which put the trust in a strong position. Following the publication of the NQB report in March 2017 The central team started mapping a Trust wide standardised approach with support from divisions to include national recommendations.

The outcome of this work was:

- delivery of a robust and standardised approach to reporting mortality data across The Trust and ultimately across our community services
- consistency in determining when to investigate deaths through an SI process
- the outcome of mortality reviews are clearly recorded and actioned where needed
- clear reporting mechanisms are in place, to escalate any areas of concern (including family concerns) identified in mortality review meetings, so that the organisation is aware and can ensure appropriate action is taken
- to provide assurance to the Trust Board that all deaths are being reviewed and to identify themes and areas of good practice, and to share the learning from these reviews
- bereaved families are included in the review process as much as possible and learning is shared with them. This will help improve clinical practice.
- all deaths of patients with learning disability and mental health condition will be flagged through EPR and follow their own pathway. The result of these reviews will be shared with the board via a quarterly report.
- there is a continued focus on reducing avoidable mortality and on ensuring that care of the dying is personalised and provided in accordance with the wishes of dying patients and their families and carers
- areas of good practice is identified and shared with staff across the Trust, following case reviews
- the Trust has elected to use the Confidential Enquiry into Stillbirth and Deaths in Infancy (CESDI) score (see **Table 12**) for identifying if death was ‘avoidable’ or ‘unavoidable’. The CESDI score is a measure of suboptimal care which may have contributed to the death. The CESDI score will be reviewed throughout the process of mortality review with the final score identifying whether the death was avoidable or not.

The Trust has decided that assigning a CESDI score of 3 will mean that death was probably avoidable.

- the learning is shared within the departmental staff by regular multi professional mortality reviews. They are also discussed as part of regular rolling departmental governance presentation at the respective Divisional Governance Board. The ACU mortality meetings are a very good sharing platform for disseminating learning across specialities. learnings from SIs are also highlighted for trust wide learning via a regular governance newsletters, the QTc. These are also reviewed at the Patient Safety Committee and the End of Life Board.
- ror deaths to be reviewed via the LeDeR process, they have to be allocated to an independent LeDeR reviewer by the Clinical Commissioning Group(CCG) LeDeR lead. The CCG LeDeR lead for City and Hackney CCG has examine the mortality review done in these cases and found the reviews satisfactory.

Moving forward the MRT will enable divisions to draw reports highlighting lessons and themes which can then be shared across the divisions. There needs to be further discussion to consider whether a newsletter will be appropriate as a tool for sharing these lessons.

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4*
2.1	Percentage of mortality case note reviews undertaken	**54%**	**100%**	**100%**	**94%**	**80%**	**20%**
2.2	Percentage/Number of mortality case note reviews undertaken for patients with learning disability	**N/A**	**100%**	**0%**	**N/A**	**0%**	**0%**
2.3	All mortality case note reviews shared through a suitable channel *(will be identified by the end of March 2018)*	**No**	**Yes**	**N/A**	**N/A**	**Yes**	**Yes**

*Q4 figure will be updated in the Quality Account report 2018/19.

We can evidence progress through:

- Mortality reviews currently form part of the core agenda at the Improving Clinical Effectiveness Committee (ICEC), which reports to Trust Management Board.

- The quarterly report to the Board of Directors.

- Currently themes and learning from mortality reviews are a standard agenda item at ICEC which reports into TMB. Lessons and themes are also shared through the paper going to the Board of Directors on a quarterly basis, the divisions, End of Life Board and through the QTc newsletter which is disseminated across the Trust.

- An increase in the number of mortality reviews by the end of March 2018.

What will we do in 2018/19 to continue improvements?

- The Trust will be using the Mortality Review Tool (MRT) as a web based online database to capture whether a death was avoidable or not, as well as lessons, areas of good practice and themes throughout the review process.
- All specialities will be using the CESDI score to determine avoidability or unavoidability of deaths.
- All specialities will be continuing sharing the learnings from the reviews in a suitable forum identified locally.
- The Safeguarding Adults Team will work closely with the Clinical Quality Team to establish a pathway between LeDeR and the Trust Mortality Review process and with the CCG to ensure that the deaths of learning disabilities patients are allocated to a LeDeR reviewer and the outcome shared with the Trust in order that any lessons learnt can be cascaded to staff.

PRIORITY THREE

Safe: To improve identification and response to acutely deteriorating patients

Background:

This priority was chosen because national studies have shown that in at least a third of cases of avoidable death, there have been missed opportunities arising from failure or delays in recognition and response to the patient's deterioration.

Our success measures have been to:

3.1 Appropriate escalation of National Early Warning Score (NEWS) ≥5 (i.e. within 30 minutes of recording)

3.2 Appropriate escalation of Neonatal Early Warning Triggers (NEWTTS)

3.3 % of patients with sepsis who were administered intravenous antibiotics within 60 minutes Inpatient (CQUIN)

3.4 % of patients with sepsis who were administered intravenous antibiotics within 60 minutes Emergency Department (CQUIN)

3.5 % of patients with sepsis who were reviewed within 72 hours of the prescribing of antibiotics who are still inpatient (CQUIN)

3.6 % patients with AKI Pharmacy Review within 24 hours of AKI alert

Data source: Safety Thermometer, Maternity Dashboard, CQUIN*, EPR*

What did we achieve to date?

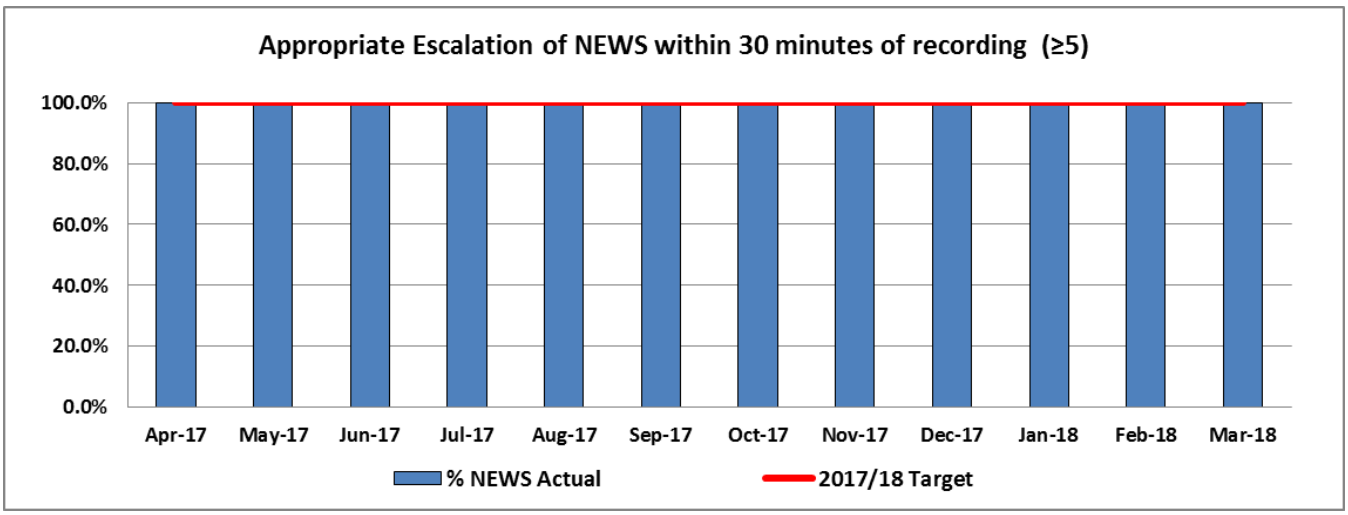
NEWS

There has been excellent performance against this metric. However, it is important to caveat that this data is collected via the Safety Thermometer, a snapshot audit looking at one time of day, on one day per month. We therefore do not take this data to indicate that our overall early warning score recognition and escalation is 100%.

Table 32: Percentage of appropriate escalation of the national early warning scores 5 above within 30 minutes of recording, assessed by National Safety Thermometer

Baseline	March 2018 Target	Q1	Q2	Q3	Q4
97.7%	98%	100%	100%	100%	100%

Figure 16: Percentage of the appropriate escalation of the National Early Warning Scores of 5 or above within 30 minutes of recording



NEWTTS

There is a strong focus on improving the quality and safety of the Trust's Maternity services, in particular in making them as safe and effective as possible. There has also been a strong focus on identifying and responding to any deteriorating mother or baby as rapidly and consistently as possible.

We have introduces some measures in the past two years which include:

In August 2015 our maternity service was rated by the CQC as 'requiring improvement'. This was an important spur for us to improve the quality of service that we deliver, to ensure that it is consistently as safe and effective as possible. Our maternity service aims to identify and respond to any deteriorating mother or baby as rapidly and consistently as possible. Some measures we have introduced over the past two years include the following.

- Enhanced training for all midwives and support workers on early recognition and escalation of the deteriorating patient.
- Developing and implementing the New-born early warning trigger and treat (NEWTT) form on EPR.
- Monthly audits are undertaken by the senior midwifery team of compliance to 5 KPIs:
  1. All babies having a chart if risk factors identified at birth
  2. Risk factors documented within the NEWTT chart
  3. Frequency of observations documented
  4. Appropriate action taken for triggering scores
  5. The observations have been completed as per guidance.

In general, performance in relation to appropriate escalation of Neonatal Early Warning Trigger and Track (NEWTTS) is consistently good, though not yet as perfect as we aspire to.

Table 33: Percentage of Neonatal Early Warning Triggers (NEWTTS) appropriately escalated

Baseline	March 2018 Target	Q1	Q2	Q3	Q4
91%	100%	93%	93%	92%	88.5%

Sepsis

The Sepsis CQUIN set out to evaluate the quality of care provided to patients with confirmed or suspected sepsis in hospital environment.

On average every month 250 patient notes are reviewed from the wards and 200 from ED, and those patients who have triggered for a sepsis related physiological reason.

They are then assessed in terms of the time for response to deterioration, the time for antibiotic therapy and the time for review of those between the national frames of 24/72h.

The percentage of patients treated with intravenous antibiotics within one hour of diagnosis is reasonable though we have managed to hit our target of 90%. Performance has improved significantly compared to 2016/17, when 50% of inpatients who were found to have sepsis received antibiotics within 90 minutes.

In September from 50 patients with confirmed sepsis, used for the CQUIN data submission, eight missed the target: “antibiotics within the hour” by an average time of 1:17.

Figure 17: Percentage of patients with sepsis who were administered intravenous antibiotics within 60 minutes – inpatients and Emergency Department

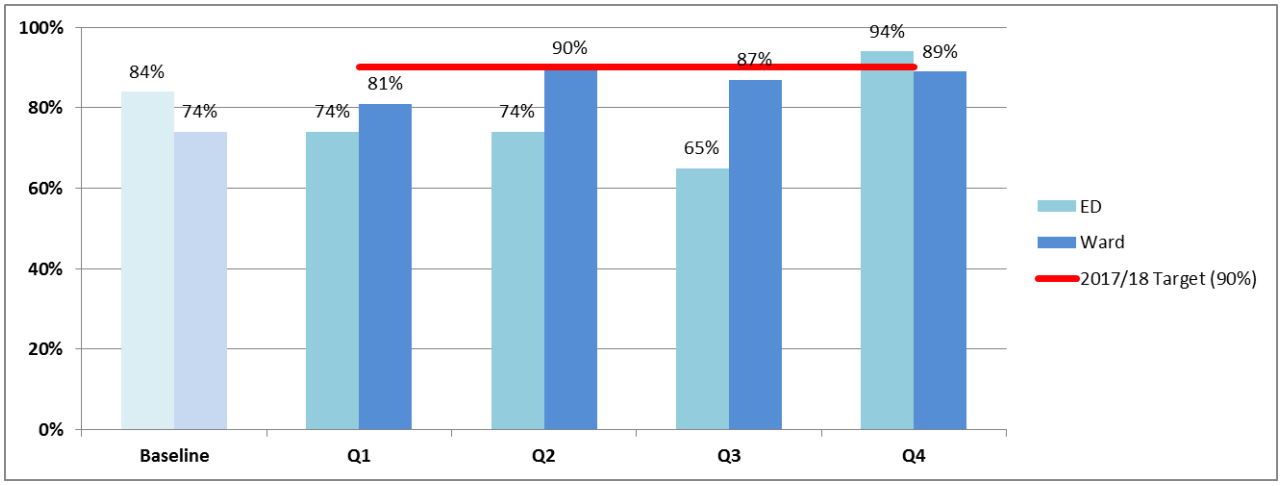
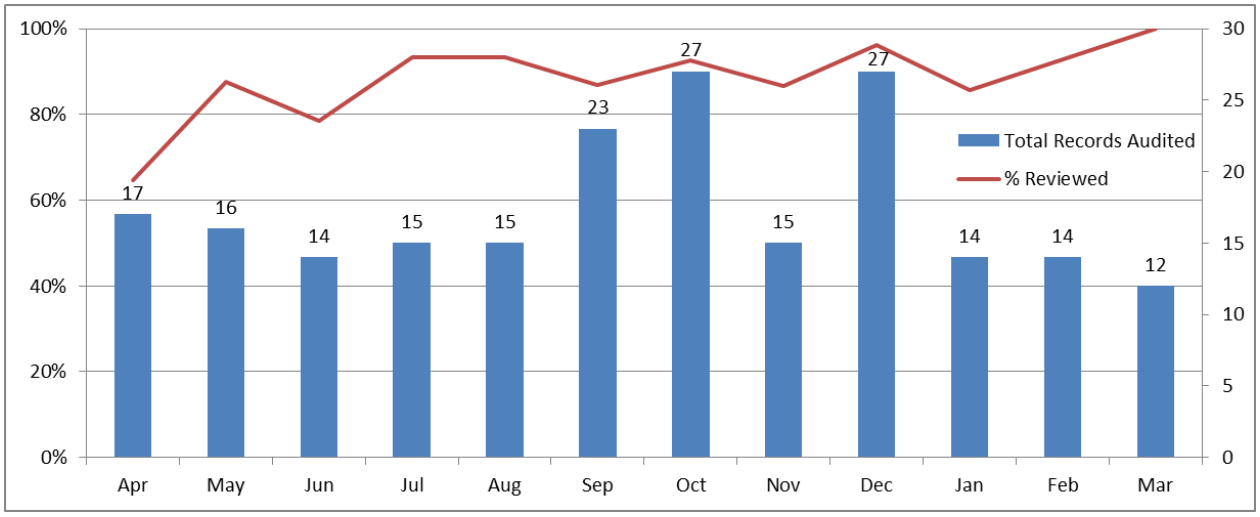


Table 34: Percentage of patients with sepsis who were reviewed within 72 hours of the prescribing of antibiotics who are still inpatient

% of patients with sepsis who were reviewed within 72 hours of the prescribing of antibiotics who are still inpatient					
Baseline	**March 2018 Target**	**Q1**	**Q2**	**Q3**	**Q4**
100%	**90%**	**77%**	**91%**	**93%**	**93%**

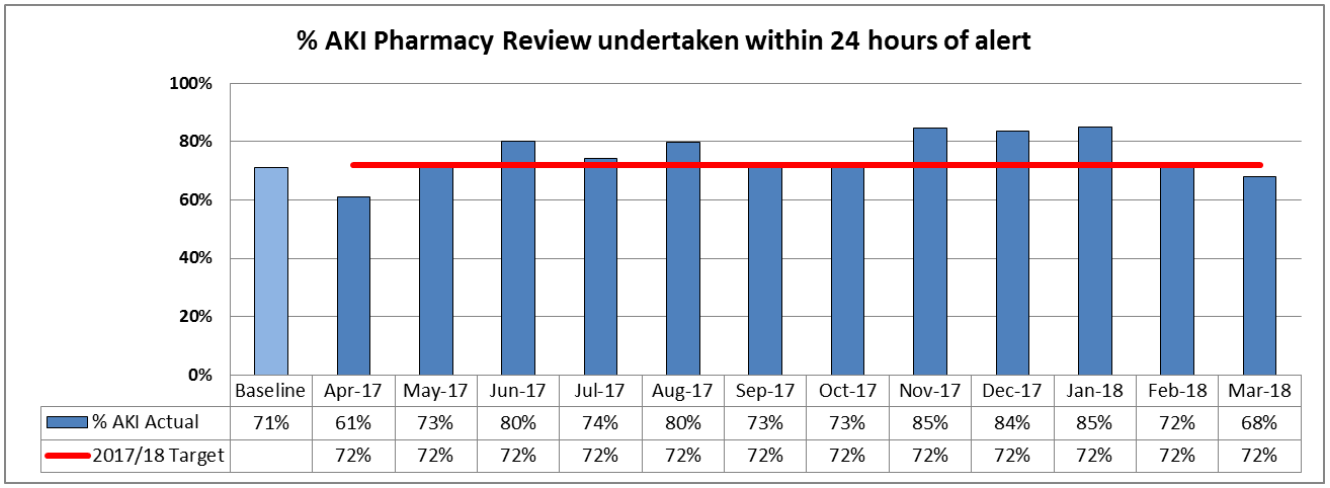
Figure 18: Total number of inpatients with sepsis audited and percentage of inpatients reviewed within 72 hours of the prescribing of antibiotics



3.5: Acute Kidney Injury (AKI)

Patients with AKI are automatically detected through our pathology laboratory results system. This triggers clinical review of the patient to look for possible causes, and a review of the patient's medication by a pharmacist to ensure they are not on drugs which can damage or exacerbate damage to the kidneys. The diagnosis of acute kidney injury and advice for further management are also added to the patient's discharge summary to support GPs in further management. Currently, pharmacy can only provide this service five days out of seven, so the target was set at 72% which would be perfect performance for the days pharmacy staff are available (5/7 x 100 = 71%). We recognise that this is not ideal, although the medication reviews carried out by pharmacy, ensuring prompt recognition and adjustment of potentially toxic drugs, are in addition to the safety checks that ward doctors carry out routinely. This target will be kept under review as pharmacy staffing is under review and we would hope to extend this service to seven days in due course.

Figure 19: Percentage of Acute Kidney Injury (AKI) reviews carried out by the Pharmacy department within 24 hours of alert



	Baseline	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% AKI Actual	71%	61%	73%	80%	74%	80%	73%	73%	85%	84%	85%	72%	68%
2017/18 Target		72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%

We can evidence progress through:

- The progress on this priority has been managed and reviewed by the Critical Care Committee (CCC).
- In December 2017, the paper form of the NEWTT chart was replaced by electronic version. The NEWTT chart is generated following the documentation of the initial baby check carried out by the midwife whom was present at birth.
- We have updated the deteriorating patient policy in line with national guidelines.
- We are very proud that in the most recent National Cardiac Arrest Audit for the period from April to September 2017, we had the lowest rate of cardiac arrest on our wards of any hospital in the Country.

What will we do in 2018/19 to continue improvements?

- We will implement the updated National Early Warning Score (NEWS) version 2.0 in early 2018, to ensure that we continue to further improve our response to deteriorating patients.
- We are in the process of implementing many innovations in relation to recognition and response to sepsis.
- Patient group directive reviews in development to reduce delays to antibiotic delivery for the outreach team.
- Extensive sepsis teaching established including on band 6 and band 5 study days, on SHO teaching sessions, and on monthly Trust induction.
- Sepsis scenarios are delivered within our multidisciplinary simulation centre teaching throughout the year, plus interactive simulated sepsis teaching on the wards, with combined multidisciplinary teaching for nurses, doctors, HCAs. A confidence score pre and post teaching is measured to check effectiveness.
- Daily ‘flash’ teaching is delivered on wards and in ED.
- All new staff in ED since October have been specifically orientated on sepsis, including system alerts, policies, guidelines, and roles & obligations.
- Educational game developed.
- Action Cards with reminder prompts about how to manage sepsis and other emergencies, developed in response to incidents are in the process of being refined and will be fully implemented in 2018.
- Patient information leaflets regarding infection and outcomes have been revised and will be issued once approved.
- From January 18, Paediatrics started submitting the CEWS data on a monthly basis through the National Safety Thermometer. This will continue into the financial year 2018/19 to ensure improvements on our response to deteriorating patients.

PRIORITY FOUR
Effective: To embed patient centred care (through improved effectiveness of joint clinical pathways between community and acute settings and training for key skills such as shared decision making and health coaching)

Background

More than half of the population today live with a long-term condition. However out of these patients, 5% counts for more than 75% of unscheduled hospital admissions. These patients have indicated that they have low levels of knowledge, skills and confidence to self-care, to manage their health and well-being and to live independently. This has resulted in a poorer quality of life. It also leads to increases in the costs of care through unwarranted use of public services.

In the National Inpatient survey 2016, 50% of Homerton patients reported they wished they had been more involved in decisions that were made about them by the health care team. In order to address this, it was agreed that training would be given to staff, followed up by service development, to increase patient involvement in decision making.

To ensure patients receive the quality of care they need for their long-term conditions, clear and concise pathways are being developed and agreed in collaboration with GPs and Homerton clinicians.

Our success measure has been to:

4.1 Pathways jointly agreed with CCG by March 31st 2018
4.2 Number of staff trained in Shared Decision Making by March 31st 2018
4.3 85% of identified staff trained by the end of the year to support the personalised care CQUIN

Jointly agreed pathways in specific clinical areas

The Clinical Leadership Programme aims to bring together a group of stakeholders to review clinical pathways within eight speciality areas.

The specific clinical areas considered agreed between the City and Hackney Clinical Commissioning Group (CCG) and HUHFT relate to:

- Catheters
- Hypertension
- Falls

- Sickle Cell
- Maternity
- Paediatric Urgent Care
- Rheumatology
- Urology

Increase the number of staff trained in 'Shared Decision Making' by March 2018. Actions related to this priority build on work summarised in last year's Quality Account. Activities undertaken by Starlight Children's Ward have been added since this fits in with an initiative called 'Hearing the Voice of the Child'.

85% of identified staff will be trained to support personalised care in line with the relevant CQUIN.

This is a two-year CQUIN aimed at embedding personalised care and support for patients with long-term conditions and has an emphasis on ensuring that relevant staff are trained in 'Health Coaching'. The CQUIN uses a 'Patient Activation Measure (PAM) and tailored interventions to demonstrate improvement in PAM scores in the second year of the programme.

Data source: EPR*, Audits

What did we achieve to date?

Progress against each of the target measures are shown in the table below:

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
4.1	Pathways jointly agreed with CCG by March 31st 2018	0	8	N/A	N/A	N/A	21
4.2	Number of staff trained in Shared Decision Making by March 31st 2018	0	101	124	154	167	167
4.3	85% of identified staff trained by the end of the year to support the personalised care CQUIN-	0	85%	N/A	78.5%	85%	91%

Scoping meetings were held between January and April 2017 for pathway optimisation against the following criteria:

- Inclusions/ exclusions
- Method for review

- Best practice
- Membership / stakeholders

From April 2017 regular pathway review meetings have taken place with the GP leads and with the stakeholders nominated for each speciality area. The reviews have seen the development of 22 new and/or revised clinical pathways (and management guidance in some cases) including a number of additional outputs.

170 staff members have been trained in shared decision making, via three external training providers, Bridges and Whittington Health for adult patients and 'Me First' for children.

A Shared Decision Making pilot was carried out on ECU – see Appendix 4 for poster. A project to increase Child Centred communication on Starlight ward has been very successful.

At the end of Quarter 4, the following milestones had been achieved:

- Identified the relevant patient populations with long term conditions.
- The following patient groups were identified to be a part of the Personalised Care and Support Planning CQUIN:
    - Epilepsy
    - Psoriasis
    - Ulcerative Colitis
    - Long term back pain
    - Arthritis
- Discussions with regards to plans for interventions / support for patients;
- Identified processes to conduct the initial surveys. Surveys are aimed at patients mainly attending nurse-led education clinics, as well as specialist consultant-led clinics.

We can evidence progress through:

We can evidence progress through the review meetings which are chaired by the GP lead and attended by Homerton clinicians. Pathway reviews are facilitated by the CCG pathway facilitator and Trust's project manager and the programme managed through an agreed project plan.

We maintain registers of staff who have participated in training. We have collected and analysed the evaluation forms completed by staff who have completed the training. There are high levels of satisfaction with the course content, relevance and delivery. Staff reported they felt completely confident to apply the skills in the workplace.

The feedback from the course participants included;

"I plan to use the skills, particularly agenda setting, in the clinical setting, probably on a daily basis." And *"Useful skills and likely to change behaviour."*

Progress can be evidenced through the number of surveys conducted in order to ascertain the cohort of patients with low activation scores - low levels of knowledge / confidence to self-manage their condition; as well as awareness of local support that is available to them.

Discussions with regards to personalised care are being recorded in clinical consultations, at the time of conducting these surveys.

What will we do in 2018/19 to continue improvements?

We plan to continue to work in partnership with the CCG to further optimise the process for reviewing pathways and to refine and structure the process and methodology to enable best value from pathway improvements.

The next step is to hold meetings on all three wards, with the relevant training providers as well as staff who have participated in the 'Me First Course'. We will ask for suggestions regarding how the learning from the courses could be embedded in ward practice. The suggested changes will then be implemented and the measures re-taken.

Plans for 2018/19 in order to continue improvements are as follows:

- Identify patients that will benefit from support planning – these will be the patients with low activation scores identified through the surveys carried out this year.
- Activate patient interventions to enable self-management – establish educational sessions.
- Record and review the number & quality of care planning conversations on EPR / RiO.
- Conduct a follow up survey to assess if the patient confidence to self-manage and their knowledge of their condition has improved; via telephone interviews.

Priority Five

Effective: To improve our End of Life care and advanced care planning

Background:

This priority has been chosen as it is recognised that when a patient is dying they will not benefit from being subjected to unnecessary treatment interventions. However, it is very important to also ensure that they receive the best possible care and their family receives the appropriate support.

Our success measure has been to:

5.1 Increase percentage of ward based patients who have a cardiac arrest with appropriate Treatment Escalation Plan (TEP) already in place.
5.2 Increase the percentage of patients at EOL who are on a personalised care plan at time of death.

Data source: local audit

What did we achieve to date?

- Any patient suspected to be within a year of death or who is seriously unwell should have a treatment escalation plan (TEP) in place with ceilings of care agreed. Therefore, almost all patients who suffer a cardiac arrest or who require admission to ITU due to acute deterioration should have a TEP in place outlining their agreed treatment limits.
- An audit of all patients known to the Specialist Palliative Care team was performed from January to June 2017. This audit recorded the number of patients who died in hospital and had an end of life care plan in place. The average percentage over the 6 months was 67%.
- The team has carried out ward based teaching with the ward nurses to promote the use of the end of life care plan but it has only been generated from the TEP since October 2017 so we should expect more systematic use of this in the future.

What did we achieve to date?

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
5.1	Total number of ward based patients with Cardiac arrest or requiring admission to ITU			4	3	6	4
	Number of ward patients with Cardiac arrest with appropriate Treatment escalation Plan (TEP) already in place			3	3	0	2
	Increase percentage of ward based patients with cardiac arrest with appropriate Treatment Escalation Plan (TEP) already in place	50%	80%	75%	100%	0%	50%

Patients who could not have been reasonably expected to suffer cardiac arrest are excluded from this data.
**3 patients out of 4 had a TEP in Q1 and 3 out of 3 in Q2. Q3 figures: Oct and Dec none of the 8 patients had a TEP form in place, there were no cardiac arrests in Nov. In Q4 there were 5 inpatients who had a cardiac arrest but only 2 had a TEP form in place, however two patients arrested before a TEP could be put in place. There were no cardiac arrest calls in February*

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
5.2	Increase the percentage of patients at EOL who are on a personalised care plan at time of death.	61%*	90%	Progress will be measured in Q3		55.80%	63.50%

** Baseline based on the audit data from April to June 17. No audits were carried out in Q2*

We can evidence progress through:

- The number of appropriate TEPs already in place for patients who have cardiac arrests on the wards.
- Increasing numbers of patients known to the palliative care team having the end of life care plan in place.
- End of Life Board meetings.

What will we do in 2018/19 to continue improvements?

- Education and empowerment of clinical staff and effective engagement with patients, relatives and friends are keys to maintaining progress in 2018/19.
- Often these conversations are extremely challenging and it is critically important that the medical staff are supported to make these decisions and receive education in management of difficulty conversations.
- The palliative care team will continue to work with ward staff to ensure the initiation of and correct review of the end of life care plan. The team will continue to audit the use and feedback to the relevant wards to improve effective use of this.

PRIORITY SIX
Effective: To improve nurse communication to positively impact on patients reporting having trust and confidence in nursing

Background:

This priority was chosen to increase patient satisfaction and confidence in nursing care. Homerton ranked as one of the lowest in the country for scores on patients having trust and confidence in their nurses when staying on inpatient wards on the National CQC survey in 2015.

Our success measure has been to:

6.1 Improve patients' Trust and Confidence in inpatient nurses by end of March 2018 recorded through the local frequent results feedback.

6.2 To run Quality Improvement Projects on 4 wards throughout the 2017/18.

6.3 Involving staff by hosting focus groups to ask them what they understand by 'Trust and Confidence in nurses' and their suggestions to improve it.

6.4 Qualified nurses working on inpatient wards to have attended communication study day (Communicating for Better Outcomes and/or Sage and Thyme study day).
Data source: EPR*

What did we achieve to date?

Trust-wide results are sitting at 91-92%. Scoping work has been completed and has yielded key areas that are affecting nurses' ability to demonstrate the behaviours and interactions patients have reported that build T&C in their nurses.

Three quality improvement projects have commenced on wards and a fourth is in planning phase.

Significant scoping work has been undertaken and completed in Q3 investigating what 'trust and confidence' means to both staff and patients/families.

We have now exceeded our target of 50% of adult inpatient nurses trained in communication for better outcomes. 46% of adult inpatient nurses have now attended the study day, with very good feedback.

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
6.1	Improve patients' Trust and Confidence in inpatient nurses by end March 2018 recorded through the Patient survey.	92%	94%	92%	91%	91%	92%
6.2	To run Quality Improvement Projects on 4 wards throughout the 2017/18	N/A	4	N/A	2	1	0
6.3	Involving staff and patients by hosting focus groups to ask them what they understand by 'Trust and Confidence in nurses' and their suggestions to improve it	N/A	Yes	Y (patient focus group held)		Y	N/A Scoping work was completed in Q3, nil further required in Q4.
6.4	Qualified nurses working on inpatient wards to have attended communication study day (Communicating for Better Outcomes and/or Sage and Thyme study day).	11%	50%	15.6%	30%	46%	46%

Activities to support the metrics in 2017/18

- Nurses & Midwives Day Stall May 2017
- Patient Engagement and Experience Forum held June 2017
- Patient Focus Group in June 2017
- Student focus group in June 2017
- Telephone survey was completed with 25 patients completed September 2017
- Band 6 nurses study day intro to QI and improving T&C in nurses' focus group was held in September
- Two QI projects aimed at addressing aspects of T&C in nurses commenced on Graham Ward and Cardiology Ward; one further in planning phase for Lloyd Ward.
- 71 adult inpatient nurses trained in communication on 'Communicating for Better Outcomes' or 'Sage & Thyme' courses.
- Analysis of scoping work completed.
- Ongoing CFBO study day – 86 adult inpatient nurses now trained, plus 16 health care assistants, 3 practice development nurses, 2 speciality nurses, 2 transitional rehab urses and 11 A&E nurses have completed the training.

We can evidence progress through:

Achievement of target for nurses trained in communication.

Three QI projects commenced on wards with a 4th in planning phase.

Scoping work: Analysis of the responses and information gathered from many sources from both service users and staff. Overall, it revealed that for the most part, nurses know what fosters a trusting relationship between themselves and their patients and relatives, but due to the ever-worsening patient flow pressures, patient complexity, and staffing and retention issues, they felt physically limited from being able to engage in the behaviours that patients identified they were looking for to be able to trust their nurse.

Patient Feedback Analysis

- Patients value 'human' side of nursing
- Being 'taken care of', or being 'cared about' instead of 'receiving care'
- Good nurses fostered a feeling of safety and optimism in their patients when they are in a vulnerable and uncertain place
- Patients look to nurses as both a trained professional but also someone they can relate to

Staff Feedback

- Nurses appear to know what is required to communicate and interact better with their patients but felt they were not in a position to do it consistently

- Continuous and unrelenting pressures of a normal working day for nurses drained their emotional capacity and physically limited their time to spend with patients
- Nurses wanted to spend more time with patients and felt that when they did it improved their working day
- Nurses did not identify some practical factors that patients reported affected their trust & confidence in them

What will we do in 2018/19 to continue improvements?

Given the findings of the scoping work, it appears that the barriers to developing trust and confidence in HUHFT nurses in part relate to nursing workplace issues. The working group has developed a plan to utilise the information gained and develop a campaign in 2018 to actively address these issues. Homerton has also contracted an organisational development consultant company ('ICE') to develop a strategy to improve retention and review organisational culture. The scoping work done on Improving Trust & Confidence in Nurses has been able to inform this work, and the working group is planning to formalise a link with the OD strategy in 2018. Additionally the group will be looking at ways to address the additional findings involving identification of nurses and areas of discrepancy between patient and staff understand are found.
We will continue to monitor and learn from engaging ward staff in QI projects, and formalise the 2018/19 strategy.

PRIORITY SEVEN
Responsive/ Effective: To improve the effectiveness of discharge from our care

Background

Increasing discharges reduces Emergency Department crowding and allows improved patient flow. With increased capacity in the mornings, patients can be admitted onto the best ward to meet their needs particularly during winter pressures, rather than wherever there is a bed. Additionally, new patients can be admitted early enough to be properly assessed and a treatment plan to be established and commenced. Overall, medical productivity is improved. Improving experience of patients at discharge remains to be of great importance at Homerton Hospital which is the reason for choosing this priority.

Our success measures have been to:

7.1 2.5% point increase in discharge to usual place of residence across Q3 and Q4 (Indicator 8b CQUIN)

7.2 2% reduction in the number of incidents related to discharge by end March 2018
7.3 10% reduction in the total number of complaints related to discharge by end March 2018
7.4 An increase in the Percentage of discharges before 1 o'clock (Medicine only)

Data source:

What did we achieve to date?

: The discharge of a patient may not be seen as the priority until they are medically optimised and this approach can then affect their length of stay and their overall inpatient experience. The IMRS medical productivity work plan focusses on making the discharge decision making and subsequent process a priority. This approach is also mirrored in the Enhanced Recovery Programme within SWSH. Ultimately this will reduce the length of stay across the organisation and enhance the patient experience.

There has been a reduction in the number of the incidents in Quarter2, these include, although the list is not exhaustive:

- delayed TTAs;
- incorrect TTAs;
- transport issues;
- poor communication re discharge destination.

: Although the medical wards have seen an increase in the percentage of discharges in the morning, this fluctuates in the individual wards from week to week depending on a variety of factors such as numbers of new admissions. Since this initiative was first introduced 12-months ago, all wards have made significant improvement in the number of patients discharged in the morning.

Improving the discharge experience for patients remains a challenge nationally. However, work on this priority continues with measurable progress made on some of the metrics. Please note that there will be variances month on month therefore it is important to focus on the current overall position rather than Quarter by quarter.

We can evidence progress through:

- The Medical Productivity Plan monitors the progress of all the key work streams, this is supported by the Operational Board who report to the Divisional Management Team. Although the plan does not specifically outline the metrics all the actions will incorporated into the plan will be assist to the achieve the metrics.
- The Enhanced Recovery Programme also monitors all the key work streams.
- Overall improved patient flow.
- Overflow beds have remained closed.

What will we do in 2018/19 to continue improvements?

- Continue to discuss patients who could be discharged in the morning in whiteboard meetings and MDMs.
- Continue to keep this high on the agenda of ward sisters, discharge planning team and the wider MDM.
- Write a discharge lounge policy
- Find ways of making the discharge lounge appealing to patients
- Investigate whether satellite pharmacies are an option for patients to increase timely TTAs
- Work with transport to improve early discharges
- Implement a discharge to assess pilot

The performance is tabled below demonstrating that the Trust has met the agreed trajectory across Q3 and Q4 and exceeded the 2.5% point increase in discharge to usual place of residence:

	Supporting Metric Description	Baseline	March 2018 Target	Q1	Q2	Q3	Q4
7.1	2.5% point increase in discharge to usual place of residence across Q3 and Q4. Indicator 8b CQUIN	**42.1*%**	**44.62%**	**N/A**	**N/A**	**45.53%**	**45.28%**
7.2	2% reduction in the number of incidents related to discharge by end March 2018	**310****	**304**	**85**	**154**	**249**	**370**
7.3	10% reduction in the total number of complaints related to discharge by end March 2018	**20****	**18**	**2**	**8**	**13**	**16**
7.4	An increase in the Percentage of discharges before 1 o'clock (Medicine only)	**20%**	**28%**	**22%**	**21%**	**19%**	**23%**

**Baseline is based on Q3 and Q4 2016/17*

***Please note that the baseline for 7.2 and 7.3 is based on previous financial year total*

PRIORITY EIGHT

Patient experience: To improve health and wellbeing of NHS staff

Background:

The aim of this priority is to improve the health and well-being of all staff working at The Trust. If we manage to do this, evidence suggests we will enhance staff engagement which in turn will improve the quality of care and the services in the organisation. This in turn will enable the Trust's ability to operate effectively and make the most of opportunities within a challenged healthcare landscape.

Our success measure has been to:

8.1 A 5 percent point improvement on Question 9a: Does your organisation take positive action on health and well-being?

8.2 A 5 percent point reduction on Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?

8.3 A 5 percent point reduction on Question 9c: During the last 12 months have you felt unwell as a result of work related stress?

8.4 A decrease in the percentage of staff experiencing physical violence from patients relatives or the public in last 12 months

8.5 A decrease in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

8.6 Achieving smoke free environment by April 2018

Data source: CQUIN*

What did we achieve to date?

Supporting Metric Description		Baseline	March 2018 Target	2017/18
8.1	A 5% point improvement on Question 9a: Does your organisation take positive action on health and well-being?	**38%**	**43%**	**35.9%**
8.2	A 5% point reduction on Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	**25%**	**20%**	**31%**

8.3	A 5% point reduction on Question 9c: During the last 12 months have you felt unwell as a result of work related stress?	**40%**	**35%**	**41%**
8.4	A decrease in the percentage of staff experiencing physical violence from patients relatives or the public in last 12 months	**11%**	**10%**	**12%**
8.5	A decrease in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**28%**	**26%**	**31%**
8.6	Achieving smoke free environment by April 2018	**N/A**	**Yes**	**Yes**

To date we have undertaken a lot of activity in support of the health and well-being agenda which will hopefully generate the staff results required to achieve to 2017/19 CQUIN.
We have implemented a broader staff engagement plan which heavily features health and well-being as one of its core strands along with culture, learning & development, equality and diversity and staff benefits.

To date we have undertaken a lot of activity in support of the health and well-being agenda which will hopefully generate the staff results required to achieve to 2017/19 CQUIN:

- Key metrics we are hoping to impact on are:
- improved staff commitment, reliability and energy to deliver better patient care;
- reduced sickness absence;
- improved timescales for returning to working following ill health absence;
- improved recruitment rates due to attractiveness as an employer;
- improved retention/reduced turnover rates;
- improved staff morale and motivation and a healthier, happier workforce;
- improved resilience in the workforce;
- improved work life balance;
- enhanced staff engagement;
- lower workplace accidents;
- improved working environments;
- improvement of the overall experience reported by staff (staff survey).

As of 2nd October, Homerton Hospital and community sites became smoke-free for staff. Any staff wishing to smoke must do it

a) outside Trust property

b) cover up their uniform

- Communication to staff has been via email, intranet, face to face through team meetings and regular walk rounds to known smoking areas. One of the smoking shelters has been removed.
- There are around 70 smoke free champions who have been identified, increased numbers of staff stop smoking groups are available and e-cigarettes (non-rechargeable) are available in the hospital shop.
- The smoke free policy has been approved and the nicotine replacement policy and e-cigarette policy are being signed off
- E-training has been set up and sign-posting to Stop Smoking services for staff is on the intranet

Much more information available on this link:

http://intralive/working-at-homerton/staff-benefits/healthy-homerton/going-smoke-free/

Disappointingly whilst good progress has been made on this priority in respect of programmed activity the forecasts that the targets for the metrics will be achieved has unfortunately not happened based on the results coming back from the 2017 Staff Survey.

We can evidence progress through:

- All planned activity has been achieved except for those related to procurement exercises (OD, EAP & Physio Tenders) which are slightly behind schedule
- The Healthy Homerton Steering Group which draws from a wide group of interested staff seeks to integrate to integrate health & wellbeing into the day to day activities of the Homerton University Hospital NHS Foundation Trust to support the creation of a positive and healthy working environment as well as achieve the CQUIN (1a) and tackle key areas of concerns which are identified as part of the staff survey.

What will we do in 2018/19 to continue improvements?

As detailed the current programme is scheduled for 17/18 planning for 18/19 will be undertaken taken by the Healthy Homerton & Staff Engagement Groups once the results of the 2017 Staff Survey have been received (c. Dec 17).

In relation to smoke free environment at Homerton Hospital, the second phase was to move to completely smoke-free environment including patients and visitors was set for 2nd January 2018. The Trust is now smoke-free since January 2018. For further information please refer to the quality achievement page 22.

Annex 1: Statements from commissioners, local Healthwatch and Overview and Scrutiny Committees

The Trust is grateful to all our scrutiny committees including our commissioners for their work in reviewing and responding to our quality account 2017/18 report. As part of 2017/18 quality improvement work, we will consider the points raised with the purpose of making continuous improvements to the care we provide to our patients.

NHS
City and Hackney
Clinical Commissioning Group

Commissioners Statement for Homerton University Hospital NHS Foundation Trust 2017/18 Quality Account

NHS City and Hackney Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from the Homerton University Hospital NHS Foundation Trust on behalf of the population of the City of London and the London Borough of Hackney.

We welcome the opportunity to provide this statement on the Trust's 2017/18 draft Quality Account and its priorities for 2018/19.

The Trust has made progress or fully achieved the target for all eight quality improvement priorities in 2017/18, and we welcome the new priorities for 2018/19.

We congratulate the Trust on improving the timely identification, treatment, and review of patients with sepsis in emergency and acute inpatient settings; improving care for patients with sickle cell disease; a lower than expected SHIMI score and enhancing personalised care and support planning for patients with long term conditions. We have worked in collaboration with the Trust and the London Borough of Hackney to support the hospital to become smoke-free.

The CCG welcomes the Trust's continued focus on identifying and responding to acutely deteriorating patients and to reducing avoidable harms. We hope that the implementation and prioritisation of more efficient discharge planning and communication will improve patient and family experience in 2018/19. We congratulate the Trust in its on-going work to improve patient experience and nurse communication skills and to improve services for patients with mental health needs and those at the end of life. These issues are raised by patients and carers, and it is great to see the Trust responding in such a positive way to these concerns.

We congratulate the Trust for their performance in relation to the four hour A&E target particularly over the winter period.

We recognise and commend the Trust's Quality Improvement Team and the work they have delivered over the last year to reduce avoidable falls in hospital wards, working with homecare agencies and primary care staff to prevent pressure ulcers, and building patient-centered care in the Trust. We hope this work will continue in 2018/19 as part of our integration plans in City and Hackney and we note the Trust's inpatient survey results have improved in the last year.

We hope in the next Quality Account there will be a greater emphasis on our City and Hackney plans for greater integration with our Local Authority partners and the development of our neighbourhood model as this can deliver a step change in patient centered care and use of precious human and financial resources.

Over the last three years, the percentage of staff responding that they would recommend the Trust to their friends and family for treatment has increased, and results are consistently above the national average. We are assured by the Trust's extensive actions to continue to drive improvement on this measure. The CCG recognises and celebrates the dedication and commitment of Trust staff to provide the highest standards of care to patients and their relatives, sometimes in difficult circumstances.

We note the Trust has missed the 62 day target relating to cancer referral to treatment times and we look forward to working with their cancer teams to improve performance in 2018/19.

We were assured by the Trust's prompt action with regards to the CQC's recommendations following the 2016 inspection of the Mary Seacole Nursing Home. The CQC rated the service as 'good' following re-inspection in 2017. The Trust's Community Health Services for adults, children, young people, and families were also rated as 'good' overall and across all five areas by the CQC in 2017.

We confirm that we have reviewed the information contained within the Account, and checked this against and data sources where these are available to us, and it is accurate.

NHS
City and Hackney
Clinical Commissioning Group

Overall we welcome the 2017/18 quality account and look forward to working in partnership with the Trust in the next year.

Dr Mark Rickets

Chair, NHS City and Hackney Clinical Commissioning Group

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

11 April 2018

Ms. Sheila Adam
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Trust Offices, Education Centre
Homerton Row
London, E9 6SR

Dear Sheila

RESPONSE TO HUH's DRAFT QUALITY ACCOUNT 2017/18 FROM HEALTH IN HACKNEY SCRUTINY COMMISSION

Thank you for inviting us to submit comments on the draft Quality Account for your Trust for 2017-18. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The Commission Members take a great interest in the performance of our key local acute trust and were pleased to learn about some of your key achievements over the past year. We are also pleased with the upward trajectory of CQC ratings from the previous year.

During this time we have continued to enjoy a good working relationship with the Trust and we greatly appreciate the willingness of the Trust's representatives to attend our Commission meetings and contribute to our work.

In July 2017 we considered a 12 month update we had requested on the safety of your maternity service and we also gave detailed consideration to your Adult Community Nursing Service with input from the CCG and the CQC (which had recently rated the service as 'Good'). In October we received another update on the future of your pathology service and we are still awaiting clarification on the final position on this. You also provided a useful update on service user input to both student and specialist nurse training. Your Chief Executive also contributed to our January item on the Unplanned Care Workstream in Integrated Commissioning as she is the Senior Responsible Officer for it. We will be returning to aspects of this in June/July with items on Delayed Transfer of Care and on the 'Discharge to Assess' pilot. We also discussed with the Cabinet Member the impact of Brexit and immigration reforms on local health providers including yourselves and the impact on recruitment and retention of staff. These remain a concern for us.

We were also grateful for your engagement with our review on 'End of life care' and your commitment to follow through on its recommendations and we are pleased at the progress being made on your Priority 5 "to improve end of life care and advanced care planning" and the fact that you have carried it forward as a priority for 2018/19.

We wish to make the following specific comments on your draft Quality Account noting that it is an early draft:

a) We commend the Trust's Emergency Department for being one of the highest performing nationally in relation to the *4 hour waiting target* which we are aware has been a struggle for many Trusts over the past year.

b) We are pleased that the Trust has maintained a solid performance in reporting against the core indicators and also across the 8 improvement priorities which were selected for 2017/18.

c) Re. p.22 we note with interest that the National Audit of Intermediate Care has highlighted how City and Hackney is a national outlier for lacking an Intermediate Care bed base and we note this data is being used to support a commissioning business case to resolve this. We look forward to the outcome of this as we have had concerns about the issue since the de-commissioning of the Median Road Resource Centre.

d) Re. p.27 we commend the Trust's continued high performance on clinical research and we note the comment that "*enhanced collaboration with the clinical support services such as Pathology, Radiology and Pharmacy as they are all integral to the successful delivery of the vast majority of our interventional studies*". As you know we have ongoing concerns about the future of the Pathology Service, which appears still undecided, and this underlines again the need for high quality pathology services to be maintained.

e) We are not able to comment on the new 'Learning from Deaths' section as the data is incomplete.

f) The Trust is to be commended for a lower than expected SHMI (Standardised Hospital Mortality Indicator) score which puts the Trust 13th lowest out of 134 Trusts, noting that you've improved recognition of impending death and end of life care through a variety of improvements.. The score is testament to the quality of care delivered both within the hospital and by the community services following discharge.

g) Re. p.59. We have concerns about the "*Cancer 62 day wait for first treatment (from urgent GP referral for suspected cancer)*" indicator. This is listed at 82.6% YTD which is below the target of 85% and is

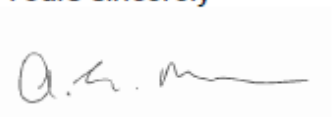
deteriorating. Yet, at City of London's Health and Social Care Scrutiny Committee on 13 February, where this matter was discussed, the performance of City & Hackney was reported as being 65.4% for urgent referrals within 62 days[1]. It was noted that this was well below neighbouring CCGs and that it was a significant cause for concern We would welcome clarification on this and an explanation of what measures are being put in place to address it.

h) Re. pp.77 and 79. The Priority on "Improving nurse communication" is important to us and we note your efforts to increase patient satisfaction and confidence in nursing care following very poor performance in previous CQC surveys. We note your comment "*Scoping work has been completed and has yielded key areas that are affecting nurses' ability to demonstrate the behaviours and interactions patients have reported that build trust and confidence in their nurses*" and we would like to explore this issue further with you when you are next at the Commission. We would be interested to learn what other than unrelenting workload pressures on nurses might be a factor here.

i) Re p. 81. We note that delays in pharmacy and availability of hospital pharmacy services 7 days a week is delaying discharge of patients. We note you're investigating "whether satellite pharmacies are an option for patients" to address this. At our February meeting the Workstream Director for Unplanned Care undertook to provide a briefing for us on the results of the pilot on 'Discharge to Assess' and we look forward to examining these issues further at our June/July meeting.

We look forward to taking up these issues with you over the next year on the Scrutiny Commission.

Yours sincerely



Councillor Ann Munn
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Tracey Fletcher, Chief Executive, HUHFT
Cllr Jonathan McShane, Cabinet Member for Health, Social Care and Culture
Dr Penny Bevan CBE, Director of Public Health, City and Hackney
David Maher, Acting Managing Director, City & Hackney CCG
Simon Cribbens, Assistant Director – Commissioning and Partnerships, City of London Corporation
Jon Williams, Director, Healthwatch Hackney

[1] http://democracy.cityoflondon.gov.uk/mgAi.aspx?ID=69417

3

Response to the Homerton Quality Account 2017/18 from Healthwatch City of London

Healthwatch City of London welcomes the opportunity to comment on this quality report and has provided the comments below following consultation with City residents and board members of the Homerton. The bus routes to the hospital have continue to be a problem for City residents meaning that the hospital is not used as frequently by residents as it could be. Healthwatch City of London has valued the involvement with the Homerton over the last year, particularly through the PLACE assessments attended and our representation on the Patient Experience Delivery Group. We welcome the balance in the document between technical detail and clear presentation which makes it possible for a wide range of readers to understand what is being said. The report gives specific examples of the activities which form component parts of the drive for quality. Some of the initiatives have been the subject of evaluation, demonstrating that change has led to improvement.

Comments made by service users:

- It was pleasing to see that special measures were in place to help overseas nurses to adapt to the local way of doing things, and that staff safety in the community was receiving attention.
- The smoothness of the discharge procedures matters greatly to patients, and the achievements of the discharge team are to be praised – although this will always remain a problem in times of straightened resources and deprivation in the community.
- The involvement of the local community in the setting or priorities is to be welcomed. From the perspective of the City of London, of course, a high priority yet to be resolved is the difficulty of access to services by public transport, as a result of which many City residents use services provided either at UCLH or in Tower Hamlets, to which access is easier.
- The deep involvement of the Trust in national audits and in appropriate clinical research is to be welcomed.
- The general satisfaction of the CQC with the Trust's services is noted.
- While noting that the death rate at the Homerton is lower than might be expected, it would be useful if the Trust could provide examples of problems that have taken place, and lessons that have been learned.
- It was pleasing to see the attention being devoted to conditions of growing importance, for example hip and knee replacements in the orthopaedic departments. Were it possible to include a few sentences on the nature of these developments, and indeed the numbers of patients undergoing them, this would have been useful.
- It is good to see that staff, in general, would recommend the care of the hospital to others.
- The extent to which the Trust meets QPIs for care and admissions is laudable.
- The attention being given to the identification and treatment of acutely deteriorating patients is welcome.
- The need to improve the trust by patients in nursing (and perhaps medical) staff is important and this is a metric consumer organisations will certainly be following.

Dear Sheila,

Healthwatch Hackney's Statutory Statement to the Homerton Hospital Quality Account 2017-18

Thank you for sending us the draft Quality Account for review. Please find below our response to the Homerton University Hospital's Quality Account for 2017/18.

1) **Co-production for Service Improvements for Patients**

We would welcome a new approach to our engagement with the HUH annual Quality Account. It that seems under the current system we contribute each year to the Quality Account, yet there is no clear feedback on how our proposals and recommendations are taken on board and influence service improvements for patients. As you know Healthwatch has the following statutory duties, which require the submission of our proposals for service improvement and evidence that these have been acted on (or reasons provided for not doing so):

a) promoting and supporting the involvement of local people in the provision and scrutiny of local care services;

b) enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;

c) obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;

d) making reports and recommendations about how local care services could or ought to be improved. These should be directed to providers of care services, and people responsible for managing or scrutinising local care services;

e) formulating views on the standard of provision and whether and how the local care services could and ought to be improved.

2) **Presentation of the Quality Account**

The style of this year's draft Quality Account has stepped back from the Account last year. Last year's report was outstanding: interesting, an enjoyable read, well presented and accessible. This year's report has returned to previous style which is much less comprehensible and would be difficult to understand for people in the community without a clinical background. It is too long, and segmented in a way that prevents the easy access to the many achievements that you record.

It is not clear who the report is intended for, but it is written as an internal technical document for staff and to satisfy the requirements of NHS Improvement. We strongly believe the report should be written in a way that is accessible to local people, celebrates your achievements and identifies areas for improvement and the means of achieving those aspirations.

Our key areas for service improvements are as follows:

3) Duty of Candour:

The statutory Duty of Candour requires the Homerton Hospital to inform and apologise to patients or their families if there have been mistakes in patients' care that led to death or significant harm.

We are very pleased with the progress made so far, but have identified two areas for improvement. Firstly, evidence that the Duty has been performed is often weak in Serious Incidents and Root Cause Analysis reports presented to the Patient Safety Committee, i.e. the evidence is not presented in each report in a consistent way. Secondly, feedback is needed from patients to determine if they are satisfied with the process and delivery of the Duty of Candour.

4) Learning from Complaints:

Complaints comprise a major source of qualitative data from patients to inform the improvement of services. Most complainants express the hope that their negative experience should not be suffered by other patients, but unfortunately, there is little evidence available that complaints influence the quality and safety of services.

We recommend that HUH provides evidence how complaints are used to improve services and promote learning, by publishing recommendations arising from all complaints investigations and the consequent actions and outcomes for patient care. This would provide a source of reassurance for patients, families and staff.

5) Investigation of Serious Incidents: The pace of investigation of Serious Incidents has improved considerable, but there are still cases where investigations are finished more than a month after the 60 day deadline.

Some delays are due to doctors not responding to requests for their contribution to SI investigations about the care they or their colleagues have provided. In some cases delay is due to doctors leaving or locums moving on. In each case of delay due to a doctor having left the hospital and/or failing to respond, it is essential that the doctors Responsible Officer is contacted and raises the matter with the doctor through the Appraisal process. Details of every doctor's Responsible Officer are available from the General Medical Council website.

6) Patient Safety Committee (PSC): The Patient Safety Committee welcomes regular attendance and participation from a representative of Healthwatch Hackney. The representative has access to all papers on Serious Incidents and Root Cause Analysis and is able to comment and suggest service improvements at the monthly PSC meetings. We commend HUH for its approach on the PSC. The low number of incidents resulting in severe harm or death is to be welcomed, but clearly all such events are unacceptable.

7) Shared Decision Making: We are very encouraged by the HUH's work on Shared Decision Making and the training being provided to staff. However, unless patients are also trained to participate, the patient is disempowered - participation in decision making is not shared unless both parties have equal empowerment. Feedback from this process is also

important to ensure that patients are benefitting in terms of enhanced patient care - evidence from only one party i.e. the clinician is not evidence of success.

8) Intermediate Care: The closure of Median Road as a centre for intermediate care was a major setback for Hackney residents. We are pleased to see that this decision is now being reviewed and hope to see full support from HUH for the prioritisation of an intermediate care centre in Hackney. We note that the National Audit of Intermediate Care has placed City and Hackney as an outlier for lack of provision of intermediate care beds, and hope that the HUH will work with other parties to re-commission this essential service. Intermediate care beds add dignity to care, enhance effective discharge and enable emergency care services to function more effectively.

9) Pathology: We remain very concerned about plans to outsource pathology services. We believe this will lead to a deterioration of services and considerable delays in getting results, especially when these are urgent. We are delighted that the pathology department gained UK Accreditation to an international standard. We also appreciate that the HUH is seeking the best service for patients.

The delays already experienced when histology specimens are sent to the Royal London Hospital is evidence of the problems that occur when pathology samples are outsourced. This problem has continued for some years **and** for example the Royal London histology lab may **not** send a report when the results are negative (see for example maternity case SI Datix 89061/89038). A better *modus operandi* should be developed with the Royal London Hospital regarding their responsiveness, provision of results in urgent cases and quality of their histology service.

10) Emergency Ear Nose and Throat (ENT): We are very concerned about the absence of an emergency ENT service at the Homerton and the potential risk for patients who need this service. There is a shortage of centres for this type of emergency care in London and action needs to be taken by the HUH and commissioners. A service that relies upon doctors who are not on an emergency roster to attend out of hours is unsafe, especially if the ENT doctor happens to be away, when a patient arrive at night or at weekends requiring emergency ENT treatment.

11) Emergency Department: Services provided by A&E are of very high quality and the HUH has the lowest amount of time lost during handover from the London Ambulance Service to A&E, compared to all other hospitals in London, even when total conveyances for each hospital are compared. HUH is to be commended for this achievement and the way it provides treatment to those attending A&E.

The 95% target for discharge or admission within 4 hours has not always being met and on occasion drops to an unacceptable level, e.g. on March 5th 2018 it dropped to 74.69% (74.69% for the week). However in recent weeks A&E has been close or above the 95% target. Clearly, in spite of recent challenges HUH has a system in place to recover from such dips. This is something to be celebrated and encourage the HUH to tell its patients and Healthwatch how it will resolve the challenges of consistently delivering on the 95% target.

We would like to see an additional paragraph in the QA that explains what steps are being taken to reduce the number of 4 hour breaches, which stood at 6500 patients for the year ending on March 31st 2018.

We would also like to see evidence of urgent plans to stop extended waits for patients requiring psychiatric care. Extended waits for psychiatric care or psychiatric beds regular occurrence.

12) Patient Transport Services (PTS): We have had meetings with the PTS team but our ambition to improve the commissioning specification by adding patient centred quality standards provided by Healthwatch Hackney has not yet been achieved. We would like our proposals to be built into the HUH specification for PTS and to be provided with evidence this has been done. We would like to see progress in this matter in the short term, to ensure that PTS is developed with the needs of the patients at the centre of the specification.

13) VTE (**venous thromboembolism) Incidence:** It is reported that the incidence of VTE in wards is high because preventative action is not always being taken for vulnerable patients. We would like to see evidence of more proactive work by the HUH Thrombolysis Committee to reduce the incidence of VTEs. The percentage of patients who were risk assessed for VTE has fallen since 2014/5 and remained static during 2015/6. The action points in the QA do not seem to be consistent with raising the number of patients who are risk assessed.

14) Falls: We note that on the Elderly Care Unit in 2017 there were 215 patient falls of which, 15 suffered low harm, 4 patients suffered moderate harm, 2 suffered serious harm. We are concerned that many of these falls may be due to patients receiving insufficient exercise and rehabilitation whilst they are in hospital, so when they do go to the toilet or attempt to participate in other activities they are unstable on their feet. The CCG funded quality improvement project appears to be having some impact on reducing the number of falls with harm (measured by KPIs). We are pleased to see the outcomes of QA Priority One on reducing the number of falls with harm.

15) Hackney Complaints Charter

We greatly welcome HUH's decision to sign the Hackney Complaints Charter and its agreement at the Annual Meeting to distribute it to patients. We would also like the Charter to be distributed to all Foundation Trust members and copied to people submitting complaints to the HUH.

We look forward to seeing your final Quality Account and action plans for delivery of the issues that we have raised in our statutory submission.

Jon Williams
Executive Director

Annex 2: Statement of Directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to March 2018.
    - Papers relating to quality reported to the board over the period April 2017 to 31st March 2018.
    - Feedback from commissioners dated 17/04/2018.
    - Feedback from governors dated.
    - Feedback from local Healthwatch organisations dated 17/04/2018.
    - Feedback from Overview and Scrutiny Committee dated 11/04/2018.
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2017.
    - The 2016 National Patient Survey.
    - The 2017 National Staff Survey published March 2018.
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated.
    - CQC inspection report:

- Community Services in May 2017
- Mary Seacole in August 2017

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

.....25/5/19.....Date.....Chairman

.....25/5/19.....Date.....Chief Executive

Appendix A: Limited Assurance Statement from External Auditors

Appendix B: 2017/18 CQUINS*

National Indicator		Description of Indicator	Value (acute and community C&H)
1a	**Improvement of health and wellbeing of NHS staff**	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.	126,620
1b	**Healthy food for NHS staff, visitors and patients**	For 2017/18: Maintain 16-17 and introduce three new changes to food and drink provision with stretch in year 2	126,620
1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	Year 1 – Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2- Achieving an uptake of flu vaccinations by frontline clinical staff of 75%	126,620
			379,861
2a	**Timely identification of patients with sepsis in emergency departments and acute inpatient settings**	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	75,132
2b	**Timely treatment of sepsis in emergency departments and acute inpatient settings**	The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.	75,132

National Indicator		Description of Indicator	Value (acute and community C&H)
2c	**Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.**	Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours	75,132
2d	**Reduction in antibiotic consumption per 1,000 admissions**	1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	75,132
			300,530
4	**Improving services for people with mental health needs who present to A&E**	For 2017/18: 1. Reduce the number of attendances to A&E for those frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.	300,530
			300,530
5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).	79,332
			79,332

National Indicator		Description of Indicator	Value (acute and community C&H)
6	**Advice & Guidance**	The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	300,530
			300,530
7	**E-referrals**	This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system.	300,530
			300,530
8a/b	**Supporting proactive and safe discharge**	Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories Emergency Care Data Set (ECDS) Type 1 or 2 A&E providers to have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017. Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	406,306
			406,306
9a	**Preventing ill health by risky behaviours - alcohol and**	Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	5% of 0.25% (0.0125%)

National Indicator		Description of Indicator	Value (acute and community C&H)
	tobacco: Tobacco screening		
9b	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**	Percentage of unique patients who smoke AND are given very brief advice	20% of 0.25% (0.05%)
9c	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication**	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	25% of 0.25% (0.0625%)
9d	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	25% of 0.25% (0.0625%)
9e	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral	25% of 0.25% (0.0625%)
			tbc
10	**Improving the assessment of wounds**	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	105,776
			105,776

National Indicator		Description of Indicator	Value (acute and community C&H)
11	**Personalised care and support planning**	Embedding personalised care and support planning for people with long-term conditions.	105,776
			105,776
			2,279,171
GE2	GE2: Activation System for Patients with LTC	To ensure patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition)	£83,099.69
B13	B13 – Automated Exchange Transfusion for Sickle Cell Care	Patients with sickle cell disease require exchange transfusions to manage their condition. This can be done manually or using automated exchange. This CQUIN scheme aims to incentivise the use of automated exchange by specified specialist centres in order to improve patient experience and use of clinical resources.	£316,314.93
B14	B14 - Sickle Cell ODN	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	£77,738.42
	Neuro-Rehab	• Reduce unnecessary duplicate referrals and the time spent in waiting for assessment • Reduce the number of 'rejected' referrals rejected simply because the information is not complete. • Improve patient experience data at a unit level • Bring Level 1/2a neuro-rehabilitation services more fully into a 'system' of care in each STP in the London.	£58,973.97
		NHSE Total	**£536,127.01**

National Indicator		Description of Indicator	Value (acute and community C&H)
	CQUIN – DENTAL		
	Participation in the NHS England (London Region) Acute dental Systems Resilience Group	Collection and submission of data on priority pathways procedures by Tier using the CQUIN dashboard. Tier 1,2, 3 – recording of data for oral surgery and orthodontics; to include restorative when published - Evidence: Submission of dental CQUIN dashboard	£25,357
	Tier 1,2 and 3 – recording of oral surgery data	Participate in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling. Evidence: Attendance and participation at SRG	£25,357
	Enabled by active participation in MCNs	Active participation in consultant led MCN with collaborative oversight of appraisal of performers. Evidence: Minutes of the meeting. NHSE have confirmed that the MCN's are not fully developed yet and in many cases are still in the LPN stage (Local Professional Network which is a proto-MCN) for each speciality. They are currently compiling a list of these meetings and the relevant contacts, and will share this to all acute providers once all the details are confirmed.	£25,357
			£76,071

National Indicator		Description of Indicator	Value (acute and community C&H)
	CQUIN – PUBLIC HEALTH		
	Bowel Cancer Screening Increasing Uptake of Screening Programmes through MECC	Training and delivery of frontline screening staff to deliver behavioural advice through a localised MECC programme that includes signposting to other screening services to improve uptake and coverage.	£34,214
	DESP London OCT surveillance programme	To support the London DES services to deliver a process that should support the implementation of OCT surveillance, as an enhanced service, offered by DESP.	£61,219

Appendix C: Glossary of terms and abbreviations

ACRT	Acute Community Rehabilitation Team
ACP	Advanced Care Planning
ACU	Acute Care Unit
AIS	Accessible Information Standard
AKI	Acute Kidney Injury
AMTS	Abbreviated mental test score
Caesarean Section	An operation to deliver a baby
CCC	Critical Care Committee
CCG	Clinical Commissioning Group
C-Diff	Clostridium Difficile
CEO	Chief Executive Officer
CEWS	Children's Early Warning Score
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy grading system
CG	Clinical Guidelines
CIP	Continuous Inpatient Spell
CLIP	Complains, litigations, Incidents Pals meeting

COPD	Chronic Obstructive Pulmonary Disease
CPEN	Community Provider Education Network
CQC	Care Quality Commission – The independent regulator of health and social care in England
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
DoC	Duty of Candour
DoH	Department of Health
DPG	Deteriorating Patient Group
DTS	Data Transfer Service
DVT	Deep Vein Thrombosis
ECU	Elderly Care Unit
ED	Emergency Department
EDPS	Edinburgh postnatal depression score
EoL	End of Life
EoLC	End of Life Care
EPR	Electric Patient Record
EPDS	Edinburgh Postpartum Depression Scale
ESP	Extended Scope Physiotherapist
GAD	Generalized Anxiety Disorder
GP	General Practitioner
HIA	High Impact Area
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement partnership
HSJ	Health Service Journal
HUH	Homerton University Hospital
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioners Office
ICEC	Improving Clinical Effectiveness Committee
ICO	Information Commissioners Office
ICU	Intensive Care Unit
IG	Information Governance
IGT	Information Governance Toolkit
IHI	Institute for Healthcare Improvement
IS	Information Standard
ITU	Intensive care unity
IV	Intravenous

KLOE	Key Line of Enquiry i.e. Five questions used by Care Quality Commission in their inspections of services: 1. Are they safe? 2. Are they effective? 3. Are they caring? 4. Are they responsive to people's needs? 5. Are they well-led?
KSF	Knowledge and Skills Framework
LocSSIPs	Local Safety Standards for Invasive Procedures
LWD	Lone Worker Device
MCS	This is a microbiology Stool test for Diarrhoea/Gastroenteritis Infection
M&M	Mortality and Morbidity
MDT	Multidisciplinary Team
MEOWS	Modified Early Obstetric Warning Scores
MRT	Mortality Review Tool
MSK	
MSNH	Mary Seacole Nursing Home
NatSSIPs	National Safety Standards for Invasive Procedures
NBV	New Birth Visits
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Scores
NEWTS	Neonatal Early Warrning Triggers
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NT-CRN	North Thames Clinical Research Network
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
NQB	National Quality Board
OAU	Obstetric Assessment Unit
OSCE	Objective Structure Clinical Examination
OLGA	Olga staging system for diagnosis of gastritis
PbR	Payment by Results
PCA	Patient-Controlled Analgesia
PDD	Planned Discharge Dates
PE	Pulmonary Embolism
PGD	Patient Group Direction i.e. written instructions to help clinicians supply or administer medicines to patients, usually in planned circumstances/ at point of need

PIPS	Patient Information Publishing System
PLACE	Patient Led Assessment of the Care Environment
Pre-MReS	
PREMS	Patient Reported Experience Measures
PrEP	Pre-exposure Prophylaxis
PROMS	Patient Reported Outcome Measures
P-POSSUM	POSSUM and P-POSSUM are used in the assessment of outcomes in surgical patients. This is a score in predicting post operative mortality.
PSC	Patient Safety Committee
PUSC	Pressure Ulcer Scrutiny Committee
QI	Quality Improvement
QIPP	Quality, Innovation, Productivity and Prevention (programme)
qSOFA	Quick Sequential Organ Failure Assessment score
QTc	Quality Teaching over coffee newsletter
R&D	Research & Development
RA	Rheumatoid arthritis
RCA	Root Cause Analysis
R4RA	Response - Resistance to Rituximab versus Tocilizumab in RA
REMPOD	Reminiscence Room
Requirement Notices	These are issued where a provider is acting in breach of the Health and Social Care Act Regulations or has a poor ability to maintain compliance with regulations, but people using the service are not at immediate risk of harm. The Requirement Notice notifies the provider that they should take steps to improve care standards because the CQC considers the organisation to be in breach of legal requirements. Please note that Requirement Notices were formerly known as 'compliance actions'.
RiO	RiO (Community EPR*) - RiO is a secure, Electronic Patient Record (EPR) which is used by Homerton's Community Services in Hackney and the City as their primary clinical system
RNRU	Regional Neurological Rehabilitation Unit
SBAR	Situation, Background, Assessment, Recommendation communication tool
SDM	Shared Decision Making
Senior Rounding	Ward visit by senior clinicians to improve visibility and accessibility
Sepsis	A life-threatening illness caused by the body's response to an infection. 'Red Flag Sepsis' is one or more criteria identified using the UK Sepsis Trust Sepsis Risk Stratification

SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SIR	Serious Incident Review
SLT	Speech and Language Therapy
SOP	Standardised Operating Procedure
SSKIN	the “React to Red Skin” screening tool
ST	Safety Thermometer
STRAP	Stratification of Biologic Therapies for RA by Pathobiology
TB	Tuberculosis
TTA	To Take Away (applies to medication given to patients at discharge)
TTC	The Trust Thrombosis Committee
UKAS	United Kingdom Accreditation Service
VTE	Venous Thromboembolism
Warning Notices	These are issued where CQC considers there to be a continuing breach of a legal requirement and there are persistent concerns and/or there are concerns about the ability of the provider to improve. The Warning Notice sets out a timescale by when improvements must be achieved. CQC aims to follow up each Warning Notice within three months of the date set out in the notice. Follow up may entail unannounced focused inspection visits.
WiFi	Technology for wireless local area networking

ANNUAL ACCOUNTS

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

Homerton University Hospital NHS Foundation Trust Annual Accounts
2017/18
For the Year Ended 31 March 2018

Homerton University Hospital NHS Foundation Trust Annual Accounts 2017/18

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Homerton University Hospital NHS Foundation Trust Annual Accounts 2017/18

Foreword to the Accounts

Homerton University Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2018 have been prepared by Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Signed……..……..

Tracey Fletcher
Chief Executive

25th May 2018

KPMG

Independent auditor's report

to the Council of Governors of Homerton University Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Homerton University Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2018, which comprise; the Statement of Comprehensive Income; the Statement of Financial Position; the Statement of Changes in Tax Payers Equity; the Statement of Cashflows; and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Overview	
Materiality: Financial statements as a whole	£4.6m (2016/17:£3m) 1.5% (2016/17: 1%) of total income from operations

Risks of material misstatement		vs 2017
Recurring risks	Valuation of land and buildings	◄►
	Recognition of NHS and non-NHS income and valuation of doubtful debt provision	◄►

Basis for opinion

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

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were unchanged from 2017:

	The risk	Our response
Valuation of Land and Buildings (£134.6million; 2016/17: £111.7million) *Refer to page 10 (Audit Committee Report), page 9 (accounting policy) and page 21 (financial disclosures)*	**Subjective valuation** Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement hospital the Trust may consider whether it would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. The valuation is completed by an external valuer engaged by the Trust. For 2017/18, this was Gerald Eve. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. Homerton University Hospital NHS Foundation Trust's desktop valuation performed at 31 March 2018 resulted in a £5,060 million increase in the value of the land and buildings balance.	**Our procedures included** **Methodology choice:** — We appraised the assumptions used in completing the valuation of land and building values and critically assessed the assumptions used for price increases in comparison to other available indices; and — We also reviewed management's methodology for assessing whether any assets on the fixed asset register required impairment as a result of value in use or deterioration in condition. **Test of details:** — We critically assessed the valuation of any additions made during the year to ensure they have been appropriately valued at fair value. We reviewed that they had been correctly capitalised, classified in the appropriate asset class, that the asset is operational at year end and that the addition occurred during the audit period. **Disclosure:** — We tested that all changes to the valuations of land and buildings as identified by the external valuation report had been accurately and completely reflected in the financial statements.

	The risk	Our response
NHS and non-NHS income and receivables Income: (£[320 million; 2016/17: £308.3 million) Receivables: (£45.2 million; 2016/17: £39.1m) *Refer to page 9 (Audit Committee Report), page 8 (accounting policy) and page 16 (financial disclosures).*	**Income 2017/18** Of the Trust's reported total income, £268.4 million (2016/17, £258.6 million) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). The majority of this income is contracted on an annual basis, however an element is based on achieving targets, such as transformation funding (£10.9m), and if the targets are not achieved the level of income is reduced. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. This incudes income the Trust receives from Health Education England to support the training of medical students (£12.8 million). The Trust reported total income of £34.4 million (2016/17: £30.5 million) from other sources. Much of this income is contracted from non-NHS bodies such as Local Authorities under contracts that confirm when income will be received; on delivery, milestones, or periodically.	Our procedures included: **Tests of details:** We undertook the following tests of details – We agreed a sample of commissioner and local authority income balances to the signed agreements in place. We assessed the contract variations identified and sought explanations as to the cause of these variances. – We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were mismatches we challenged management's assessment of the level of income they were entitled to and the receipts that could be collected. In doing so we examined supporting correspondence for any formal disputes or arbitration for consistency with the accounting treatment within the financial statements; and – We agreed the Sustainability and Transformation Funding (STF) recognised in the financial statements to the letter received from NHS Improvement informing the Trust of it's allocation; **Methodology choice:** – We evaluated the approach to impairing receivables to assess that they are in line with the Trust's accounting policies, and that the judgement for the level of impairment is appropriate;

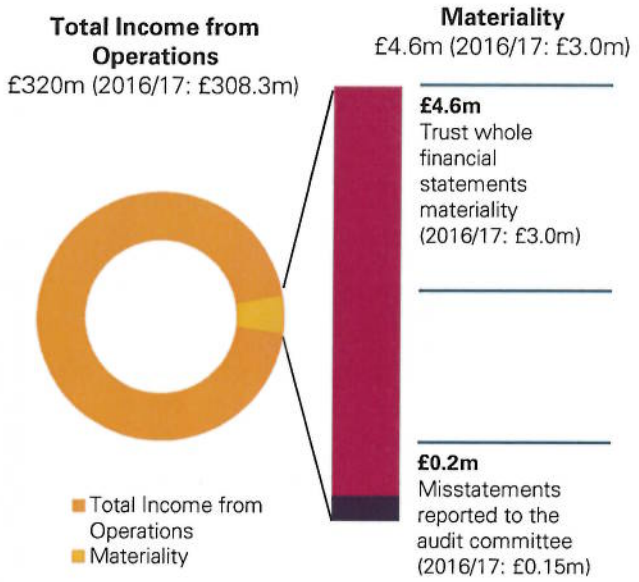
We continue to perform procedures over Valuation over the Pathology building site (the asset was still under construction). However, following the impairment of the building site in 2016/17, we have not assessed this as one of the most significant risks in our current year audit and, therefore, it is not separately identified in our report this year.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.6 million (2016/17: £3 million), determined with reference to a benchmark of total income from operations (of which it represents approximately 1.5%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.2 million (2016/17:(£0.15 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Hackney, London.



4. We have nothing to report on going concern

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

5. We have nothing to report on the other information in the Annual Report

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

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

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 59, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

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

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

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

We have nothing to report in this respect.

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

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

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

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

No significant risks were identified in relation to the Trust's arrangements for securing economy, efficient and effectiveness in the use of resources.

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

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Homerton University Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

J Lees

Joanne Lees for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square, Canary Wharf, London E14 5GL

29 May 2018

Homerton University Hospital NHS Foundation Trust Annual Accounts 2017/18

Statement of Comprehensive Income for the year ended 31 March 2018

	NOTE	**2017/18** **£000**	2016/17 £000
Revenue			
Operating income from Patient Care Activities	3	**285,675**	277,829
Other operating income	3	**34,408**	30,515
Operating expenses	4	**(304,355)**	(306,558)
Operating surplus from continuing operations		**15,728**	1,786
Finance costs:			
Finance income	7	**77**	34
Finance expenses	7	**(203)**	(279)
Public dividend capital dividends payable	17	**(3,853)**	(4,072)
Net finance costs		**(3,979)**	(4,317)
Other gains		**16**	-
Retained surplus / (deficit) for the year		**11,765**	(2,531)
Other comprehensive income			
Revaluations	SOCITE	**5,060**	(4,665)
Total comprehensive income / (expense) for the year		**16,825**	(7,196)

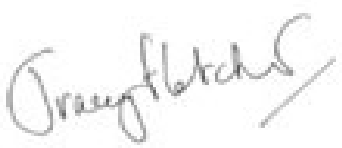
Surplus adjusted for Impairments		
Retained (deficit) for the year	**11,765**	(2,531)
Add back ; Impairment	**447**	5,640
Retained Surplus for the Year before Impairments	**12,212**	3,109

Statement of Financial Position as at 31 March 2018

	NOTE	**For the year ending 31 March 2018 £000**	For the year ending 31 March 2017 £000
Non-current assets			
Intangible assets	8	**4,535**	6,426
Property, plant and equipment	9	**134,612**	127,727
Trade and other receivables		**50**	-
Total non-current assets		**139,197**	134,153
Current assets			
Inventories	10	**2,586**	2,523
Trade and other receivables	11	**42,118**	39,065
Cash and cash equivalents	12	**26,283**	20,208
Total current assets		**70,987**	61,796
Total assets		**210,184**	195,949
Current liabilities			
Trade and other payables	13	**(29,465)**	(33,070)
Borrowings	13	**(323)**	(323)
Provisions	13	**(6,689)**	(6,570)
Tax payable	13	**(6,914)**	(6,626)
Other liabilities	13	**(6,569)**	(5,746)
Total current liabilities		**(49,960)**	(52,335)
Net current assets		**21,027**	9,461
Total assets less current liabilities		**160,224**	143,614
Non-current liabilities			
Borrowings	13	**(5,635)**	(5,957)
Provisions	13	**(931)**	(940)
Total non current liabilities		**(6,566)**	(6,897)
Total assets employed		**153,658**	136,717
Financed by taxpayers' equity			
Public dividend capital	17	**91,703**	90,648
Retained earnings	SOCITE	**24,730**	12,080
Revaluation reserve	SOCITE	**37,225**	33,050
Total taxpayers' equity		**153,658**	135,778

Statement of Changes in Taxpayers' Equity (SOCITE) can be found on page 5.

The financial statements on pages 3 to 34 were approved by the Board and signed on its behalf by:



Signed: ……...(Chief Executive) **Date: 25th May 2018**

Tracey Fletcher

Statement of Changes in Taxpayers' Equity (SOCITE) 2017-18

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2017	**90,648**	**12,080**	**33,050**	**135,778**
Changes in taxpayers' equity for 2017-18				
Total comprehensive income for the year:				
Retained surplus for the year	-	11,765	-	11,765
Revaluations of Property, Plant and Equipment	-	-	5,060	5,060
Transfers between Reserves	-	885	(885)	-
New PDC received	1,055	-	-	1,055
Balance at 31 March 2018	**91,703**	**24,730**	**37,225**	**153,658**

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Changes in Taxpayers' Equity 2016-17				
Balance at 1 April 2016	**90,648**	**14,550**	**37,776**	**142,974**
Total comprehensive income for the year:				
Retained deficit for the year	-	(2,531)	-	(2,531)
Revaluations of Property, Plant and Equipment	-	-	(4,665)	(4,665)
Transfers between Reserves	-	61	(61)	
New PDC received	-	-	-	-
Balance at 31 March 2017	**90,648**	**12,080**	**33,050**	**135,778**

Statement of Cash Flows for the year ended 31 March 2018

	NOTE	**2017/18 £000**	2016/17 £000
Net cash inflow from operating activities	18	**16,495**	21,640
Cash flows from investing activities			
Interest received		**77**	34
Payments for intangible assets		**(401)**	(388)
Payments for property, plant and equipment		**(6,814)**	(3,472)
Proceeds from disposal of plant, property and equipment		**16**	26
Net cash outflow from investing activities		**(7,122)**	(3,800)
Net cash inflow before financing		**9,373**	17,840
Cash flows from financing activities			
Public dividend capital received	17	**1,055**	-
Loans repaid to the Department of Health		**(292)**	(1,368)
Other loans repaid		**(31)**	(31)
Interest paid		**(203)**	(275)
Public dividend capital dividends paid		**(3,827)**	(4,584)
Net cash outflow from financing		**(3,298)**	(6,258)
Net increase in cash and cash equivalents		**6,075**	11,582
Cash and cash equivalents brought forward as at 1st April		**20,208**	8,626
Cash and cash equivalents carried forward at 31 March		**26,283**	20,208

Notes to the Accounts

1. Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents

1.2 Accounting Convention

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

1.3 Basis of Consolidation

The Trust is the corporate trustee to Homerton University Hospital NHS Foundation Trust Charitable Fund, however the Charity's results have not been consolidated with those of the Trust in 2017/18 on the grounds of materiality. The Charity's accounts for 2017/18 will be published in September and can be found at www.homertonhope.org.

1.4 Critical accounting judgements and key sources of estimation of uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting policies

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

- Depreciation rates applied to property, plant and equipment (note 9 to the accounts).

- Valuation methodoligies and external indices applied to the valuation conducted by Gerald Eve LLP (note 9 to the accounts).

1.4.2 Sources of estimation uncertainty

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

- Provision for injury benefit claims, early retirements, impairments of receivables, and others (notes 11 & 15 to the accounts)
- Estimates for partially completed patient episodes.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies , the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transaction in the period which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income and is disclosed separately from operating costs.

1.6 Pooled budgets

The Trust has not entered into any pooled budget arrangements.

1.7 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Trust.

1. Accounting Policies (Continued)

1.8 Revenue

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially completed spell is accrued and agreed with the commissioner.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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 that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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

1.9 Employee Benefits

1.9.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 Pension costs

NHS Pensions

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. These schemes 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. These schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the expenditure at the Trust commits itself to the retirement, regardless of the method of payment.

Employers pension cost contributions are charged to operating expenses as and when they become due. The employer contribution payable in 2017/18 was £17.9m (2016/17 £17.7m).

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.10 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10.2 Value added tax

Most of the activities of the Trust are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charges or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Corporation tax

The Trust is not liable to to pay corporation tax.

1. Accounting Policies (Continued)

1.12 Property, Plant and Equipment

1.12.1 Recognition

Property, Plant and Equipment is capitalised if:

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

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

1.12.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive expenditure in Statement of Comprehensive Income.

1.12.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12.4 Depreciation

Items of property held at current value, are depreciated over their remaining Useful Economic Lives (UEL) as assessed by the NHS Foundation Trust's professional valuers in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have infinite life and is not depreciated. Leaseholds are depreciated over the primary lease term. Plant and Equipment initially held at current cost, is depreciated over the estimated UEL.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated. Assets in the course of construction are not depreciated until the asset is brought into use.

The following UELs apply to each individual asset category based on standard asset lives adjusted for local use and expected technology changes:

- Land - Land is not depreciated because it is considered to have an infinite life
- Non-residential buildings and dwellings - average remaining useful economic life of the building block in accordance with the Independent Qualified Valuers report (up to 90 years)
- Plant and Machinery - 5 to 15 years
- Transport Equipment - 7 years
- Furniture and Fittings - 3 to 10 years
- Office and IT Equipment - 3 to 5 years
- Mainframe IT Type Installation - 5 to 9 years
- Computer Software Licenses - the shorter of 5 years or length of licenses

1. Accounting Policies (Continued)

1.13 Investment properties

Investment properties are measured at fair value, changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.14 Intangible Assets

1.14.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it's probable that the future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

(i) Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• the way in which intangible assets will generate probable future economic or service delivery benefits e.g. the presence of a market for its output or, where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical or other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

(ii) Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset. Costs associated with maintaining software are recognised as an expense when incurred.

Capitalised computer software is amortised over the expected useful economic life or 5 years, whichever is the shorter.

1.14.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in the development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.15 Depreciation

Freehold land, assets under construction or development, investment properties, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over the estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

1. Accounting Policies (Continued)

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.16 Donated Assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.17 Leases

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

1.17.1 The Trust as a lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 The Trust as a lessor

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

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

1. Accounting Policies (Continued)

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

1.19 Cash and equivalents

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

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

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 0.10% (2016-17: 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of - 2.42 % (2016-17: -2.70%) for expected cash flows up to and including 5 years.
- A medium term rate of -1.85% (2016-17: -1.95%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of -1.56% (2016-17: -0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

1.21 Clinical Negligence

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1. Accounting Policies (Continued)

1.24 Contingent liabilites and contingent assets

A contingent liability is:

● a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or

● a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably;

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss, held to maturity investments, available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.25.1 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.25.2 Impairment

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 that occurred after the initial recognition of the asset and that have 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 expenditure.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1. Accounting Policies (Continued)

1.26 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.26.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

● donated assets (including lottery funded assets)

● average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)

● any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.]

1.28 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1. Accounting Policies (Continued)

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

1.30 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.32 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

●IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

●IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

●IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

●IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

●IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

●IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Segmental Analysis

All activities of the Trust are considered to be one segment, Healthcare. There are no individual reportable segments on which to make disclosures. Income and expenditure is not reported on a segmental basis to the Trust Board and as such the Trust is managed as a single segment.

3. Operating income from continuing operations

3.1 Income from activities	2017/18 £000	2016/17 £000
Elective income	**27,505**	25,783
Non-elective income	**37,430**	34,907
Outpatient income	**47,984**	49,415
A&E income	**13,859**	13,196
Non PbR activity income	**101,220**	91,618
Community income	**42,225**	45,196
Private and Overseas patient income	**828**	1,199
Other non-protected clinical income	**14,624**	16,515
	285,675	277,829
Other operating income		
Research and development	**1,232**	1,188
Education and training	**12,825**	13,560
Non-patient care services to other bodies	**3,566**	2,033
Sustainability and Transformation Fund (STF)	**10,867**	7,979
Other income	**5,918**	5,755
Total other operating income	**34,408**	30,515
Total operating income	**320,083**	308,344

Other income includes property rent and leasing income of £4.3m (2016/17 - £1.5m).

3.2 Overseas Patient Income

Income from Overseas Patients is £0.23m in 2017/18 (2016/17 - £0.6m). Cash payments received in year relating to Overseas Patients totalled £0.1m (2016/17 - £0.1m) and amounts added to the provision for impairment of receivables were £0.04m (2016/17 - £0.59m). Receivables relating to Overseas Patients of £0.4m were written off in the year (2016/17 - £0.1m)

3.3 Income by Source	2017/18 £000	2016/17 £000
NHS Foundation Trusts	**4,669**	867
NHS Trusts	**985**	441
CCGs and NHS England	**263,453**	253,333
Health Education - England	**14,004**	13,560
NHS Other	**-**	50
Local Authorities	**20,409**	19,169
Non NHS: Private Patients	**828**	563
Non NHS: Overseas Patients	**234**	637
NHS Injury Scheme	**480**	614
Sustainability and Transformation Fund (STF)	**10,867**	7,979
Other operating income	**4,154**	11,131
Total	**320,083**	308,344

NHS Injury Scheme income is subject to a nationally prescribed provision for doubtful debts of 22.84% (2016/17 22.94%) to reflect expected rates of collection.

3.4 Commissioner Requested Services

	2017/18 £000	2016/17 £000
Commissioner Requested Services	**268,394**	258,551
Non - Commissioner Requested Services	**51,689**	49,793
Operating income from continuing operations	**320,083**	308,344

As part of Monitor's role under the Health and Social Care Act 2012 to licence providers of NHS services, it requires commissioners to designate Commissioner Requested Services (CRS). Prior to this designation occurring, all of the Trust's previous Mandatory Services have been designated as CRS.

4. Operating Expenses

4.1 Operating Expenses by type	**2017/18**	2016/17
	£000	£000
Purchase of healthcare from NHS bodies	**6,133**	4,544
Purchase of healthcare from non-NHS bodies	**1,757**	2,594
Directors' costs	**1,261**	1,193
Non executive directors' costs	**126**	124
Other Staff costs	**201,223**	194,385
Supplies and services - clinical (excluding drug costs)	**21,780**	22,642
Supplies and services - general	**8,226**	9,240
Establishment	**3,554**	2,611
Patient Transport	**1,629**	2,033
Premises	**16,467**	17,529
Increase in bad debt provision	**509**	1,301
Drugs costs	**17,468**	18,065
Depreciation on property, plant and equipment	**6,136**	6,836
Amortisation of intangible assets	**1,351**	1,327
Audit fees - statutory audit	**65**	65
Audit related assurance services	**14**	14
Audit fees - internal audit	**117**	64
Consultancy	**1,002**	1,441
NHSLA insurance premium	**11,077**	9,196
Other	**4,013**	5,714
Total (excluding impairment)	**303,908**	300,918
Impairments of property, plant and equipment	**447**	5,640
Total (including impairment)	**304,355**	306,558

In 2017/18 audit fees for statutory audit, and audit related assurance services (Quality Accounts), excluding VAT, were £53.8k and £12k respectively (2016/17 - £53.8k and £12k).

4.2 Operating leases

4.2.1 Operating lease Rentals	**2017/18**	2016/17
	£000	£000
Rental of plant and machinery	**1,186**	212
Rental Hire of building	**376**	478
	1,562	690

4.2.2 Operating lease commitments

			2017/18	2016/17
	Land and buildings	**Plant and Machinery**	**Total**	Total
	£000	**£000**	**£000**	£000
Annual commitments on leases expiring:				
Within 1 year	376	155	**531**	690
Between 1 and 5 years	-	797	**797**	737
Greater than 5 years	**-**	234	**234**	234
Total	376	1,186	**1,562**	1,661

Operating leases relating to buildings are in respect of premises owned by Hackney Community College in which the Trust occupies space. Leases in respect of plant and machinery relate to a CT scanner and other smaller items of medical equipment.

5. Staff costs and staff numbers

5.1 Staff costs

	2017/18 Total	2016/17 Total
	£000	£000
Salaries and wages	**139,891**	137,725
Social Security costs	**15,679**	15,043
Employer contributions to NHS Pensions Agency	**17,960**	17,701
Pension Cost - Other	**5**	5
Termination Benefits	**255**	-
Bank Staff	**16,507**	14,673
Agency staff	**12,187**	11,707
	202,484	196,854

The staff costs above are shown in Operating Expenses (note 4.1) as Directors' costs and Other Staff Costs.

5.2 Average number of persons employed

	Permanently Employed Number	**Other Number**	**2017/18 Total Number**	2016/17 Total Number
Medical and dental	458	61	**519**	500
Ambulance staff	-	-	**-**	1
Healthcare assistants and other support staff	494	115	**609**	613
Nursing, midwifery and health visiting staff	1,156	199	**1,355**	1,349
Nursing, midwifery and health visiting learners	-	-	**-**	31
Scientific, therapeutic and technical staff	668	39	**707**	623
Administration and estates	709	166	**875**	751
Other	-	-	**-**	2
Total	**3,485**	**580**	**4,065**	3,870

5.3 Employee benefits

There are nil individual employee benefit costs for 2017/18 (2016/17 Nil).

5.4 Retirements due to ill-health

	2017/18 Number	**2017/18 £000**	2016/17 Number	2016/17 £000
Early retirements agreed on the grounds of ill-health	**-**	**-**	2	61

The costs of early retirements due to ill-health are not included in Operating Expenses as the liability is met by the NHS Pensions Agency.

5.5 Staff exit packages

	Number of compulsory redundancies	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	2	2	4
£10,000 - £25,000	1	5	6
£25,001 - £50,000	6	-	6
Total number of exit packages by type	**9**	**7**	**16**
Total cost (£'000s)	**255**	**85**	**340**

5.6 Analysis of Other Departures

	Agreements Number	**Total Value of agreements £000's**
Contractual payments in lieu of notice	6	80
Non contractual payments requiring HMT approval	1	5
Total	**7**	**85**

6. The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within Other Interest Payable arising from claims made under this legislation.

7 Finance income	2017/18	2016/17
	£000	£000
Interest on loans and receivables and bank current accounts	77	34
Total	77	34

7.1 Finance expenses - finance liabilities	2017/18	2016/17
	£000	£000
Interest on Loans from the Independent Trust Financing Facility	201	267
	201	267

8. Intangible Assets

All Intangible fixed assets relate to software licences.

8.1 2017/18	Software	Assets Under Construction	Total
	£000	£000	£000
Gross cost at 1 April 2017	7,998	164	8,162
Additions - purchased	401	-	401
Reclassifications	86	(86)	-
Disposals	(2)	-	(2)
Gross cost at 31 March 2018	**8,483**	**78**	**8,561**
Amortisation at 1 April 2017	2,675	-	2,675
Provided during the year	1,351	-	1,351
Disposals	-	-	-
Amortisation at 31 March 2018	4,026	-	4,026
Net book value			
- Purchased at 31 March 2017	5,323	164	5,487
- Purchased at 31 March 2018	4,457	78	4,535

8.2 2016/17			
	£'000	£'000	£'000
Gross cost at 1 April 2016	6,724	1,201	7,925
Additions - purchased	294	94	388
Reclassifications	1,131	(1,131)	-
Disposals	(151)	-	(151)
Gross cost at 31 March 2017	**7,998**	**164**	**8,162**
Amortisation at 1 April 2016	1,499	-	1,499
Provided during the year	1,327	-	1,327
Disposals	(151)	-	(151)
Amortisation at 31 March 2017	**2,675**	**-**	**2,675**
Net book value			
- Purchased at 31 March 2016	5,225	1,201	6,426
- Purchased at 31 March 2017	**5,323**	**164**	**5,487**

9. Property, Plant and Equipment

9.1. As at 31 March 2018

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	21,500	115,907	1,886	28,432	118	7,035	1,799	**176,677**
Additions - purchased	-	2,318	2,474	2,856	-	722	37	**8,407**
Revaluations	840	4,220	-	-	-	-	-	**5,060**
Impairments - Charged to SOCIE	-	(129)	(318)	-	-	-	-	**(447)**
Reclassifications	-	1,160	(1,628)	222	-	242	4	**0**
Disposals	-	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2018	**22,340**	**123,476**	**2,414**	**31,510**	**118**	**7,999**	**1,840**	**189,696**
Depreciation at 1 April 2017	-	25,703	-	17,584	90	4,072	1,501	**48,950**
Provided during the year	-	2,586	-	2,544	5	953	48	**6,136**
Depreciation at 31 March 2018	**-**	**28,289**	**-**	**20,128**	**95**	**5,025**	**1,549**	**55,086**
Net book value								
- Purchased at 1 April 2017	21,500	89,129	1,886	10,350	11	2,964	296	**126,136**
- Donated at 1 April 2017	-	1,075	-	497	17	-	2	**1,591**
Total at 1 April 2017	**21,500**	**90,204**	**1,886**	**10,847**	**28**	**2,964**	**298**	**127,727**
Net book value								
- Purchased at 31 March 2018	22,340	94,308	2,414	11,202	7	2,974	291	**133,536**
- Donated at 31 March 2018	-	879	-	180	16	-	-	**1,075**
Total at 31 March 2018	**22,340**	**95,187**	**2,414**	**11,382**	**23**	**2,974**	**291**	**134,611**

9. Property, Plant and Equipment

9.2. As at 31 March 2017

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	30,128	114,913	3,905	26,872	118	7,985	1,782	**185,703**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions - purchased	-	46	1,136	2,288	-	409	17	**3,896**
Revaluations	(8,552)	3,887	-	-	-	-	-	**(4,665)**
Impairments - Charged to SOCIE	(76)	(3,068)	(2,496)	-	-	-	-	**(5,640)**
Reclassifications	-	129	(602)	48	-	426	-	**1**
Disposals	-	-	(57)	(776)	-	(1,785)	-	**(2,618)**
Cost or valuation at 31 March 2017	**21,500**	**115,907**	**1,886**	**28,432**	**118**	**7,035**	**1,799**	**176,677**
Depreciation at 1 April 2016	-	22,667	-	15,644	85	4,827	1,432	**44,655**
Provided during the year	-	3,036	-	2,696	5	1,030	69	**6,836**
Disposals	-	-	-	(756)	-	(1,785)	-	**(2,541)**
Depreciation at 31 March 2017	**-**	**25,703**	**-**	**17,584**	**90**	**4,072**	**1,501**	**48,950**
Net book value								
- Purchased at 1 April 2016	30,128	90,931	3,905	10,028	14	3,159	344	**138,509**
- Donated at 1 April 2016	-	1,315	-	1,199	19	-	6	**2,539**
Total at 1 April 2016	**30,128**	**92,246**	**3,905**	**11,227**	**33**	**3,159**	**350**	**141,048**
Net book value								
- Purchased at 31 March 2017	21,500	89,129	1,886	10,350	11	2,964	296	**126,136**
- Donated at 31 March 2017	-	1,075	-	497	17	-	2	**1,591**
Total at 31 March 2017	**21,500**	**90,204**	**1,886**	**10,847**	**28**	**2,963**	**298**	**127,727**

9.3 Assets held at market value

At 31 March 2018 the Trust held land assets at market value for existing use of £22,340,000 (31 March 2017, £21,500,000).

9.4 Valuation of land & buildings

The buildings have been valued as at 31 March 2018 using a Modern Equivalent Asset basis of valuation, as discounted for wear and tear.

Land has been revalued at 31 March 2018 at market value for existing use.

Both valuations were carried out by Gerald Eve LLP whose address is 72 Welbeck Street, London. W1G 0AY.

Buildings have estimated useful economic lives ranging up to 73 years (2016/17 - 90 years).

9.5 Assets held under finance leases and hire purchase contracts at 31 March 2018

The Trust did not hold any finance leases or hire purchase contracts during 2017/18.

9.6 Fixed Asset Investments

There were nil fixed asset investments held at 31 March 2018 (31 March 2017 - Nil).

10. Inventories

10.1. Inventories	**2017/18**	2016/17
	£000	£000
Drugs	**1,076**	1,135
Consumables	**1,466**	1,334
Energy	**45**	54
Total	**2,587**	2,523

10.2 Inventories recognised in expenses	**2017/18**	2016/17
	£000	£000
Total Inventories recognised as an expense in the year	**16,093**	16,511

11. Trade and other receivables

11.1 Amounts falling due within one year:	31 March 2018 £000	31 March 2017 £000
NHS receivables	**12,061**	19,414
Non NHS receivables	**7,241**	6,320
Provision for impaired receivables	**(3,883)**	(3,900)
Prepayments	**1,483**	1,217
Accrued income	**21,874**	13,141
PDC Dividend Receivable	**315**	342
Other receivables	**3,028**	2,531
Total	**42,119**	39,065

11.2 Analysis of the provision for impaired receivables

	31 March 2018 £000	31 March 2017 £000
At 1 April	**3,900**	2,877
Arising during the year	**509**	1,301
Utilised during the year	**(526)**	(278)
At 31 March	**3,883**	3,900

By age:	31 March 2018 £000	31 March 2017 £000
Up to three months old	**292**	53
In three to six months old	**125**	390
Over six months old	**3,466**	3,457
Total	**3,883**	3,900

11.3 Age analysis of unimpaired Trade Receivables

	31 March 2018 £000	31 March 2017 £000
Up to three months old	**10,936**	14,143
In three to six months old	**1,399**	1,659
Over six months old	**8,248**	7,920
Total	**20,583**	23,722

12 Cash and cash equivalents

	31 March 2018 £000	31 March 2017 £000
Balance as at 1 April	**20,208**	8,626
Net change in year	**6,075**	11,582
Balance at 31 March	**26,283**	20,208
Of which:		
Commercial banks and cash in hand	**161**	137
Cash with the Government Banking Service	**26,059**	20,058
Other current investments	**63**	13
Total cash and cash equivalents in the Statement of Cash Flows	**26,283**	20,208

13. Liabilities

13.1 (i) Current liabilities: Amounts falling due within one year	31 March 2018 £000	31 March 2017 £000
NHS payables	**4,194**	5,426
Non-NHS payables	**5,747**	8,600
Trade payables - Capital	**2,573**	979
Other payables	**269**	2
Accruals	**16,682**	18,063
Trade and other payables	**29,465**	33,070
Borrowings	**323**	323
Provisions	**6,689**	6,570
Tax payable	**6,914**	6,626
Deferred income	**6,569**	5,746
Total amounts falling due within one year	**49,960**	52,335

13.1 (ii) Non Current Liabilities: Payables due after more than one year	31 March 2018 £000	31 March 2017 £000
Provisions	**931**	940
Borrowings	**5,635**	5,957
	6,566	6,897
13.1 (iii) Total payables	**56,526**	59,232

14 Loans - payment of principal falling due:

	31 March 2018	31 March 2017
	£000	£000
Within one year	**323**	323
Between one and two years	**323**	323
Between two and five years	**969**	969
After five years	**4,343**	4,665
Total	**5,958**	6,280

Of which:

	31 March 2018	31 March 2017
	£000	£000
Wholly repayable within five years	**1,615**	1,615
Wholly or partially repayable after five years by instalments	**4,343**	4,665
Total	**5,958**	6,280

15. Provisions for liabilities and charges

	Pensions relating to former Directors	Pensions relating to former Staff	Clinical negligence	Redundancy	Other	**31 March 2018 Total**	31 March 2017 Total
	£000	£000	£000	£000	£000	**£000**	£000
At 1 April	90	902	90	94	6,334	**7,510**	4,044
Arising during the year	4	25	-	100	2,384	**2,513**	5,093
Change in discount rate	1	13	-	-	-	**14**	33
Utilised during the year	(7)	(47)	-	-	(2,232)	**(2,286)**	(1,662)
Reversed unutilised	-	-	(13)	-	(120)	**(133)**	(10)
Unwinding of discount	-	2	-	-	-	**2**	12
At 31 March	**88**	**895**	**77**	**194**	**6,366**	**7,620**	7,510
Within one year	6	46	77	194	6,366	**6,689**	6,571
Between one and five years	25	187	-	-	-	**212**	211
After five years	57	662	-	-	-	**719**	728
Total	**88**	**895**	**77**	**194**	**6,366**	**7,620**	7,510

Pension related provisions as at 31 March 2018 consist of £0.649m in relation to Injury Benefits and £0.336m relating to Early Retirement benefits payable to former employees of the Trust. These benefits are calculated and paid to the individuals concerned by the NHS Pensions Agency (NHSPA) and the provision represents the future liability of the Trust based on expected lifetime calculations discounted appropriately.

The Clinical Negligence provision totals £0.077m and is based on the estimated liability arising in the next year relating to claims that are being dealt with by the NHS Litigation Authority on behalf of the Trust. Redundancy provisions of £0.194m are based on the likely obligation of the Trust towards a small number of staff who are at risk of redundancy in the next year due to the outsoucing of certain back office administrative functions to an external provider.

The most significant elements of the other provisions figure are the following: £3.4m in respect of potential data challenges from commissioners relating to clinical contract income, £1.0m relating to the estimated value of untaken annual leave owed to Trust employees as at 31 March 2018, £0.598m in relation to a contractual issue with the Trust's facilities management provider, £0.36m in relation to potential back-dated utilities charges and £0.77m in relation to disputed property rental charges.

16. Clinical Negligence Liability

The amount provided by the NHSLA in respect of clinical negligence liabilities of the trust as at 31 March 2018 is £182,305,000 (2016/17 - £129,303,420).

17. Movement in Public Dividend Capital

	2017/18	2016/17
	£000	£000
Public Dividend Capital as at 1 April	**90,648**	90,648
New PDC received	**1,055**	-
Public Dividend Capital as at 31 March	**91,703**	90,648

The dividend payment for the year was £4.2m (2016/17 £4.6m). Further details on how the dividend was calculated are set out in note 1.16.

18. Notes to the cash flow statement

18.1 Reconciliation of operating (deficit) / surplus to net cash inflow from operating activities:

	2017/18	2016/17
	£000	£000
Total operating surplus	**15,728**	1,786
Depreciation and amortisation	**7,487**	8,163
Impairment	**447**	5,640
(Increase) in inventories	**(63)**	-
(Increase) in receivables	**(3,130)**	(7,537)
(Decrease) / Increase in payables	**(4,910)**	8,462
Increase in other liabilities	**823**	1,614
Other movements	**113**	3,512
Net cash inflow from operating activities	**16,495**	21,640

18.2 Reconciliation of net cash flow to movement in net funds

	2017/18	2016/17
	£000	£000
Increase in cash in the year	**6,075**	11,582
Cash inflow from debt repaid and finance lease capital payments	**322**	1,400
Increase in net funds resulting from cash flows	**6,397**	12,982
Net funds at 1 April	**13,928**	946
Net funds at 31 March	**20,325**	13,928

18.3 Analysis of changes in net debt

	At 1 April 2017	Cash changes in year	At 31 March 2018	At 31 March 2017
	£000	£000	£000	£000
GBS cash at bank	20,058	6,001	**26,059**	20,058
Commercial cash at bank and in hand	137	24	**161**	137
Debt due after one year	(5,957)	322	**(5,635)**	(5,957)
Debt due within one year	(323)	-	**(323)**	(323)
Current investments	13	50	**63**	13
Total	**13,928**	**6,397**	**20,325**	13,928

19. Contractual Capital Commitments

There were £1.2m of commitments under capital expenditure contracts as at 31 March 2018 (31 March 2017 - £1.3m).

20. Contingent liabilities

	2017/18	2016/17
	£000	£000
Liabilities to Third Parties Scheme (LTPS) member's contribution	**51**	68
	51	68

21. Related Party Transactions

There were nil related party transactions with individuals during the financial year (2016/17 nil).

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year Homerton University Hospital NHS Foundation Trust has had a significant number of material transactions with Government Departments and their agencies. The largest of these entities are listed below:

Name	Relationship	Income	Expenditure	Receivables	Payables
		£000	£000	£000	£000
East London NHS Foundation Trust	NHS Foundation Trust	3,881	529	2,202	182
Barts Health	NHS Trust	778	4,611	1,830	2,006
Health Education England	Special Health Authority	14,004	(1)	7	-
NHS England	Commissioner	55,776	(1)	12,901	98
NHS City And Hackney CCG	Commissioner	159,628	11	8,303	616
NHS Waltham Forest CCG	Commissioner	15,403	-	655	-
NHS Newham CCG	Commissioner	7,609	193	132	232
NHS Tower Hamlets CCG	Commissioner	5,421	145	705	50
NHS Islington CCG	Commissioner	5,139	-	559	-
NHS Redbridge CCG	Commissioner	5,103	-	441	-
NHS Barking And Dagenham CCG	Commissioner	2,595	-	225	-
NHS Enfield CCG	Commissioner	2,092	-	(137)	-
NHS Haringey	Commissioner	5,137	-	648	-
NHS Resolution	Other NHS Whole of Government Accounts Bodies - Insurer	-	11,095	-	7
HM Revenue & Customs - VAT	Central Government WGA Body	-	-	1,148	-
NHS Pension Scheme	Central Government WGA Body	-	17,960	-	8
HM Revenue & Customs - NI Fund & PAYE	Central Government WGA Body	-	16,434	-	6,913
London Borough of Hackney	Central Government WGA Body - Local Authority	18,586	1,039	4,151	-

The Trust has also received revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund. The Charity is registered with the Charity Commission (Charity Number 1061659) and has its own Trustees drawn from the NHS Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) and these documents are available on request from the Trust.

22. Private Finance Initiative Transactions

The Foundation Trust has no PFI schemes.

23. Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have played during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. In light of the continuing service provider relationship the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Audit Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures and their delegated authorities.

The Trust's financial instruments comprise loans, provisions, cash at bank and in hand and various items, such as trade receivables and trade payables, that arise directly from its operations. The main purpose of these financial instruments is to fund the Trust's operations.

23.1 Financial Instruments - Assets

	At 31 March 2018 £000	At 31 March 2017 £000
Floating rate	**26,283**	20,208
Non-interest bearing	**39,224**	35,566
Total	**65,507**	55,774

Financial assets consist of cash and cash equivalents and trade and other receivables excluding provisions less prepayments and PDC receivable.

23.2 Financial Instruments - Liabilities

	At 31 March 2018 £000	At 31 March 2017 £000
Fixed rate	**5,958**	6,280
Non-interest bearing	**37,085**	40,580
Total	**43,043**	46,860

Financial liabilities consist of current and non-current liabilities less deferred income, payments received on account, tax and PDC payable.

23.3 Analysis of Financial Instruments

	At 31 March 2018 £000	At 31 March 2017 £000
23.3 (i) Financial assets (Book and fair value)		
Cash	**26,220**	20,195
Receivables within one year	**39,224**	35,566
Other current investments	**63**	13
Total	**65,507**	55,774
23.3 (ii) Financial liabilities (Book and fair value)		
Payables within one year	**36,154**	39,640
Provisions over 1 year	**931**	940
Loans	**5,958**	6,280
Total	**43,043**	46,860

Notes

a) Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by HM Treasury's discount rate of 3.7% in real terms (2016/17 - 3.7%).

24. Third Party Assets

The Trust held £5,700 of patients' monies at 31 March 2018 (31 March 2017 - £7,106). This amount has been excluded from the cash at bank and in hand figure reported in the accounts.

25. Intra-Government and Other Balances

25.1 Receivable and Payable balances	Receivables: amounts falling due within one year At 31 March 2018 £000	Payables: amounts falling due within one year At 31 March 2018 £000
English NHS Foundation Trusts	**2,683**	**2,706**
English NHS Trusts	**2,244**	**2,343**
Department of Health	**-**	**-**
Public Health England	**1**	**1**
Health Education England	**7**	**-**
NHS England & Clinical Commissioning Groups	**26,005**	**996**
Other NHS Whole of Government Accounts bodies	**3**	**1,563**
Other Whole of Government Accounts bodies	**5,378**	**6,972**
Total	**36,320**	**14,581**

25.2 Income and expenditure values for the year	Income Year Ended 31 March 2018 £000	Expenditure Year Ended 31 March 2018 £000
English NHS Foundation Trusts	**4,670**	**2,825**
English NHS Trusts	**985**	**5,038**
Department of Health	**-**	**-**
Public Health England	**-**	**-**
Health Education England	**14,004**	**(1)**
NHS England & Clinical Commissioning Groups	**274,319**	**347**
Other NHS Whole of Government Accounts bodies	**1**	**15,881**
Other Whole of Government Accounts bodies	**20,409**	**36,870**
Total	**314,388**	**60,960**

26. Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases £000	Total number of cases	Total value of cases £000
LOSSES:				
1. Losses of cash due to:				
Other Losses - Pharmacy Expired / Damaged Stock	-	-	12	17
2. Fruitless payments and constructive losses	-	-	-	-
3. Bad debts and claims abandoned	715	618	277	285
4. Damage to buildings, property etc.(including stores losses)	-	-	-	-
TOTAL LOSSES *	**715**	**618**	**289**	**302**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	-	-	-	-
6. Extra contractual to contractors	-	-	-	-
7. Ex gratia payments in respect of:				
Loss of personal effects	11	2	5	1
Personal Injury with Advice	3	27	3	2
Other	12	4	4	1
8. Special Severance payments	1	5	-	-
9. Extra statutory and regulatory	-	-	-	-
TOTAL SPECIAL PAYMENTS *	**27**	**37**	**12**	**4**
TOTAL LOSSES AND SPECIAL PAYMENTS *	**742**	**655**	**301**	**306**

* Losses and Special Payments have been calculated on an accruals basis but exclude provisions for future losses.

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton
University Hospital
NHS Foundation Trust

Homerton University Hospital
Homerton Row
London E9 6SR
Tel: 020 8510 5555

Incorporating hospital and community health services, teaching and research

www.homerton.nhs.uk