

ANNUAL REPORT
AND ACCOUNTS

2015/16

Homerton University Hospital NHS Foundation Trust
Annual Report and Accounts 2015/16

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 2015/16

This Annual Report follows best practice in corporate reporting by articulating our strategy; reporting back on our performance against strategic objectives and national targets; and presenting information about our service and financial performance.

The structure of the report is as follows:

Annual Report

Introduction

Performance report:

Including statement from the Chief Executive, our strategic vision, performance against the strategic priorities in 2015/16 and details of our strategic priorities for 2016/17, as well as our financial performance and non-financial performance against national targets.

Accountability report:

including details of the Board of Directors, Council of Governors, Trust Audit Committee, Foundation Trust membership and Annual Governance Statement.

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 2016/17.

Finance

including the consolidated Annual Accounts for the financial year 2015/16.

Introduction

Chairman's report

The challenges facing the NHS continue to grow, with increasing numbers of patients suffering from increasingly complex medical problems whilst, at the same time, we face ever greater financial pressures.

The Trust has inevitably been affected by these in 2015/16. Although we have continued to operate effectively and have met most of our key targets, the Trust incurred a deficit for the first time for several years. The report which follows illustrates a number of our operational achievements, including that our A&E department continues to meet demanding national targets most of the time. This is due to the extraordinarily dedicated work by our staff, not only in A&E, but also in many other parts of the Trust where coordinated effort is required to ensure that our emergency standards remain high.

The professionalism and commitment of our staff is often taken for granted, and I would like to highlight just how remarkable they have been this last year.

It is the staff who enable us to achieve our targets, and moreover who do so in ways that mean we score very highly in national comparisons of staff openness and patient care. What is more, they have the ability to work even harder when things go wrong and need to be put right.

In her report, Tracey Fletcher refers to two CQC inspections in the last calendar year, which required us to make improvements in our maternity department and Mary Seacole Nursing Home. As the year progressed it was evident that significant improvements were being made in the areas affected, for which the staff concerned deserve great credit. It is also the case, as Tracey points out, that staff are contributing significantly to the efforts we are making to improve our financial position.

Recognising the growing operational and financial pressures on the NHS and the Trust, it is worth explaining briefly what we are doing to address these. The staff contribution to our financial recovery plans is central to our ambition to return to a sustainable position as soon as we can. But beyond this, there are further opportunities to deliver health care more effectively and efficiently by working more closely with other health care organisations, both in Hackney and the City and in the wider local community. Thus we are developing a "devolution" proposal

which involves close working with, among others, the GP Confederation in Hackney, our local Clinical Commissioning Group, and the London Borough of Hackney. We are also participating in a wider North East London Sustainability and Transformation Plan.

For these plans to develop and operate effectively requires a high level of cooperation and commitment throughout the organisations involved. It also requires a level of investment to generate a good financial and operational return. Furthermore, a huge effort is required to reduce the ever-growing pressures on the NHS through improving public health.

So we have some work to do! In this regard, I would like to finish by thanking both the Governors and my colleagues on the Board of the Trust for their unstinting support and commitment through these difficult times. There is only one change to the membership of the Board that I would like to mention, and that is the departure of our interim Finance Director, Matthew Metcalfe, to pastures new. He will be succeeded by Jonathan Wilson, who is currently Finance Director of the Royal National Orthopaedic Hospital in Stanmore and who joins us in July 2016. In the meantime, John Yarland is working with us as interim Finance Director. He has a long experience in similar roles in the NHS and is playing a key role in addressing the financial challenges I have described.



Tim Melville-Ross

Annual Report



Our Values

• PERSONAL
• SAFE
• RESPECTFUL
• RESPONSIBILITY



Overview

Chief Executive's Report

The Annual Report describes the Trust's principal activities over the past year (April 2015 – March 2016), and examines the progress made in developing the range, scope and quality of our services. It also sets out objectives for the coming year.

The Performance Report contains an outline of our achievements against our 2015/16 objectives. The Accountability Report covers our business review in detail, and includes details on our governance, remuneration of senior staff, regulatory ratings and staff related issues. The Quality Account follows, and lastly, we include the Annual Accounts.

Our principal activities

Homerton University Hospital NHS Foundation Trust provides hospital and community services for Hackney, the City and the surrounding communities, and a bespoke 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.

We have unconditional registration from the Care Quality Commission.

The main hospital, which opened in 1986, is based on one site. Homerton became an NHS Foundation Trust in 2004, under the Health and Social Care (Community Health and Standards) Act 2003. 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.

Care Quality Commission visits

Following two visits by the Care Quality Commission to the maternity department in 2015, our maternity team worked extremely hard to make significant improvements to our patients' experience. We welcome the CQC's recognition of this work following their second visit to the service in October/November 2015, and the lifting of the three warning notices which had been put in place following the earlier inspection. We know that there is still more to be done and will continue our good work in embedding good practice and strengthening our governance procedures.

The Care Quality Commission also visited Mary Seacole Nursing Home on two occasions during the year, and the inspectors' feedback highlighted some concerns in relation to the 'Safe' domain. The Trust took immediate action to address the issues that they raised. We are very grateful for the positive support that we have received from our residents and their families, and await further feedback from the CQC following their most recent visit.

Transforming care through technology

Improving the way in which we provide care is at Homerton's heart, and this has been demonstrated in outstanding fashion this year with the implementation of two major IT programmes: Acute Clinical Excellence (ACE) and Open RiO. These projects have demanded an unprecedented degree of working across specialities and professions and indeed, between clinical and non-clinical staff members, and represent not only a significant improvement in our technological capabilities, but a sea-change in our clinical practice. ACE has brought electronic prescribing and online clinical noting to our wards and acute clinical areas, and has made it easier to identify patients who are at risk of deteriorating, allowing our clinicians to intervene earlier and more effectively to provide better and safer care. Open RiO is supporting our community services by matching the ways in which they work with the technology they use, providing better and more accessible information for our clinicians. The remarkably smooth implementation of both these programmes reflects the extraordinary degree of planning and commitment on the part of our staff.

This technology is already enabling our staff members to make changes to the way they provide care, with a measurable impact on our clinical outcomes. In Quarter 4, at least 93% of patients with acute kidney injury received an early pharmacy review and a diagnosis which was communicated to their GPs along with follow-up arrangements, while all patients with severe sepsis received antibiotics within one hour.

Twin challenges: financial and operational performance

Across the NHS, the financial environment continues to be extremely challenging, and Homerton has concluded the year in deficit. We took a number of steps to mitigate our financial position and have worked with our divisions to develop comprehensive financial plans for the year ahead. We have also sought suggestions

on improving our financial position from our frontline staff and have not only received an encouraging number of responses, but have been impressed by work done by individual teams, such as our blood transfusion team, to support the more efficient running of their services. We will continue to encourage this involvement of our frontline staff throughout the coming year.

Maintaining Homerton's good performance has been a particular challenge in the latter half of the year, with the widely publicised instances of junior doctor industrial action. With significant planning and working with both our consultant and junior doctor colleagues, we are proud to have so far maintained safe services. Homerton is the only acute trust in London to have met the national target of seeing 95% of A&E patients within four hours this year, supported by our ongoing work to ensure that patient flow works well throughout the hospital.

Homerton did suspend its Referral To Treatment (RTT) reporting for a period of time in the second half of the year in order to address some technical issues in the ways that these reports were being run. These have now been fully resolved, and the Trust has resumed reporting.

Staff wellbeing and engagement

Staff wellbeing and engagement remains a key priority for Homerton, and we are delighted to have achieved 'Excellence' status in the Healthy Workplace Charter this year. The introduction of Schwartz Rounds has been of particular value, supporting our staff members to discuss issues affecting them at work in a confidential and safe environment. This year, to further support our staff, we have refreshed our work on diversity and inclusiveness, with new resources and workshops. The staff survey continues to provide valuable and encouraging information on how our staff feel about Homerton: we were delighted that 92% of our staff this year said that they believed that their role made a difference to patients.

Key objectives

We are now in the third year of the Trust's strategy, Achieving Together, with its three pillars of quality, integration and growth, and associated corporate objectives. Our quality priorities set out the key areas of focus for continually improving the safety and quality of the care that we provide, and can be found on page 13. Details of each of our key strategic priorities are

provided on page 13.

Our focus on partnership working has been further strengthened this year, with Hackney granted devolution pilot status. This involves health and social care organisations coming together to break down traditional barriers to accessing care, and we look forward to working with our partner organisations to provide more joined-up and easier to access care.

Risks

We anticipate that the year ahead will be very challenging from a financial perspective, both for the wider health economy, and locally, for Homerton. Our clear focus will be on improving our financial position while maintaining, and indeed, improving, our quality and performance. Our approach to our objectives must continue to be informed by our environment, as the way in which we work with our partners, both as part of the devolution pilot and through the national Sustainability and Transformation Plan (STP) work.



Tracey Fletcher

Chief Executive

25 May 2016

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.

We are licensed by NHS Improvement (NHSI) and have unconditional registration from the Care Quality Commission.

The main hospital, which opened in 1986, is based on one site. Homerton became an NHS Foundation Trust in 2004 under the Health and Social Care (Community Health and Standards) Act 2003. 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.

The hospital has almost 500 beds spread across 11 wards, a nine bed intensive care unit and maternity, paediatric and neonatal wards. We have three day surgery theatres and six main operating theatres for all types of general surgery, trauma and orthopaedics, gynaecology, maxillofacial, urology, ENT, obesity, bariatric and obstetrics. We also have a surgical treatment room within the main theatres complex.

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

The clinical services are led and operated by three divisions within the hospital: surgery, women's and sexual health services; children's services, diagnostics and outpatients; and integrated medical and rehabilitation services. 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 2015/16

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

Despite a recent history of achieving surpluses, the Trust posted a year-end deficit of £5.45m. Our forward planning is focused on improving this position and bringing the 2016/17 position back into surplus.

The Trust's strategy 'Achieving Together' was established in 2013 and is the blueprint 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. 'Achieving Together' outlines the strategy to take the Trust up to 2020.

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 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's Strategic Objectives in 2016/17

The Trust's mission – 'Safe, caring, effective health and social care provided to our communities with a transparent, open approach' – remains the same from last year, as does its commitment to 'Achieving Together'.

The strategic priorities were established within the context of a five year strategic plan, 2014 – 2019, and two year operational plan 2014 – 16. The strategic priorities remain: Quality; Integration; and Growth; which continue to be supported by the 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.

Principal risks and uncertainties facing the Trust

All of the principal risks identified by the Trust are monitored regularly through standing reports to the Risk Committee and Trust Board.

Key risks identified include the following.

- A lack of adherence to latest research, or practice not compliant with the best evidence could lead to a less effective service provision (both in-year and future risk).
- Failure to develop an engaged and motivated workforce undermines 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 (both in-year and future risk).
- The patient receives avoidable harm from poor practice which is the result of a failure to comply with required Trust safety policies and lessons learned (both in-year and future risk).
- If culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust failing to deliver safe care to patients (both in-year and future risk).
- Failure to achieve financial balance resulting in difficulties in funding future investment plans, liquidity issues, and increased scrutiny from Monitor (both in-year and future risk).
- Risks associated with the condition of community health service buildings posing a risk to the ability to deliver clinical services and meeting regulatory compliance in these locations (both in-year risk and future risk).
- Risk to Trust income and performance as a result of the changing provider landscape with some services being commissioned by the CCG, some by NHS England and some by the London Borough of Hackney (both in-year and future risk).
- Poor reviews and performance outcomes by regulators, other bodies, the press and public result in a damaged reputation that diminishes the Trust's ability to grow (both in-year and future risk).

Through the Trust's governance structures, the Board of Directors has reviewed the risks that may prevent the Trust from achieving its objectives, complying with its NHSI Licence Conditions and achieving the operating and financial plan over the review period.

Performance report

Outcomes are assessed through performance reports to the Trust Board. The risks that threaten achievement of the principal objectives are identified within the Board Assurance Framework, which is reviewed regularly by the Board of Directors.

The Trust's Risk Register and governance processes are designed to assess the impact of identified risks on the Trust's plans, and ensure that they are appropriately mitigated or managed.

A 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 analysis

Performance against strategic priorities 2015/16

During the course of 2015/16 we have recorded a number of achievements:

- Trust scored 'above average' for 53% of the key questions on the national staff survey
- Opening of the Integrated Independence Team (IIT), combining teams from across health and social care to provide a single point of access and management structure

- Good compliance against the key operational and quality requirements including delivery of emergency and elective access standards across the year albeit it with quarterly fluctuations and a specific challenge in the latter half of the year with RTT reporting
- Trust financial turnover increased by 5.2%
- Delivered targeted plan to improve adult community nursing
- Enhanced health visiting service in line with local commissioning intentions and successfully won the competitive tender to continue providing the service for the next five years
- Worked with City & Hackney CCG to apply the concept of alliance working to improve mental health provision
- Developed a pilot approach to ambulatory emergency care to achieve inpatient efficiency and timely discharge of patients
- Increased activity through theatre efficiency
- Expanding outpatient outreach provision, particularly in locations external to the hospital site
- Restructured Orthopaedics department and enhanced this subspecialty service
- Successfully completed the CQC action plan in the maternity services and consequently having had three warning notices removed
- Successfully Implemented significant clinical information systems enhancement, targeted at providing safer care
- Increased nurse staffing numbers
- Improved consultant support to the acute medicine and emergency surgery pathways



Review of financial performance

The Trust had an Income & Expenditure (I&E) deficit of £5.45m for the financial year 2015/16, compared to the planned surplus of £0.5m. 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 gain on transfers and impairments) is shown in the table below.

2015/16	Plan £m	Actual £m	Variance £m
Income			
Clinical contracts	243.5	243.5	0.0
Other income	40.7	40.9	0.2
Total income	284.2	284.4	0.2
Expenses			
Pay	(194.5)	(194.7)	(0.2)
Non pay	(78.1)	(83.5)	(5.3)
Total expenses	(272.6)	(278.3)	(5.7)
EBITDA*	11.6	6.1	(5.5)
Depreciation and amortisation	(6.6)	(6.9)	(0.3)
PDC dividends	(4.4)	(4.5)	(0.1)
Net interest	(0.1)	(0.2)	(0.1)
Sub-total	(11.1)	(11.6)	0.5
Net surplus	0.5	(5.5)	(6.0)

*Earnings Before Interest, Tax, Depreciation and Amortisation.

Figures may not add due to rounding

Activity and income was broadly on plan across a number of types of activity (as set out on pages 16-21). Other income was higher than plan due to additional non-recurrent investment provided by City and Hackney CCG.

The Trust achieved £9.9m of savings during the year as part of its Quality, Innovation, Productivity and Prevention (QIPP) agenda. Projects included staffing and skill mix reviews, service reconfiguration and more efficient use of our capacity.

The Trust's liquidity position deteriorated in-year due to the income and expenditure deficit together with delays in payment for performance invoices by commissioners. The Trust ended the year with debtors £11m higher than the last year-end and its cash balance £9m lower.

Capital expenditure totalled approximately £7m, including: £4.2m on IT (including the ACE and Rio programmes), £1.8m on new and replacement medical equipment and £0.9m on estates projects.

Monitor assesses financial risk using the "Financial Sustainability Risk Ratings" (FSRR). This rating measures the Trust's liquidity and its ability to service its debts, together with the degree to which the Trust is operating at a surplus or deficit and the variance between this and its planned surplus or deficit. The Trust achieved a score of 2 from Monitor for 2015/16 (the highest rating available is a 4). This was a deterioration from 2014/15 when the Trust achieved a score of 3, predominantly due to the variance from the planned £0.5m surplus.

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 – that is for at least the next 12 months from the date of signing the Annual Accounts.

Accounting policies for pensions are set out in note 1.5.2 to the accounts and details of senior employees' remuneration can be found in note 4.3 of the Annual Accounts.

Counter fraud policies and procedures

The Trust has a counter fraud policy for dealing with suspected fraud and corruption, 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 our local counter fraud specialist, provided by TIAA.

Performance report

Review of non-financial performance

Patient activity

In 2015/16, the Trust has continued to experience an increase in demand for the majority of its clinical services compared with previous years. However, there were some activity categories where the Trust did not achieve its planned level of activity. The table below provides a summary of observed activity levels against the Trust's 2015/16 activity plan.

Category	2013/14 Activity	2014/15 Activity	2015/16 Plan	2015/16 Activity	% above/below plan
A&E attendances (inc Primary and Urgent Care Centre)	118,676	120,008	121,497	122,137	0.5%
Hospital (acute) non-elective spells (including deliveries)	26,377	26,170	25,902	27,848	7.5%
Hospital outpatient attendances	236,806	249,417	256,233	258,899	1.0%
Hospital (acute) elective spells	19,659	20,004	21,381	22,182	3.8%
Adult community services – attendances and contacts	252,747	324,500	330,024	321,079	-2.7%
Children's community services – attendances and contacts	235,687	218,890	285,095	296,255	3.9%
Adult critical care and rehabilitation – occupied bed days	29,442	31,283	31,358	31,459	0.3%
Neonatal critical care – occupied bed days	13,619	13,880	14,249	14,397	1.0%
Direct access diagnostics	1,114,095	1,199,647	1,284,797	1,190,694	-7.3%
Other attendances (fertility, regular attenders, therapies and podiatry)	18,328	20,020	20,933	20,423	-2.4%

Non-elective activity

In 2015/16, the Trust has experienced a significant level of activity over plan. This has largely been in relation to A&E attendances to majors and injuries, rather than the Trust's Primary and Urgent Care Centre.

Having witnessed emergency admissions plateau in 2014/15, the Trust and its commissioners anticipated a small reduction in emergency admissions in 2015/16. However, this reduction has not materialised.

A significant proportion of the activity above plan relates to the number of admissions to the Trust's Observational Medical Unit (OMU). As a consequence, although emergency admissions are higher than last year and higher than planned, this has not resulted in a direct increase in the Trust's acute bed utilisation figures as the OMU does not form part of the Trust's general and acute bed capacity. Therefore, the number of short-stay emergency admissions has increased. OMU activity was 25.3% above its activity plan.

Regardless of this, the Trust did experience general and acute adult emergency admissions at a rate of 4.6% above the activity plan excluding the Trust's sickle cell service. When this is included, the rate becomes 6.4%

With regard to paediatric and neonatal emergency admissions, the excess over plan was 9.4%, but in maternity, activity was below plan by 2.7%.

As would be expected with significant levels of activity over plan in emergency admissions, critical care activity was also over plan in both adult (4.1%) and neonatal critical care (1%). Although the overall excess in neonatal care was small, it should be noted that in relation to high dependency and intensive care, the activity was 9.6% above plan indicating an increase in the acuity of admissions.

Planned care activity

With regard to the Trust's planned care activity (outpatients, day case and elective), activity was over-plan in most areas, with the exception of outpatient first attendances where activity was 5.6% below plan.

Outpatients

Despite being under-plan overall, the Trust has 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):

- genito-urinary medicine
- cardiology
- paediatric phlebotomy
- rheumatology.

However, outpatient first attendance activity has been significantly (-10% or more) under plan in the following specialties (excluding maternity and only including where the annual activity exceeds 1,000 attendances):

- general surgery
- dermatology
- diabetes
- accident & emergency
- respiratory medicine (including allergy)
- adult ENT.

With regard to outpatient procedures, the Trust position was 6.9% above plan in 2015/16. This was predominantly as a consequence of significant activity above plan in cardiology, ENT (adult and paediatric), gynaecology and dermatology.

Day case

Day case activity was 3.4% above the Trust's activity plan in 2015/16. The specialties that were significantly above plan (50 cases or more above plan) were:

- general surgery
- ear, nose and throat surgery (paediatric)
- gastroenterology
- oral & maxillofacial surgery
- urology
- gynaecology.

Whereas, the high volume services (50 cases or more below plan) that contributed to the under-performance were:

- trauma & orthopaedics
- pain management
- allergy.

Elective

The activity in 2015/16 in relation to elective procedures was 5.3% above plan. Specialties that were above plan (more than 10% and 100 or more procedures) were:

- respiratory sleep studies
- general surgery
- gastroenterology
- urology.

Performance report

The only specialty below plan (more than 10% and 100 or more procedures) was gynaecology.

Community services

In totality, the community services activity was 0.3% over-plan.

Adult community services were 2.7% under plan and this was primarily driven by the following service:

- Primary & Urgent Care Centre (PUCC)
- primary care psychology
- wheelchair services.

Children's community services were 3.9% over plan, primarily driven by the following services:

- First Steps
- community paediatrics
- Children's Community Nursing Team
- LEAP.

Adult rehabilitation

The Trust's three rehabilitation services – general adult, stroke and neuro-rehabilitation – delivered to their activity plan in 2015/16.

Stroke rehabilitation was 2.6% under-plan and this was predominantly linked to a reduction in activity relating to the Trust's contract with Haringey. General rehabilitation was also slightly under-plan (0.5%).

However, neuro-rehabilitation was 2.9% above plan this year with an average occupancy rate of 97.7%.

Neonatal critical care

Neonatal critical care activity was 1% above the Trust's activity plan in 2015/16; however, within this there were variances within the levels of care:

- intensive care – 9.4% above plan
- high dependency care – 9.9% above plan
- special care – 8.7% below plan.

Direct access diagnostics

As in previous years, the demand for a number of direct services increased compared to the previous year; however, as in 2014/15, the overall activity was 7% below plan.

The key contributing specialty to the activity being under plan was pathology where activity was 8.6% below plan.

There was however significant activity over plan in the following services:

- direct access phlebotomy
- direct access radiology.

Our operational performance

2015/16 saw the Trust deliver against the majority of its key performance indicators. However, the Trust experienced significant challenges in relation to the delivery of the standards.

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

Key Performance Indicators	2015/16 Target	2015/16 Performance
A&E patients discharged < 4hrs	95%	95.15%
Cancer		
2 Week Wait	93%	96.70%
31 Day Target	96%	99.20%
62 Day Target	85%	87.20%
Infection Control		
MRSA	0	1
<i>Clostridium difficile</i> (C.diff)	7	10
18 Week RTT Indicator		
Incomplete (March only)	92%	93.99%
IAPT Indicators		
6 week target	75%	79.0%
18 week target	95%	98.2%



It is worth noting that with regard to RTT reporting, the Trust suspended its reporting in November 2015 and agreed a remedial action plan with Monitor (now NHSI), NHS England and City & Hackney CCG. The action plan has been fully delivered and the Trust re-commenced reporting in April for March 2016 data.

With regard to the 4 hour A&E standard, although the Trust met the target from an annual perspective, it is worth noting that the standard was not achieved in Quarter 4 and has been formally identified as a risk in the Trust's 2016/17 Operational Plan.

This is also the case with regard to the Trust's 62 day cancer target where the Quarter 4 standard was not met.

As in previous years, The Trust was set challenging targets with regard to MRSA and *Clostridium difficile* infection (*C.diff*). The Trust achieved its *C.diff* objective in-year, and although the Trust had one MRSA case reported, it should be noted that there have been no cases since April 2015. Further details regarding the actions being taken to minimise hospital acquired infections are detailed in our Quality Account.

With effect from Quarter 3, the Trust was also required to report its performance against two IAPT indicators. The Trust has reported compliance against these standards and continues to work closely with City and Hackney CCG to improve access to psychological services.

Care Quality Commission visits

The Care Quality Commission visited the Trust on two occasions within the year and once again in early 2016/17. The first visit was a follow up inspection to the Trust's maternity department, where they lifted three warning notices relating to regulations: 9 (care and welfare of service users); 10 (assessing and monitoring the quality of service provision); and 12 (cleanliness and infection control). However the overall feedback of the follow-up visit was that the Trust maternity service requires improvement.

An inspection of Mary Seacole Nursing Home in September 2015 resulted in a "requires improvement" rating and an action plan is in place to address the issues raised. The CQC also returned to Mary Seacole and conducted a follow up visit on 6 and 7 April 2016, however the results of this visit have not yet been published.

Quality governance

The Trust has regard for Monitor's Quality Governance Framework; it conducted an assessment against 150 key elements of the framework in the previous year and utilises its quality governance structures to ensure compliance with it. Details of the quality governance are presented in the Quality Account.

Sustainability report

The NHS Sustainable Development Unit's "Saving Carbon, Improving Health" set a target for NHS trusts to reduce their carbon emissions by at least 10% between 2007 and 2015.

Energy use in NHS buildings accounts for 15% of NHS carbon emissions, while 72% is from the procurement of pharmaceuticals, medical devices and gases and the remaining 13% from travel as well as the transport of patients and goods [NHS Sustainable Development Unit (NHS SDU), *Sustainable, Resilient, Healthy People & Places. A Sustainable Development Strategy for the NHS, Public Health and Social Care system. (2014)*, NHS SDU: Cambridge].

Whilst much focus recently has been on buildings and energy - for instance the implementation of new gas-fired boilers linked to a combined heat and power plant - there has been less focus to date on procurement and transport. See MAC Curves over page for more detail.

Performance report

The Trust benefited in 2015/16 from an extremely mild winter.

A gap analysis was undertaken in 2015 by WRM Ltd, covering a number of different areas including:

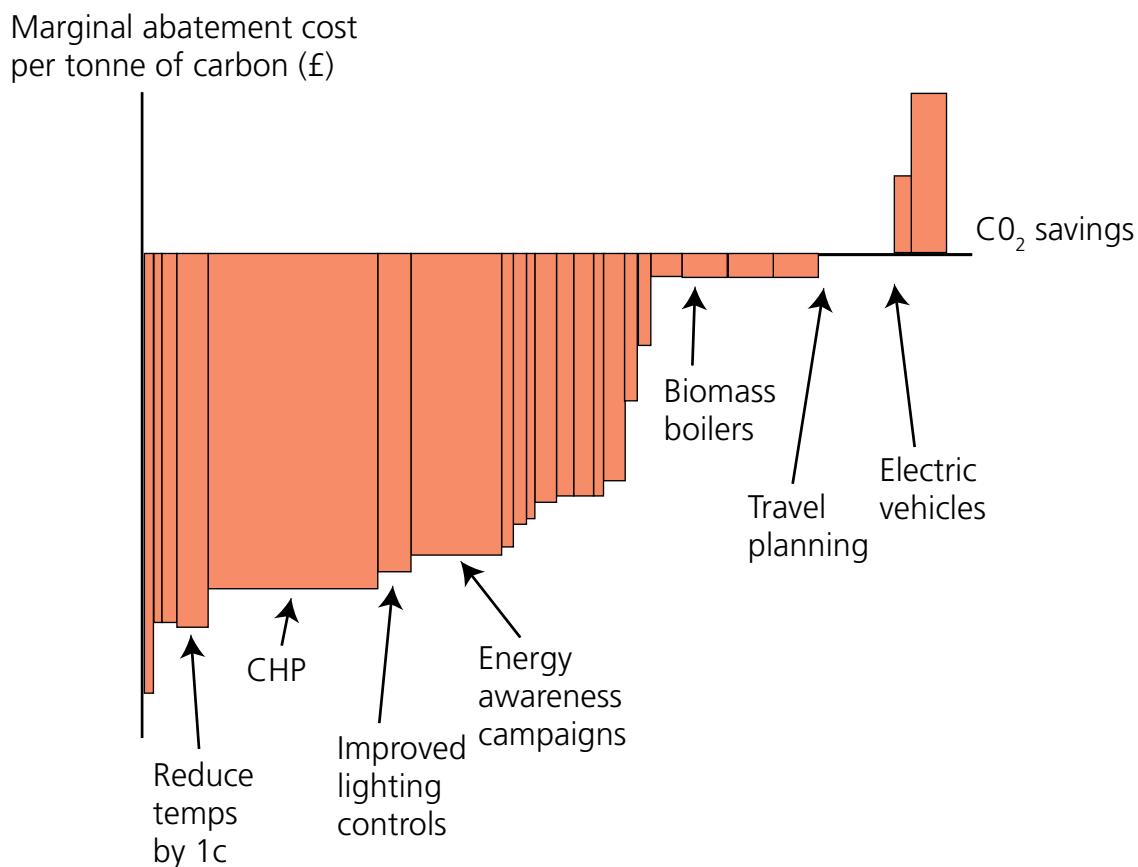
- Energy: the Trust's carbon footprint from energy has reduced over the last three years. This is predominately due to the installation of a combined heat and power (CHP) plant which has reduced the Trust's reliance on oil fuel.
- Water and waste: total waste excluding recycling has marginally reduced from 2013/14 to 2014/15 and the proportion of residual waste being recycled is steadily increasing and currently stands at 21.7%. In October 2015 the Trust changed its soft FM supplier from Medirest to ISS Mediclean. The new contract includes waste and recycling, with challenging targets to minimise waste and increase recycling. The Trust will benefit from this over the five to seven year life of the contract. Water usage fell by 18% from 2013/14 to 2014/15.

WEEE (Waste Electronic and Electrical Equipment): the review of the existing Waste Management Policy highlighted that the section on WEEE (Waste Electrical and Electronic Equipment) should be updated in line with the new regulations which were published in 2013, came into force on 1 January 2014 and contain new product categories which include LEDs and photo voltaic cells and the requirement to provide evidence that infected medical equipment has been decontaminated.

Recommendations include:

- revise the Sustainable Development Management Plan (SDMP)
- complete the Good Corporate Citizenship (GCC) tool
- set clear carbon reduction targets
- obtain and analyse travel data
- undertake energy audits
- develop staff engagement groups
- develop a Sustainable Procurement Policy
- sustainable models of care.

Example measures in NHS MAC curve



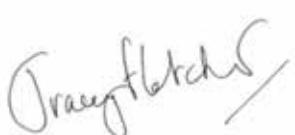
Summary environmental performance is shown in the table below.

Environmental Performance		
Utilities	15/16	14/15
Electricity (MWh)	11,215	11,856
Gas* (MWh)	20,685	6,809
Oil (MWh)	-	*16,051
Total		
Recycling(tonnes)	92	90
Clinical (tonnes)	204	283
Offensive (tonnes)	176	157
High Temp Incineration (tonnes)	96	98
Total	568	628

* The Trust only used oil in case of loss of gas pressure or loss of gas, and for the generators, so although it bought a tanker load, it hasn't burned it so can't state what the Mw/hr would be.

The Trust's Carbon Management Strategy was reviewed, and approved, in late 2015/16.

The marginal abatement cost curves (MAC Curves) prepared for the NHS SDU in February 2010 are a means of ranking the various carbon reduction measures in terms of quantity of CO₂ saved and cost effectiveness (saving, or cost, per tonne of CO₂ reduced). Installing a CHP plant is high on the list of priorities.



Tracey Fletcher
Chief Executive

25 May 2016

How 'sepsis six' improved outcomes

by Dr Manab Mohanty – ED Consultant
Dr Neil Spencer – CT3 Emergency Medicine

When Homerton took part in a Royal College of Emergency Medicine national audit of hospital Trusts into the incidence of sepsis in 2014, the Trust was rated as an average performer.

After receiving the result from the audit, we formalised sepsis care by writing the sepsis policy for the emergency department and it was then extended to rest of the Trust. The policy was then rolled out trust wide last summer.

Initiatives introduced included:

- 1** introducing a sepsis bay in the emergency resuscitation room, where everybody who triggered on the SIRS criteria was directly taken and immediately seen by a senior doctor.
- 2** introducing a sepsis trolley with copies of pathway, antibiotics guidelines, culture bottles and swabs etc in one place which helped in stream lining the process.

A Sepsis antibiotics cupboard was also developed with all commonly used drugs for sepsis as per hospital guidelines.

A sepsis diagnosis check card was developed which was given to all emergency clinical staff and is now also being given to all new staff in the department and also local London Ambulance crews, which has sepsis criteria and sepsis 6 on it to help as an aide-mémoire.

Sepsis training was then included into the emergency nursing mandatory training and junior doctors training. The sepsis card was given to all staff, monthly sepsis updates/e-mails with data and encouragements, naming sepsis champions (staff who did exceptionally well) in the emergency department's newsletter, and a sepsis screen saver in the department.

Everybody in emergency got personally involved in sepsis care and sepsis was pushed to the top agenda for the department. Everybody tried to do their best for these patients and be a sepsis champion. And the sepsis figures for the Trust as a whole have improved over the past 12 months.

Sepsis care is now a part of everyday practice and we aspire to meet the 100% standard and become an exemplar site for sepsis care.



Directors' report

The following disclosures relate to the Trust's governance arrangements and illustrate the application of the main and supporting principles of Monitor's 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.

Board of Directors

Composition of the Board

The Board of Directors had six Executive and seven Non-Executive Directors, including the Chairman, on 31 March 2016. The Chairman and Non-Executive Directors are held to account by the Council of Governors. The Board provides leadership to the hospital and sets the strategic direction of the organisation. The Board decides upon matters of operational performance, risk, 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 2015/16 the Board had the following members:

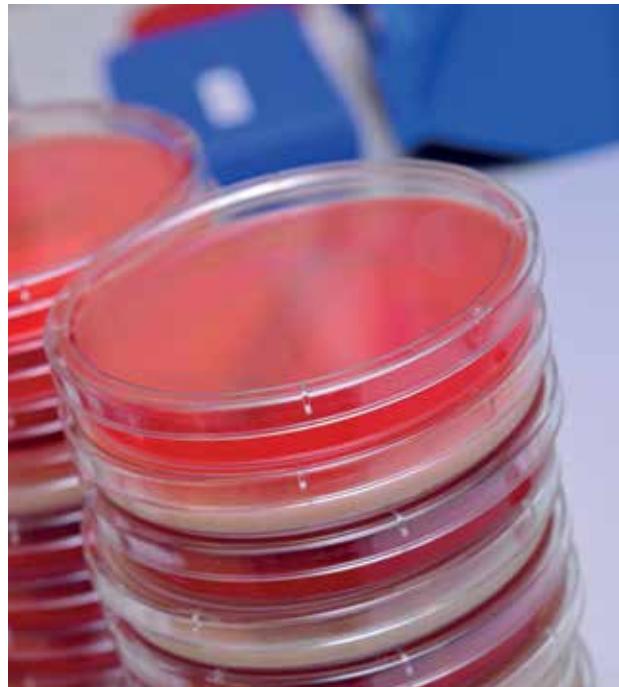
Non-Executive Directors:

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

Executive Directors:

Tracey Fletcher, Chief Executive; Martin Kuper, Medical Director; Dylan Jones, Chief Operating Officer; Sheila Adam, Chief Nurse & Director of Governance; Matthew Metcalfe, Interim Director of Finance; and Daniel Waldron, Director of Organisation Transformation.

Matthew Metcalfe completed his contract as Interim Director of Finance on 28 April 2016. During April 2016, John Yarnold was appointed as Interim Director of Finance and agreed to hold the post until Jonathan Wilson takes up the post substantively in July 2016.



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. The appointment process is outlined in Section 13 of the Trust's constitution. Tim Melville-Ross was reappointed as Chairman and Vanni Treves was reappointed as a Non-Executive Director, in-year.

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 members of the Council of Governors. Details of disqualification from holding office of a Director can be found in the FT Constitution.

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

Balance of Board membership and independence

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 fulfill its function and remain within its Terms of Authorisation. Non-Executive Directors meet the independence criteria laid down within the Code.

Accountability report

Performance evaluation

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. Executive Directors have an annual appraisal with the Chief Executive. The performance of Non-Executive Directors is evaluated annually by the Chairman.

The Audit Committee and Risk Committee both provided annual reports to the Board of Directors and Council of Governors detailing their performance over the previous year.

Board meetings

The Board has regular scheduled meetings and can also, when necessary, convene special meetings. There were 11 ordinary meetings and one extraordinary meeting during 2015/16.

Attendance at Board of Directors' meetings

Brief details of each Board member's record of attendance at Board meetings are shown below.

Name	Attendance
Tim Melville-Ross CBE	12/12
Sir John Gieve	11/12
Vanni Treves CBE	12/12
Polly Weitzman	12/12
Jude Williams	12/12
Susan Osborne CBE	11/12
Martin Smith	11/12
Tracey Fletcher	12/12
Martin Kuper	11/12
Sheila Adam	12/12
Matthew Metcalfe	12/12
Dylan Jones	11/12
Daniel Waldron	12/12

Members of the Board of Directors

Non-Executive Directors

Tim Melville-Ross CBE, Chairman

Mr 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, the last 10 as Chief Executive. He was then Head of the Institute of Directors for five years. Mr Melville-Ross is also the chair of the Higher Education Funding Council for England. Mr Melville-Ross chairs the Remuneration and Nomination Committee. He is a member of the Risk Committee and also sits on the Trust's Charitable Funds Committee.

He was reappointed to a further three-year term in February 2016.

Sir John Gieve

Sir John Gieve was 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 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.

He was reappointed to a further three-year term in July 2015.

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.

Polly Weitzman

Ms Weitzman has been with Ofcom for the past 10 years 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 sits on the Audit Committee.

Susan Osborne CBE

Miss Osborne is 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, London 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 independent management and nursing consultant undertaking interim director posts in challenged Trusts until 2015. 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 sits on the Risk Committee.

Martin Smith

Mr Smith had been the Chief Executive of the London Borough of Ealing since 2009, which he recently retired from 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, goes back to 1977. He also led on the health agenda on behalf the chief executives of all 33 London councils and is Chair of the London Health Chief Officers' Group. He is a qualified Chartered Public Finance Accountant and now chairs 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 sits on 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.

Sheila Adam, Chief Nurse and Director 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 and the Risk Committees.

Matthew Metcalfe, interim Director of Finance

Mr Metcalfe joined the Trust in April 2015. He has been an interim finance director and consultant to a range of healthcare businesses in the commercial sector, and Deputy Finance Director at UCL Hospitals NHS Foundation Trust. Matthew began his career at Arthur Andersen, where he qualified as a chartered accountant, following which he had a 15 year career at Rothschild advising companies on corporate strategy and transactions. His last day in post was 28 April 2016.

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).

Accountability report

Daniel Waldron, Director of Organisation Transformation

Mr Waldron was appointed Director of Organisation 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.

Register of Directors' interests

Some of our Directors hold interests that may be relevant or material to NHS business matters. All directors declare those interests in The Register of Directors' Interests. The register is available for inspection by members of the public. The directors' interest are published annually through the Board papers. Anyone who wishes to see the register of directors' interest should make enquiries to the Foundation Trust Company Secretary.

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.



Council of Governors

The Council of Governors represents the interests of Foundation Trust members, public and staff and shares information about key decisions with membership.

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

- **14 Public (elected)**
10 representing Hackney,
2 representing the City of London and 2 representing adjoining boroughs;
- **6 Staff (elected)**
4 representing clinical staff and
2 representing non-clinical staff; and
- **5 Appointed Governors**
nominated from 5 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 have 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 put questions to them. The Governors held five meetings in 2015/16 including one joint meeting of the Council of Governors and the Board of Directors. The Trust 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, formally.

The following table summarises the record of Governor attendance at Council of Governors' meetings.

Name	Constituency	Date elected or appointed	Attendance*
Tim Melville-Ross	Chairman	N/A	5/5
Shuja Shaikh	Public (Hackney)	Sept 2015 (1st term)	2/3
Patricia Bennett	Public (Hackney)	Sept 2013 (2nd term)	4/5
Suri Friedman	Public (Hackney)	Sept 2013 (3rd term)	3/5
Talaat Qureshi	Public (Hackney)	Sept 2012 (2nd term)	2/2
Christopher Sills	Public (Hackney)	Sept 2013 (1st term)	5/5
Stuart Maxwell	Public (Hackney)	Sept 2012 (1st term)	5/5
Julia Bennett	Public (Hackney)	Sept 2012 (1st term)	5/5
Joe Lobenstein	Public (Hackney)	Sept 2012 (1st term)	0/1
Paul Ashton	Public (Hackney)	Sept 2013 (1st term)	5/5
Helena Charles	Public (Hackney)	Sept 2014 (1st term)	3/5
Danny Turton	Public (Hackney)	Sept 2014 (1st term)	3/5
Ayse Ahmet	Public (Hackney)	Sept 2015 (1st term)	3/3
Wayne Head	Public (City)	Sept 2013 (1st term)	4/5
John Bootes*	Public (City)	Mar 2013 (2nd term)	5/5
Hazel Mckenzie	Public (Outer)	Sept 2015 (1st term)	2/3
Jess Brand	Public (Outer)	Sept 2013 (1st term)	0/1
Siva Anandaciva	Public (Outer)	Sept 2014 (1st term)	3/5
Hilda Walsh	Staff (Clinical)	Sept 2013 (1st term)	3/5
Charlotte Adeniregun	Staff (Clinical)	Sept 2013 (1st term)	5/5
Suzanne Levy	Staff (Clinical)	Sept 2014 (1st term)	4/5
Caroline Bowring	Staff (Non Clinical)	July 2014 (1st term)	4/5
Helen Cognoni	Staff (Clinical)	Sept 2015 (1st term)	0/3
Marion Rabinowitz	Staff (Non Clinical)	Sept 2013 (1st term)	3/5
Dr Mark Ricketts	NHS City and Hackney CCG	Appointed 2015	4/5
Dr Lisa Reynolds	City University	Appointed 2015	4/5
Emma Price	City of London	Appointed 2015	3/5
Ben Hayhurst	Hackney Council	Appointed 2014	3/5

If individuals joined or left the Council of Governors during the financial year, the number of meetings they could attend has been adjusted accordingly.

*Nominated lead Governor

Accountability report

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

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 cannot resolve it, 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 section 15(2) of Schedule 7 of the Act, will decide the disputed matter.

Public and staff Governors are elected by the membership. Elections are held in accordance with the election rules, as stated in the Constitution, using a single transferable vote system. Elections for vacancies in three constituencies (Hackney, Outer, and Staff (clinical)) 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 can be removed, if needed, as set out in the Trust constitution.

Foundation Trust membership

The Trust is committed to recruit a membership that is representative of age, gender, sexuality, disability and ethnic background, thus reflecting the community it 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 increased over the past year with 908 new members recruited and 256 members leaving.

	At year start April 1 2015	New members	Members leaving	At year end March 31 2015
Public	5033	162	47	5148
Staff	4473	746	209	5010
Total	9506	908	256	10,158

The public constituencies – Hackney, City and Outer – are broadly representative of the areas from which the majority of patients come to Homerton.

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.

Active membership is highest within the London Borough of Hackney. The staff constituency is divided into clinical and non-clinical 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 largely representative of the local population in terms of ethnicity and gender. The Hackney 2010 Census data has been used for comparison of the local population, as the majority of Trust's patients live in the borough with the majority of public members in the Hackney constituency.

The Trust is able to closely 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.

Regular membership recruitment sessions, supported by governors, were held at the hospital and health centres across the borough. The Trust is looking at measures for the further recruitment and involvement of younger people in the membership scheme. Several membership engagement events were held throughout the year, hosted by governors, and featuring a lecture from a member of staff on a health topic of interest. Informal 'meet a governor' drop-in sessions were also held. Governors were encouraged to canvass members' on views related to the Trust, informally and at membership events, and the Council of Governors, along with a dedicated focus group, assisted in forming the 2016/17 operational plan. Memberlink newsletters were sent to all public members providing information, election details and news about the Trust's services.

The Trust established, in early 2016/17, a Membership and Engagement Committee of the Council of Governors. This new group will work to expand the

membership and assist with member events and communications.

Get in touch

If a member of the public wishes to contact a governor they can do so via members@homerton.nhs.uk or by phoning the Trust Offices on 020 8510 5221. A member of the team will then put the query through to a Governor.

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 four times in 2015/16.

Name	Attendance
Martin Smith (chair)	4/4
Sir John Gieve	4/4
Polly Weitzman	2/4
Jude Williams	3/4

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 eight reports from the internal auditors that seek 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 the framework of risk management, governance and internal control to ensure that it remained adequate and effective.

During the year, the Internal Auditors provided four reasonable assurance (amber green) opinions, three partial assurance (amber red) opinions and one no assurance (red) 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 including: Standing Orders; Standing Financial Instructions, and Scheme of Delegation and Reservation of Powers to the Board. The Committee also discharges 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 12 to the accounts), and the valuation and accounting treatment of the trust's property portfolio (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	281,551
Non-health care income	2,879
Total income	284,430

The Trust has included within "health care income": all income from contracts for patient services; all income for the supply of health workers to other bodies, and all 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.

The Trust has included within "non-health care income": income from private patients; rental income

Accountability report

from non-healthcare bodies; income from overseas visitors, and other miscellaneous non-healthcare related income.

Better payment practice

During the financial year to 31 March 2016, the Trust paid 82.6% by volume and 80.1% by value of all non-NHS suppliers within 30 days.

Cost allocations

In 2015/16 the Trust was audited for the first time on its 2014/15 reference costs submission including its compliance with HM Treasury costing guidance. It received an audit finding of 'not compliant' predominantly in regards to the basis of its allocation of NHSLA CNST costs to activity specialities. All aspects of this report have been reviewed and actions to address these elements are included within the 2015/16 reference cost submission plan due in June 2016 and presented to the Audit Committee.

The Trust will comply with HM Treasury and Monitor cost allocation and charging guidance, including incorporating action plans and feedback from the audit recommendations of the previous (2014/15) years submission.

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 Deloitte LLP, appointed by the Council of Governors in July 2011. Their fees for audit services undertaken in 2015/16 were £95,000. Deloitte's accompanying report on our financial statements is based on their audit conducted in accordance with International Financial Reporting Standards and the Financial Reporting Manual issued by Monitor. Their work includes a review of our 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 2015/16.

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.

Homerton Hope - Homerton Hospital charitable fund

The main Charity was created by the Declaration of Trust made on 19 March 1997. The Corporate Trustee is Homerton University Hospital NHS Foundation Trust (the 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 Board of the Trust has delegated the responsibility of managing the charitable fund to the Charitable Fund Committee. The Director of Finance is responsible for the day-to-day management and control of the administration of the charitable fund and chairs the Charitable Fund Committee. The Director of Finance has particular responsibility to ensure that spending is in accordance with the objectives and priorities agreed by the Charitable Fund 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 Fund 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.

Regular reports are produced on financial activity and fundraising programmes and are presented to the Charitable Fund Committee.

The Trust recognises that a well governed Charitable Fund Committee is essential if the charity is to be effective in achieving its objectives. The Committee must seek to be representative of the people with whom the charity works and must have available to it all of the knowledge and skills required to run the charity.

Charitable fund 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 our overall objective we ensure all spend pertains 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.

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

The activities carried out during 2015/16 to meet the strategic objectives are summarised below.

Review of achievements and performance

During 2015/16, 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 we have been able to appoint an HIV Support Services Co-ordinator. The post holder has been in post for over five years and facilitates the provision of comprehensive health and social care for people living with HIV attending our unit by liaising with antenatal, acute medical and voluntary sector organisations. The introduction of the Social Care Co-ordinator post has had a positive impact on patients and professionals alike.

Peer navigators project

With the help of a donation from the MAC Aids Fund we have been able to run 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.

Living well with sickle cell and thalassaemia project

Our charity has invested in a programme of providing alternative therapies for patients living with sickle cell and thalassaemia disease. Chronic pain is a major problem for patients with this disease. Alternative therapies have been shown to improve quality of life through relaxation, flexibility and relieving pain. This is the only such project currently available in UK and we have high number of patients taking up alternative therapy sessions. The Charity expects to continue funding this project of patient welfare.

Patient reading services

Over the last two years the Charity has engaged the services of Interact, a charity that provides reading services to Homerton patients. The interactive service provided actors to read to patients on the stroke ward and Regional Neurological Rehabilitation Unit. This provides the patients with extra contact with people, has improved the mood of patients and can improve confidence. Furthermore this service also assists our own clinicians to better understand our patients and to improve therapy provided to patients.

Christmas presents for inpatients

The Charity was able to provide small gifts to patients who were staying in hospital during Christmas 2015.

Staff welfare

Staff welfare expenditure included funding a number of courses/ conferences for staff to attend, together with the staff BBQ and a contribution towards the Healthy Homerton project.

Other fundraising activities

During the year we continued to manage a range of other fundraising activities as set out below.

Book sales & Make Up stands

The Charity has continued to receive contributions from these stalls amounting to over £2600 during the year.

Accountability report

Recycling, collection boxes and money spinner

The Charity continued to receive income via a range of other initiatives including printer toner recycling, collection boxes and money spinners located around the hospital. Total funds received were in excess of £1,700.

Donations to charity received

The Charity received a number of donations from various donors through the JustGiving website. Total funds received were in excess of £13,400. The Charity also received two significant donations of £63,500 (MSM Peer mentoring project) & £68,000 (Peer Navigator project) from MAC Aids fund.

The Charity received over £52,000 from the art event organized with the help of the well-known local artist "Stik", who donated a number of his prints to be sold. The funds received are being utilized by the charity's Art Fund.

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

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 the Non-Executive Directors. In the case of recruiting a new chairman, the senior independent director replaces the current chairman for interview purposes. The Committee selects a candidate who is appointed by the Council of Governors. The Committee met twice in-year and recommended to the Council of Governors, the reappointing of Tim Melville-Ross and Vanni Treves as Chairman and Non-Executive Director, respectively.

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. The Committee met once this year and recommended, to the Council of Governors, that, due to the current financial challenges and from benchmarking, that the salaries and conditions of the Chairman and Non-Executive Directors remain at their current rate.



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 Number is determined by a 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 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.

In October 2015, in line with the arrangements of many other trusts, the Board of Directors approved the merging of the Remuneration Committee and Nomination Committee. Both committees, and the subsequent new committee, comprised the Chairman and all Non-Executive Directors as members. The new committee retained the responsibilities of the two separate committees, including to appoint the Chief Executive and Executive Directors of the Trust and to approve their conditions. The Committee meets 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.

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 £321k for early retirements relating to ex-members of staff.

The remuneration of the highest paid director in Homerton University Hospital NHS Foundation Trust in the financial year 2015/16 was £180,484 (2014/15 £179,882). This was 5.3 times (2014/15 5.4 times) the median remuneration of the workforce, which was £33,924 (2014/15 £33,396).

Salary and pension entitlements of senior managers are available in the accounts at note 4.3 (a) and (b) and expenses are in note 4.3 (c).

Chairman of Remuneration Committee report

Nominations and Remuneration Committee of the Board of Directors

The Committee (once in its previous form as Remuneration Committee, and once in the new form) met twice in 2015/16.

The Remuneration Committee of the Board of Directors met once in 2015/16 (before becoming the Nominations and Remuneration Committee) and, on 28 October 2015. 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 to the committee that materially assisted the Committee with the matters before them.

The Committee reviewed its performance against its terms of reference and noted that it had complied with them, except for a requirement to produce a remuneration policy, which was addressed in a later item in the meeting. The Committee reviewed and approved an Executive Director Remuneration Policy.

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. After a discussion, it was decided not to increase any director salaries for the coming year.

The Nominations and Remuneration Committee met on 24 February 2016 to receive the advice of the selection panel to appoint the new director of finance. The Committee approved the selected candidate, which the Board later ratified.

Accountability report

Senior managers' remuneration policy

Component	Purpose	Operation	Opportunity	Performance measures	Recovery
Salary	<p>The Trust has 3 strategic priorities</p> <ul style="list-style-type: none"> • Quality • Integration • Growth <p>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.</p>	<p>Executive Directors are on spot salaries, which are agreed upon appointment.</p> <p>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.</p> <p>A remuneration benchmarking report, based on a basket of similar trusts, is prepared for the Remuneration Committee.</p>	<p>Executive Directors are paid a flat salary that is not linked to performance outcomes.</p> <p>Currently based on performance and benchmarking decisions are made by members of the Remuneration Committee in respect of the potential for pay awards.</p> <p>In future using the recently introduced PDR process an Executive Director must achieve a performance rating of 3 or 4 (on a scale of 1 to 4) to be eligible for a pay increase.</p>	<p>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.</p> <p>An overall rating of 3 or 4 must be achieved for any employee to be eligible for a pay increase.</p>	<p>There are no provisions for withholding or recovering payments.</p>
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.
- At the next Trust Remuneration Committee the Terms of Reference which cover Executive Director Remuneration will be reviewed to incorporate the recently introduced Trust Performance, Development Review (PDR) policy, which describes the Trust's method of linking pay to performance, to ensure consistency of approach.
- Employees were not consulted as part of the preparation of the current 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 2016

Accountability report

Staff report

Our staff

The number of staff directly employed by Homerton increased by 18.95 FTE from 3469.14 FTE in 2014/15 to 3488.09 FTE in 2015/16. Excluded from these figures are most pre and postgraduate health care practitioners who were placed with us for training, bank and agency, staff holding honorary contracts and catering and domestic personnel.

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

Note 4.2 Average number of employees (WTE basis)	08K	08L	08M
	2015/16	2015/16	2015/16
	Total number	Permanent number	Other number
Medical and dental	441	426	15
Ambulance staff	0	-	-
Administration and estates	736	736	-
Healthcare assistants and other support staff	428	428	-
Nursing, midwifery and health visiting staff	1,116	1,116	-
Nursing, midwifery and health visiting learners	45	45	-
Scientific, therapeutic and technical staff	559	559	-
Healthcare science staff	166	166	-
Social care staff	0	-	-
Agency and contract staff	174	-	-
Bank staff	314	-	-
Other	6	6	-
Total average numbers	3,985	3,482	503

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

Total expenditure on consultancy for the year was £583k, which included support for bid writing for the health visiting and eye screening bids, and professional advice on the Soft FM contract renewal process.

Staff performance indicators

Performance against workforce indicators overall remains consistent, with the Board and the service managers receiving monthly performance information. Although the establishment increased slightly over the year, vacancy rates increased from 5.91% at April 2015 to 9.38% at March 2016. This increase is largely explained by a data quality review exercise that took place in the summer of 2015 and resulted in a three percentage point increase in the vacancy rate. The staff turnover rate has decreased over the last financial year by 0.01 percentage points and 650 staff joined the Trust over the course of the year. The highest increase in the turnover rate has been within the staff group Estates and Ancillary and Nursing & Midwifery staff group Administration, Professional, Scientific and Technical.

Staff support and wellbeing

The sickness rate has declined steadily over the course of the year from 3.09% to 2.96% and is now below the Trust target of 3%. The reduction can, in part, be attributed to a revised sickness policy that was introduced in 2014 with specific changes aimed at supporting and reducing short term sickness. There has also been a large decrease in staff off on long term absence over the last 12 months principally supported by the Employee Health Management Service which has been particularly effective at supporting staff to remain in or return to the workplace where ill health is a feature. The percentage of total days lost to long term sickness remains at 28% of total days lost during 2015/16.

The Trust's staff influenza vaccination campaign resulted in 1,638 staff being vaccinated, including 47.6% of frontline staff which represents an increase of 6.5 percentage points on the previous year's campaign. As part of the Trust's health and well-being offering which included the provision of an Employee Assistance Programme, Homerton launched an eight week mindfulness course for all staff which has received huge interest and uptake. In addition to this, employees continue to have access to fast access physiotherapy and with these key provisions we aim to tackle the most prevalent causes of workforce ill health - musculoskeletal and mental health conditions. Homerton Health Works initiative continues, offering exercise and lifestyle improvement activities for staff. Other staff benefits include child care support, social events and staff discounts. The Trust's achievements were recognised by the Greater London Authority by

awarding the Trust Healthy Workplace 'Excellence' status in January 2016.

Staff involvement and engagement

The Trust have established mechanisms to ensure the involvement of staff and staff representatives in the planning and development of services. A 'Team Brief' system operates which cascades 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). The Trust intranet has been established 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.

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

Work has continued throughout 2015 to embed the Trust Values across the organisation. The Values are now intergrated into the Trust recruitment, induction and appraisal processes. Data from our staff exit survey demonstrates that 97% of staff are aware of the Trust's values.

In addition to the annual staff survey, the Trust runs a shorter quarterly survey to seek feedback from staff and to monitor levels of engagement and satisfaction. A survey based around the same themes is also sent to all staff that leave the Trust. This feedback is reviewed and monitored by the Trust's staff engagement group who also oversee delivery of the Trust's staff engagement improvement plan.

Accountability report

Staff survey

Between September and November all staff were asked 86 questions about their working life and these were then distilled into 32 key findings which in turn have been presented under eight headings four of which echo four of the pledges in the NHS Constitution as well as three additional themes and an overall Engagement Score.

Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients,	Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety.	Staff Pledge 4: To engage staff in decisions that affect them and the services they provide
Additional theme: Equality and diversity	Additional theme: Errors and incidents
Additional theme: Patient experience measures	Overall Engagement

Based on a whole Trust sample (3613 staff mailed) the Trust received a 34.3% response rate which was a reduction on the previous year (43%). In terms of results this may have had an impact on ratings as higher response rates typically correlate with higher satisfaction ratings.

Whilst the results of the survey were positive when compared to many peers, overall there does appear to be a worsening of scores between 2014 and 15

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

Number	Ranking*	%
17	Better than average	53%
7	Average	22%
8	Worse than average	25%

*Ranking, compared with all Combined Acute and Community Trusts in 2015 (39 in total)

There were no areas where it was identified that the Trust statistically significantly improved since 2014. Areas in which it was identified the Trust has statistically worsened since 2014 were:

Key Finding	2015	2014	Change	Nat Ave	Best 2015*
KF1 Recommend as a place to work or receive treatment	3.89	4.02	-0.13	3.71	4.22
KF11 % appraised	70%	82%	-12%	86%	94%
KF29 % reporting errors, near misses or incidents	88%	93%	-5%	90%	94%
KF31 Staff confidence and security in reporting unsafe clinical practice	3.73	3.83	-0.10	3.64	3.81
KF32 Effective use of patient/service user feedback	3.85	3.96	-0.11	3.65	3.98

*Compared with all Combined Acute and Community Trusts in 2015 (39 in total)

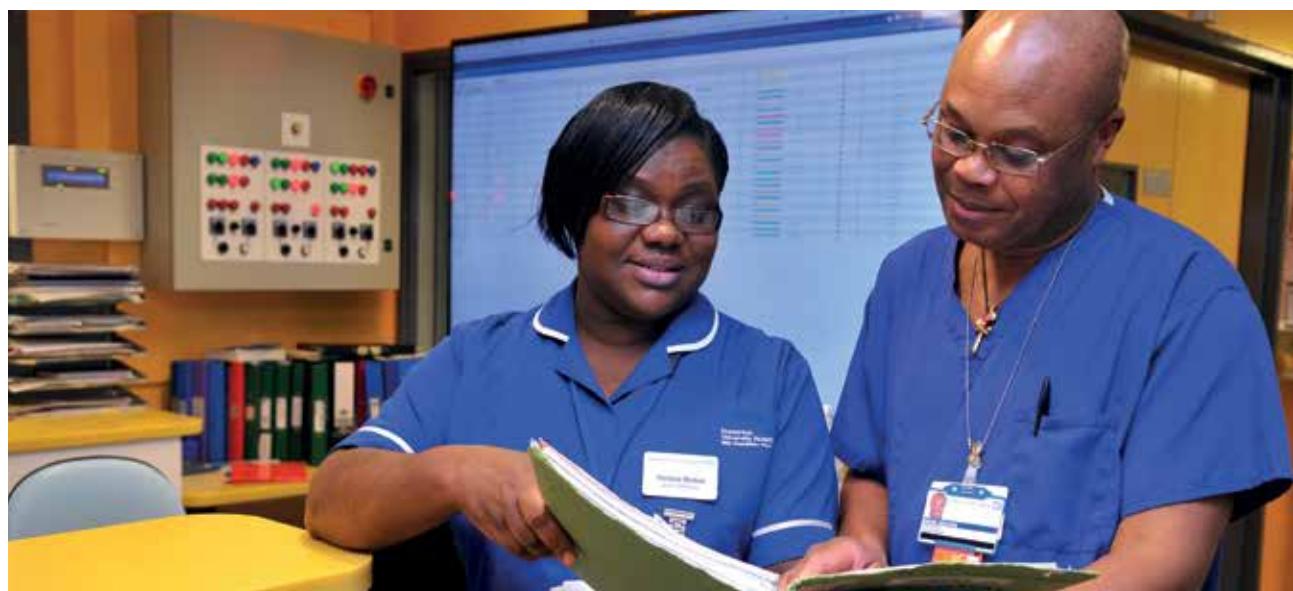
Results of the top 5 and bottom 5 ranking score are set out below.

Top 5 scores

Key Finding	2015	2014	Change	2015 Average
KF12 Quality of appraisals	3.37	new	N/A	3.06
KF6 Percentage of staff reporting good communication between senior management and staff	43%	42%	+1%	32%
KF32 Effective use of patient and service user feedback	3.85	3.96	-0.11	3.65
KF22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	9%	9%	0	14%
KF13 Quality of non-mandatory training, learning or development	4.13	new	N/A	4.04

Bottom 5 scores

Key Finding	2015	2014	Change	2015 Ave
KF11 Percentage of staff appraised in the last 12 months	70%	82%	-12%	86%
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression and promotion	77%	79%	-2%	87%
KF20 Percentage of staff experiencing discrimination at work in last 12 months	17%	17%	0%	11%
KF17 Percentage of staff suffering work related stress in the last 12 months	41%	38%	-3%	37%
KF16 Percentage of staff working extra hours	76%	73%	-3%	72%



Accountability report

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.

Theme	Key Action
Equality and Diversity	Recommence Unconscious Bias Training to develop awareness of inadvertent discrimination and bias
	Finalise the Trust's secondment and acting up policy to counter perceptions of favouritism
	Commission and commence a career development programme specifically targeted at Black, Asian and Minority Ethnic (BAME) staff.
	Work with the recently established BAME group to better understand how the trust provides support to staff from diverse backgrounds
	Seek to engage staff with a disability to understand how we support them with their careers
Career progression and recognition	Undertake further analysis in outlier services to better understand the underlying issues
	Develop a series of 'career ladder' documents that demonstrate to staff across the Trust career development routes and the skills and experience required for progression.
	Talent management approach to be developed as stage 3 of the PDR project
	Provide career development workshops and mentoring
Appraisal, learning and development	Target of 90% of staff to be appraised prior to their increment date. Compliance to be closely monitored through PDR system
	Appraisal/Vital Conversations training to be mandatory for all supervisors to support high quality appraisal
	Further improvements made to the education commissioning process to ensure wide engagement
	Areas with lowest satisfaction rates to be actively targeted with information on how to access training and development.
Staff health and Well Being	Build on Healthy Workplace 'Excellence' to ensure all staff know what is on offer as well as actively seek to expand the offer especially in relation to stress
	Provide resilience and mindfulness sessions for staff
Errors and Incidents	Review systems to ensure all staff are aware of reporting systems and they are easy as possible to use/remove any barriers
	Explore with staff what can be done to improve staff confidence and security when reporting incidents
	In line with national guidance review Raising Concerns at Work policy and appoint a Freedom to Speak Up Guardian
General – Engagement	Seek to improve the staff survey response rate for 2016 setting a target of 50%
	Work with management and
General – Values	Following issuing of the Trust Values in 2014 develop a programme to review and refresh their application in the workplace
Divisions/Units	Work to develop action plans to address negative outliers

Education and related activities

Statutory and mandatory training

The past 12 months have seen continued developments in the statutory and mandatory training offered to Trust personnel and the Trust ended the year with a minimum of 75% compliance across all areas. The biggest areas of improvement over the year were seen in blood transfusion and basic life support, which increased compliance rates by seven and 13 percentage points respectively. We continued to expand our e-learning approach in 2015/16, with child safeguarding modules coming on line. In the year ahead we also plan to add adult safeguarding modules. Our fire training rates were less positive this year falling from 86% in April to 75% in March, consequently we are currently reviewing our approach to fire training and plan to move to a more tailored, risk based approach delivered at a service level.

Leadership development

Development of the leadership capacity and capability has continued to be a priority for the Education and Training function. Working with NHS Elect, the Trust has reviewed and redesigned the internal leadership programmes which we re-launched in October 2015. The revised programme is based on a multidisciplinary approach and is built around two core programmes aimed at staff new into management and more experienced managers looking to develop their leadership skills. Alongside the core programmes a number of leadership workshops have been delivered in-house, equipping senior staff with key business and personal-effectiveness skills to succeed in their roles. Staff have engaged with the NHS Leadership Academy, including the Mary Seacole, Elizabeth Garrett Anderson and Nye Bevan programmes, as well as the London-wide coaching and mentoring network. Noteworthy health care leaders, including Helen Bevan and Nigel Edwards, have visited Homerton to share their experience of leading change and improvements within the health system.

Apprenticeships

Apprenticeships have continued to be a key part of the educational offering for existing staff, with the scheme now including clinical programmes and a Health Informatics programme. Fifty staff have started an apprenticeship programme in the past year, benefitting from this opportunity to improve their skills and gain a

formal qualification. Particular recognition goes to Luke McCarthy-Jones, who has progressed from his Level 2 apprenticeship onto his Level 3 Clinical Healthcare apprenticeship and was runner-up in the Health Education North Central and East London Apprentice of the Year competition. A strategy to introduce sustainable recruitment of apprenticeships has been developed with apprentices being recruited into various clinical and administrative roles. This continues to expand, as the Trust looks to prepare itself for the Apprenticeship Levy over the next year.

Nurse and midwifery education

Our Education and Training Plan for 2015/16 reflected Trust priorities in sustaining the development of a workforce aligned with Trust values, and addressing the wider requirements set out by our Local Education and Training Board (Health Education England, North Central East London) which include:

- the promotion of multi-professional approaches to workforce education and training
- supporting integrated working by bringing together staff groups across sector boundaries to learn together
- the use of e-learning and simulation technologies
- the involvement of our patients, service users and their carers in the design and delivery of education programmes.

We continued to prioritise training and education in working with people with dementia and their families. All newly appointed Trust employees (clinical and non-clinical) receive accredited Level 1 dementia awareness training, delivered by our trained dementia champions; we commissioned a Level 2 dementia simulation programme with Oxford Brookes University targeted towards groups of staff in specific clinical areas, including elderly care, community nursing, surgical wards, and Mary Seacole Nursing Home. This highly successful programme provided an opportunity for inter-professional learning – staff from a range of clinical backgrounds (nurses, therapists, health care and therapy assistants, care workers), learning together through simulation and role play.

Recognising the crucial role that our administrative and reception staff have in providing a high quality service for patients and their families, we invested in an education programme specifically designed for staff in these positions. This programme helps participants to consider the need for and effect of change, how to enable a positive patient experience, how to

Accountability report

work under pressure and build resilience, as well as developing key skills in effective communication, problem solving and time management.

Our Care Certificate programme continues to ensure that all newly appointed and existing assistant and support staff have the skills knowledge and behaviour to provide safe compassionate and quality care. Working closely with nurse and therapy supervisors, between April 2015 - March 2016, 69 staff have been through the 12 week programme.

Working in partnership with Hackney Community Volunteer Service we have created opportunities to involve service users in the design and delivery of our education programmes for student nurses and administrative/reception staff. Staff feedback has been extremely positive about having this perspective incorporated into their training.

Medical education

In 2015/16 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 very positive.

97% of supervisors have now completed all seven domains of the Professional Development Framework and attended an educational appraisal. Homerton has also delivered regional teaching days for core medicine and gastroenterology trainees.

Feedback from the Barts and the London School of Medicine and Dentistry Quality Visit was also positive. The Trust has increased the numbers of medical students on placements and initial feedback from students is very good. Homerton continues to see a good number of medical students who have undertaken placements at the Trust choosing to return to Homerton for foundation programme or specialty training.

The simulation centre was highly commended for excellence in multi professional education receiving an award from HENCEL. The centre was again successful in securing bids and delivering numerous courses. The ACERS team received an award in March 2016 for Innovative Simulation Training supported by the Simulation team. In situ simulation also expanded to include additional wards and departments. This has been reported in the Quality Account for 2015/2016. In situ simulation was shortlisted for the HSJ awards in the Improving Outcomes Through Learning and Development category.

The Newcomb Library continues to offer a much-appreciated service to Homerton staff and students on placement and the library membership process is now paperless. Over the course of the year the e-book collection was further developed and access to journals is now largely electronic. Work is continuing to develop library services in line with Health Education England's national framework for NHS library and knowledge services, Knowledge for Healthcare.

Research and development

The Homerton Research & Development Department have received a grant of £458,176 from NT-CRN to support research activity within the Trust in the year 2015/16. This has enabled the Trust to support 15 research nurses and clinical trials co-ordinators, along with 1.5 WTE pharmacists. R&D also contributes to the radiology and pathology departments. This sum has been supplemented by a further amount in excess of £80,000 achieved through specific project bids. This serves to demonstrate increased research activity in the Trust with more NHIR portfolio studies being opened and achieving recruitment target in 2015 than previous years. As of 31 March 2016, 139 studies were recruiting or in follow up across the Trust with 52 studies being approved during the course of the year.

Nevertheless, the R&D Department has undergone a challenging year in line with the national research landscape. Fewer patients (receiving NHS services provided or sub-contracted by the Trust) were recruited to National Institute for Health Research (NIHR) portfolio studies in 2015/16; 1107 against 1409. This was in part, however, due to the closure of several high recruiting studies and the delay in opening certain planned studies until April 2016. Additionally, the complexity of the trials recruited for was greater with more intensive (i.e. a larger number of clinical trials of investigational medicinal products and fewer questionnaire studies). 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. During 2015/16, the Trust met the benchmark as far as delivery of clinical trials (100% of closed trials recruiting to target). Three out of 11 trials approved did not reach the initiation benchmark (i.e. did not recruit within 70 days of trial approval), likely due to the factors described above. All studies met the approval time benchmark. Support continues to be afforded to staff submitting funding bids with

several successes in grant applications. Dr Paul Fleming received a grant in excess of £400,000 for a study involving neonates, Professor Homburg is in receipt of a commercial grant (>£200,000) to explore a novel drug therapy in patients who are finding it difficult to conceive. A number of other studies have also received smaller sums in order to support recruitment and retention of Homerton patients to a study. Conversely, 2015 saw the withdrawal of an HTA grant worth around £1,000,000 for the LOPAC trial in sexual health. This was due to lack of progress of the study caused, in part, by lack of consensus between the clinicians and the clinical trial unit. However, the Chief investigator has been invited to reapply later this year and is currently working on this application/feasibility.

The R&D Department will continue to support this

study in whatever way possible.

Equality and diversity

The Trust lead for equality and diversity is the Director of Organisation Transformation. The Equalities Report 2015, our Equality Objectives and Workforce Race Equality Standard (WRES) are available from our 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 2014 the objectives were reviewed by the Group to take account of the progress made. The objectives for 2014-2017 are as follows:

OBJECTIVE	SUCCESS MEASURES
Establish a broad based equality and diversity group to lead on the implementation of the NHS Equality Delivery System (EDS2) framework and champion our programme of work related to equality and diversity.	<ul style="list-style-type: none"> • The E&DG to facilitate the implementation of the NHS Equality Delivery System (EDS2) framework • Lead and champion equality and diversity and in particular the most pressing issues for protected characteristic groups within the Trust workforce and community
The Trust will develop an organisation which understands the cultural needs of our patients and staff and encourages an inclusive environment. This will be done through a series of activities including cultural awareness campaigns.	<p>The success measures for this objective are:</p> <ul style="list-style-type: none"> • Encourage an inclusive environment of equality and diversity at the Trust • Provide support for and enable staff to develop diversity groups • Engaging with service users and community groups, to tackle inequalities in the wider
The Trust will continue to build on our work to ensure the needs of vulnerable patients are met when receiving healthcare. This will include promoting the MENCAP 'Getting it Right Charter' for learning disabilities and MIND/Rethink mental health 'time to change' campaign.	<p>The success measures for this objective are:</p> <ul style="list-style-type: none"> • We will continue to promote both the 'Getting it Right' Charter and MIND/Rethink 'Time for Change' campaigns • Develop and promote the 'Health Passport' • We will continue to work with community groups to ensure that we are making our

Accountability report

Summary of Trust workforce and Foundation Trust membership diversity data (2014/15 and 2015/16 staff data taken from the Trust's equality and diversity reports)

	Staff						Membership			
	2014/15	%	2015/16	%			2014/15	%	2015/16	%
Age					Age					
16-25	255	7%	279	7%	16-25	185	6%	209	6%	
26-35	1,187	32%	1226	32%	26-35	932	28%	1005	30%	
36-45	998	27%	1020	27%	36-45	924	28%	954	28%	
46-55	854	23%	838	22%	46-55	827	25%	812	24%	
56-65	383	10%	376	10%	56-65	369	11%	370	11%	
66+	42	1%	44	1%	66+	39	1%	44	1%	
75+	1	0.03%	2	0.05%	75+	1	0.03%	2	0%	
Not Stated	0	0	0	0	Not Stated	0	0	-	-	
Total	3,720		3,785		Total	3,277		3,396		

Ethnicity					Ethnicity				
White	1,722	46%	1756	46%	White	1,473	45%	1535	45%
Mixed	102	3%	111	3%	Mixed	89	3%	100	3%
Asian or Asian British	537	14%	558	15%	Asian or Asian British	463	14%	485	14%
Black or Black British	1,127	30%	1100	29%	Black or Black British	1,060	32%	1055	31%
Other Specified	140	4%	146	4%	Other Specified	120	4%	122	4%
Not Stated	92	2%	111	3%	Not Stated	72	2%	99	3%
Undefine	0	0%	3	0.08	Undefined	0	0	0	0%
Total	3,720		3,785		Total	3,277		3,396	

Gender					Gender				
Male	860	23%	827	22%	Male	725	22%	728	21%
Female	2,860	77%	2958	78%	Female	2,552	78%	2668	79%
					Undisclosed				
Total	3,720		3,785		Total	3,277		3,396	
Recorded Disability	86	2%	101	3%	Recorded Disability	76	2%	88	3%

By year-end, the Trust had 11 male and 10 female senior management staff, including board members, directors (including Directors of divisions and associate medical directors).

Policies in relation to disabled employees and equal opportunities

Trust 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.

Stakeholder relations

The Trust continues to have strong relationships with stakeholders within the 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 Better Care Fund programme and the One Hackney initiative.

The Trust, furthermore, 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 our 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 we are also represented at Overview and Scrutiny Commission meetings, which are held in public, providing members with regular service and performance updates.

Exit packages

	Reason	Redundancy	PILON	Other	A/L	Total
1	Dismissal an	£0	£0	£3,000	£0	£3,000
2	Agreed Termination	£0	£0	£2,000	£0	£2,000
3	Agreed Termination	£0	£5,677	£0	£2,240	£7,916
4	Agreed Termination	£0	£6,179	£0	£1,706	£7,885
5	Redundancy	£66,927	£10,917	£18,500	£1,546	£97,890
6	Agreed Termination	£0	£11,289	£0	£1,945	£13,234
7	Agreed Termination	£0	£12,438	£0	£3,006	£15,444
8	Agreed Termination	£0	£3,605	£0	£1,074	£4,679
9	Redundancy	£12,358	£17,064	£0	£985	£30,407
10	Partial Redundancy	£7,368	£0	£0	£0	£7,368
11	Redundancy	£18,643	£5,664	£0	£0	£24,307
12	Agreed Termination	£0	£24,700	£0	£0	£24,700
13	Agreed Termination	£0	£3,153.74	£0	£907.22	£4,060.96
Totals		£105,296	£100,687	£23,500	£13,409	£242,891

Accountability report

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(2012)17 published by HMRC in 2012/13.

- For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

Number of existing engagements as of 31 March 2016	6
--	---

Of which...

Number that have existed for less than one year at time of reporting.	3
Number that have existed for between one and two years at time of reporting.	3
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 six 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 2015 and 31 March 2016, for more than £220 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 2015 and 31 March 2016	3
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested	3

Of which...

Number for whom assurance has been received	3
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received.	-

For the three new engagements or those that reached six months during the year 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 any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

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.	1

There were no engagements of Board members during 2015/16.



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 2016 the Trust complied with all the provisions of the Code as set out in Monitor's (now NHS Improvement) Annual Reporting Manual 2015/16.

Regulatory ratings

In line with Monitor's Provider Licence requirements, each foundation trust must submit an annual plan including detailed financial forecasts each financial year.

Monitor use the information in the plan submitted by foundation trusts to evaluate the risk of failure to comply with the Trust's Provider Licence and to assign risk ratings covering finance and governance.

Explanation of ratings

The Risk Assessment Framework describes Monitor's approach to assessing an NHS foundation trust's compliance with two specific aspects of its provider licence: the continuity of services and governance licence conditions.

Monitor's assessment of a foundation trust under the risk assessment framework aims to identify:

- significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services and/or
- poor governance at an NHS foundation trust, including poor financial governance and inefficiency.

Risk assessment framework continuity of services and financial efficiency rating - Monitor focuses on two leading indicators of risk to financial viability, to assess the risk of actual failure. The two ratios for assessing risk are continuity of service, and financial efficiency.

The continuity of services risk rating incorporates two common measures of financial robustness: these are the liquidity ratio derived from the Trust's working



capital balance/annual operating expenses and capital servicing capacity derived from revenue available for capital service/annual debt service. The financial efficiency rating incorporates the Trusts underlying performance derived from an Income & expenditure margin, and the variance from plan being the variance in income & expenditure margin as a percentage of income.

The financial sustainability risk rating is Monitor's view of the level of financial risk a foundation trust faces to the ongoing delivery of key NHS services and its overall financial efficiency. The rating ranges from 1, the most serious risk, to 4, the lowest risk.

Risk assessment framework governance rating - Monitor assesses governance at NHS foundation trusts by using a range of methods, including the following:

- performance against a specified set of national metrics, including A&E waiting times, cancer waiting times and rates of *C. difficile* infection
- CQC judgments on the quality of care provided
- relevant information from third parties
- how staff and patients perceive the hospital, as expressed through such metrics as satisfaction ratings and staff turnover
- independently commissioned governance reviews
- reviews of financial governance and efficiency, such as performance against the different elements of the financial sustainability risk rating.

In addition to the above, Monitor also uses other sources of information as they are made available during the year. These include corporate governance statements, the annual governance statement, forward plans and regular governance reviews. Where they could represent governance concerns Monitor will adjust the governance rating accordingly. Monitor rate

Accountability report

governance risk using a graduated system of green and red, where green indicates low risk and red indicates high risk.

Performance is reviewed in-year by Monitor and since August 2015, NHS foundation trusts have been required to submit financial and governance information monthly as well as quarterly.

Summary of performance

The tables below show Homerton's risk rating scores for 2015/16:

2015/16	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	3	3	2	2	2
Governance rating	Green	Green	Green	Green	Green

* Subsequent to approval of the annual report, Monitor confirmed these ratings on 1st June 2016
Continuity of service rating

2014/15	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	4	4	4	4	4
Governance rating	Green	Green	Green	Green	Green

During 2015/16, Monitor consulted on and implemented a number of proposed changes to the risk assessment framework calculation to reflect the challenging financial context in which foundation trusts are operating and to strengthen their regulatory regime to support improvements in financial efficiency across the sector.

As a result of the Trust's financial position deterioration and variance from planned surplus, the organisations rating score reduced to 2. A review of the 2015/16 financial position has been incorporated within the 2016/17 planning process, along with national initiatives in regards to agency staffing and pricing, and an executive led detailed review of cost pressures. The governance around cost control and cost improvements is being strengthened and the target for savings increased above that needed to meet the in year target to allow for in year slippage, by using the Lord Carter findings to identify further opportunities for improved efficiency.

There were no formal interventions introduced by Monitor.

Stik supports his local hospital

An open sale of 100 limited edition prints of 'sleeping baby' the mural painted at the hospital by renowned street artist, Stik, raised over £50,000 for the Hospital Hope charity.

The sale was on a first come first serve basis, each print being sold at £500. Over 200 people queued for the prints, and the disappointed potential buyers were cheered up by the artist himself who signed personalised A4 posters of the sleeping baby.

The unique wall mural of the sleeping baby has been catching the eye of patients and visitors walking along the main corridor or drinking their coffee in the hospital coffee shop since it was painted earlier this year.

The mural in striking blue and white, portrays a sleeping baby and is in keeping with the artist's very own style.

Stik said: "I am delighted to offer my work to the hospital which is such an important part of the east London community. Homerton is my local hospital and has been there for me and my friends when we needed it. I wanted to give something back and this is my way of doing it."

Trust Chairman Tim Melville-Ross, said: "We are extremely grateful to Stik for supporting our arts



programme with the generous gift of these limited prints. This is a fantastic gesture made better by the fact that the original work of art can be seen by anybody visiting our hospital."

Shaun Caton, Art Curator: "This is an act of tremendous generosity from Stik, whose work has great popular appeal within the hospital. Gestures like this go to show that art is not elitist and can significantly enhance and improve the environment of a hospital courtyard, providing a landmark which is both fun and poignant. The Trust is delighted that Stik values his local hospital so much and has chosen to help us continue with our art projects which will benefit the lives of patients, staff and visitors. This was a truly an amazing event."

The money raised will be invested in developing the arts therapy work in the hospital led by Shaun.



Accountability report

Homerton University Hospital NHS Foundation Trust Consolidated Annual Accounts 2014/15

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 Monitor.

Under the NHS Act 2006, Monitor has directed Homerton University Hospital NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance,
- prepare the financial statements on a going concern basis.

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

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



Tracey Fletcher
Chief Executive

25 May 2016

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 2016 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 interim Director of Finance has delegated responsibility for managing financial risk. All Executive Directors take responsibility for risk identification, management and mitigation within their areas of work and practice.

The Risk Committee, as a Board committee, takes overall responsibility for coordinating and monitoring all risks within the Trust including scrutiny of reports

from both internal and external sources. A number of sub-committees and working groups report to the Risk Committee on both clinical and organisational risks. Key risks are reviewed by the Board either as part of its regular monitoring of performance, such as receiving reports from both the Risk and Audit Committees, or in the context of specific issues that arise. The Board Assurance Framework (BAF), which manages the principal risks to the Trust's strategic objectives, is reviewed monthly by the executive team and the Board. The Risk Committee also resolved, late in 2015/16 to establish a Risk Scrutiny Committee to oversee trust-wide risks and risks rated below 12.

In particular:

- the Risk Committee, which has been established for a number of years, 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. The Risk Committee meets on a quarterly basis and reports to the Board of Directors;
- the Risk Committee is kept informed about all aspects of risk management through a variety of reports, including updates from the trust-wide risk register, updates regarding information governance, litigation, Care Quality Commission (CQC), as well as receiving annual reports from the Improving Patient Safety Committee, Information Governance Committee, Policy Group, Improving Clinical Effective Committee, Improving Patient Experience Committee and Health & Safety Committee;
- the divisional quality and patient safety managers report regularly via the Head of Quality and the Head of Patient Safety and Risk to the Chief Nurse and Director of Governance. The Non-Clinical Risk Manager reports to the Director of Estates, Facilities and Capital Projects, who has responsibility for health and safety to the Chief Executive;
- the Audit Committee concludes upon 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 in the annual report on page 27.

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 and the divisions regularly

Accountability report

review their risk registers. They foster a culture of risk awareness throughout their divisions and ensure 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 management training is provided through the induction programme for new staff. In addition tailored training for individual roles is identified by managers and agreed with staff through personal development plans. The Board of Directors is due to have risk management training in 2016/17. The corporate induction programme ensures that all new staff are provided with details of the Trust's risk management systems and processes, and is augmented by local induction organised by their line managers. 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. The programme of risk training is subject to internal review.

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 on 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 and the Board of Directors formally reviews the BAF monthly.

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. In addition, on-going risk assessments form part of the departmental arrangements with regard to risk management. Best practice is highlighted and shared across divisions through divisional leads, the Improving Patient Safety Committee and Improving Clinical Effectiveness Committee and their respective sub-groups.

The key elements of the quality governance arrangements are as described in Monitor's Quality Governance Framework; strategy, capabilities and culture, processes and structure and measurement. Compliance to the Quality Governance Framework is supported through the following:

- The Trust quality governance arrangements are organised through the divisional structure with each division headed by an operational and clinical lead. Each division has in place a governance structure that supports the achievement of all quality priorities. The divisions review a summary of key quality governance and performance data 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 on a monthly basis against a range of performance measures including quality and safety at Clinical Division Performance Review meetings.
- The Trust Management Board, chaired by the Chief Executive, meets monthly and reviews and monitors quality issues for the whole Trust.
- The Risk Committee and the Quality and Patient Safety Board, Improving Patient Safety Committee and Improving 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 back. This supports the process for enabling that

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

- 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 questions 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), with 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 standardized 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 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 recovery plan
- the Board also reviews serious incidents in detail at its meeting in private.

The report includes details of actions that are being taken to address any areas of concern.

The Trust did not achieve the 62-day cancer wait target in quarters one and four, however it performed well throughout quarters two and three. The year-end key performance indicators are referenced on page 15 of the annual report.

The Trust had a period of not reporting its performance against the 18-week incomplete standard. As a result of the remedial action plan, the Trust recommenced

reporting at the beginning of the 2016/17 financial year for the previous month. Based on the remedial work undertaken, the Trust is confident that full compliance against the target will be achieved in 2016/17. Given the reporting challenges, the delivery of the standard has been formally identified as a risk.

The Trust had three warning notices served in connection with regulations 9, Care and Welfare of Service Users, 10, Assessing and monitoring the quality of service provision, and 12, Cleanliness and infection control, in maternity services, which were served in March 2015 and all three were lifted at the CQC's follow up inspection in February 2016. The overarching rating of the maternity service was "Requires Improvement" and there is an action plan, compiled jointly with City and Hackney CCG, in place to deliver sustained improvement. An inspection of Mary Seacole Nursing Home in September 2015 resulted in a "requires improvement" rating and an action plan is in place to address the issues raised.

The internal auditor reported on small works and maintenance within the Trust and raised concerns that irregular activities were potentially occurring. The Trust LCFS, on the recommendation of internal audit, conducted a review and recommended a further investigation be conducted by the Trust, which was nearing completion. They also recommend that the SFIs be altered to tighten the related controls further. These were amended at the March 2016 Board of Directors meeting.

The Trust is reporting a c£5.45m retained deficit for the financial year 2015/16 before impairments, behind our planned position for the financial year of £0.5m surplus, representing a c£6.0m deterioration, predominantly as a result of agency staffing costs being higher than planned, delivering additional activity at a premium cost versus income, slippage on the cost improvement programme and higher than planned non pay costs. A review of the 2015/16 financial position has been incorporated within the 2016/17 planning process, along with national initiatives in regards to agency staffing and pricing, and an executive led detailed review of cost pressures. The governance around cost control and cost improvements is being strengthened and the target for savings increased above that needed to meet the in-year target to allow for in-year slippage, by using the Lord Carter findings to identify further opportunities for improved efficiency.

The Trust is committed to continuous improvement and learning; from incidents and complaints, outcomes

Accountability report

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 Trust is registered with the CQC without conditions.

The implications for the Trust registration with CQC is 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.

The Trust's Intelligent Monitoring Report (IMR) developed by the CQC to provide a summary of the risk of non-compliance with the standards is reviewed regularly by the Risk Committee. This is an example of proactive assessment and response to clinical risks which relate to how the Trust meets the CQC standards.

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 on the Trust risk register. Assurance has been provided through the scrutiny, at Trust Board level, of the delivery of actions set out in the action plan developed in response to CQC recommendations for improvement. These recommendations contained in CQC inspection reports have been supplemented with learning points identified within the Trust as part of the preparation for inspection visits.

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. These objectives were set out in the Trust's 2015/16 annual operational plan, which also identified risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance available to demonstrate the effectiveness of those controls. 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.

Key risks identified include the following:

- due to a complex and challenging operating environment, partnership building to achieve the creation of seamless services across the sector may not be effective
- failure to develop an engaged and motivated

workforce undermines 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

- if culture within the Trust is not a learning one with openness and transparency supporting learning and improvement, it may result in the Trust failing to deliver safe care to patients
- a lack of adherence to latest research, or practice not compliant with the best evidence could lead to a less effective service provision
- failure to expand and retain sufficient activity leads to an unsustainable organisation.

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. Equality impact assessments are undertaken for major service changes as well as for policies and procedures.

Incident reporting is openly encouraged through staff training and further embedded by the Trust's adoption of a culture of fair blame. Risks identified from serious untoward 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 Improving Education and Leadership 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).

There are 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.

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

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, as based on UKCIP 2009 weather projects, to ensure that this organisation's

obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

In addition to the financial review of resources within the quarterly monitoring returns to 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, provides another mechanism to achieve this aim. The Trust also has a comprehensive Quality, Innovation, Productivity and Prevention (QIPP) programme in place to identify and deliver efficiencies against the Trust target for savings. This programme is led by the Chief Operating Officer, progress and associated risks are reported to the Board of Directors.

Information governance

The Trust has an established process of Information Governance led by the medical director, as Caldicott Guardian. The chief operating officer was the Trust SIRO. Systems and processes have been reviewed, including using the Information Governance Toolkit. 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

Accountability report

controlling risks to data security and oversees an information governance risk register. An information governance report is made to each Risk Committee meeting, which reports to the Board.

All Information Governance security related incidents were reported via the Trust's incident reporting tool during the financial year 2015/16. There was one incident involving the inadvertent disclosure of personal information relating to two patients. This incident met the criteria for reporting the incident to the Information Commissioner's Office and the Health & Social Care information centre.

Annual Quality Report

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



The Annual Quality Account 2015/16 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 gained through the following:

- 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 Quality and Patient Safety Board.
- Consultation is carried out with internal and external stakeholders 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 CEO'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 sign off 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 who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee 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 Monitor providing additional assurance with regard to compliance with our licence conditions.

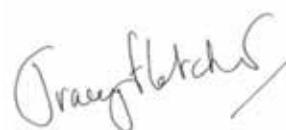
The key considerations of my review of the effectiveness of the system of internal control can be summarised as follows:

- The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing reports and minutes 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. 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, site any issues that required flagging as significant control issues, although they advised, as stated in this report, that the audit on small works and maintenance be sited in the annual governance statement. The statement was revised by the Board in private at its April meeting and will be reviewed by the Audit Committee and approved by the Board in May 2016.

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 that have arisen in-year and continue to work towards successful assurance outcomes.



Tracey Fletcher

Chief Executive

25 May 2016

Quality account



Our Values

• PERSONAL
• SAFETY
• RESPECTFUL
• RESPONSIBILITY



Quality Account

2015/16 Quality Account

What is a Quality Account?

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. All NHS foundation trusts are required to produce reports on the quality of their care (as part of their Annual Reports). Quality accounts help trusts to improve public accountability for the quality of care they provide. 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.

The Quality Account incorporates all the requirements of the quality accounts' regulations as well as Monitor's (the regulator for foundation trusts until April 2016) additional reporting requirements.

The purpose of the account is to promote quality improvement across the NHS, with a public accountability. Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2015/16.

The Quality Account also describes the organisation's quality priorities and aims for the coming year.

Glossary symbol:

This symbol * indicates a term's inclusion in the Glossary on page 165.

Contents

Part 1: Statement on quality

Chief Executive's statement on quality

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

2.1 Priorities for improvement

Quality achievements for 2015/16

Priorities for improvement during 2016/17

2.2 Statements of assurance from the Board

Progress on 2015/16 priorities

2.3 Reporting against core indicators

Part 3: Quality Performance Indicators

Annex 1: Statements from commissioners, local Healthwatch and Overview and Scrutiny Committee

Annex 2: Statement of Directors' responsibilities

Annex 3: Glossary of terms and abbreviations

Part 1: Statement on quality from the Chief Executive

I am pleased to present our Quality Accounts for 2015/16, which detail Homerton's work and position on quality over the last year, and which provide assurance that we continue to strive to provide the highest quality clinical care. We are proud of maintaining our reputation of complying with our key performance and regulatory requirements while delivering high quality care for our patients and service users.

Quality has always sat at the heart of the organisation, and is one of our three core strategic priorities. This year, we have focused on developing our quality improvement strategy, with the aid of our Improving Quality Team, supporting measurable and systematic improvement work to become deeply embedded across the organisation. We have already seen our services and the improving quality team deliver some impressive results, and are looking forward to building on this work in the coming months.

One area where we have particularly focused on quality this year was our maternity department: following the CQC's visits the previous year, the service worked extremely hard to make significant improvements to our patients' experience. We welcome the CQC's recognition of this work following the inspectors' return to the service this year, and the lifting of the three warning notices which had been put in place following the earlier inspection. We know that there is still more to be done and will continue our good work in embedding good practice and strengthening our governance procedures.

Care Quality Commission inspectors also visited Mary Seacole Nursing Home on two occasions this year and their feedback highlighted some concerns in relation to the 'Safe' domain. The Trust took immediate action to address the issues that they raised. We are very grateful for the positive support that we have received from our residents and their families, and await further feedback from the CQC following their most recent visit.

Our quality improvement programme for 2016/17 will continue to be influenced by national requirements and those set out by our commissioners. We remain positively challenged to ensure that high quality care is provided at all levels across our Trust.

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 and 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 re-analyse historic data.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, 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
25 May 2016

Homerton approach to improving quality

Homerton University Hospital NHS Foundation Trust has always placed the quality of the services provided uppermost in the strategic aims of the organisation and at the heart of decisions taken by the Board. As part of this the Trust has focused on quality improvement over the last year with the development of a quality improvement strategy and development programme. This strategy and programme will contribute to the delivery of the quality priorities set for 2016/17.

A broad review of quality improvement activity across the Trust has identified some key strengths of the current culture and it is proposed that the Trust's approach to quality improvement (QI*) builds on these. The current culture is characterised by the following themes:

- improvements are driven as close to the front line as possible
- people who are affected by changes are involved in making the change
- managers take an interest in improvement work and are visible in doing so
- there is room to try changes even if they don't always work first time or at all
- staff are supported to explore areas of improvement that interest them.

Whilst these are necessary conditions for a successful culture of improvement, they may not be sufficient to embed a systematic approach to quality improvement as business as usual.

Embedding a bottom up, organisation wide culture of quality improvement will also require some strengthening in areas such as:

- aligning improvement activities with Trust quality priorities
- education and training to enhance knowledge and understanding of improvement science
- access to expert advice and coaching
- data systems that support measurement for improvement
- a Trust wide approach to quality improvement
- access to intelligence about evidence based and best practice.

Quality achievements in 2015/16

Our Trust is located in the London Borough of Hackney and we are an integrated provider of acute (hospital) and community based services; providing services across parts of the City of London and the London Borough of Hackney. As a Foundation Trust, we continue to maintain our reputation as a high performing provider; and strive to work in partnership with our commissioners, local GPs* and other voluntary and statutory groups to ensure that the care we deliver is safe, effective and a positive experience for our service users.

During 2015/16, we have a number of achievements that we are proud of, and which support our drive and commitment to provide high quality services to our community. The following is a snapshot of these:

- enhancement of electronic patient records (EPR)
- improving quality team implementation
- becoming a 'dementia friendly' Trust
- partnership working recognised
- hospital simulation training team short listed for national award
- Bevan Prize for Health and Wellbeing – TB team
- non-clinical navigators sign post health options for patients
- Homerton chosen as centre for diabetic eye screening service
- sexual health service in partnership with neighbouring boroughs
- health visiting service appointed provider for Hackney by the London Borough of Hackney.

Enhancement of electronic patient records

Homerton has had a basic Electronic Patient Record (EPR*) system for over 10 years now. This year we carried out a substantial upgrade to improve patient safety, enhance our record keeping, multidisciplinary working and communication and move towards the NHS goal to be paper light by 2018.

Our upgrade project was named ACE (Acute Clinical Excellence) because we want to provide first rate care and to get it right the first time and every time; and to remain top-scorers for our patients, carers, commissioners and GPs. With input from many of our most respected clinical teams, we have designed and built a robust system to facilitate patient safety and

Quality Account

multidisciplinary working.

The ACE enhancements help us keep good, clear, accurate records of everything that happens to a patient during their time with us, both for staff involved with the patient's care at the hospital, and also the patient's GP. This has been achieved through the e-prescribing (electronic prescribing); automated vital signs recording, via our bedside device system; and improvements to the notes we write. Furthermore, it has improved access to key relevant information to support clinical decisions resulting in improved patient safety.

In addition to the upgrade, we have also invested in wireless computer/ medication trolleys, to enable electronic drug rounds on the wards.

Improving quality team implementation

Although change and improvement have long been a part of NHS culture, in recent years there has been a drive towards establishing a systematic approach to improving quality.

In the summer of 2015, we appointed a new Head of Quality Improvement, Victoria Newlands-Bentley. The role supports and further develops our improvement capability through a more strategic approach to improvement. It also provides support to staff in their improvement work building on the bottom up culture of continuous improvement to deliver and spread good practice.

Our improving quality team

To extend the improvement agenda Victoria created a team of quality improvement leads to help manage centrally driven projects and provide coaching and support around the Trust. In addition to providing support for staff to make improvements in their area, the team also focuses on getting the maximum benefit for patients by spreading lessons and improvements.

An important element of this work has been education and training days, including hosting an Improving Quality Sharing Event in December 2015. The day was aimed at staff across the Trust. The event got off to a great start with a key note speech on 'Leadership for Improvement' by Nigel Edwards, CEO of the Nuffield Trust and Richard Bohmer, international visiting Fellow at the King's Fund. Throughout the morning 21 posters were displayed, showcasing improvement projects carried out by multiple services across the organisation. Additionally, 11 projects were presented showcasing a variety of work from Trust wide projects.

The team has supported a number of improvement projects to date including:

- high quality care for older people, a day of shared learning and discussion
- creating bespoke packs for neonatal intensive care to aid staff in inserting intravenous lines
- thus reducing cost, time and risk of infections
- an improving communications project on the Elderly Care and Acute Care units, to explore communication difficulties and how to overcome
- Locomotor service pathway redesign, to establish clearer pathways of care while maintaining high quality standards.



Our improving quality team



Quality sharing day delegates



Posters - Quality Improvement Sharing Day

Thoroughly brilliant day!
Informative and engaging.
I have already identified
three projects that will
improve the of my team

Well done!
Quality is definitely
on Homerton's radar

They has set up a web based 'Improving Quality' resource and provide library support services.

The image displays three screenshots of digital resources:

- Education and Training:** Shows a group of people in a training session. Text includes "Homerton University Hospital", "UCL Partners", and "Education and Training". It lists a "1 Day Introduction" agenda: History of Improvement, Model for Improvement, Measurement for Improvement, Testing Theory and Ideas, Understanding Systems, and Process Mapping. It also shows a bar chart titled "Overall how would you rate the day?" with categories: Excellent, Good, Fair, Poor, and Very Poor.
- Best Practice Review:** Features a circular logo for "Improving Quality", the title "Best Practice Review", and the "Homerton University Hospital" logo. It includes a bulleted list: "Links to Newcastle Library", "Literature Search Service", and "Active participants of improvement collaboratives".
- Intranet IQ Resource Hub:** Shows a screenshot of a website with the title "Intranet IQ Resource Hub". It features a search bar, a sidebar with "About the Resource Hub", and various resource pages.

Quality Account



Our REMPOD

Becoming a 'dementia friendly' Trust

This year the Trust started to make changes to the environment on our Elderly Care Unit (ECU). We have used advice from Stirling University as a reference for our environmental work to ensure we are supporting patients appropriately. Stirling is a centre of excellence in dementia research.

We changed the signage on bathroom doors to ensure they were of a high contrast and easy to see from the end of a bay. The toilet seats were changed from white to blue to help differentiate the toilet bowl from the seat.

Since this change, there has been a significant reduction in the number of bathroom related falls. Between August 2015 and January 2016 there were three bathroom related falls, compared to the previous six month period where on average 18-20 falls occurred (83% reduction). The patient bays have been colour coded to provide additional support to orientation.



Falls prevention signage

We also revamped the large meeting room on the ECU. This is now a facility for both patients and staff and has been developed into a bright, modern looking room with separate areas for seating and tables to encourage patients to have lunch together. The room supports patient activities with therapies each day and also doubles as a quiet space when a patient may be experiencing an episode of distress.

We provided a weekly programme of patient therapies to promote wellbeing and to support the rehabilitation process. These include a reminiscence group, a leisure group, art therapy and supporting patients to eat together at least twice per week.

Speakers have been installed into each of the bays, and side rooms and gentle music played for an hour or two in the evening to promote restful nights.

A REMPOD (reminiscence room) has been set up in the small therapy room on the Elderly Care Unit. The room has books and artefacts from the 1960s era as well as a replica television complete with hidden DVD player where old films and news reels are played.

We have been using dementia specific quality of life inventories to measure whether there are any improvements to wellbeing. Twenty-two patients used the pod between September and December 2015, all reporting some improvement in mood and

wellbeing. Ward sisters have reported a more calming environment with fewer stat calls to the security team since the introduction of a regular therapy programme.

A cinema pod has also been set up at Mary Seacole Nursing Home, where residents and respite users are able to enjoy old films and musicals. Quality of life inventories are currently being implemented.

We have implemented the 'forget me not' scheme across the inpatient wards as part of improvements to bedside information for staff. The small blue flower has helped staff to think about their interventions when working with patients with dementia.



Alongside the 'forget me not' scheme we are encouraging patients, carers and staff to complete the 'This Is Me' document. This person centred approach helps staff properly support patients with dementia when they are in unfamiliar environments. Our dementia care support workers have been pivotal in helping to deliver the 'This Is Me' and 'Forget Me Not' programmes.



Partnership working recognised

For the second year in a row, NHS performance measures show that, with the support of Homerton's services, City and Hackney's GPs are ranked amongst the best in the country when supporting people with long term conditions such as diabetes, asthma or kidney disease.

The Quality Outcomes Framework is used by the NHS to look at how well patients in different areas of the country are treated. Annually, it uses national quality standards to check how each Clinical Commissioning Group (CCG) area is doing. For long term conditions, City and Hackney CCG was placed first, second or third in England in nearly 45% of categories. These include the number of people with kidney disease having regular blood tests; newly diagnosed diabetes patients



Art therapy on Elderly Care Unit

whose blood pressure is controlled at a safe level; and patients being referred to services that help them understand more about their illness.

Public Health England has calculated that this should lead to 122 fewer heart attacks and strokes, and 75 fewer deaths over the next 10 years, when compared to the average London CCG.

Dr Clare Highton, City and Hackney CCG Chair and Clinical Lead for Long Term Conditions said: "Effective collaboration between staff from different organisations in the area has been crucial to this success. Once again, we're seeing the combined work of GPs, practice nurses, healthcare assistants and staff at Homerton Hospital paying real dividends in terms of helping patients to manage their illnesses. Long term conditions, especially those related to lifestyle factors such as smoking and diet, are a particular issue for patients in the borough and can drastically reduce quality of life. But with the right support and monitoring, many people can manage their condition really effectively and early warning signs can be picked up."

Quality Account

Hospital simulation training team short listed for national award

In December 2015, Homerton Hospital's innovative simulation training centre was short listed for a prestigious national award for its achievements in taking training on to the hospital's wards.



The simulation team were finalists in the category: 'Improving Outcomes through Learning and Development' for the annual Health Service Journal Awards, 2015. The team, led by Val Dimmock, Simulation and Clinical Skills Lead Specialist and Dr Deblina Dasgupta, Consultant Geriatrician, had been seeking easier ways to deliver training. They found a potential solution in the introduction of in-situ (in the appropriate position) simulation training on the wards.

Subsequently, scenario based training has now been introduced to the several areas across the Trust. The 'on the spot' training has proved popular with staff who have given a 100% agreement response that the training was relevant to their practice and that there were many benefits to training within their usual working environment.

Val Dimmock said: "In situ simulation provides training for health care professionals in their everyday environment and ensures that learning becomes part of the normal working day. By doing this we are able to ensure clinical staff become familiar with equipment and techniques within their own working environment. It also provides a forum for discussion of hospital systems and protocols and ensures that staff spend as little time as possible away from their patients."



Homerton team - HSJ Awards ceremony



Bevan Prize for Health and Wellbeing – TB Team

The Trust's TB (Tuberculosis) team has been awarded the UK-wide 2015 Bevan Prize for Health and Wellbeing, sponsored by UNISON, The Open University and Aneurin Bevan Society. The prize is awarded to individuals and organisations that have made an exceptional commitment to advancing health and wellbeing in their field, while championing the founding principles of the NHS.

The team won the Bevan Team Prize for their innovative work to tackle the high rate of TB amongst homeless people in Hackney. The team aim to house patients who are being treated for Tuberculosis with no recourse to public funds through the use of a service level agreement with the London Borough of Hackney Housing Department.

Patients know that for the duration of their time on medications they have secure accommodation and in return they are more able to comply with their medication regime. It has meant the completion rate of this cohort has seen only one patient "lost to follow up" out of 30 who have been through this programme. It also facilitates discharge from hospital in circumstances where the only alternative would be to keep the patient in hospital for the duration of treatment.

Non-clinical navigators sign post health options for patients

Our pioneering 'Non-Clinical Navigator' scheme to help people choose the right option to meet their health needs, has been proving successful in 2015/16. Hackney's non-clinical navigators are based in the Primary Urgent Care Centre (PUCC) at Homerton Hospital and offer advice and support in helping patients find the most suitable NHS service in the London Borough of Hackney.

This service is the first of its type in London, and helps relieve pressure and demand on our Emergency Department (ED). The navigators steer patients to the best service to meet their needs, be it their GPs, local pharmacies or other NHS services. They can smooth the way for GP appointments for patients who are already registered; help patients not registered to find a GP and register by providing appropriate forms and details of GP practices where people can join; in addition to giving advice on how to access services provided by the local authority and voluntary organisations. Their work was covered by the regional BBC news.

Homerton chosen as a centre for diabetic eye screening service

Homerton was chosen as one of five London centres to provide a specialist eye screening service for people with diabetes. The Trust was selected by NHS England as the service provider for patients across north east London. The service commenced in November 2015.

Eye screening is a key part of diabetes care to check for diabetic retinopathy, a condition that can lead to sight loss if it is not detected and treated early. All diabetic patients aged 12 and above are invited for this test once a year.

This new London wide service introduced a standardised screening model to significantly improve the effectiveness and efficiency of the programme. Jo Murfitt, Director of Public Health Commissioning for NHS England (London), said: "Regular eye screening is very important for people with diabetes. We want to ensure that the quality of this service is consistently high across the capital, and all patients who need it are accessing this important service. The new service will build on the commitment, hard work and professionalism current providers have demonstrated over the years in delivering the diabetic eye screening service in London."

The Trust has been working with other NHS trusts to ensure a seamless transfer of patients to the new eye screening service.

Sexual health service in partnership with neighbouring boroughs

The Camden and Islington Young People's Sexual Health Network celebrated its launch in September 2015.

The Young People's Sexual Health Network consists of three provider organisations: The Brandon Centre, Brook, and Homerton, who have been delivering services across both boroughs since April 2015. The three organisations have been working together to deliver Level 2 core contraceptive and sexual health clinics, counselling, and to offer sex and relationship education support to schools. These services are for young people up to age 25.

In addition to the core services, each provider delivers a specialty on behalf of the Network. We are now running our service from a new base, Pulse on Holloway Road; providing clinical outreach in various locations; and coordinating within the Network, to support outcomes for the Network.

The Network has recruited a Young People's Engagement Coordinator to ensure the continued involvement of young people in every aspect of service development, evaluation and quality assurance.

The Network is committed to partnership working, and is focusing on strengthening pathways and linking to other services that young people come into contact with.

Part 2: Priorities for improvement and statement of assurance from the board

2.1 Priorities for improvement 2015/16

Between January and March 2015, the Trust carried out several consultation events to help determine our 2015/16 Quality Account priorities. This involved consultation with key stakeholders i.e. patients, staff, Healthwatch and Council of Governors, to ascertain their views on quality. In particular, what aspects of quality mattered most to them, and their views on the Trust's strategic document 'Achieving Together'.

Following consultation, it was agreed that Quality Account priorities would continue to build on the progress made during 2014/15 in several areas, where potential to make further improvements was evident. Additionally, it was decided that the Quality Plan for 2015/16 would form 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, whilst addressing the health needs of our diverse community.

For each of these priorities we set metrics to measure performance and progress throughout the year. Having set ambitious aims in 2015/16, some of which require more than a year to deliver, the Trust has demonstrated progress against all targets although full achievement has not always been possible. For this reason, several priorities will be carried over into 2016/17 and work will continue on them.

Descriptions in detail of the work and progress against each of these improvement priorities are in Part 3.

2.1.1 Priorities for improvement for 2016/17

This section contains an outline of the Trust's quality priorities for 2016/17.

An initial list of proposed priorities was drawn up. This was based on our progress against 2015/16 priorities, external drivers such as national improvement initiatives and key areas identified as part of our regulatory inspections.

As part of a consultation process, between December 2015 and March 2016, the Trust undertook several consultation events with patients, staff and visitors, external stakeholders, and the Council of Governors.

A face-to-face engagement exercise was carried out in the outpatients department, reception area and on one inpatient ward. Patients and hospital users were asked, 'what top three things mattered to them during their care and treatment at Homerton?' Managers attended the 'Homerton Improving Discharge for Patients Group' to discuss the Quality Account and priority setting for the 2016/17. The group were asked to consider the three quality areas i.e. safety, effectiveness and patient experience, both in relation to the issues of the group, but from a wider agenda; and to feedback any proposals for consideration.

Following initial feedback from patients and visitors, the Trust drew up a list of potential priorities. These were discussed with the Quality and Patient Safety Board, to tighten up objectives; after which a 'Survey Monkey' of our staff was carried out. In addition, the priority proposals were presented to the Council of Governors and their opinion sought.

The final stage involved publishing priority proposals on the internet and sharing them with our Healthwatch colleagues to invite comment before discussing and signing these off with the Trust Board.

Building on the progress that we have made during 2015/16, the Quality Account priorities and Quality Plan for 2016/17 will form 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.

This year the Trust has again set ambitious priorities to drive high quality care and respond to the challenge of meeting the health needs of its diverse community.

Table 1: Presents a summary of the 12 priorities agreed

Summary of our Quality Improvement Priorities for 2015/16

Domain	Priority No.	Priority Title	Carried forward (2014/15)	New Priority (2015/16)	2015/16 Progress
Safe	1	Improve the reduction in harm to our patients	✓		✓
	2a	Improve the response to acutely deteriorating patients and reduce failure to rescue	✓	✓	✓
	2b	Improve monitoring and escalation for high risk women using the Maternity Early Obstetric Warning Score (MEOWS)		✓	✓
	2c	Reduce number of babies born at Homerton University Hospital (HUH) admitted to NICU at term with evidence of severe acidosis		✓	✓
	3	Enhance adult safeguarding experience		✓	✓
Effective	4a	Reduce the number of patients who are readmitted within 30 days of discharge	✓		✗
	4b	Reduce number of postnatal readmissions		✓	✓
	5a	Improve mental health by monitoring	✓		✓
	5b	Improve District Nursing communication with key stakeholders	✓		✓
	6	Improve integrated pathways between community and acute care		✓	✓
	7	Improve quality of dementia care for our patients and carers	✓		✓
Patient Experience	8	Improve our end of life care and advanced care planning		✓	✓
	9	Improve the effectiveness of discharge from our care	✓		✓
	10	Improve the management and control of pain	✓		✓
	11	Improve the way we communicate and ensure respect, dignity and compassion	✓		✓
	12	Improve Health and Wellbeing of Trust Staff and achieve excellence		✓	✓

✓ Target fully achieved ✓ Progress towards target achieved ✗ Minimal (possibly no) progress towards target achieved

Quality Account

Table 2: Quality Account priorities 2016/17

Domain	Priority No.	Priority Title	Carried forward (2014/15)	Underpinning drivers				
				Links to CQC		Links to 2016/17 CQUIN	Links to national initiative	Linked to Patient and public engagement Top 3
				Inspection	KLOE			
Safe	1	Aim to deliver effective Venous Thromboembolism (VTE) risk assessment, to improve learning and increase prevention	✓ No1		✓	✓ Local	Sign up to safety	
	2	To support safer care for patients undergoing invasive procedures through National Safety Standards for Invasive Procedures					NatSSPs	
	3	To improve monitoring and escalation of response to acutely deteriorating patients and reduce failure to rescue focusing on sepsis, acute kidney injury (AKI), and obstetric patients	✓ No. 2a/2b		✓	✓ National		
Effective	4	To maximise learning, and minimise avoidable deaths by implementing a consistent approach to mortality case note review			✓		✓	
	5	To develop our NICE guidelines, audit and quality improvement processes to reliably implement best practice pathways to deliver better patient care			✓		National audit programme	
	6	To implement electronic GP clinic correspondence to deliver better coordination of patient care			✓			
	7	To improve the identification of mothers with maternal mental health concerns through evidence based assessment and provision of Health Visitor led intervention and/ or onward referral for specialist care as per Health Visiting Mental Health Pathway	✓ No.5a		✓			
Patient Experience	8	To improve shared decision making with patients			✓	✓ Local	Right care programme	✓
	9	To enhance quality of patient information and use of alternative media			✓			
	10	To improve our EoLC and effectiveness of advanced care planning in partnership with primary care	✓ No.8		✓			✓

Please note the as part of the Trust's 2016/17 annual operational plan we have submitted three quality priorities to Monitor i.e. **3, 4 and 10**.

2.2 Statements of assurance from the Board

Review of services

During 2015/16 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 2015/16 represents 100% of the total income generated from the provision of relevant health services by the the Trust for 2015/16.

Participating in National Clinical Audit

The Trust continues to participate in relevant national audit programmes, and its processes are currently being reviewed and developed to ensure that it has

demonstrable evidence of changes made as a result of this practice.

During 2015/16, 32 national clinical audits and three national confidential enquiries covered relevant health services that Homerton provides. During that period the Trust participated in 91% 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 national confidential enquiries that the Trust was eligible to participate in during 2015/16 are as follows (see Figure 1).

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see Figure 1).



Quality Account

Figure 1

Audit Title	Eligible for participation	Did Homerton Participate?	% cases submitted	Number of cases required	No. cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✗	0% ³	0	0
Bowel cancer (NBOCAP)	✓	✓	100%	90	90
Case Mix Programme (CMP)	✓	✓	100%	476	476
Diabetes (Adult)	✓	✗	100% ¹	2,4504	2,4504
Elective surgery (National PROMs Programme) Hip Replacements	✓	✓	82%	103	84
Elective surgery (National PROMs Programme) Knee Replacements	✓	✓	109%	127	138
Elective surgery (National PROMs Programme) Groin Hernia	✓	✓	54%	271	146
Emergency Use of Oxygen	✓	✓	100%	17	17
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	✓	100%	12	12
Head and neck oncology (DAHNO)	✓	✓	63%	8	5
Inflammatory Bowel Disease (IBD) programme	✓	✓	89%	135	120
Lung cancer (NLCA)	✓	✓	92%	85	78
Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	51%	134	68
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	✓	96%	68	65
(NCEPOD) Acute Pancreatitis	✓	✓	80%	5	4
(NCEPOD) - Sepsis	✓	✓	67%	3	2
(NCEPOD) - Gastrointestinal Haemorrhage	✓	✓	100%	5	5
National Audit of Intermediate Care	✓	✗	0% ²	0	0
National Cardiac Arrest Audit (NCAA)	✓	✓	100%	90	90
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	✓	100%	52	52
National Comparative Audit of Blood Transfusion programme	✓	✓	100%	24	24
National Complicated Diverticulitis Audit (CAD)	✓	✓	100%	7	7
National Emergency Laparotomy Audit (NELA)	✓	✓	155%	53	82
National Heart Failure Audit	✓	✓	100%	265	265
National Joint Registry (NJR)	✓	✓	99%	217	214
National Prostate Cancer Audit	✓	✓	98%	128	125
Neonatal Intensive and Special Care (NNAP)	✓	✓	100%	919	919
Oesophago-gastric cancer (NAOGC)	✓	✓	85%	27	23
Paediatric Asthma	✓	✓	195%	20	39
Procedural Sedation in Adults (care in emergency departments)	✓	✓	100%	28	28
Rheumatoid and Early Inflammatory Arthritis	✓	✓	100%	76	76
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100%	95	95
UK Parkinson's Audit (previously known as National Parkinson's Audit)	✓	✓	100%	20	20
Vital signs in Children (care in emergency departments)	✓	✓	77%	100	77
VTE risk in lower limb immobilisation (care in emergency departments)	✓	✓	94%	100	94

- We participated in 1 of the 3 elements of the National Diabetes Audit that we were required to collect data for in 2015/16. We did not participate in the National Diabetes Foot Care and Diabetes in Pregnancy Audit this year but will do so in the year ahead. Therefore data entered above represents quota relevant to two areas for which we submitted data.
- We did not participate in the National Audit of Intermediate Care in agreement with Hackney CCG as the service specification and configuration was in flux.
- Unfortunately, whilst the clinical data has been collected for this national audit, the Trust has not been able to process the data.

The reports of 19 national clinical audits were reviewed by the provider in 2015/16 and the Trust intends to take the following actions to improve the quality of health care provided.

Description of actions to be taken (see Table 3 below).

Table 3: Examples of changes from a national audit:

National Audit Project	Actions Taken
National Audit on Blood Transfusion	As a result of this audit, in the interim period, we have set up a new data base that will automatically send an email to Staff whose training is about to expire, prompting them to stop collecting blood and access training.
National Audit of Falls and Fragility Factors	We have developed a Strategic Falls Group in response to the recommendations from the National audit.
Maternal, New-born and Infant Clinical outcome review programme	We have introduced a system to ensure that all late foetal losses from 22 weeks as well as stillbirths and neonatal deaths have a multidisciplinary assessment of their antenatal and intrapartum care.

Local clinical audit

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe and clinical practice is based on nationally agreed standards of good practice and evidence-based care. The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence.

The reports of 142 local clinical audits were reviewed by the provider in 2015/16 and the Trust intends to take the following actions to improve the quality of health care provided.

Description of actions to be taken (see Table 4).

Table 4

Local Audit Project	Actions Taken
Inclusion of target food following negative food challenge	The audit highlighted that many patients are undergoing a food challenge procedure, not because they want to include the food in their diet if the challenge is successful, but rather they want to know that if the food is consumed accidentally, it is unlikely there will be any allergic reaction. This was a surprising result and something that we now discuss with families as part of the pre- challenge consultation.
Secondary Care Referrals in 2014 From City and Hackney	As a direct result of the audit, an orthopaedic shoulder MDT meeting has been set up to improve integrated care for orthopaedic shoulder patients and improve our surgical conversion rates. This was in response to the fact that the audit highlighted that these patients have the lowest surgical conversion rates of all patients referred from the community ESP clinics.
Retrospective audit of the Specialist ABI Outreach Team (RNRU).	They have all benefited the service by reducing duplication of tasks in the care pathway, improving data collection for research purposes and improving efficiency of the service to patients. <ul style="list-style-type: none"> • Re-introduction of the role of key worker to assist with role distribution within the team and to support collection of core data and transition through the pathway for patients – thus reducing the turn-over time of reports, therefore speeding up the placement of appropriate support packages or other needs • Re-introduction of the ‘care pathway’ has helped ensure key assessments and reports are completed in a timely way

»

Quality Account

Local Audit Project	Actions Taken
» Retrospective audit of the Specialist ABI Outreach Team (RNRU)	<ul style="list-style-type: none"> • Revision of the Outreach Team service standards is in progress. This will outline more appropriate performance measures, which can be used in the future to demonstrate service performance levels and outcomes • The audit template is currently being redesigned to allow it to provide a more accurate portrayal of the positive outcomes for patients – such as the reporting of 'patient satisfaction surveys, which are currently audited separately • A new billing spread-sheet has been designed and implemented by the team manager with the result of reducing the time spent on 'billing activities' and improving the accuracy of data collection and reducing the time taken for analysis of this data for future audits. This also makes the service more transparent to our key stakeholders and commissioners.
Calls to Delivery Suite for a neonatologist to attend delivery	Based on our audit we produced a new guideline for when neonatal doctors should be called to attend deliveries and this is currently in use.
Compliance with "Huddle" Communication on the Acute Care Unit	Huddle compliance improved as result of the audit, as it highlighted and reminded staff of the need to have 'Huddle' meetings.
Platelet Transfusion in babies at NICU	Following the audit, a recommendation of introducing fluorescent stickers for platelet transfusion was made to minimise unnecessary platelet transfusion in babies. This is to be reviewed by neonatal consultant body before implementation.
Comparison of echocardiography and cardiac magnetic resonance imaging in detecting intracardiac shunting at atrial level	<p>As a result of the audit we have now added:</p> <ul style="list-style-type: none"> • Pulmonary artery diameter into Echo reporting template • Pulmonary artery pressure into transoesophageal echo reporting template.
Induction of Labour	<p>Since the audit, we have implemented the following action points to improve service:</p> <ul style="list-style-type: none"> • Use of an induction of labour checklist to include offer of membrane sweep, provision of information leaflet and prescription of prostaglandin to avoid delays of administration • Updated the induction of labour guideline • Improved education regarding CTG monitoring, observation frequency and MEOWS scoring • Availability of terbutaline in the antenatal clinic (setting for outpatient inductions) and obtained PGD to ensure timely administration <p>In the process of obtaining PGD For prostaglandin for outpatient of labour.</p>
Lower Limb Rehabilitation Group	<p>The service has benefited by the audit because:</p> <ul style="list-style-type: none"> • Confirmation that the class is being well utilised by staff for onward referral (91.3% of new patient slots allocated to patients) • Confirmation that patients have low DNA rate (79.3% attending initial appointment, 75.8% attending follow ups)

»

Local Audit Project	Actions Taken
» Lower Limb Rehabilitation Group	<ul style="list-style-type: none"> • Demonstrated the class is effective in patient treatment (improvements in PREMs and PROMs) • Identified areas requiring better data collection (waiting times, pathologies presenting, PROM's and PREM's) <p>An audit tool (Excel spread sheet) has now been set up to improve future data collection and analysis.</p>
GP open access echo service	<p>The service was highly rated by GPs and the GPs are more aware of referring by email.</p>
Venous doppler ultrasound referrals in the diagnosis of DVT	<p>One of the improvements that was made was to add Well's score's to the electronic referral form used by ED to request Doppler ultrasounds.</p>
An audit to improve the consideration and use of Augmentative and Alternative Communication (AAC) aids by Speech and Language Therapists (SLT)	<p>The audit helped to improve documentation and the inventory kept by the SLT – this in turn has raised awareness of the AAC available to patients.</p>
Imaging guided breast biopsies	<ul style="list-style-type: none"> • Better service planning for the current capacity and for the coming years (staffing, rotas, biopsy consumables) because the audit has shown that this increase in biopsy numbers is a constant trend and not just a blip • It has shown that we are following the current guidelines and not over biopsying the lesions found i.e. there is no need to reduce the biopsy numbers • The patients are having less procedures/appointments when a biopsy is done as a first line examination rather than fine needle aspiration with inconclusive cytology and the biopsy as a further examination i.e. better service for patients and also saving money by reducing the appointments.
Clinical audit of serum Holotranscobalamin and Methylmalonic acid as sensitive indicators of vitamin B12 deficiency in Bariatric patients	<p>Following this audit</p> <ul style="list-style-type: none"> • Cut off limits for reflex testing of Holotranscobalamine (active B12) and Methylmalonic acid (MMA) were revised which has helped in getting more patients diagnosed with functional vitamin B12 deficiency but normal serum vitamin B12 levels • Interpretative comments provided with serum vitamin B12, Holotranscobalamine (active B12) and Methylmalonic acid (MMA) levels have led to increased number of clinical queries from the GPs and hospital users per day. This has been beneficial for early diagnosis and better clinical outcomes. This should also reflect in decreased number of acute admissions in the hospital.
Audit on Groin Hernias operations	<p>The audit has demonstrated that General Surgery provides excellent service regarding groin hernia operations. We do better than the recommended standards.</p>

Participation in clinical research

The Research and Development (R&D) department continues to grow both in size and in the breadth of studies it undertakes demonstrating the Trust's continued commitment to clinical research. It also establishes the Trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of health care nationally and internationally.

Participating in research helps to ensure that our clinical staff remains abreast of the latest treatment modalities. Additionally, it has been evidenced that trusts that have an active research culture provide a better quality of care for their patients, and it has been shown that patients involved in research have better clinical outcomes.

Changes within in the national agenda in relation to approving clinical trials has resulted in a centralised approval process of commercial and National Institute for Health Research (NIHR) approved studies, giving the local office responsibility to concentrate on study delivery and local projects. Thus, the constitution of the office has changed significantly over the past year, now incorporating many of the research nurses and clinical trial practitioners. This has led to better oversight of management of trials within the Trust and a more cohesive approach to clinical trial delivery.

To facilitate the change in structure, the Trust has subscribed to 'EDGE'* a cloud based research management programme that enables timely recruitment rates along with easy access to study related documentation. Benefits also include:

- easy access, no software installations
- single system with real time data management - avoids duplication
- improves data quality
- free of charge to Homerton University Hospital Foundation Trust
- flexibility to adapt and grow with organisational needs
- use for NIHR CRN portfolio and non-portfolio studies.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1,224.

Participating in research helps to ensure that our clinical

staff stay up-to-date with the latest treatment options, and active participation in research leads to better outcomes. This can be demonstrated through studies outlined below.

ASPRE study

ASPRE is a large multi-centre, international study to develop screening and prevention of preeclampsia. The ASPRE screening study aims to identify women who are at high risk of developing preeclampsia at the time of the 12 week ultrasound scan. The screening algorithm includes maternal characteristics and medical history, measurements from the ultrasound scan and two biochemical markers in the blood.

Women identified as high risk are invited to join the ASPRE randomised controlled trial where they are randomised to take either 150mg aspirin or placebo. Participants are subsequently given serial scans to assess the wellbeing of both woman and baby.

Although women have been given aspirin to prevent PE in the past, this was based on medical and obstetric history alone and did not include biophysical evidence from the scan and blood tests. Furthermore, there is some evidence that a significant number of women do not respond to the standard 75mg dose of aspirin, which is why ASPRE is using the 150mg dose.

The ASPRE study hopes to confirm the use of the screening algorithm amongst a large population (33,600 participants) and provide evidence for the use of aspirin to prevent preeclampsia in high risk women. Detailed clinical information and blood samples over the 12 month period will also enable further investigation and better understanding of preeclampsia as a serious disorder of pregnancy.

The first phase of this study is now complete and the pregnancy outcomes are being monitored.

Freeze All study

Until recently it has been universally believed that a fresh embryo in assisted reproductive technology has the best chance of resulting in a pregnancy. Thawed frozen embryo transfers have only been used where the transfer of a fresh embryo transfer has been unsuccessful and supernumerary embryos were available.

In an attempt to improve the pregnancy rates in women who are at high risk of hyper stimulation and to eliminate ovarian hyper-stimulation syndrome

completely, an alternative policy was introduced in Homerton Hospital Fertility Centre (Elective Freezing; October 2014). The Elective Freeze policy opted for the strategy of freezing suitable embryos of high responding women and thawing and replacing it at a later date.

A retrospective case control design was adopted to investigate the clinical effectiveness of the elective cohort freezing followed on by thawed embryo transfer, compared with the previous policy of fresh embryo transfer in women who were high responders and were undergoing IVF/ICSI. It was found that there is a significant increase in clinical pregnancy rates in the above group of women who did not go ahead with a fresh transfer and opted for a frozen-thawed embryo transfer.

As a result the department has recognised that they could improve treatment outcomes, reduced hyper stimulation and reduce the amount of treatments patients require to achieve a live birth.

Patients are keen to be included in this study which is in the early recruitment phase.

POPPY Study

When HIV first began affecting patients, there were very few treatment options available and knowledge surrounding the virus was limited. Unfortunately, this meant that in many cases HIV often progressed to AIDS and the diagnosis carried with it a decreased life expectancy.

Due to advancements in clinical care and constant developments in Anti-Retroviral Therapy, people living with HIV are now expected to live well into old age.

The POPPY study (Pharmacokinetic and Clinical Observations in People over 50) is an observational study which aims to gain a better insight into how HIV may affect the ageing process; this is done by comparing outcomes of three cohorts of patients.

The cohorts compared are:

- people living with HIV aged >50yrs,
- people who are HIV negative over >50yrs old
- a control group of people <50yrs who are living with HIV.

Patients have three clinic visits in total which can last between 3-4 hours over a period three years. Various assessment methods including blood sampling, clinical history taking, neurocognitive function assessments,

pain assessments and full body DXA scan for bone mineral density are performed during the visits in order to compare outcomes between the cohorts. Demographics, socio-economic status and lifestyle factors are also taken into consideration.

The recruitment phase is now complete and the recruits are being followed up.

TITRATE trial

The rheumatology department continues to expand its portfolio of studies investigating conditions associated with rheumatoid arthritis (RA) with the aim of improving the quality of lives for patients with this disease process. In particular there is currently no evidence based treatment approach to follow for patients with intermediate disease activity.

One trial that is examining this area is TITRATE. This trial aims to compare intensive management with standard care to increase remissions, reduce disability and enhance quality of life.

The intensive management regimen will be based on reviewing patients monthly and immediately adjusting treatment regime based on changes in their clinical care, by giving DMARD combinations, steroids and, in some patients, biologics, with the aim of achieving remission. Intensive management will also involve supportive non-drug interventions which will be individualised to meet each patient's specific needs. These non-drug approaches will be combined in a 'treatment support' programme. They will span psycho-education, goal-setting and skills teaching to address identified problem areas, such as pain, fatigue and low physical activity.

Standard care will involve maintaining suppressive treatment with DMARDs and steroids. In standard care, patients are reviewed at least once each year. Urgent specialist reviews will be arranged for patients in either treatment arm using routine approaches if there is a clinical need.

Patients recruited to this trial have noted that there was a need for this kind of study. Additionally, research and clinical staff have been coached in motivational interviewing skills which have added to their professional armoury.

At any given time around 130 studies are actively recruiting patients. The four described here offer just a tiny flavour of the contribution Research and Development offer to the patients we treat at Homerton.

Quality Account

CQUIN* payment framework

During 2015/16 the Trust continued to work with the Commissioning for Quality and Innovation (CQUIN*) scheme to drive quality improvements across the organisation.

A proportion of Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals. These were 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 2015/16 and for the following 12 month period are available electronically at <http://www.england.nhs.uk/nhs-standard-contract/15-16/>.

In 2015/16, 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 specialised services contract. In addition, the Trust also agreed additional CQUINs* with NHS England screening commissioners.

The estimated 2015/16 CQUIN value is £3.68m for all CCGs and NHSE on acute services and is £0.71m for community services which is conditional upon achieving quality improvement and innovation goals;

£3.47m is the associated payment for 2014/15. Appendix B provides details of our 2015/16 CQUIN.

Care Quality Commission (CQC) – registration and compliance

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 taken enforcement action against the Trust during 2015/16. In March 2015, CQC issued three Warning Notices* in relation to the maternity service for:

- care and welfare of people who use services
- assessing and monitoring the quality of service provision
- cleanliness and infection control.

The Trust developed and implemented a detailed action plan which was scrutinised, and progress reported on via service, clinical division and Trust

Board level committees. CQC inspectors carried out an unannounced inspection in October/November 2015 and found that improvements had been made and resulted in all three Warning Notices were removed. The inspection team concluded that monitoring systems had improved however, the governance structures needed to be further reviewed and embedded, and a Requirement Notice* was issued. The maternity action plan was revised to reflect the latest findings and implementation continues to be monitored closely.

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

Homerton's rating display in Figure 2 above shows that three services are rated 'Requires Improvement' for the 'Is the service safe?' question. These relate to the following issues:

1. Sufficient members of suitably qualified, skilled and experienced staff deployed on the medical wards

Improvements centred on establishing the number and type of staff needed in line with patients' health and care needs using an evidence-based 'Safer Nursing Care Tool'. This resulted in a phased approach to recruiting nursing staff for the medical and other wards in the hospital. In addition, there has been on-going monitoring of key indicators linked to the quality of nursing care such as hospital associated infections and also pressure ulcers has continued during 2015. The Trust Board continues to scrutinise these data and ensure that timely response is made when staffing levels need to change accordingly.

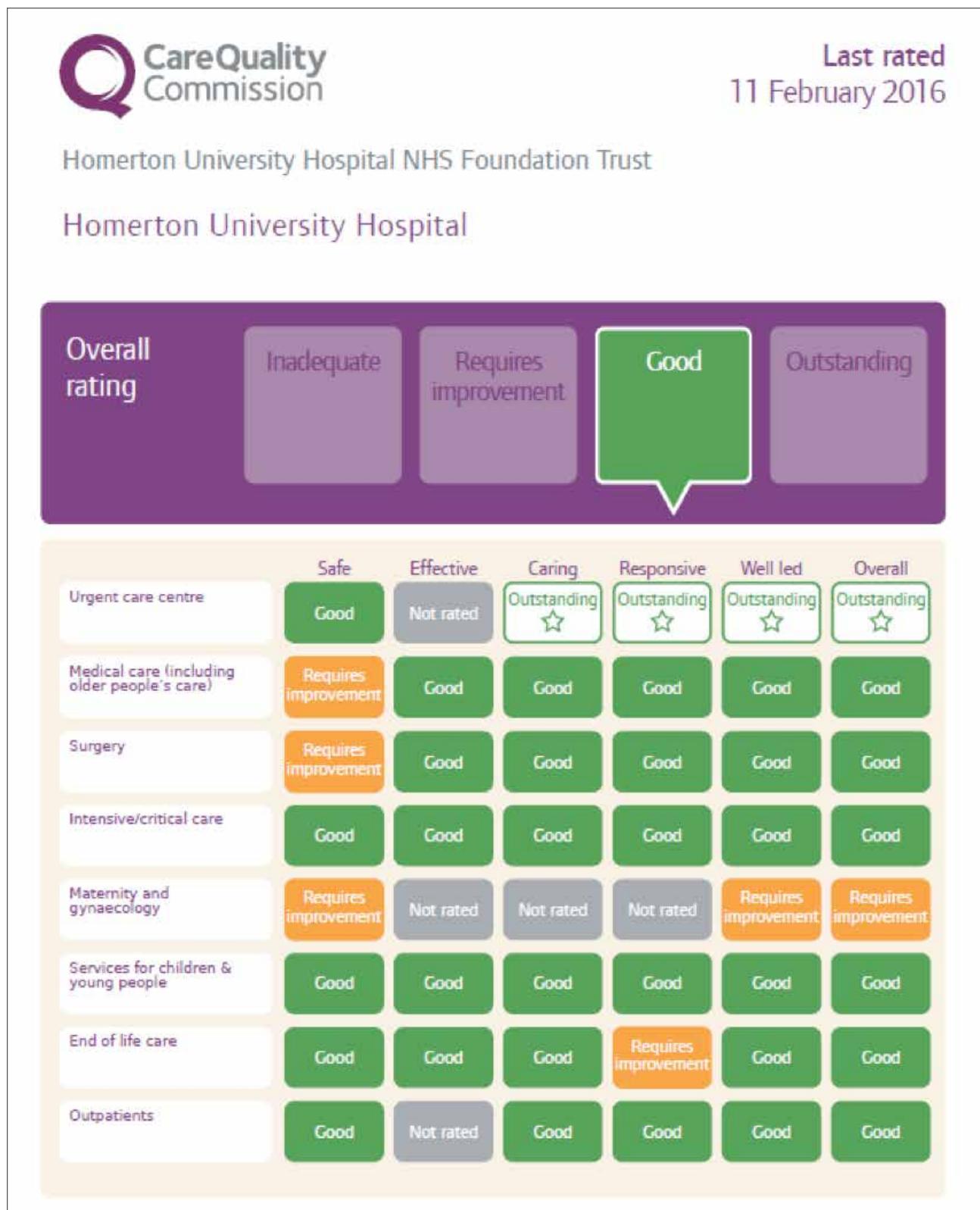
2. Accurate records are kept which include appropriate information about care and treatment planned and provided to each patient

During 2015, the Trust has transformed the way in which clinical care is documented electronically so that there is 'real time' reporting of vital signs and other clinical observations in the hospital. Regular audits of the quality of record keeping are undertaken as part of 'rounding' visits by senior nursing staff. In addition, audits of the way in which care and treatment are escalated in response to early warning signs are carried out.

3. Strengthen governance structures and reporting systems in the maternity service

CQC carried out an inspection in October/November 2015, to follow up on the responsive inspection carried

Figure 2



Quality Account

out in March 2015. Inspectors found improvements had been made resulting in the removal of three Warning Notices. However, the Trust was asked to continue to improve the way in which clinical observations in babies are recorded and responded to, and to further strengthen the way in which the central clinical governance staff and the staff in the maternity unit worked together. The Trust has developed a detailed action plan which addresses these elements. The review of how clinical governance staff work together is part of the work being undertaken by an external advisor and fits with the Trust-wide review of governance undertaken by the Head of Corporate Governance and Chief Executive.

3a. Trust view of the elements in the maternity service shown as 'Not rated'

The inspection in October/November 2015 did not explicitly examine whether the maternity service was 'Effective', 'Caring' or 'Responsive' which is why the CQC rating is shown as 'Not rated'. A rating of 'Good' was awarded by CQC for these elements in 2014, and the Trust believes that this is an appropriate rating for the maternity service due to the improvements made following the CQC inspection in March 2015.

4. Improvements to the leadership of the maternity service

The 'Is the service well-led?' Key Line of Enquiry was rated 'Requires Improvement' and is linked to the finding on 'Is the service safe?'. The external advisor is also contributing to a review of leadership in the maternity service as part of the detailed action plan.

5. Patients and/or their relatives must be involved in 'do not attempt cardiopulmonary resuscitation' decisions and ensure these are adequately documented

In 2014, the End of Life care pathway was rated 'Requires Improvement' for the question 'Is care responsive? Action taken by the Trust included the formation of an Advanced Care Planning involving a range of staff and external organisations such as St Joseph's Hospice. This group has developed an end-of-life strategy which includes scrutiny of, and improvements in, the documentation of decisions related to resuscitation

The Trust manages Mary Seacole Nursing Home, which is a residential nursing home based in Shoreditch. The nursing home was inspected by CQC in September 2015 and rated 'Requires Improvement' overall

(see Figure 3). A detailed action plan was devised and actions are being monitored and reported on through divisional and Trust wide committees. Key actions focus on:

- improving the management of medicines
- monitoring the levels, skills and experience of staff providing care and support to residents
- strengthening the systems for staff supervision.

All actions are on track to be completed by September 2016.

The CQC has not rated community health services, though an inspection is expected to take place during the summer of 2016. Preparatory work which includes a systematic analysis of all relevant services against the Key Lines of Enquiry is underway. This will underpin the self-assessment and rating of these services and pathways using CQC published handbooks and rating characteristics. CQC previously inspected community based services during December 2013 and January 2014. The Trust was found to be compliant with all six Essential Standards of Quality and Safety.

Data quality

Homerton submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

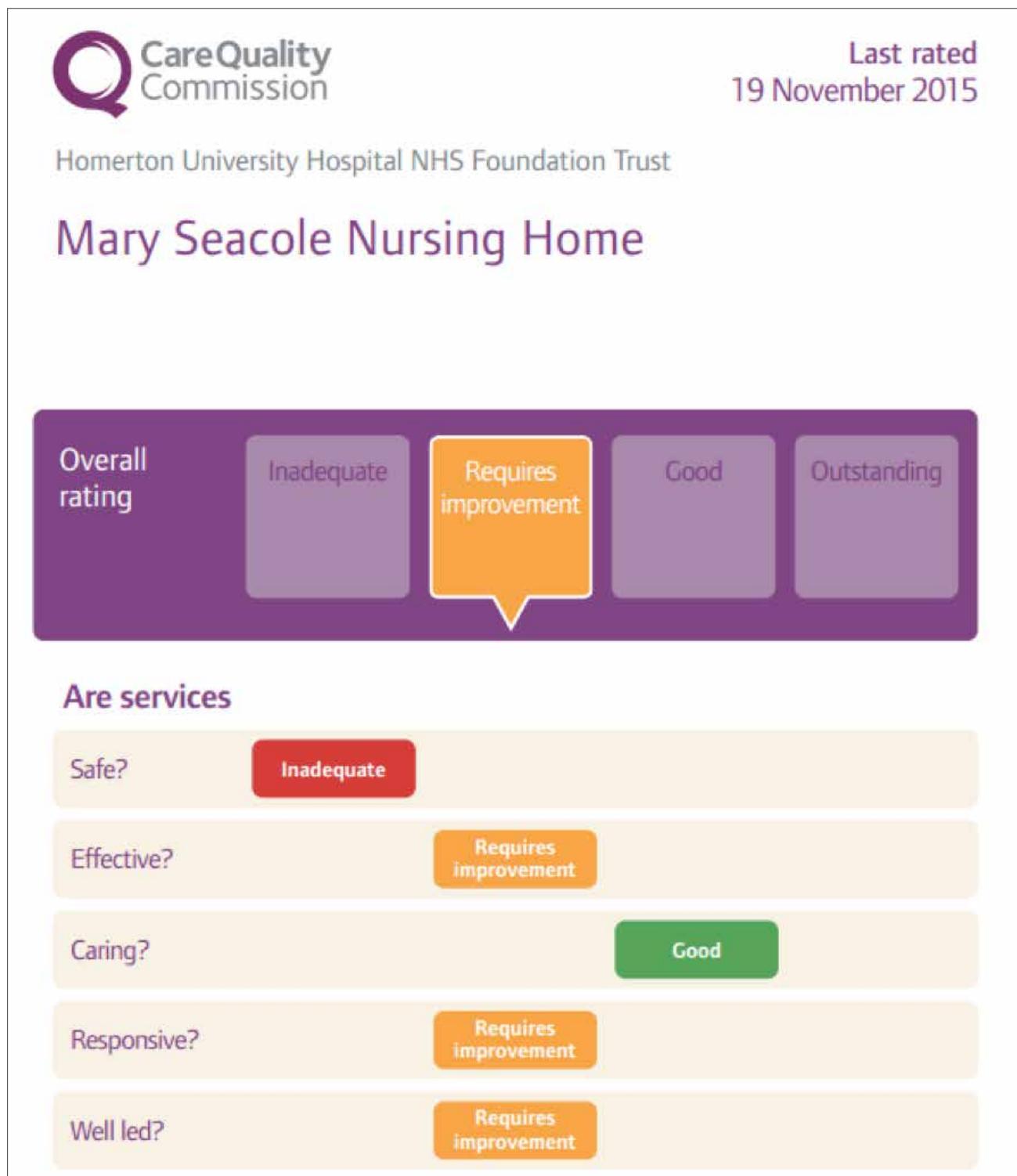
The percentage of records in the published data:

- which included the patients valid NHS number was:
 - 98.4% for admitted patient care
 - 99.3% for outpatient care
 - 93.2% 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
 - 99.9% 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.

The implementation of the Data & Information Quality Working Group in 2015/16 is now the platform

Figure 3



Quality Account

through which strategies, policies and standards are monitored to ensure they align with operational requirements. This is also the vehicle through which issues are raised and analysed to identify their impact and manage resolution. The formal governance for this group is the Informatics Committee. The Trust has also introduced a real-time spine tracing system enabling the validation and correction of electronically held patient demographic detail and NHS numbers at the first point of contact.

We will be taking the following actions to improve data quality:

- assessment and development of training programmes to support colleagues in the maintenance of high quality data
- creation of a Data Quality Dashboard to support Trust Management teams to monitor high data quality compliance within their given areas
- develop current audit programme and broaden scope to provide information assurance
- proactive use of benchmarking to ensure the Trust meets best practice standards
- training and development of data quality team members to enhance their informatics and data management skills.

Information Governance (IG)

The Trust recognises that information is an important asset, supporting both clinical and management needs and ensure that information is respected, held securely and used professionally. We also make 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 our compliance across a broad spectrum of information handling initiatives, we are required to complete an annual self-assessment, which is supported by relevant evidence, using the Information Governance Toolkit (IGT). We use the IGT to identify areas of weakness and risks in terms of information management within the organisation. These areas

are then targeted with action plans to ensure that we continue to improve our compliance with the Information Governance agenda.

The Trust's Information Governance toolkit assessment report overall score for 2015/16 was 73% and was graded as "Not Satisfactory". This was because the requirement relating to Information Governance training was assessed at level one and to achieve an overall 'Satisfactory' rating, organisations are required to achieve a minimum attainment of level two against all of the toolkit requirements. The Trust will develop an action plan in 2016/17 to ensure that it complies with this target and attains at least level two against all of the toolkit requirements.

Assessment	2015/16	2014/15
Level 0	0	0
Level 1	1	0
Level 2	34	30
Level 3	10	15
Total requests	45	45
Overall score	73%	77%
Self-assessed grade	Not satisfactory	Satisfactory

IG Incidents

All Information Governance security related incidents were reported via the Trust's incident reporting tool during the financial year 2015/16. There was one serious untoward incident involving the inadvertent disclosure of personal information relating to two patients. This incident met the criteria for reporting the incident to the Information Commissioner's Office and the Health & Social Care information centre.

Clinical coding error rates

The Trust was not subject to the Payment by Results (PBR) clinical coding audit during 2015/16 by the Audit Commission.

The Trust continues to focus on ensuring that high quality information is available to support the delivery of safe, effective and efficient clinical services.

A programme has been developed to further enhance the accuracy of clinical coding, through establishing

closer links between the clinical and coding teams. This programme has focused on improving the quality of information through education sessions and inclusion of Clinical Coding on the Trust induction programme for doctors.

Although a PBR audit has not taken place this year, a Clinical Coding Auditor was appointed in July 2015 to provide regular feedback to the coding team on the quality and accuracy of coding. Additionally, four specialty specific training workshops for the clinical coding team took place.

The Trust will be taking the following actions to improve data quality:

- further engagement sessions with clinical teams, to improve the quality of information
- extending internal discharge audits across specialties
- proactive use of benchmarking data to ensure that the Trust is meeting best practice standards.

2.3 Reporting against core indicators

All NHS foundation trusts are required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC*). Where the required data is made available by the HSCIC, 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 HSCIC and may not reflect a trust's current position.

Table 5: national performance indicators

No*	Prescribed Information	NHS Outcomes Framework Domain
1	a. Summary Hospital 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 Measure Scores (PROMS) for: <ul style="list-style-type: none">• Groin hernia surgery• Varicose vein surgery• Hip replacement surgery• 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: 0-15; and 16 and over	
4	Responsiveness to the personal needs of patients	
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: <ul style="list-style-type: none">• Accident and Emergency• Inpatients	
7	Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE*)	
8	<i>C.difficile</i> infection rate per 100,000 bed days	
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

Quality Account

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

The Summary Hospital-level Mortality Indicator (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.

SHMI has three bandings. 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 HSCIC website at: <http://www.hscic.gov.uk/SHMI>. 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.

The latest data available is for the period of October 2014 to September 2015. Homerton achieved 0.945 SHMI rate, putting it in the 'as expected' range, Band 2. Over the last three reporting periods (as detailed in the Table 6) there has been a slight rise in our SHMI rate which has caused us to fluctuate between the 'as expected' and 'lower than expected' bandings.

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

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 Clinical Effectiveness Committee.

Table 6: Summary Hospital-level Mortality Indicator (SHMI) Rate

	Reporting Period:		
	2013/14	2014/15	Oct 14-Sep 15
Homerton	0.820 (Band 3)	0.881 (Band 3)	0.945 (Band 2)
National Average	1.00	1.00	1.00
Lowest Performing Trust	1.190	1.210	1.177
Highest Performing Trust	0.530	0.670	0.652

Nationally there is a gradual upward trend on the SHMI, and according to the HSCIC presentation at the joint Trust Development Authority (TDA) and Monitor National Mortality Learning Community event in July 2015, this is in part due to the previous mild winter which led to a lower baseline, as a consequence of which many trusts are seeing a rise in SHMI. Also, the SHMI indicator is designed to look at mortality at a particular time point, not at changes in mortality over time. However, the Trust's SHMI score has been benchmarked against other trusts and has remained similar over the past three years and the HSMR (another mortality indicator) is also stable. In addition, the numbers of actual deaths are also relatively stable.

Table 7: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

	Reporting Period:		
	2013/14	2014/15	Oct 14-Sep 15
Homerton	23.3%	25.1%	23.9%
National Average	23.6%	25.7%	26.6%
Lowest Performing Trust	48.5%	50.9%	53.5%
Highest Performing Trust	0%	0%	0.2%

Patients who are receiving palliative care and have been coded as such are included within the SHMI calculation. The SHMI makes no adjustments for palliative care, because palliative care coding varies significantly

between trusts. Table 7 details Homerton's proportion of patient deaths coded as palliative care.

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

- rolling out a process of systematic mortality review which has been piloted in 2015/16 in the Elderly Care Unit and Acute Care Unit
- participating in the new national mortality case review process
- prioritising recognition and response to the deteriorating patient in our improving quality programme in 2016/17
- reviewing our critical care and critical care outreach provision to ensure we can best care for patients at higher risk.

2. Patient Reported Outcome Measures (PROMS)

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

1. Hip replacements (primary and revisions)
2. Knee replacements (primary and revisions)
3. Groin hernia
4. Varicose vein (Homerton does 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 PROM, 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.

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

Homerton 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. There is also not necessarily a direct relationship between quality of life enquired about six months after a surgical procedure, and the quality of that procedure.

Quality Account

Table 8: The patient reported outcomes measures scores (PROMS): adjusted average health gain (based on EQ-5D index)

	Groin hernia surgery	
	2014/15	Apr-Dec 15
Homerton	*	*
National Average	0.084	0.087
Lowest Performing Trust	0.000	0.024
Highest Performing Trust	0.154	0.156

	Hip Replacement Surgery (primary)	
	2014/15	Apr-Dec 15
Homerton	0.347	*
National Average	0.436	0.449
Lowest Performing Trust	0.331	0.27
Highest Performing Trust	0.524	0.543

	Hip Replacement Surgery (secondary)	
	2014/15	Apr-Dec 15
Homerton	*	*
National Average	0.277	0.286
Lowest Performing Trust	0.185	*
Highest Performing Trust	0.376	*

	Knee Replacement Surgery (primary)	
	2014/15	Apr-Dec 15
Homerton	0.229	*
National Average	0.315	0.331
Lowest Performing Trust	0.204	0.215
Highest Performing Trust	0.418	0.4

	Knee Replacement Surgery (secondary)	
	2014/15	Apr-Dec 15
Homerton	*	*
National Average	0.257	0.268
Lowest Performing Trust	0.184	*
Highest Performing Trust	0.331	*

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

The Trust intends/or has taken the following actions to

improve this indicator, and so the quality of its services, by:

- ▶ expanding our orthopaedic department which now numbers seven consultants
- ▶ 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.

3. 28 day emergency readmission rate

This indicator on the HSCIC Portal was last updated in December 2013 for the period of 2011/12. Due to their 'statistical method' in Continuous inpatient spell (CIP) construction, we are unable to completely replicate the data produced by HSCIC (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 HSCIC 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 HSCIC 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 9: Readmission rates from local data

	Readmission Rate (Adult: 16+)		
	2013/14	2014/15	2015/16
Homerton	12.69%	12.29%	12.60%
Readmission Rate (Child 0-15)			
Homerton	3.94%	3.68%	3.83%

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

- ▶ introducing ward based coordinators to support patient discharge
- ▶ providing intermediate care and reablement post discharge
- ▶ post discharge follow up for patients known to the Community Nursing Team.

4. Responsiveness to personal needs of patients

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

This 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 Care Quality Commission (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 10: Responsiveness to the personal needs of patients

	Reporting Period:		
	Jun – Aug 2013	Jun – Aug 2013	Jun – Aug 2013
Homerton	64.8	61.8	64.3
National Average	68.1	68.7	68.9
Lowest Performing Trust	57.4	54.4	59.1
Highest Performing Trust	84.4	84.2	86.1

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

- ensuring that the real time responses to these questions are built in to our improvement plans
- embedding our Patient Experience and Engagement Strategy
- engaging with key stakeholders through our Improving Patient Experience forum and delivery group to address gaps in our performance
- monitoring our overall performance through our Quality and Patient Safety Board.

5. Staff recommending the Trust to family and friends

The NHS Staff Survey provides the opportunity for organisations to survey their staff in a consistent and systematic way. Obtaining feedback from staff, and taking into account their views and priorities is vital for driving real service improvement in the NHS.

The survey was based on all full and part time staff employed by the organisation on the 1 September 2015 (with certain exclusions). The survey was then completed during September to December 2015 by 34% of the total number of survey recipients.

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

This forms part of the annual national staff survey which is conducted independently of the Trust. However, the Trust follows the guidance and methodology as set out by the Department of Health (DOH) in provision of data to Picker Institute, an approved contractor.

Actions were taken during 2014/15 to improve staff engagement, this included, engagement with staff to create our 'Living our Values' strategy; clear objectives for our Equality and Diversity group; listening to our staff and using their feedback to improve services; ensuring that we have the right staff, with the right skills caring for each patient, and providing continuity of care through good communication and teamwork.

Table 11: Staff recommending the Trust to Family and Friends from HSCIC

	Reporting Period:			
	2012	2013	2014	2015
Homerton	74.8	75.7	77.8	73.8
National Average*	61.7	64.5	64.7	69.2
Lowest Performing Trust*	35.3	39.6	38.2	45.7
Highest Performing Trust*	85.7	88.5	89.3	89.0

* Average of 'acute trusts'

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

- responding to the our latest staff survey by themes (see Table 12 overleaf).

Quality Account

Table: 12

Theme	Key Action
Equality and Diversity	<p>Provide Unconscious Bias Training to develop awareness of inadvertent discrimination and bias</p> <p>Finalise the Trust's secondment and acting up policy to counter perceptions of favouritism</p> <p>Commission and commence a career development programme specifically targeted at Black, Asian and Minority Ethnic (BAME) staff.</p> <p>Improve engagement with staff with a disability to understand how we support them with their careers</p>
Career progression and recognition	<p>Develop a series of 'career ladder' documents that demonstrate to staff across the Trust career development routes and the skills and experience required for progression.</p> <p>Talent management approach to be developed as stage 3 of the PDR project</p> <p>Provide career development workshops and mentoring</p> <p>Target of 90% of staff to be appraised prior to their increment date. Compliance to be closely monitored through PDR system</p> <p>Appraisal/Vital Conversations training to be mandatory for all supervisors to support high quality appraisal</p> <p>Create communication campaign promoting the benefits of appraisal PDR.</p>
Staff health and Well Being	<p>Build on Healthy Workplace 'Excellence' to ensure all staff know what is on offer, as well as actively seek to expand the offer especially in relation to stress</p> <p>Provide resilience and mindfulness sessions for staff</p>
Errors and Incidents	<p>Review systems to ensure all staff are aware of reporting systems and they are easy as possible to use/remove any barriers</p> <p>Explore with staff what can be done to improve staff confidence and security when reporting incidents</p> <p>In line with national guidance review Raising Concerns at Work policy and appoint a Freedom to Speak Up Guardian</p>
General – Engagement	<p>Seek to improve the staff survey response rate for 2016 setting a target of 50%</p> <p>Work with management and staffside colleagues to better understand reduced engagement scores and how to improve them</p>
General – Values	Following issuing of the Trust Values in 2014 develop a programme to review and refresh their application in the workplace
Divisions/Units	Work to develop action plans to address negative outliers

6. Patients recommending the Trust to family and friends

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

The Trust follows the guidance and methodology as set out by the Department of Health (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.

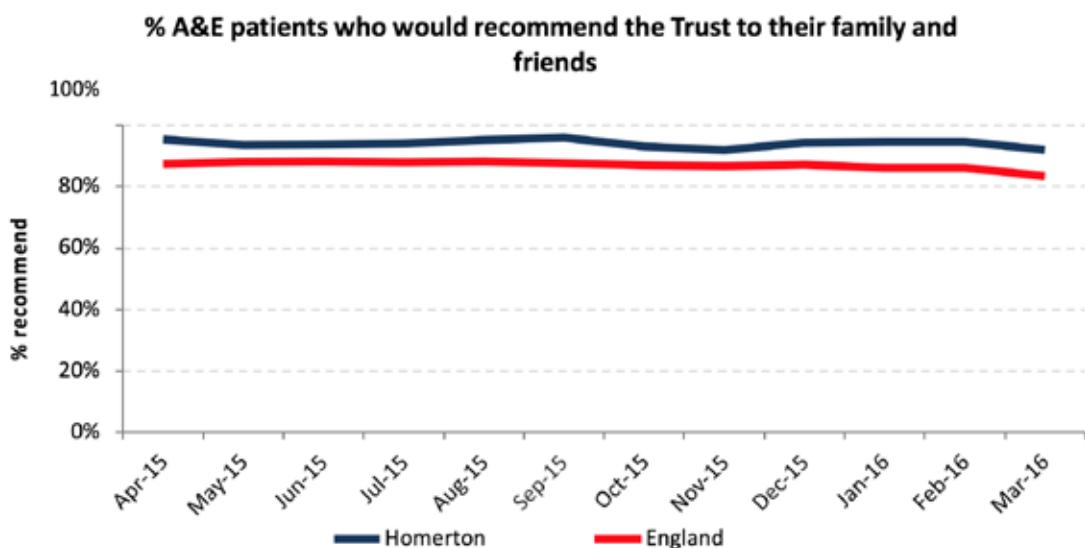
Our inpatient results have declined, due to cleanliness, catering, and noise and need for patients to be more involved in their care.

Figure 4: Percentage of patients who would recommend the Trust to their family and friends

A&E	Reporting period:	
	2014/15	2015/16
Homerton	94%	94%
National Average	87%	88%
Lowest Performing Trust	67%	50%
Highest Performing Trust	99%	99%

Inpatient	Reporting period:	
	2014/15	2015/16
Homerton	91%	91%
National Average	94%	95%
Lowest Performing Trust	78%	74%
Highest Performing Trust	100%	100%

Figure 5: % A&E patients who would recommend the Trust to their family and friends



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

- constantly scrutinising our patient feedback to learn from this
- changing our catering and cleaning provider
- introducing silent bins
- introducing 'Sleep-Well-Boxes'
- launching a train the trainer model, together with Hackney Community Volunteer Services, to help improve Homerton staff communication
- implementing shared decision making to enhance patient/ clinician communication.

Quality Account

7. Rate of admissions assessed for VTE

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

We have identified VTE risk assessment as a Trust priority. Local education and training have ensured high levels of assessment with a robust clinical information system to capture these. This has resulted in us consistently achieving above the national average.

Table 13: Percentage of patients admitted to hospital and who were risk assessed for VTE.

	Reporting Period:			
	Q4 Jan to Mar 15	Q1 Apr to Jun 15	Q2 Jul to Sep 15	Q3 Oct to Dec 15
Homerton	96.7	96.2	96.9	94.3
National Average*	96.0	96.0	95.8	95.4
Lowest Performing Trust*	79.2	86.1	75.0	61.5
Highest Performing Trust*	100.0	100.0	100.0	100.0

* based on the average of 'acute trusts'

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

- implementing a new Trust Thrombosis Committee to galvanise the current good performance to match the achievements of the highest performing Trust. This will include updating policies, the online risk assessment tool, using clinical informatics for smart risk assessment and re-assessment and further education and training.

8. Clostridium Difficile Rate (*C.diff*)

Acute hospitals in England are required to report all *clostridium difficile* (*C.diff*) toxin positive stool samples in those patients over two years of age. During the 2015/16 reporting period, our national threshold not to be exceeded for patients developing *C.diff* at Homerton, was no more than seven cases. There have been 10 Homerton attributable cases this year, in addition to which we have admitted four patients with *C.diff*. Whilst this is an increase on the previous year, and has exceeded the national threshold, the Trust still reported a relatively 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 these cases were associated with lapses in care. The Trust has done a considerable amount of work in order to reduce the risk of patients developing *C.diff*.

Our *C.diff* rate per 100,000 days as shown in the table below is sourced from the Health and Social Care Information Centre (HSCIC) website and is up to March 2015. The data shows a fluctuation in our rates over the last three years, however the 2014/15 results are the second lowest we have experienced since 2009. In addition, when compared against our peer group, we have the lowest rate per 100,000 bed days.

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

The data below has been sourced from the Health and Social Care Information Centre 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 has done a lot of work over the recent years at reducing the risk of *C.diff* infection to patients. 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 14: Rate per 100,000 bed days of cases of *C.difficile* infection

	Reporting Period:		
	2012/13	2013/14	2014/15
Homerton	10.2	1.6	5.3
National Average*	17.4	14.7	15.1
Lowest Performing Trust*	31.2	37.1	62.2
Highest Performing Trust	0.0	0.0	0.0

* based on the average of 'acute trusts'

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

- ▶ correct hand hygiene
- ▶ prudent antibiotic prescribing
- ▶ prompt identification of possible cases
- ▶ isolation of all patients with diarrhoea
- ▶ sample testing of all diarrhoeal stools
- ▶ environmental decontamination
- ▶ education and training of staff
- ▶ regular audits to ensure compliance with national and local guidelines.

Table 15: *C.difficile* rate Homerton Vs national average

***C.diff* infection per 100,000 bed days - 2014/15**



9. Patient safety incidents

Each year thousands of patients are treated and cared for at Homerton. The vast majority of patients are treated safely and effectively, however, sometimes incidents affecting the patient can occur irrespective of how dedicated, caring and competent our staff are.

The Trust actively encourages all members of staff to report incidents that have caused harm or have the potential to cause harm to our patients. This is to ensure that lessons can be learnt and necessary action taken to prevent the same or similar incidents from occurring in the future. According to the National Patient Safety Agency and the NHS Commissioning Board, increased reporting is considered as a 'positive indicator of a healthy safety culture, giving organisations the chance to learn and improve'.

Monitor and the Trust Development Authority (together now known as NHS Improvement) have recently published a new league to encourage openness and transparency. Data for the 2015/16 league table is drawn from the 2015 NHS Staff Survey and from the National Reporting and Learning System (NRLS). Homerton was rated as 'good', ranked 26th out of 230 organisations and the second highest ranked acute trust in London.

Whilst over the last few years the number of incidents reported to the Trust has increased, 2015/16 experienced a slight reduction, as can be seen in the tables overleaf.

Quality Account

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 CLIP (Complaints, Litigation, Incidents and PALS) and/ or monthly divisional governance groups and reported to the Trust Management Board every month.
- 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 and Trust Management Board.
- Incidents are validated before submission to the National Reporting and Learning System (NRLS).

Table 16: Rate of patient safety incidents per 1,000 bed days

	Reporting Period:		
	Apr 14 - Sep 14	Oct 14 - Mar 15	Apr 15 - Sep 15
Homerton	55.06	41.43	46.92
National Average*	35.29	36.24	38.11
Lowest Performing Trust*	74.86	82.21	74.67
Highest Performing Trust*	5.75	3.57	18.07

Table 17: Number of patient safety incidents

	Reporting Period:		
	Apr 14 - Sep 14	Oct 14 - Mar 15	Apr 15 - Sep 15
Homerton	3,057	2,820	2,966
National Average*	4,196	4,539	4,647
Lowest Performing Trust*	12,020	12,784	12,080
Highest Performing Trust*	35	443	1,559

Table 18: Number of patient safety incidents resulting in severe harm or death

	Reporting Period:		
	Apr 14 - Sep 14	Oct 14 - Mar 15	Apr 15 - Sep 15
Homerton	14	8	8
National Average*	20	23	20
Lowest Performing Trust*	97	128	89
Highest Performing Trust*	0	2	2

Table 19: Percentage of patient safety incidents resulting in severe harm or death

	Reporting Period:		
	Apr 14 - Sep 14	Oct 14 - Mar 15	Apr 15 - Sep 15
Homerton	0.46%	0.28%	0.27%
National Average*	0.49%	0.50%	0.43%
Lowest Performing Trust*	82.86%	5.19%	2.92%
Highest Performing Trust*	0.00%	0.05%	0.07%

* based on the average of 'acute (non specialist) trusts

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

- Increased DATIX training sessions. These are 'drop-in' sessions that are held once every two to four weeks for staff to receive more comprehensive training on how and when to report incidents and how to use and manage the system effectively. Additional ad hoc training is provided as required.
- The 'Serious Incident Reporting Policy' and the 'Incident Management Policy' is currently under review following a consultation process. The Policies detail the process for managing all incidents and the investigation process.
- The amalgamation of these policies into one policy will provide a streamlined pathway and clear guidance and support for Homerton staff in managing, investigating and reporting of incidents.
- Divisional CLIP Reports have been re-designed so that themes and trends can be more easily identified and highlighted in a quarterly report to PSC.

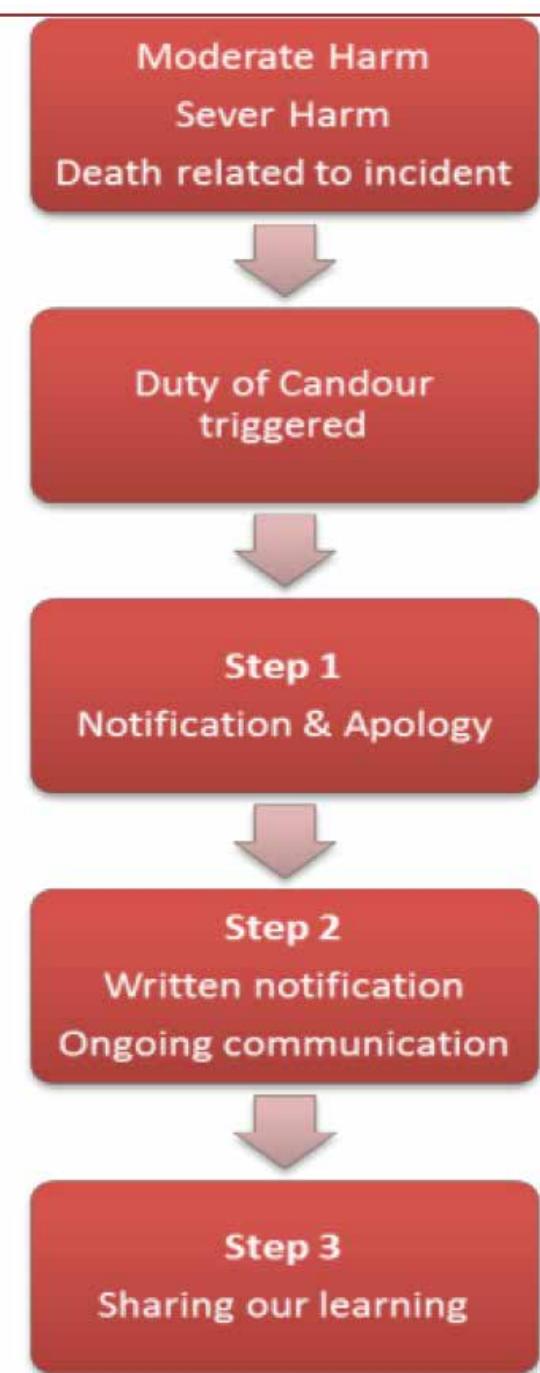
➤ **Duty of Candour**

The Duty of Candour is a legal and contractual requirement whereby the Trust must be open and honest with patients and/or their family/carer/representative, when things go wrong and where there is moderate or severe harm to the patient.

In October 2015 the Trust appointed a Patient Incident and Liaison Officer to support the delivery of Duty of Candour (DoC) and to make sure we were fully compliant with new regulations i.e. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 which came into effect on 1 April 2015, and our 'Being Open and Duty of Candour Policy' published in July 2015.

DoC involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment. Our aim is to be open and honest with patients and their relatives when things go wrong; to provide timely and appropriate communication, apology and support to those affected, and to ensure we share and disseminate our learning. Our process can be found in Figure 6.

Figure 6: Duty of Candour Algorithm



Quality Account

► Sign Up To Safety

The Trust has made the following pledges as part of its Sign up to Safety campaign:

Pledge 1
<ul style="list-style-type: none">• Consistently deliver harm free care, as identified within the Safety Thermometer, to over 97% of Homerton patients• Further reduce harm to patients caused by pressure ulcers, falls, urinary catheter infections and venous thrombo-embolism
Pledge 2
Safer Medicines: <ul style="list-style-type: none">• To reduce medication errors and associated adverse events via safe, effective and timely prescribing, dispensing, administration and monitoring of medication
Pledge 3
<ul style="list-style-type: none">• Achieve and maintain a position in the lower quartile of NHS organisations for the Summary Hospital-level Mortality Indicator (SHMI)
Pledge 4
Improve how and when we identify that a patient is deteriorating, and improve the effectiveness and efficiency of our rescue response to the deterioration: <ul style="list-style-type: none">• Sepsis• In-hospital cardiac arrest rates• AKI• Emergency Laparotomy Working Group

These pledges align with our work on quality priorities and details of our achievements thus far can be found in the appropriate quality priority.

This programme of work is being led through our Improving Quality Board and is now entering into year two of delivery.

Part 3: Quality Performance Indicators

3.1 National/Monitor performance indicators

Homerton University Hospital NHS Foundation Trust endeavours to meet all national targets and priorities. We have provided a summary of the national targets and indicators (including those set out in Monitor's Risk Assessment Framework) in the tables below.

Other national/local priorities are detailed in Part 2 of this publication.

Monitor targets / indicators	Indicator Description	Target 2015/16	2015/16	2014/15	2013/14
Infection Control	Number of <i>Clostridium Difficile</i> (<i>C.diff</i>) cases	7	10	7	2
Access	Referral to treatment time (incomplete pathway) - within 18 weeks ¹	92%	U/A**	97.9%	96.8%
	28 day emergency readmission rate	-	17.3%	16.7%	N/A
	A&E - total time in A&E under 4 hours (from arrival to admission/transfer/discharge)	95%	95.1%	95.4%	96.2%
	Cancer: 31-day wait from diagnosis to first treatment	96%	99.2%	98.4%	100.0%
	Cancer: 31-day wait for second or subsequent treatment: surgery	94%	97.3%	97.0%	97.7%
	Cancer: 31-day wait for second or subsequent treatment: drug treatments	98%	100.0%	100.0%	100.0%
	Cancer: 31-day wait for second or subsequent treatment: radiotherapy	94%	N/A	N/A	N/A
	Cancer: 62 day wait for first treatment (from urgent GP referral for suspected cancer)	85%	87.3%	88.2%	85.5%
	Cancer: 62-day wait for first treatment (from NHS Cancer Screening Service referral)	90%	100.0%	100.0%	N/A
	Cancer: two week wait from referral to first seen date (all urgent referrals cancer suspected)	93%	96.7%	96.4%	96.6%
	Cancer: two week wait from referral to first seen date (symptomatic breast patients - cancer not initially suspected)	93%	96.7%	96.5%	94.4%
	People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	79%	N/A	N/A
	People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	98%	N/A	N/A

Quality Account

Monitor targets / indicators	Indicator Description	Target 2015/16	2015/16	2014/15	2013/14
Outcomes	Community Services data completeness: referral to treatment information	50%	67%	66.7%	66.8%
	Community Services data completeness: referral information	50%	98%	98.5%	87.5%
	Community Services data completeness: treatment activity information	50%	98%	98.2%	75.6%
Infection Control	Number of MRSA Bacteraemias (hospital acquired) cases	0	1	3	5
Cancelled operations	Number of breaches of 28 day readmissions guarantee as % of cancelled ops	0	0	0	0
Immunisation*	Immunisations for DTaP/IPV/Hib - Age 1	85%	84.5%	85.8%	86.5%
	Immunisations for PCV - Age 2	83%	86.7%	89.8%	89.0%
	Immunisations for Hib/MenC - Age 2	83%	85.6%	89.4%	88.4%
	Immunisations for MMR - Age 2	83%	85.6%	89.2%	90.5%
	Immunisations for DTaP/IPV - Age 5	75%	79.7%	80.9%	79.4%
	Immunisations for MMR - Age 5	75%	84.3%	87.5%	85.7%
Breastfeeding	Breastfeeding coverage (%) at 6-8 weeks	95.1%	99.0%	98.8%	98.6%
	Breastfeeding prevalence (%) at 6-8 weeks	81.8%	82.7%	82.3%	82.0%

Note: With regard to the RTT Incomplete indicator the Trust is not reporting a position for 2015/16 in the Quality Account due to the fact that it suspended reporting half way through the year as a result of internally identified concerns about the robustness of its reporting logic. A detailed recovery plan was developed and agreed with commissioners in order to rectify these issues and the Trust's Board of Directors approved a return to reporting at its meeting on 30 March 2016 following an external assurance review of the revised reporting arrangements. Accordingly the Trust expects to be reporting performance against the RTT Incomplete indicator throughout 2016/17 and to publish this in its 2016/17 Quality Account as normal.

For information purposes, the A&E 4 hour waiting times, 62 day cancer waiting times and pressure ulcer incidents were audited by Deloitte during the 2015/16 financial year. See Appendix B for further information.

3.1.2 Pressure ulcers

Pressure ulcers, also known as bed sores or pressure sores, are areas of damage to the skin and deeper layers of tissue. They can occur in people who are unwell and immobile, and can cause pain, discomfort and reduced mobility, lead to longer stays in hospital and community beds and may increase the risk of acquiring complications such as infection.

Pressure ulcers can be categorized, according to the level of severity. There are four main categories (also known as stages or grades), with category one being the less severe and category four being the most severe.

Pressure ulcers can, on the whole, be preventable. Reducing harm from pressure ulcers is a key quality priority for our Trust. We are focused in making all the efforts to identify those patients who are at risk and taking precautions to protect skin integrity and prevent those who already have tissue damage from experiencing further deterioration.

The Trust has continued to promote incident reporting through DATIX and all pressure ulcers category 3 and above are subject to a root cause analysis process to identify barriers to maintaining harm free care and gaps in practice.

Process for review:

1. All pressure ulcers are reported on Datix. Reporting has been tailored to include information such as whether: a patient was transferred from another hospital/ nursing home; a Safeguarding alert has been completed; immediate care actions have been taken, there is also a section for Tissue Viability CNS's to write a fuller review.
2. A weekly report of all pressure ulcers reported on Datix is populated each Monday for the preceding week.
3. The Pressure Ulcer Scrutiny Committee (PUSC) review each incident to:
 - i. establish cause of ulcer to approve pressure ulcer status
 - ii. validate the grade
 - iii. determine whether ulcer has been previously reported, and if so to establish whether it is a duplicate report or if the category has changed
 - iv. consider whether there are any immediate safeguarding concerns

- v. decide if the ulcer is Homerton acquired.
4. For grade 2 pressure ulcers the handler investigates the incident to ascertain if the ulcer was avoidable or unavoidable, and to ascertain if there are any lessons to be learned.

For Homerton acquired grade 3 and above pressure ulcers:

- a rapid review is instigated
- the ward sister/ community team leader is contacted and asked to investigate and report back to the next available Pressure Ulcer Scrutiny Committee (PUSC)**. They are asked to complete the draft report and email it to their Lead Nurse and Head of Nursing, and once a final draft is approved, attach the report to the Datix incident.

For non-Homerton acquired pressure ulcers where another care provider is involved:

- the Quality and Patient Safety Manager (QPSM) contacts their equivalent at the other organisation to inform them about the pressure ulcer. The Lead for Adult Safeguarding attends PUSC and decides on course of action.
- 5. Rapid reviews are presented to Pressure Ulcer Scrutiny Committee to
 - i. establish whether Trust staff carried out the appropriate care and documented this or any deviations from this and escalated them accordingly
 - ii. determine the cause of the pressure damage and whether the ulcer could have been avoided or not
 - iii. identify any learning points.
- 6. Post meeting:
 - i. Any confirmed non-Homerton acquired pressure ulcers where another care provider is involved:
 - the Quality and Patient Safety Manager (QPSM) contacts the respective provider to speak to their equivalent regarding the outcome of the meeting
 - ii. Datix system updated by QPSM.

During 2015/16, a total of 253 pressure ulcers were reported on Datix (incident reporting system). Of these, 54 were categorised as grade 3 or 4, and as such, required a rapid review to be undertaken. To date, 52% of these incidents have been through the rapid review process. Of the 28 reviewed, 10 (36%) have

Quality Account

been classified as avoidable and 18 (64%) unavoidable. However, the Trust still needs to complete a further 26 rapid reviews before being able to determine if these were unavoidable or not.

In May 2016 Deloitte Auditors audited this process on behalf of the Trust. Upon initial testing of 17 records, 5 showed inconsistencies between the rapid review results and what was recorded on Datix. These issues were resolved and a new dataset provided to the auditors. A further seven cases were assessed, and no further issues were identified.

Two recommendations were made:

1. A clear terms of reference should be developed for the Pressure Ulcer Scrutiny Committee, in addition to Standard Operating Procedures / complementary guidance to be developed which clearly sets out the roles and responsibilities of all stakeholders involved in the process.
2. Assign a specific member of staff responsibility for updating Datix and other relevant documentation with the outcomes from the Pressure Ulcer Scrutiny Committee, which will ensure the data is accurate and up to date at any given time.

The Trust has responded to these recommendations in the following way:

1. The Trust will provide a revised Terms of Reference for the Pressure ulcer scrutiny committee and an outline of roles and responsibilities of key stakeholders in the process will be produced by June 2016.
2. The responsibilities of the Lead Tissue Viability Nurse and the Quality and Patient Safety Manager have been agreed and will be documented formally as part of recommendation 1.

** A Pressure Ulcer Scrutiny Committee (PUSC) was established in 2014. It is made up of a multi-professional group of nurses from the acute and community setting, Tissue Viability Specialist Nurse (TVN), Safeguarding Adults representative and is chaired by a Head of Nursing. The committee is supported by one of the Quality and Patient Safety Managers.



3.1.3 Review of 2015/16 priorities

The following section provides a detailed description of progress made against the 12 improvement priorities we selected in 2015/16. Additionally, we will provide details of future work to continue our improvements in 2016/17. Although several priorities will not be continued, we will ensure these will be monitored through the most appropriate channels.

Priority One

Safe: Improve the reduction in harm to our patients



Target fully achieved

Background:

The Trust participates in the National Safety Thermometer programme, collecting patient data in relation to potential harms. It is a point prevalence survey (that is the number of harms seen at a particular point in time) and can be used to show trends in the number of harms suffered as an indicator of the safety of our patients over time. Once the data is collected it is entered into the safety thermometer software and uploaded to a national portal. Every patient in our care is assessed for four specific areas of harm; this gives an understanding of the level of harm-free care including pressure ulcers and venous thromboembolism (VTE).

Although significant progress was made in the reduction of harm in 2014/15, we believed further work could be undertaken to reduce this further.

What did we say we would do?

Deliver harm-free care to 96% of patients every month during 2015/16

- reduce the incidence of avoidable pressure ulcers to less than two per month consistently during 2015/16 (Homerton Hospital/ Community acquired grade 3 or above)
- to further reduce harm to our patients through medication safety by 5% - building on progress made during 2014/15
- to establish an accurate baseline for the incidence of VTE* and show demonstrable improvements during 2015/16

What did we do?

During 2015/16 we have delivered harm free care to 96.4% of our patients (see Figure 7). This is an improvement on 2014/15, where just over 95.6% of our patients received harm free care. In fact, every month except September, we experienced an increase on the previous year, as illustrated in Figure 7.

In addition, as the graph below shows, we have delivered 'new' harm free care to 98.9% of our patients. New harm free care excludes any harms (within the specific categories of pressure ulcers, falls, UTI & catheters and VTE*) the patient already experienced prior to or on admission to hospital. It is noteworthy that the Trust ranks second in our benchmark comparator group and almost 10 percentage points higher than the national average (see Figure 8).

Quality Account

Figure 7

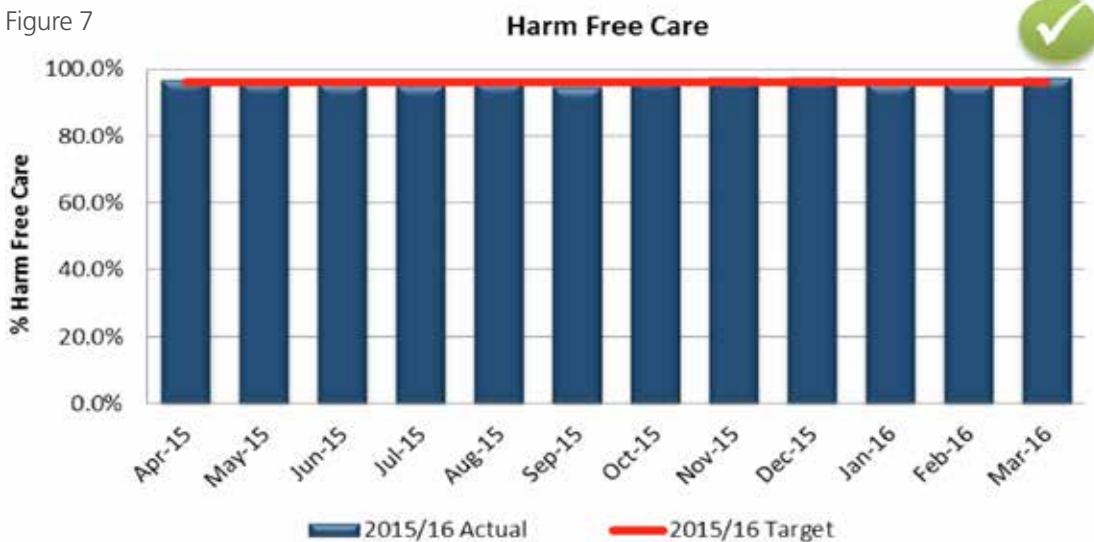


Figure 8

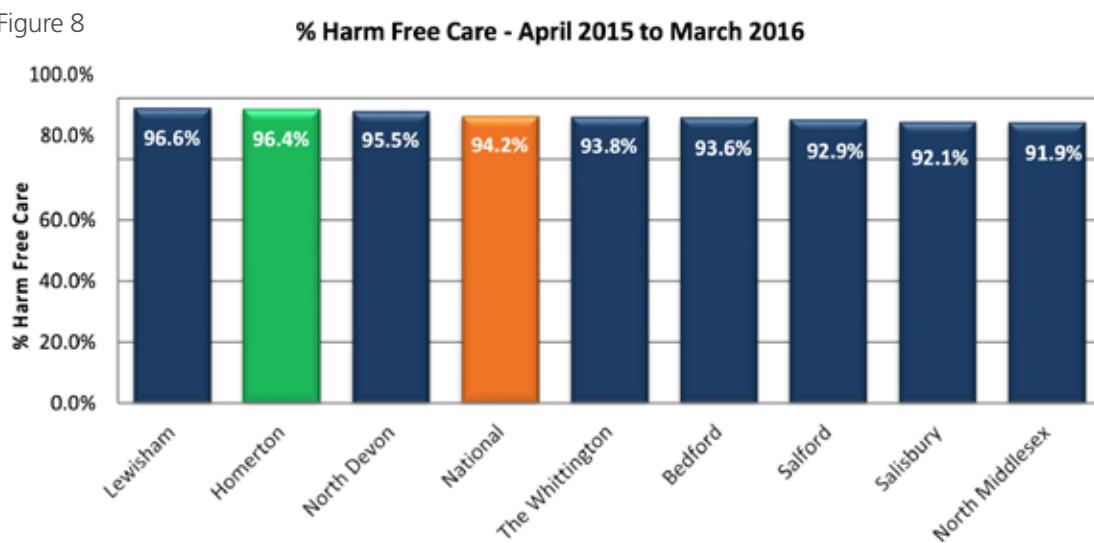
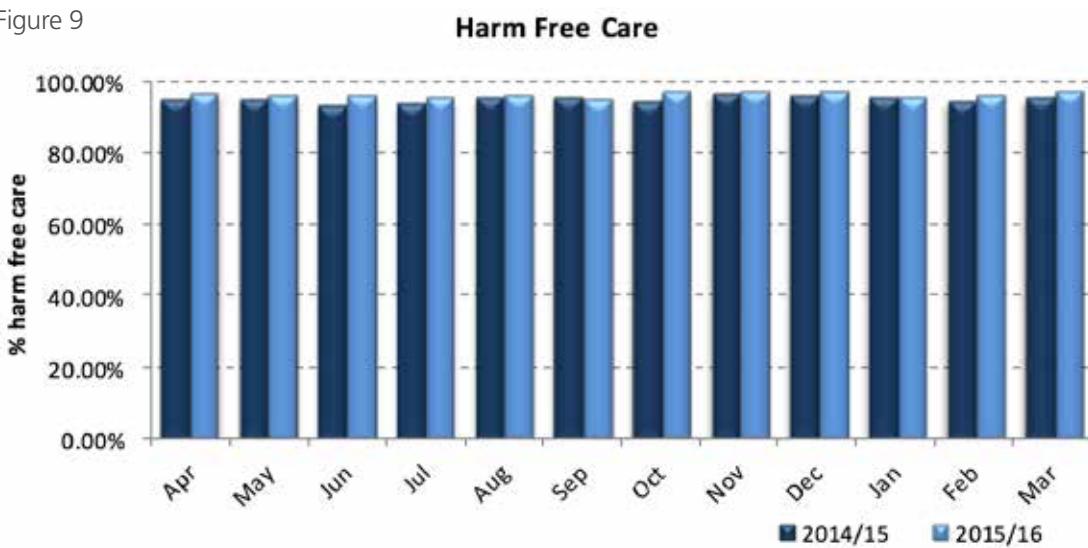


Figure 9



Source: National Safety Thermometer/Local Data

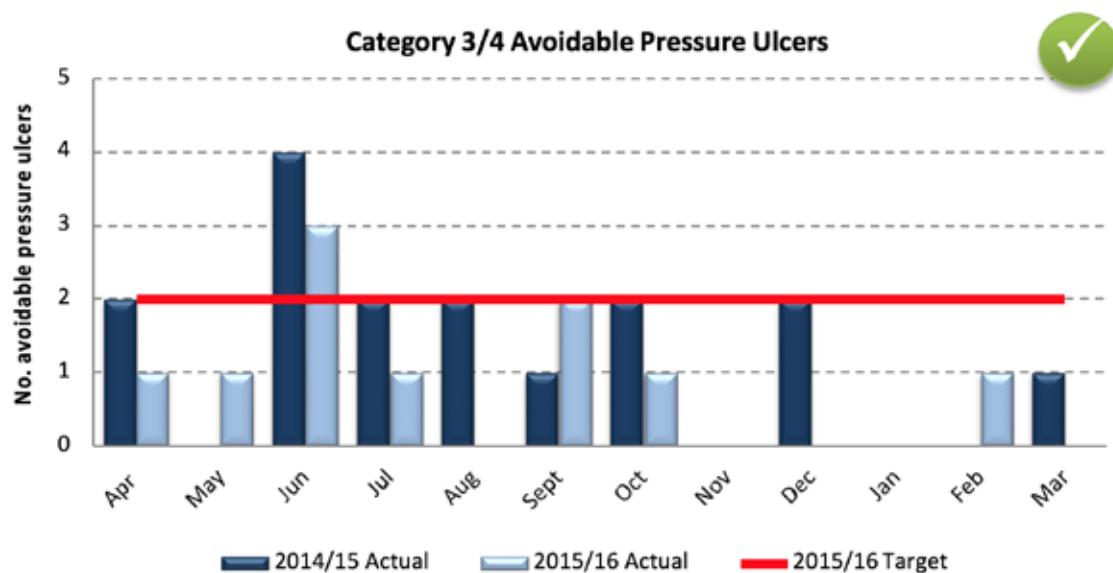
This year we have developed and introduced a fully electronic reporting system for the safety thermometer; this has led to significant progress and has significantly improved the overall quality of reporting, with every ward returning a complete data set.

Pressure ulcers:

During 2015/16 the Trust reported 45 new pressure ulcers acquired within our care as part of the National Safety Thermometer point prevalence survey. Of all patients surveyed during 2015/16, 0.46% developed a new pressure ulcer.

The number of avoidable pressure ulcers reported during 2015/16 was 10. However, of note, we currently have 26 rapid reviews outstanding (this is the review process we subject all grade 3 and 4 pressure ulcers to) which could increase this figure. However, based on the current ratio, we would still expect to come in under the target set for 2015/16. This measure was audited by Deloitte in May 2016. Please see section 3.1.2 for further information in relation to this audit.

A new chair was appointed by our Pressure Ulcer Scrutiny Committee and subsequently the review process has been strengthened to ensure reports arrive in a timely manner, and validation is carried out at the earliest opportunity.



Source; National Safety Thermometer/Local data

A tissue viability lead nurse was appointed in January 2016; this has led to a re-focus on training for the prevention of pressure ulcer occurrence both at home and in hospital.

We undertook a specific project to enhance harm free care through prevention of pressure ulcers across Hackney. The primary aim was to agree the use of a common pressure risk screening tool and escalation process for non-nursing providers.

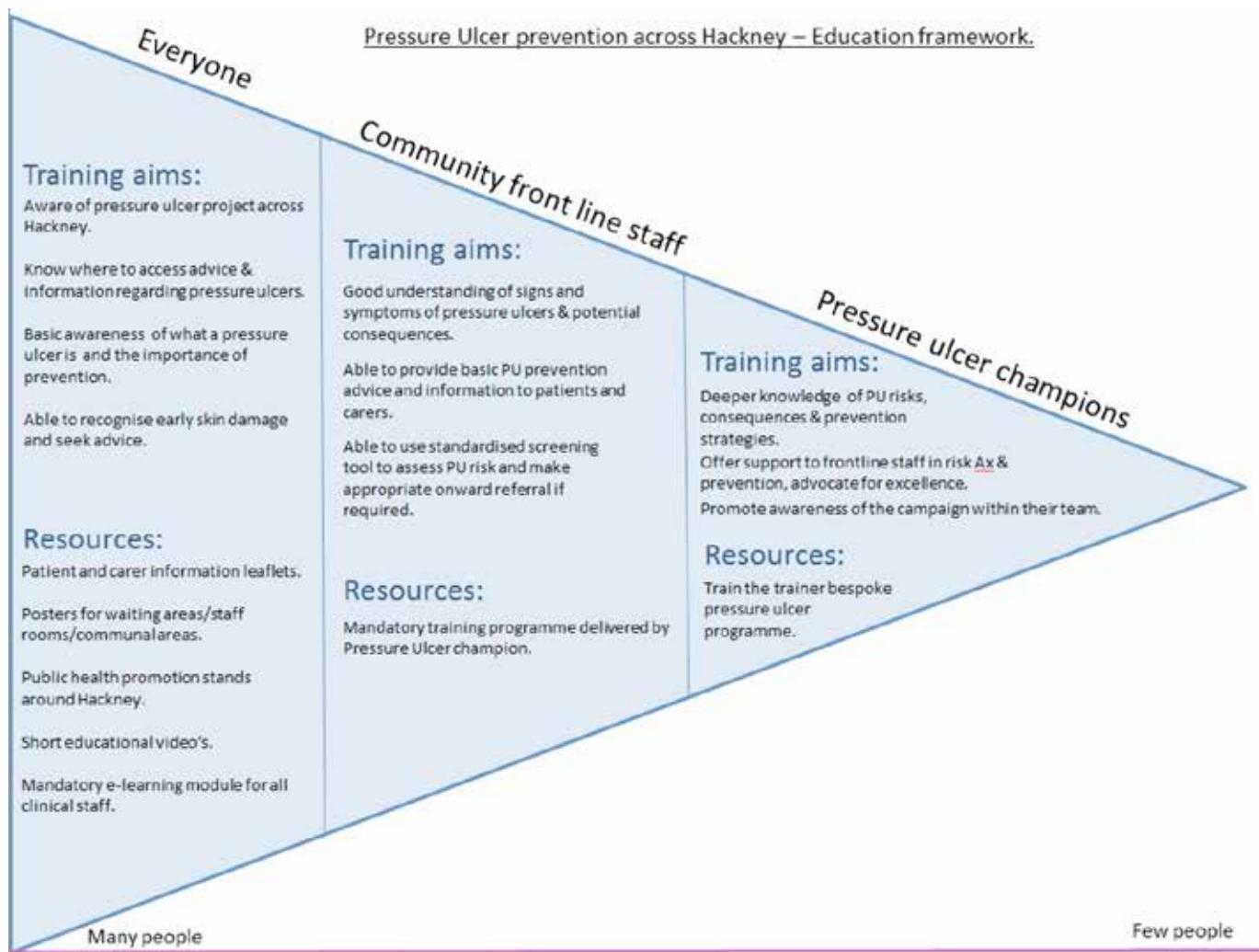
A working group was established, with representation from our Community Nursing and Therapies Team, CCG, GP confederation, Community Education Provider Networks and London Borough of Hackney.

The Hackney wide working group have now developed and agreed an education framework (see Figure 10); pressure damage assessment tool for non-nursing care staff, which has been piloted by four services; and have developed raising awareness pack for care workers, nursing and residential homes.

Quality Account

Over recent months the Trust has begun to develop a series of clinical dashboards in which a range of activity data is being monitored, that will aid appropriate decision making. It is recommended that data on pressure ulcers form part of the minimum dataset for these dashboards.

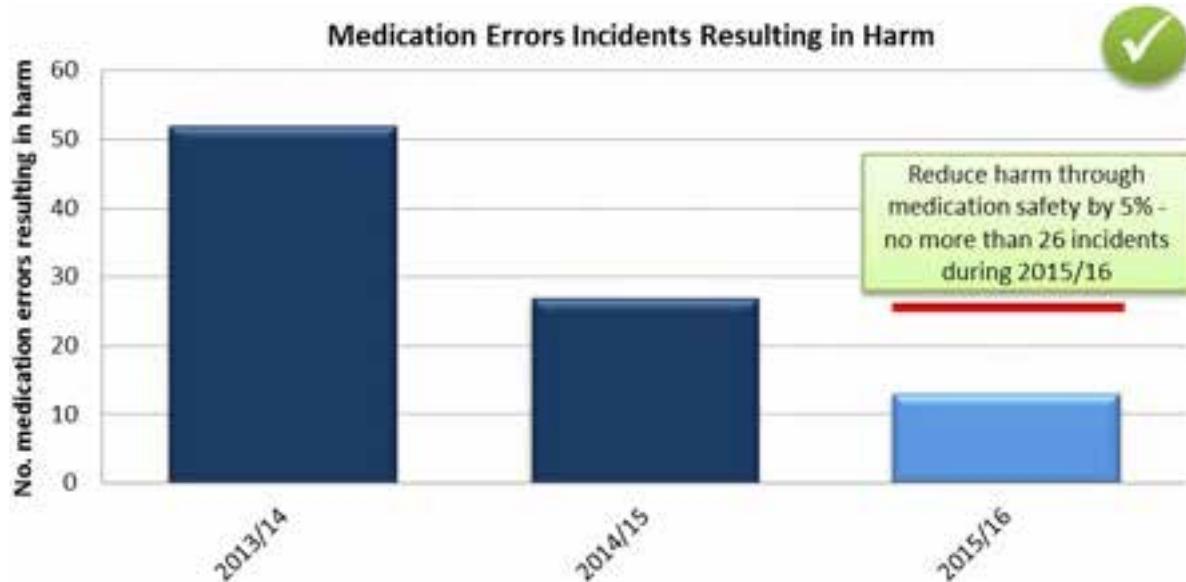
Figure 10



Medication errors:

During 2015/16 we continued our efforts to monitor and reduce medication errors resulting in harm and have achieved a 52% reduction on 2014/15 baseline (see Figure 11). A number of initiatives are in place to support this. Our key achievement this year was the introduction of a new Electronic Medicines System (EMS). All prescribing and drug administration is now completed electronically with the exception of neonatal and outpatients. EMS allows us to identify every aspect of medications history from original prescriber to who gave their medication to take home. In addition, EMS prevents illegible prescriptions and misplaced drug charts.

Figure 11



Source: DATIX – Incident Reporting System

Other initiatives to prevent harm from medication include but not exclusively:

- Regular reporting to our Patient Safety Committee and Prescribing Programme Board.
- Continued support for incident and near miss reporting and trend identification, ensuring these are formally discussed.
- Monthly medication incident review by MSO (Medication Safety Officer) and Chief Pharmacist.
- Regular intranet medicine safety information updates for staff.
- Online Clinical Skills training and new self-assessments to identify training needs for all registrants (i.e. for clinicians not exposed to medicines often).
- Mandatory training for medicines management, ensuring session is up-to-date drawing on current issues and enables cascading of information.

This year, together with Parkinson UK, we have looked at ways to improve the Parkinson patient experience, and to support 'Get-it-on-Time' campaign. We have secured charitable funds for pill timers. The timers will assist nurses to administer medicines in a timely manner i.e. when the patients require them, rather than administering at set drug round times. To support this, our Parkinson clinical nurse specialist (CNS) has commenced a nurse education programme. This is underway on our Elderly Care Unit after which it will be cascaded across the Trust.

A Venous Thromboembolism (VTE) Committee has been re-established following the appointment of a new haematology consultant in September 2015. Following a number of VTE* incidents, local anticoagulation policies are under review. Areas of improvement have been identified and an action plan is under development. Electronic patient record (EPR) VTE risk assessments are being mandated to ensure completion within the required 24hr assessment window.

Quality Account

To establish an accurate baseline for the incidence of VTE and show demonstrable improvements during 2015/16 the Trust has used the Datix incident reporting system as a record of Trust-attributable VTE.

We can evidence progress through:

- Pressure Ulcer Scrutiny Committee
- Medication Safety Committee
- Trust Board performance reports

In 2016/17 we will:

- ensure Harm Free Care remains a priority through the Sign-Up-To-Safety programme
- continue to report overall progress to Trust Board
- aim to deliver harm-free care to at least 95% of our patients consistently
- in 2016/17 we will improve VTE monitoring through the re-established Trust Thrombosis Committee, ensuring effective VTE risk assessment to improve learning and increase prevention.

For this reason this will be one of our Quality Account priorities and will be monitored by the Improving Clinical Effectiveness Committee.

Priority Two A

Safe: Improve the response to acutely deteriorating patients and reduce failure to rescue



Progress towards target achieved

Background:

The Trust implemented NEWS in 2014/15 to ensure an effective and appropriate response for patients who become acutely unwell.

The National Early Warning Score (NEWS*) is a simple scoring system, whereby a score is allocated to six physiological measurements routinely carried out when patients are in hospital i.e. respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.

A score is allocated to each measure based on normal values, the scores are then combined, and used to determine whether the patient's condition warrants an increase in observation frequency or is deteriorating and requires immediate escalation to a doctor.

There is currently a national focus on the deteriorating patient, particularly those with sepsis (a life-threatening illness caused by the body's response to an infection) and AKI* (acute kidney injury i.e. sudden damage to the kidneys that causes them to stop working properly).

Despite the successful roll out of NEWS* in 2014/15, it was apparent further work was required to embed the core requirements of the deteriorating patient pathway across the Trust, and to facilitate the national CQUIN* targets through early and timely identification of sepsis and AKI*.

What did we say we would do?

This year we set out to build on the progress made by:

- improving NEWS* reporting (completion rates) i.e. 90% by March 2016
- improving the NEWS* overall response rates (escalation where appropriate) i.e. 90% by March 2016
- ensuring 90% of eligible patients (Emergency Department only) receive antibiotics in line with Trust Policy on Sepsis by Quarter 4.

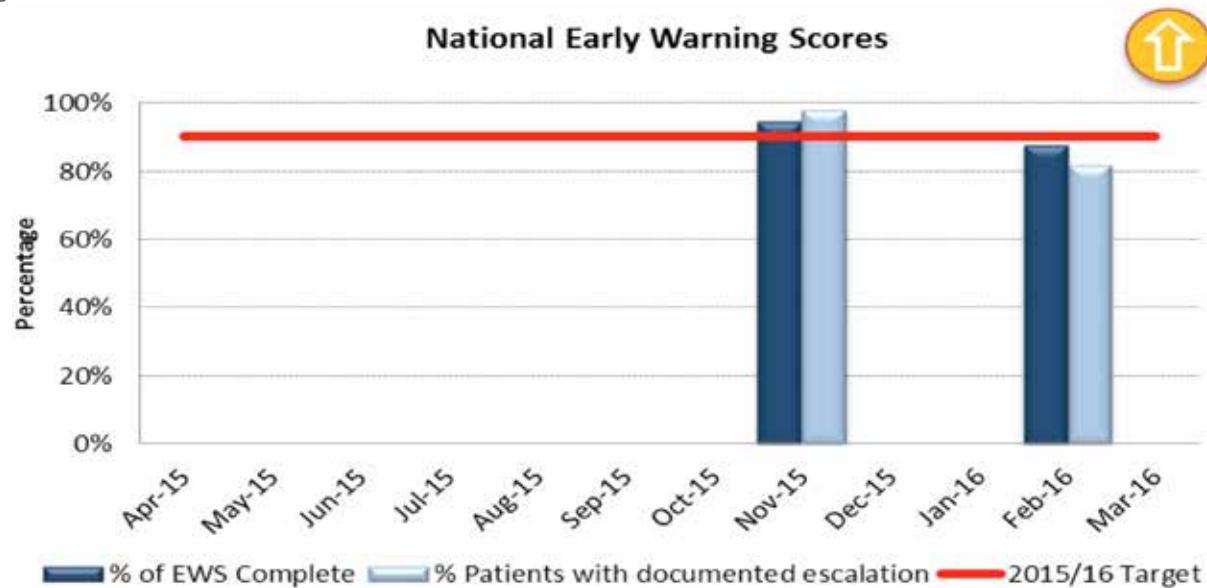
What did we do?

National Early Warning Scores (NEWS*)

Our improvement work has included the following actions

- Upgrade of our Electronic Patient Record (EPR*) System in summer 2015. This enhanced system gave greater visibility to the recording and escalation of the NEWS*. In addition, we implemented new observation (e.g. blood pressure) taking technology to enable direct data upload to EPR*, to avert recording errors and release administrative time for clinical duties.
- Targeted staff education to encourage and highlight the importance of clinical observations for patient outcomes. Further supported by a programme of 'Senior Rounding'* including but not exclusively a weekly 'Chief Nurse Ward Round'.
- Review and revision of our sickle cell protocol to support NEWS* measures/ escalation.
- Implementation of dedicated Quality Improvement Team support in October 2015.
- Audit (see Figure 12) and feedback

Figure 12



Source: Local audit data based on national definitions of NEWS

Due to changes in audit methodology, comparative and historical performance is not available.

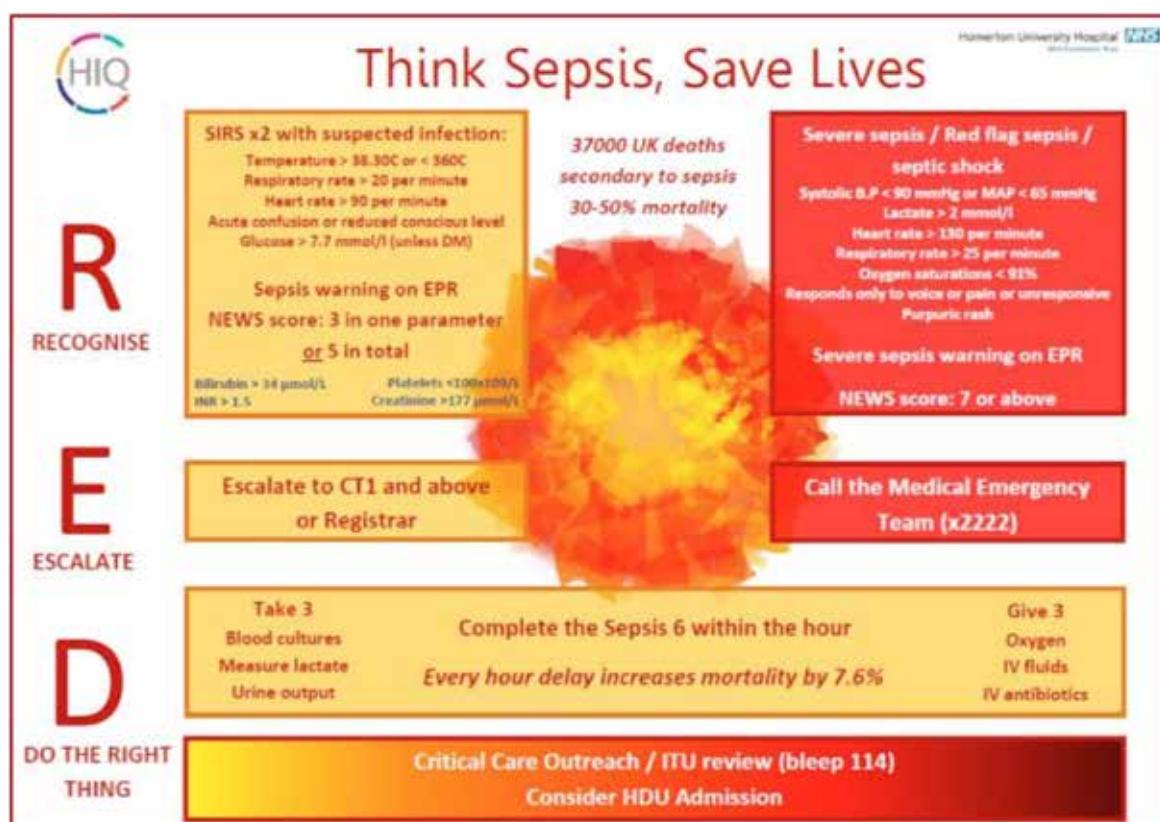
Despite significant effort, we have not yet achieved our target to improve completion and escalation of NEWS for 90% of our patients. Further understanding and work will be required to ensure this process is fully adopted.

Quality Account

Sepsis

Our improvement work has included the following actions

- Use of the 'Sepsis Six'* principles to drive our local programme, including the development of a diagnosis check card for all emergency staff and local ambulance crews.
- Education and communication including targeted teaching for surgeons and Acute Care Unit (ACU) staff, and an induction training programme for all junior doctors in the Emergency Department (ED), and to ensure lessons learnt and performance is shared with staff.
- Upgrade of EPR to identify 'at risk' patients; recommend treatment plans; and allow direct links to Trust Sepsis Policy.
- Establishing a 'sepsis bay' in the ED resuscitation room, to allow immediate transfer and senior clinician review of any patient triggering a 'systemic inflammatory response syndrome' criterion.
- Introduction of a sepsis trolley in both ED* and the ACU*, to ensure essential information and equipment is together such as, sepsis pathway, antibiotics guidelines, blood culture bottles, swabs etc.
- Creating a sepsis cupboard to hold all commonly used sepsis drugs.
- A sepsis 'Patient Group Direction'* has been developed to enable senior nurses in ED* to administer antibiotics as soon as possible - this is currently being tested.
- Application of paediatric sepsis policy and preliminary launch.



Acute Kidney Injury (AKI*)

Along with the focus on escalation of deteriorating patients, there has been a specific improvement programme for AKI, this work has centred around technology to improve communication with our staff, patients, and primary care teams at time of discharge.

We now have a clear process in place for:

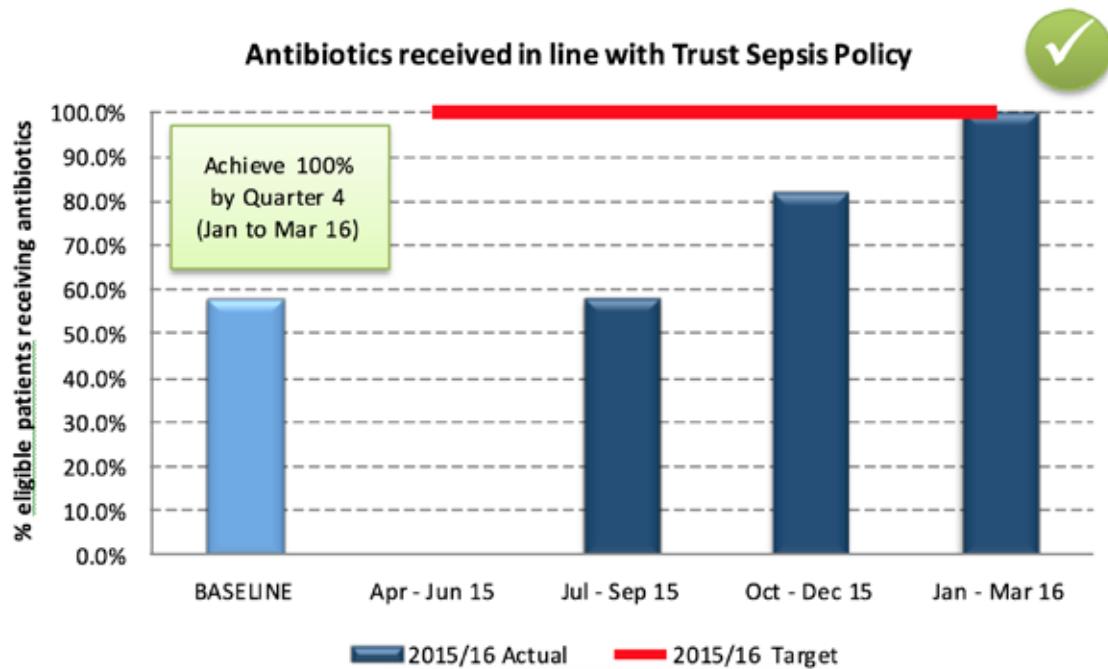
- electronic alert on the patient record for the presence of AKI
- a targeted pharmacy review
- effective communication to GPs.

We have introduced a specific AKI junior doctor education programme; and have launched a fortnightly fluid balance training programme on ACU to improve record keeping and aid optimal fluid management.

Antibiotics

Significant work has been undertaken to improve the administration of intravenous (IV) antibiotics within one hour to all patients who present with severe sepsis, red flag sepsis or septic shock in to the ED. During October 2015 to March 2016, 325 ED attendees required sepsis screening of which 93% were screened. Based on discharges coded with sepsis, 37 patients met the criteria for IV antibiotic administration within one hour, and this was achieved in 92% of cases. The ED team scrutinise all antibiotic breaches on a regular basis to develop and inform compliance improvement plans (see Figure 13).

Figure 13



Source: Local Data

Quality Account

We can evidence progress through:

- Critical Care Committee and Deteriorating Patient Group
- Improving Clinical Effectiveness Committee

In 2016/17 we will:

- continue to work with our staff to maintain the success that we have demonstrated in 2015/16
- extend achievements to out of hours practice
- continue to work towards improving time to treatment for patients with Sepsis
- continue to work towards improving time to treatment for patients with AKI*
- continue to improve our communication with GPs* and referral centres regarding patients with AKI .

Priority Two B

Safe: Improve monitoring and escalation for high risk women using the Maternity Early Obstetric Warning Score (MEOWS*)



Progress towards target achieved

Background:

This was a new priority for 2015/16 to build on our objective to improve patient safety through using National Early Warning Score (NEWS), to ensure additional improvements were made within our maternity service.

The Modified Early Obstetric Warning Score (MEOWS) system was introduced into the department in 2013/14, following recognition that our escalation system had limitations. However, an unannounced CQC inspection in March 2015 raised concerns regarding the consistent safe monitoring and escalation of women and babies in the maternity unit, requiring a refocus.

What did we say we would do?

We said we would show demonstrable improvements in the Modified Early Obstetric Warning Score (MEOWS) system when monitoring and managing the care of high-risk women to ensure:

- 100% of relevant maternity staff to have completed their training in recognition and management of the acutely unwell women within one month of commencing post
- 100% women seen in triage (maternity) have MEOWS scores documented as part of the triage process
- use of MEOWS for 100% of high risk women (i.e. maternity)
- 100% appropriate escalation will occur when MEOWS triggered.

What did we do?

We introduced a number of initiatives to address our goals.

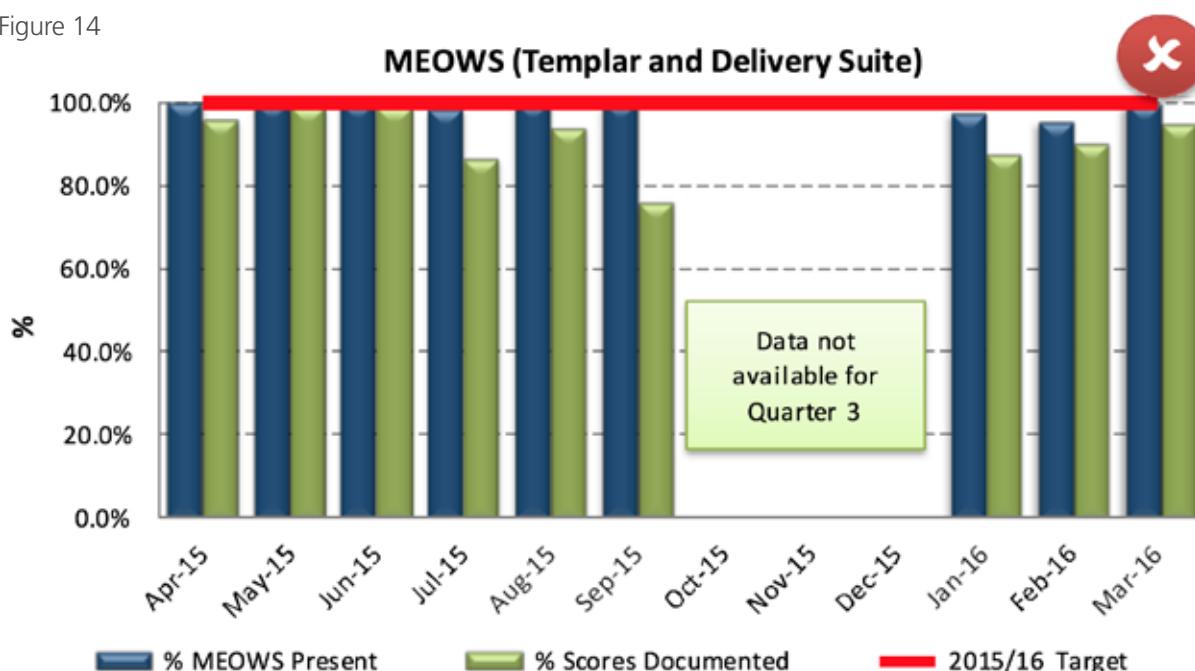
All staff groups working in the maternity unit received face to face MEOWS refresher training from a Band 7 midwife. Recognition of the deteriorating patient and management of the acutely unwell woman has been introduced into our maternity mandatory training weeks to provide greater focus; subsequently, 100% of all relevant staff have undergone training. Additionally, there has been specific targeted training on the recognition and escalation of the deteriorating patient for OAU (Obstetric Assessment Unit) and maternity triage staff.

In April 2015, we introduced senior midwives daily compliance rounds (a real time audit of MEOWS* compliance throughout the maternity department). Although we found every woman had a MOEWS* chart present in their notes, we found the frequency of observations was not documented consistently and staffs were not recording overall score on the charts. For this reason, senior midwife compliance rounds were carried out daily for three months; reducing to three times a week as compliance improved. However, as senior visibility reduced, we found compliance dipped; subsequently frequency has been increased to drive improvement.

Over the year we saw a steady rise in compliance with indicators measured that is: 99.5% of women (not just those at high risk) had a MEOWS chart and 95.9% women had their MEOWS* scores documented as part of the triage process (see Figure 14)

Unfortunately, we are unable to provide our accurate position in relation to 'appropriate escalation when MEOWS are triggered'. Following a recent audit of our MEOWS activity data, an error in the calculation method was identified, and the information collected didn't completely support this measure. The error was immediately rectified, and the data for January to March 2016 was re-audited to reflect the correct methodology. Results show that 96.6% of women were appropriately escalated when required. Whilst we are unable to provide demonstrable evidence in support of this measure over a 12 month period, we are confident that women who are assessed as being at risk, and who may potentially require additional escalation during their pregnancy and delivery, receive the appropriate care.

Figure 14



Source: Local Audit Data and Electronic Patient Record System (EPR)

This is a new measure monitored during 2015/16 and no historical data is available

Quality Account

More recently, we have conducted out of hours audit to identify behaviour to develop further understanding and to help steer focus.

We can evidence progress through:

- monthly Maternity Risk Management Review Meeting (MRMR)
- tracked monthly on the Maternity Dashboard:
 - Reviewed by Executives at Trust Performance meeting
 - Trust Board review
 - Maternity Programme Board (City & Hackney CCG*)

In 2016/17 we will:

- ensure progress is made to ensure MEOWS compliance and escalation is monitored and embedded, to improve monitoring and escalation of response to acutely deteriorating patients and reduce failure to rescue
- continue this work as a 2016/17 Quality Account priority, to be combined with sepsis and acute kidney injury.



Priority Two C

Safe: Reduce number of babies born at Homerton University Hospital admitted to NICU at term with evidence of severe acidosis



Progress towards target achieved

This is a new priority for the Trust and measures are set to ensure that additional improvements are made within our Neonatal cohort.

Whilst inside the womb, a baby depends on good placental transfer of oxygen and carbon dioxide for healthy development. When placental transfer is inadequate, low oxygen levels or an accumulation of waste products can lead to a build-up of hydrogen ions in the blood system and acidosis (a reduction in the pH of the blood). When severe and acute, or if prolonged, acidosis can result in long term damage to an otherwise normal baby. Life threatening complications can occur during the course of any pregnancy and it is essential that all hospitals have systems in place whereby babies can be delivered without delay when necessary.

The Royal College of Obstetricians and Gynaecologists published good practice guidelines in 2010, encouraging universal use of a nationally accepted classification system for caesarean section, with the aim of reducing communication difficulties between and within teams, for improved care for women and babies. The system identifies four risk categories, with a grade 1 Caesarean Section* requiring decision to delivery of less than 30 minutes where there is considered to be an immediate threat to the life of the woman or foetus. Adherence to this guidance should minimise the risk of long term harm to mother or baby.

This classification system was adopted at Homerton soon after publication, but the annual audit of grade 1 Caesarean sections consistently showed failure to meet this target; between January and March 2015 only 75% of cases were delivered within 30 minutes of the decision. Timely delivery requires correct interpretation of foetal heart rate patterns (the cardiotocograph - CTG) as well as constant team work between midwives, obstetricians, anaesthetists and theatre staff.

What did we say we would do?

- 100% of grade 1 emergency caesarean sections meet the RCOG decision to delivery standard (unless clinically inappropriate)
- 100% of midwives have completed K2 CTG training in the past 12 months
- 100% of obstetricians have completed K2 CTG training in the past 12 months

What did we do?

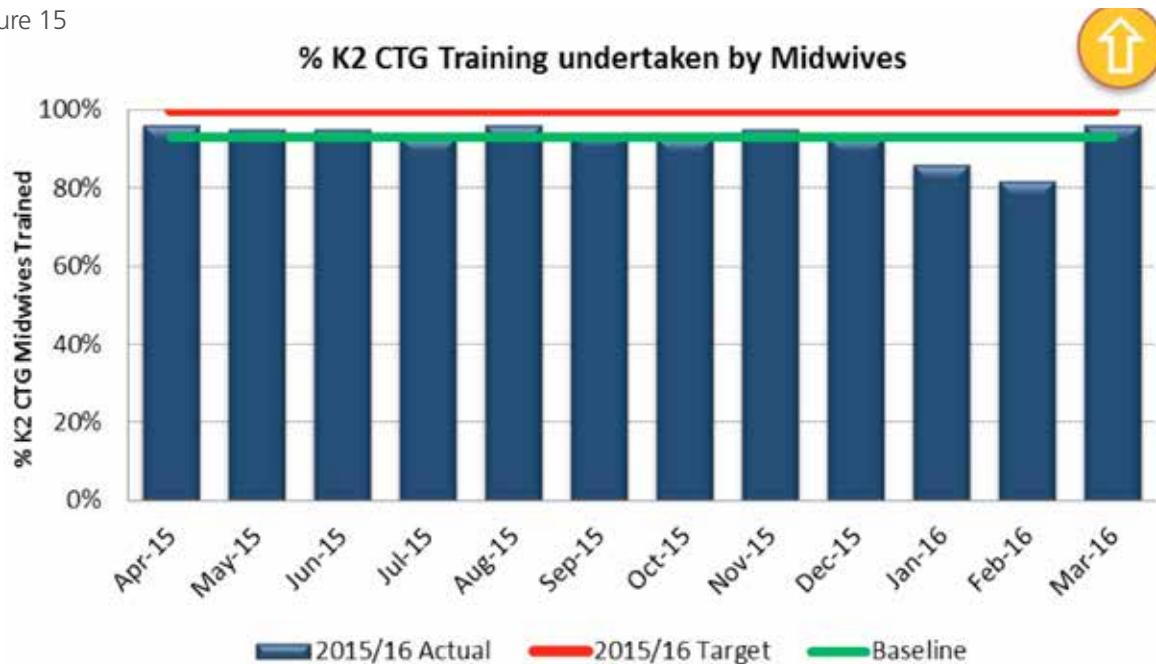
A multifaceted approach was adopted to achieve our goal. From April 2015, the induction process for all junior doctors working in obstetrics and gynaecology was changed to incorporate hands on training with simulation. The simulation was consultant-led with focus on the systems in place in the department to facilitate good communication and appropriate action in an emergency situation. From April 2015 cases of grade 1 caesarean section were reviewed and those where the care had been particularly good or where the decision to delivery had taken more than 30 minutes were presented at the weekly departmental multidisciplinary meeting.

Midwifery mandatory training underwent formal review in May 2015 and an updated and refreshed training programme was launched in June 2015. Again the focus was on effective communication in an emergency situation with multiple “hands-on” simulation stations on the final day of the course. Each member of staff working in Maternity is required to attend mandatory training on an annual basis.

Quality Account

Correct interpretation of a foetal heart rate trace (CTG*) is fundamental to appropriate grading of caesarean sections and subsequent action in what can be an enormously stressful situation for all concerned. In 2015/16 96% of our Midwives and 100% of our Obstetricians underwent K2 CTG training (see Figure 15 and Figure 16). Whilst CTG training has been compulsory for all staff working in maternity, the training was changed to incorporate additional "scenario" training with a formal assessment built in. Those staff who failed their assessment were required to re-sit the test and were not able to work alone until the assessment had been passed. An internationally recognised expert in CTG* interpretation led a study day at Homerton in December 2015. This day was attended by 124 maternity staff.

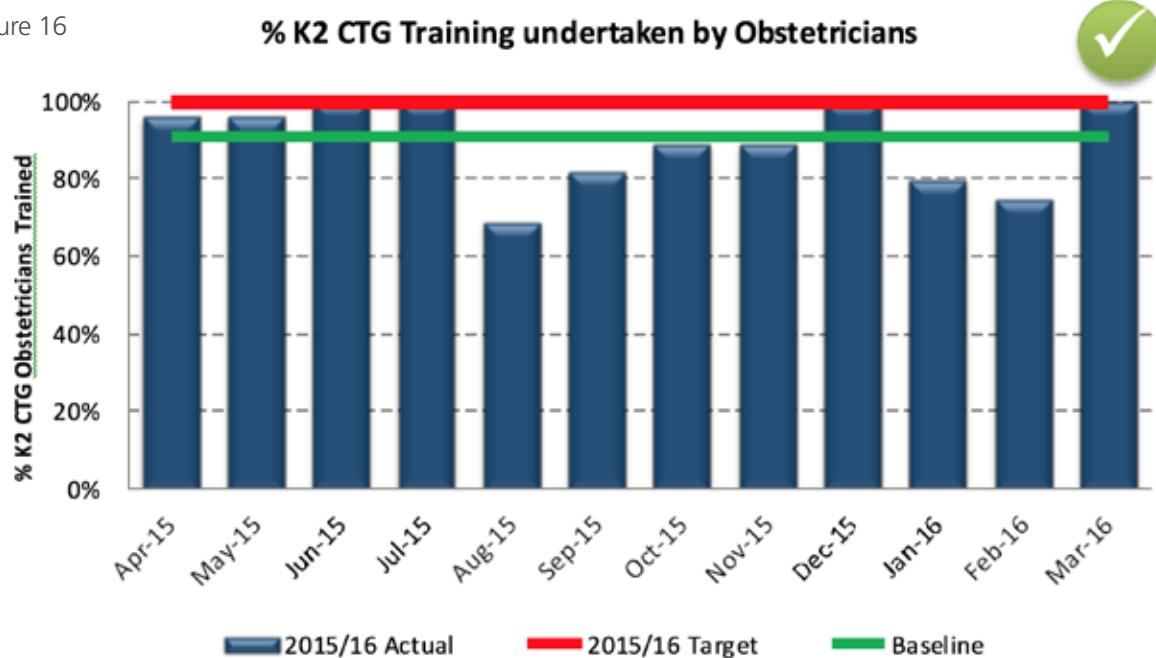
Figure 15



Source: Local Data

This is a new measure monitored during 2015/16 and no historical data is available

Figure 16



Source: Local Data

This is a new measure monitored during 2015/16 and no historical data is available

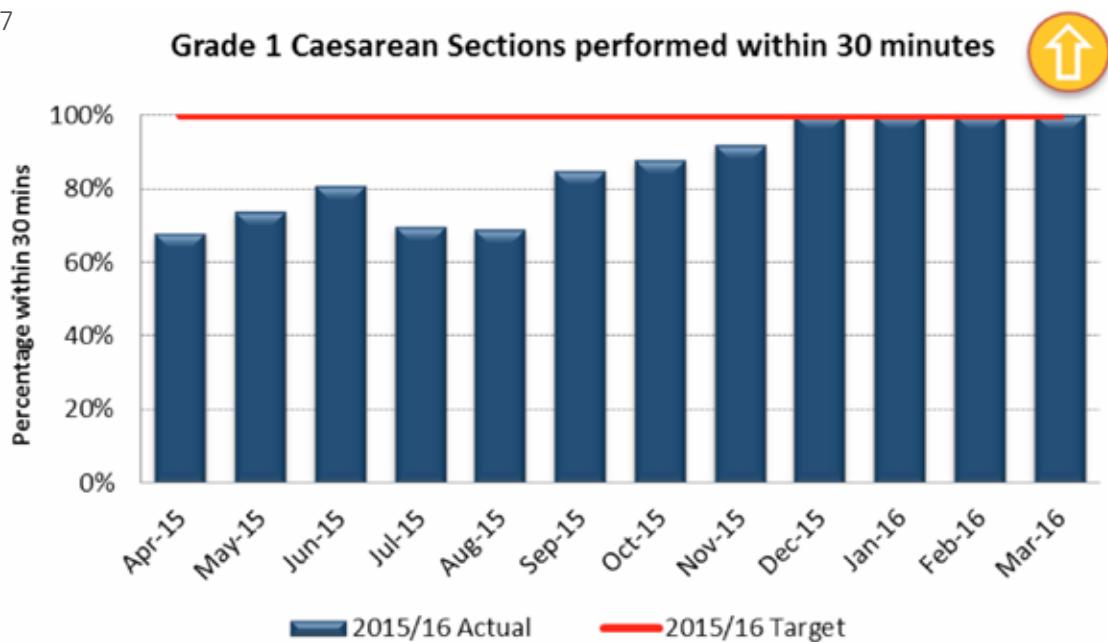
Individual de-brief is now provided to any staff involved in a case where the decision to delivery time for a grade 1 Caesarean Section* was greater than 30 minutes so that any contributing factors can be assessed. Where factors could apply in other cases, a plan is devised to address and make necessary changes to prevent recurrence.

For several years the maternity and anaesthetic staff have met twice yearly for a morning of multidisciplinary teaching/audit and case review. As it was proving difficult to demonstrate consistent improvement in meeting the target to deliver all grade 1 caesarean sections within 30 minutes despite the work that had been carried out with maternity staff, this year the frequency of anaesthetic/ theatre/ maternity meetings was increased to alternate monthly from October 2015.

Whilst the RCOG grading of caesarean sections has been adopted nationally, it is clear that there is significant variation between individuals and units as to what constitutes a grade 1 delivery. This had led to what appeared to be inappropriate grading within the department and difficulty in meeting the target of 100% of cases being delivered within 30 minutes (where clinically appropriate). A meeting was held attended by senior members of staff in maternity, and an agreed guideline for the classification of caesareans at Homerton was devised, circulated and embedded in the department in November 2015. This system is now used in midwifery and obstetric mandatory training and is utilised in the fortnightly in situ simulation sessions that occur within the department.

The following table documents the progress made in addressing this target over the course of the year. Although we did not initially achieve 100% compliance with Grade 1 decision to deliver interval targets, gains have been made month on month in the last six months, and we have achieved 100% consistently since December 2015 (see Figure 17) therefore the target has been met.

Figure 17



Source: Local Data

This is a new measure monitored during 2015/16 and no historical data is available

We can evidence progress through:

- The Maternity Risk Management Review Group have overseen this work

In 2016/17 we will:

- Continuing excellence in communication and team working to facilitate timely grade 1 Caesarean Section*
- On-going K2 CTG* training for all relevant staff.

Quality Account

Priority Three

Safe: To 'Make Safeguarding Adults Personal' by capturing the views and wishes of patients and clients on the outcome of the safeguarding adult process.



Progress towards target achieved

Background:

This is a new priority for the Trust and measures are set to ensure that improvements are made to enhance adult safeguarding in relation to the recently revised Care Act.

The Care Act is said to be 'the most complete overhaul of legislation' for 70 years. In relation to safeguarding adults, most of the provisions in the Act came into force in April 2015. The Care Act 2014 challenges all organisations to 'Make Safeguarding Personal'. This means that safeguarding should be person-led and outcome-focused. It should engage the adult at risk in conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. As a result, the focus of safeguarding shifts from 'process' and thresholds of care to delivering 'outcomes' with the adult at risk's views and wishes at the centre of safeguarding activities.

The safeguarding adult priority in the Quality Account 2015/16, aims to be a practical demonstration of 'Making Safeguarding Personal' by improving the way in which the Trust seeks and records the views of the 'adult at risk' as part of the safeguarding adult's process.

What did we say we would do?

We took a two-pronged approach to personalise safeguarding adults: 1. re-design materials used in Safeguarding Adults training, to ensure the importance of seeking patients/clients views is emphasised and communicated clearly, and 2. improve the systems used to capture and record safeguarding adults concerns and disclosures, so that staff are prompted to seek the views of patients/clients and record these clearly.

To help achieve this we set out to:

- Ensure all (100%) Safeguarding Adults level 1 and level 2 training including a focus on personalised care, more specifically, a case study to illustrate the 'Empowerment' principle in safeguarding adults. This is best summarised in the personalised statement, 'I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens'.
- Improve the system used by staff to report safeguarding adults concerns i.e. by developing a Datix safeguarding component to prompt staff to seek and record the views of patients/clients on the outcome of the safeguarding adult's process.
- Achieve a 25% increase in the recording of the wishes of the 'adult at risk' when a safeguarding adult referral is made to the local authority. This would be achieved through implementing the form designed by the Association of Directors of Adult Social Services (ADASS) for making safeguarding adults referrals to the local authority. The form contains a set of questions, which enables staff to record the outcomes the person may want to achieve from the safeguarding process.

What did we do?

This year we achieved the following.

- Redeveloped Safeguarding Adults levels 1 and 2 training to ensure all training includes a case study that demonstrates the importance of 'Making Safeguarding Personal', together with practical steps for implementation. Training includes an interactive case study discussion.
- Designed and developed a bespoke safeguarding adults component on Datix, this includes a prompt which enables us to ask and record the views of patients/ clients on the outcome sought from the safeguarding adults process. Over 70 staff were involved in this process from a wide range of community and hospital based services. Case studies and scenarios were used to stimulate discussion and test incident reporting/ disclosure via the Datix system.
- Made sure the safeguarding adult referral form was made available to all Homerton staff following its release by ADASS in July 2015. An audit of safeguarding adult referrals completed between July 2015 and March 2016 found that, 23% of the referral forms completed during this period contained information on the outcome sought by the patient/ client from the safeguarding adult process (see Figure 18). Our original ambition to achieve 25% was centred on implementation of the revised Datix component. Unfortunately, we have been unable to do so due to staffing issues; however, work is now underway and we plan to launch in spring 2016.

We can evidence progress through:

- Homerton Safeguarding Adults Committee
- Children Safeguarding and Regulation Committee
- Patient Safety Committee.

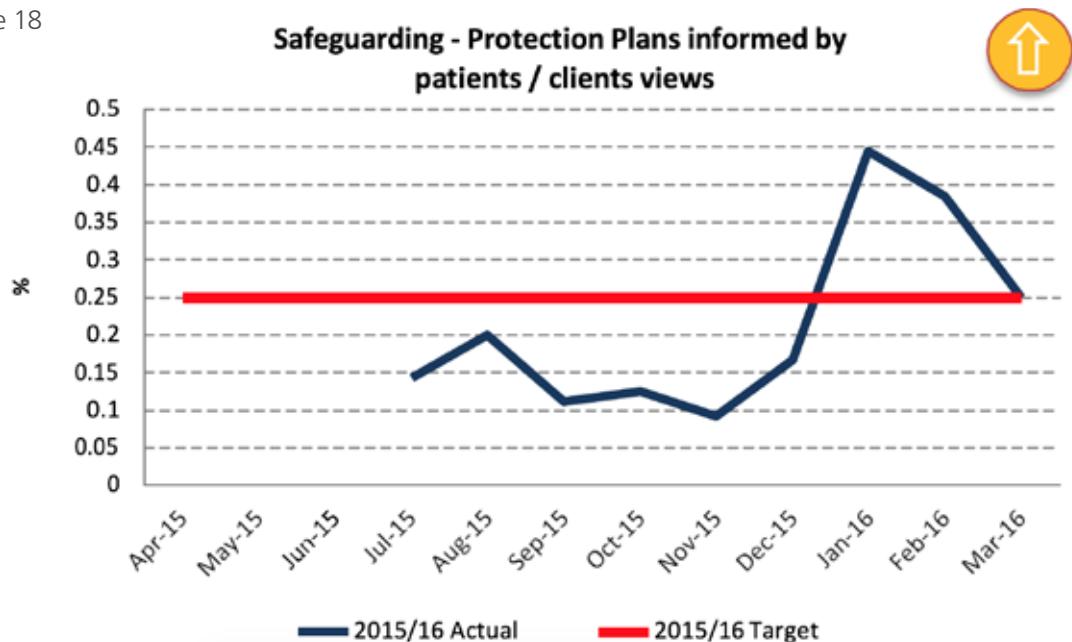
In 2016/17 we will:

We are committed to continuing to improve the way in which we safeguard 'adults at risk' in our care. We will build on the processes we have developed during 2015/16 in particular:

1. Improve safeguarding adult training by developing competence and confidence in our staff. We will use an approach which blends different teaching and learning methods tailored to the needs of our staff. This will include e-learning, case study focussed workshops and simulation exercises.
2. Implement and embed the use of the safeguarding component on Datix to improve and increase reporting of safeguarding adult incidents/ disclosures and concerns. We will monitor and follow up on safeguarding adult incident/ disclosures to ensure that the views of patients/ clients on the outcome sought from the safeguarding process is recorded and acted upon.
3. Work with individual staff and services to improve the quality of safeguarding adult referrals.
4. Re-audit the referrals to monitor the progress of this work and ensure that this is scrutinised by the Homerton Safeguarding Adults Committee.

Quality Account

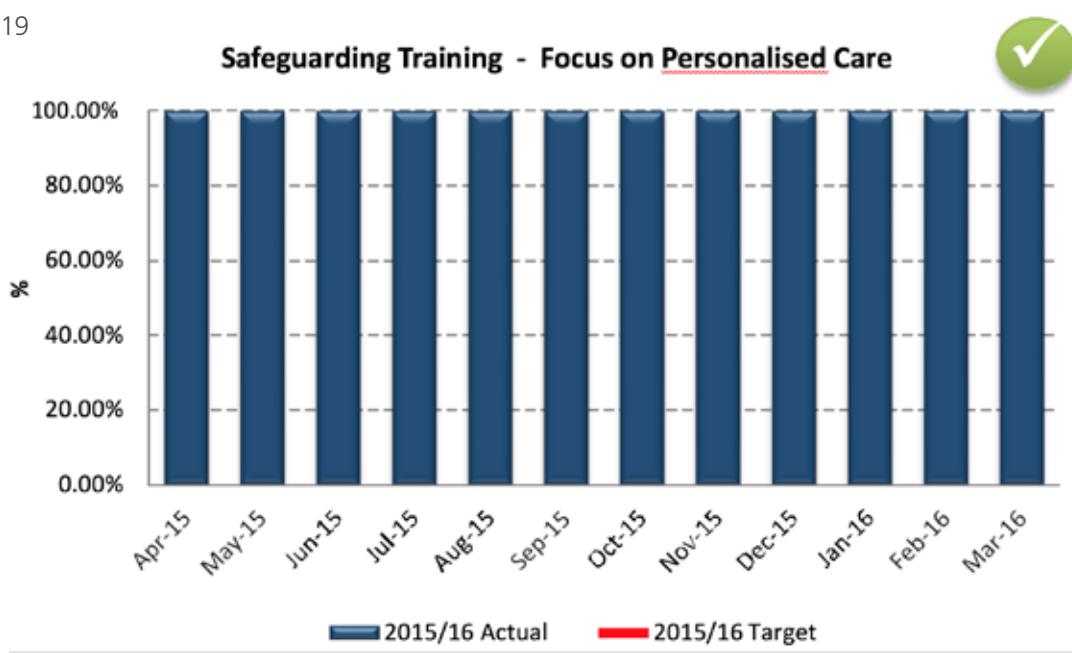
Figure 18



Source: Local Data

This is a new measure monitored during 2015/16 and no historical data is available

Figure 19



Source: Local Data

This is a new measure monitored during 2015/16 and no historical data is available

Priority Four A

Effective: To reduce the number of patients who are readmitted within 30 days of discharge



Minimal (possibly no) progress towards target achieved

Background:

Reducing avoidable hospital readmission rates is both a national and local priority for the Trust. Low readmission rates is an indication of the delivery of high quality care and appropriate decision making by staff, which ultimately improves the patient's experience as well as reducing hospital costs. To facilitate this, a Discharge Management Group (DMG) was established with the aim of exploring ways to reduce hospital readmissions.

What did we say we would do?

We said we would embed the readmission reduction initiatives started in 2014/ 15 to:

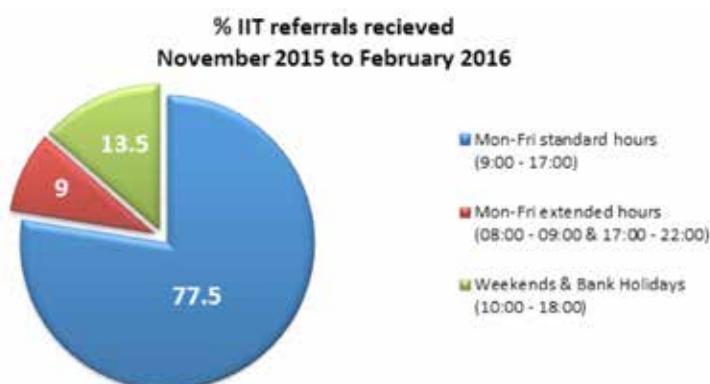
- reduce emergency readmissions within 30 days by 10% for all patients
- reduce readmission within 30 days - divided by particular groups and linked with one or the new quality pathways
- monitor patients who are readmitted within 30 days but who also have been discharged with support from the community nursing service.

What did we do?

The following actions were initiatives were carried out in 2015/ 16 to support patients at home following discharge from hospital.

- An Integrated Independence Team (IIT) was launched in November 2015. This integrated health and social care team provides intermediate care and reablement to patients either being discharged from hospital or referred from the community. The team includes nurses, therapists, geriatricians and care workers, runs from 08:00-22:00 Monday to Friday and 10:00-18:00 Saturday, Sunday and Bank Holidays. Patients are referred through a single point of access and directed to the most appropriate care provider. Activity data can be seen in Figs. 20 – 22.

Figure 20



This is a new measure monitored during 2015/16 and no historical data is available

Quality Account

Figure 21

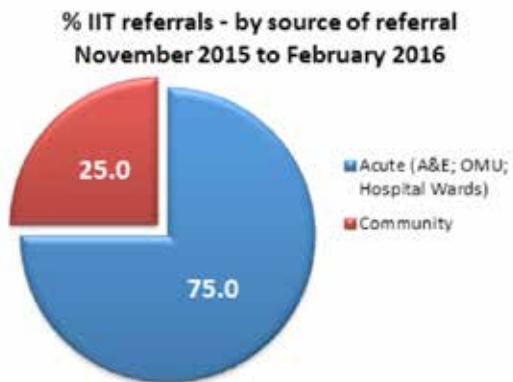
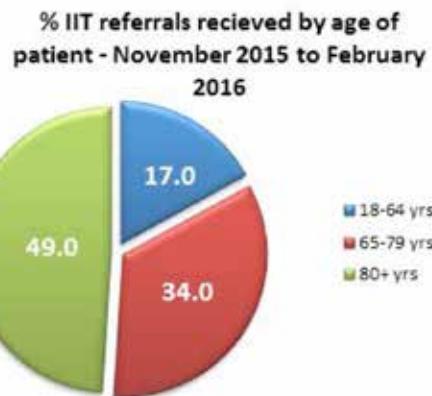


Figure 22



This is a new measure monitored during 2015/16 and no historical data is available

- We signed up to a two part Adult Community Nursing CQUIN, whereby patients on the adult community nursing caseload were reviewed post-discharge by the community nursing team, either by telephone or face-to-face within 48 hours, or 72 hours if the patient was not already on the caseload and had a hospital length of stay of more than 24 hours. During January to March 2016, 91% of patients (including those readmitted within 30 days) were followed up within 48 hours of discharge, and 90% of patients were followed up within 72 hours where appropriate.
- We continued to provide ward-based discharge coordinators on several wards. These are care professionals dedicated to supporting patient discharge from hospital. This includes telephone follow-up for all patients to check everything is ok at home.
- Despite a large proportion of patients now receiving post-discharge contact from relevant care professionals, and timely support for identified issues and concerns, our interventions have not led to a readmissions reduction this year, current readmission rate is 6.7% (see Figure 23). Further exploration of our readmitted patients is required to better understand the reasons for this, and to plan our care, services and pathways.

Figure 23



Source: Electronic Patient Record

■ 2014/15 Actual ■ 2015/16 Actual ■ 2015/16 Target

We can evidence progress through:

- reports to Discharge Management Group (DMG).

In 2016/17 we will:

- continue to embed and monitor our readmission reduction initiatives
- further examine emergency readmissions, to mature our prevention strategy.

Priority Four B

Effective: To reduce number of postnatal readmissions



Progress towards target achieved

Background:

This is a new priority for the Trust and measures are set to ensure that additional readmission improvements are made within our maternity services.

What did we say we would do?

We set the following targets as quality measures for postnatal readmission on the maternity unit:

- no more than 15 maternal readmissions per month
- 95% of maternal readmissions to be seen by an obstetrician ST3 (specialist trainee level 3) or more senior before the decision to admit was made
- 100% of maternal readmissions to be seen by a consultant obstetrician within 12 hours of readmission
- 100% of postnatal women with severe pre-eclampsia to remain in hospital for at least 4 days postnatally (excluding those who discharge against medical advice).

What did we do?

We have continued to work with City & Hackney CCG to ensure on-call GPs* are the first point of call for postnatal patients with raised blood pressure. This is the leading cause for maternal postnatal readmission, and as such, once this is in place, our readmission rates should reduce even further.

To facilitate readmission reductions 2015/16 we have changed the pathway for postnatal readmissions attending the Emergency Department (ED). All patients are now seen either on the delivery suite or in ED by an obstetrician ST3 or above, and the on-call consultant is informed of all readmissions upon admission. We now conduct daily consultant ward rounds on the postnatal ward.

An incident form is submitted via Datix for all postnatal readmissions to enable audit and review by postnatal ward manager and consultant, to ensure appropriate management is in place.

Maternal readmission rates have been lower than we predicted, 86 in total (average of seven per month) since April 2015 (see Figure 24). Despite this, only 72% (see Figure 25) of our readmissions were seen by a senior obstetrician before a decision to admit was made; 44% (see Figure 26) of readmissions were seen by a consultant obstetrician within 12 hours of admission; and 81% of women with severe pre-eclampsia remained in hospital for the required four days post-delivery (see Figure 27).

Quality Account

Figure 24



Figure 25

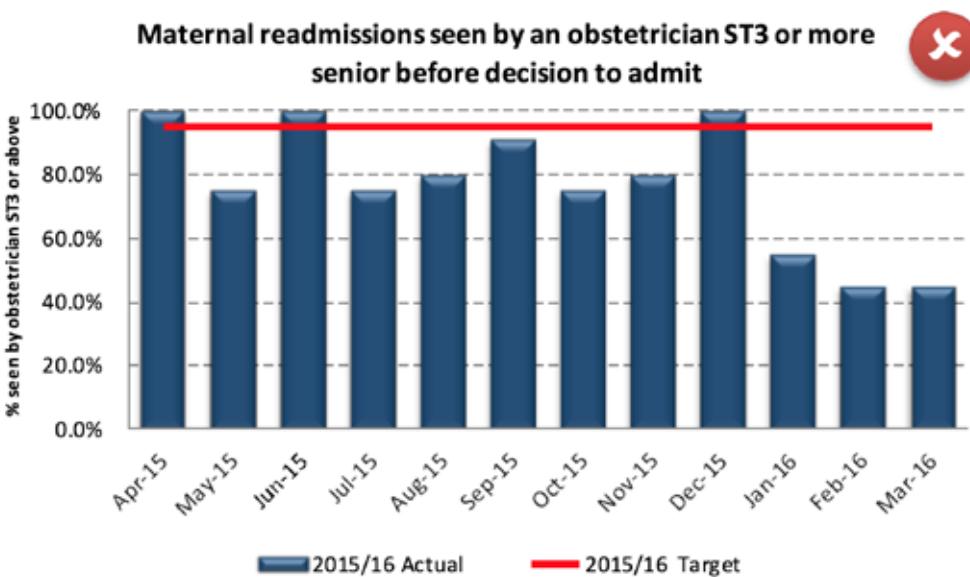
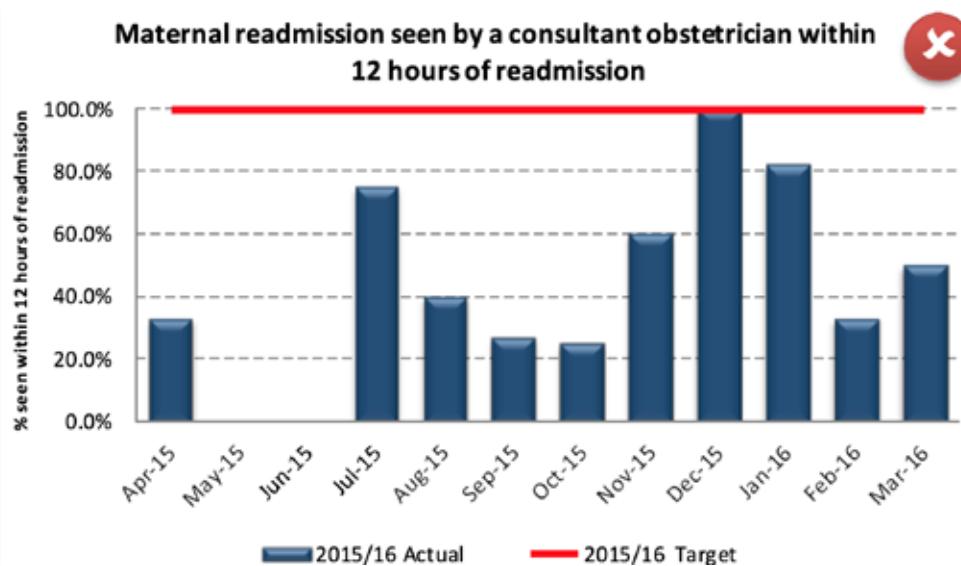
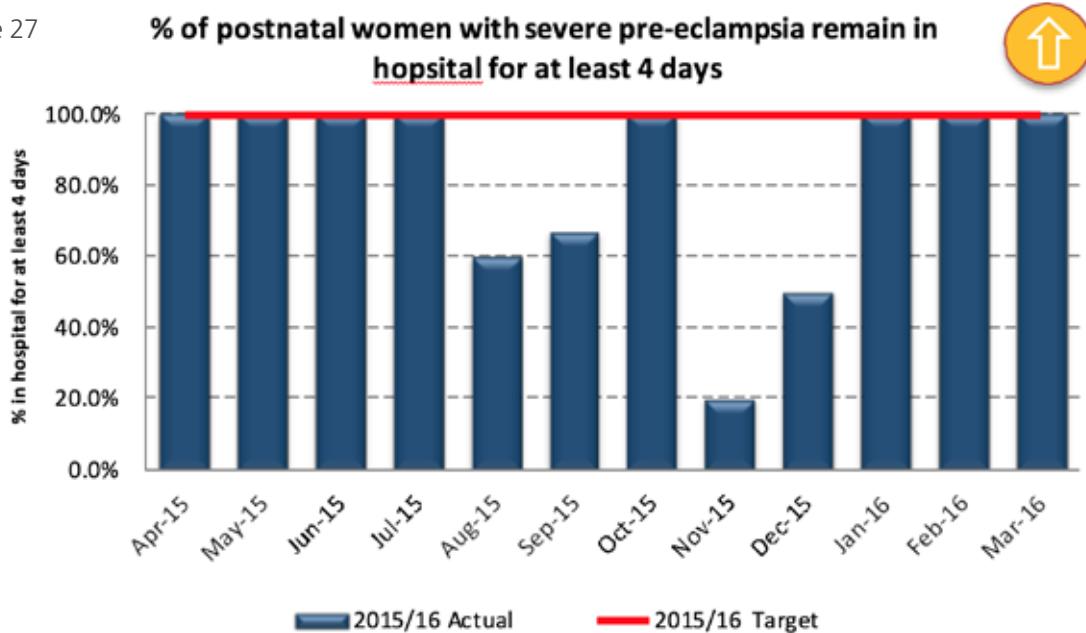


Figure 26



Source: Electronic Patient Record This is a new measure monitored during 2015/16 and no historical data is available

Figure 27



To increase our opportunities of improving our processes, a monthly 'Readmissions Review Panel' has been set up, chaired by the lead postnatal care consultant and informatics midwife, to ensure any emerging themes are identified, and to monitor the grade of the decision maker, and consultant input.

We can evidence progress through:

- maternity Risk CLIP meeting which takes place monthly.

In 2016/17 we will:

- ensure timely pathway and protocol education is in place for middle grade trainees and locum doctors
- enhance pathway and protocol training for consultant obstetricians
- review current protocols to ensure these reflect current best practice.

Quality Account

Priority Five A

Effective: Improve maternal health by monitoring using a value score card



Progress towards target achieved

Background:

Our health visitors working within the community offer a range of services available in local settings, such as, children centres, GP premises and health centres as well as visiting families in their homes. They support families through pregnancy and up to when a child becomes five years old.

In 2014/15, the Trust joined UCL Partners to develop and test a 'Value Score Card' for maternal mental health bringing together and testing a range of indicators and interventions, to help increase the identification and management of mothers at risk of mental health issues.

Improving maternal mental health is one of the six high impact areas that the Department of Health has identified where Health Visitors can make to improve short and long term outcomes for children and families. The six areas are:

1. Transition to parenthood and the early weeks
2. Maternal Mental Health
3. Breastfeeding (initiation and duration)
4. Healthy weight, healthy nutrition (to include physical activity)
5. Managing minor illness and reducing accidents (reducing hospital attendance / admissions)
6. Health, wellbeing and development of the child aged two [Two year old review and support to be 'ready for school']

Although steady progress was made throughout 2014/15, it was recognised that further improvements were needed, through refinement of the tool and improved data collection.

What did we say we would do?

To enhance maternal health monitoring in 2015/16 we said we would:

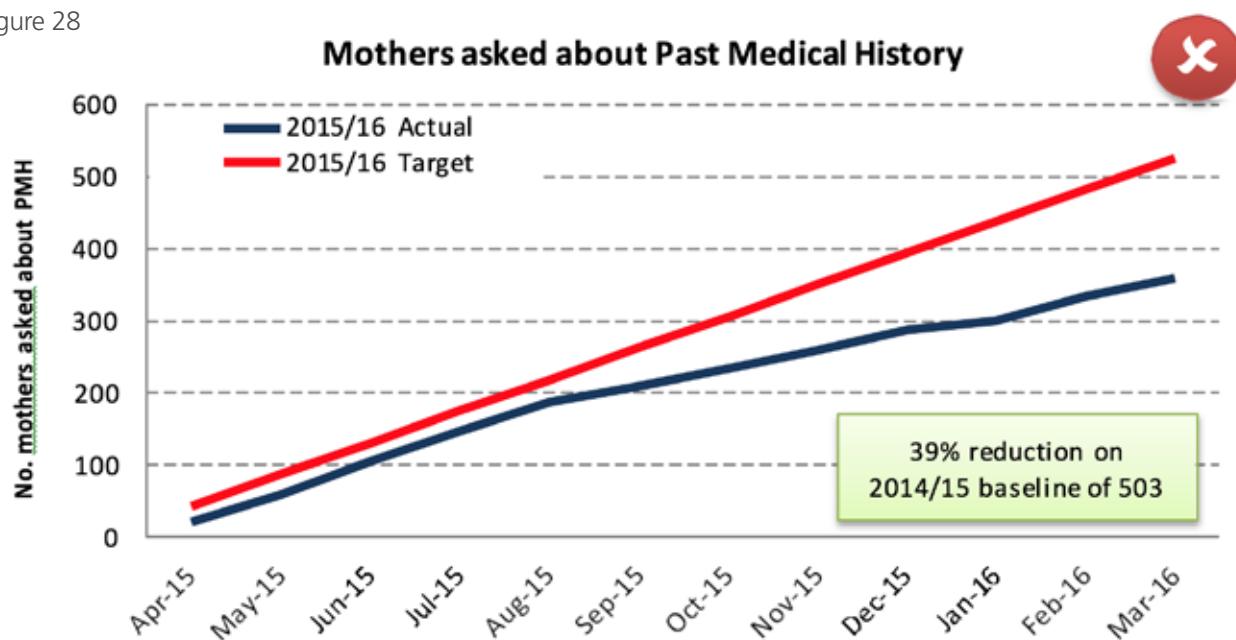
- increase by 5% the number of mothers asked about Past Medical History and evidenced in RIO template
- develop a template in RIO to records EPDS (Edinburgh post natal depression score) pre and post listening visits (one of the indicators used in the Values Score Card).

What did we do?

During 2015/16, the health-visiting service has worked hard to improve use and reporting of the interventions that make up the indicators within the value score card, and to increase the identification of women with a past medical history of mental health. They are asking all mothers asked about past medical history (PMH) of mental health at the antenatal assessment and/ or the new birth contact and documenting this on the PMH record on our community patient information system i.e. RiO. This includes all first contacts with mothers including those who have more than one child

During a focused quality improvement training project conducted during May and June of 2015, a clear improvement was seen in the number of clients being asked about their PMH. However, since September 2015, there has been some slippage in the number of clients asked and subsequently we have not achieved our 5% increase against baseline (see Figure 28). Unfortunately our numbers actually decreased during 2015/16. Plans are being developed to re-focus and motivate health visitors to complete assessments.

Figure 28



Source: Community Electronic Patient Record (RiO)

We have worked with the RiO informatics team to develop a template to record a variety of mental health assessments including:

- Whooley Score
- GAD2 Score
- EDPS score pre and post listening visits (these are mental health assessments, elements of which are included in the values score card)
- monitor activity of listening visits (these are conducted by Health Visitors)
- record referral activity (onward referral to mental health services and social care when required).

The template has been completed by the team and we are now entering a testing phase. To support this the team have developed a mental health, health-visiting pathway to link in with the perinatal and vulnerable women's pathway, and are standardising the training for health visitors on identification of mental health issues.

We can evidence progress through:

- health visiting Performance Meeting held monthly.

In 2016/17 we will:

- ensure this remains a priority in 2016/17
- re-focus training to motivate health visitors to complete assessments
- fully launch RiO template.

Priority Five B

Effective: Improve District Nursing communication with key stakeholders



Target fully achieved

Background:

The Adult Community Nursing Team (ACNT) provides a nursing service to the residents of the City of London and Hackney. It is made up of approximately 70 nurses, and provides community nursing care to patients with a wide range of conditions. The team is divided into four clusters, to cover Hackney and the City of London.

Cluster 1: North West

Cluster 2: North East

Cluster 3: South East

Cluster 4: South West and the City

Historically, our GP colleagues had raised concerns regarding the effectiveness of working relationships with community nurses, specifically communication, engagement and responsiveness. Subsequently, GPs requested enhanced working with community nursing teams to support, this by:

- attending practice meetings
- responding to referrals within the set times (90% compliance).

During 2014/15 the Adult Community Nursing Teams service has targeted these defined measures and made concerted efforts to improve communication with GPs*, thereby improving our delivery of care and the patients' experience. Although steady progress was made throughout 2014/15, it was recognised that additional improvements could continue to be made.

What did we say we would do?

We took the following approach to improve our communication with key stakeholders i.e. GPs*:

- 98% attendance by a team community nurse at planned practice meetings
- monthly data collection and monitoring of referral date sent, acknowledged and date patient seen.

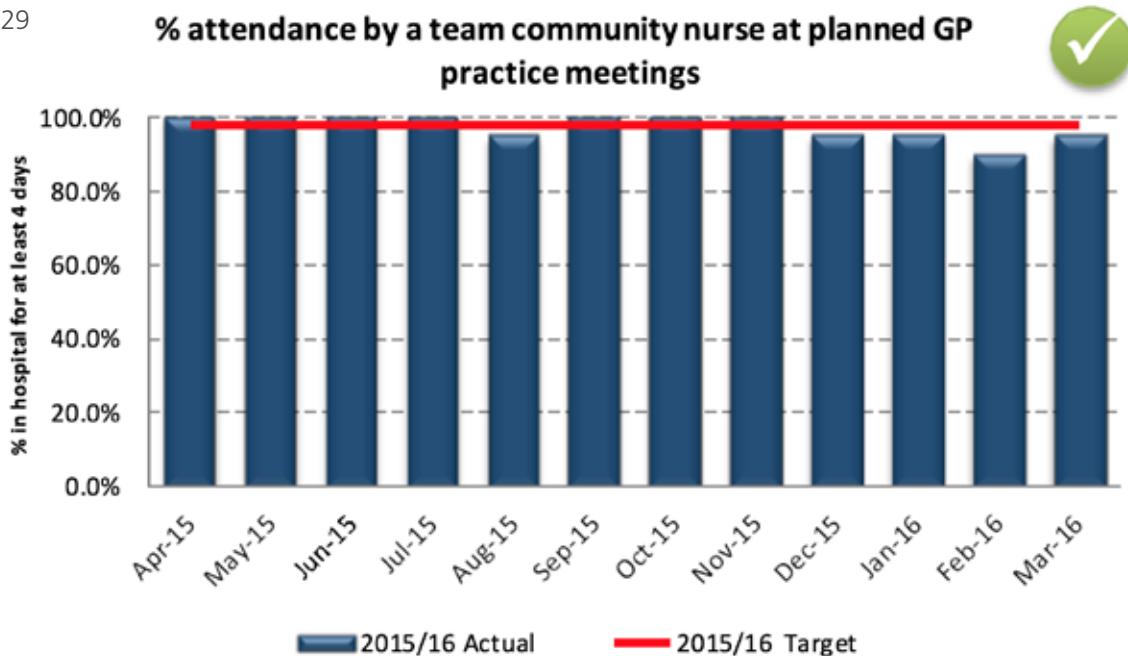
What did we do?

Significant work has taken place within the teams throughout 2015/16 to enhance communication and improve integration with our GP* partners.

The community nursing service recognised shortfalls in their communication and acknowledged their practice meeting attendance was less than desirable. Additionally, they accepted that, as well as improving partnership working, regular practice meeting attendance was essential to improving communication, which would ultimately benefit patient care, which is our top priority.

Our community nurses are now attending 98% (see Figure 29) of all planned practice meetings, and feel this has allowed them to develop more effective working relationships with their individual practice, and provides a regular forum to discuss issues and concerns, and individual patients. This is an improvement on 2014/15, where 96% of planned practice meetings were attended.

Figure 29

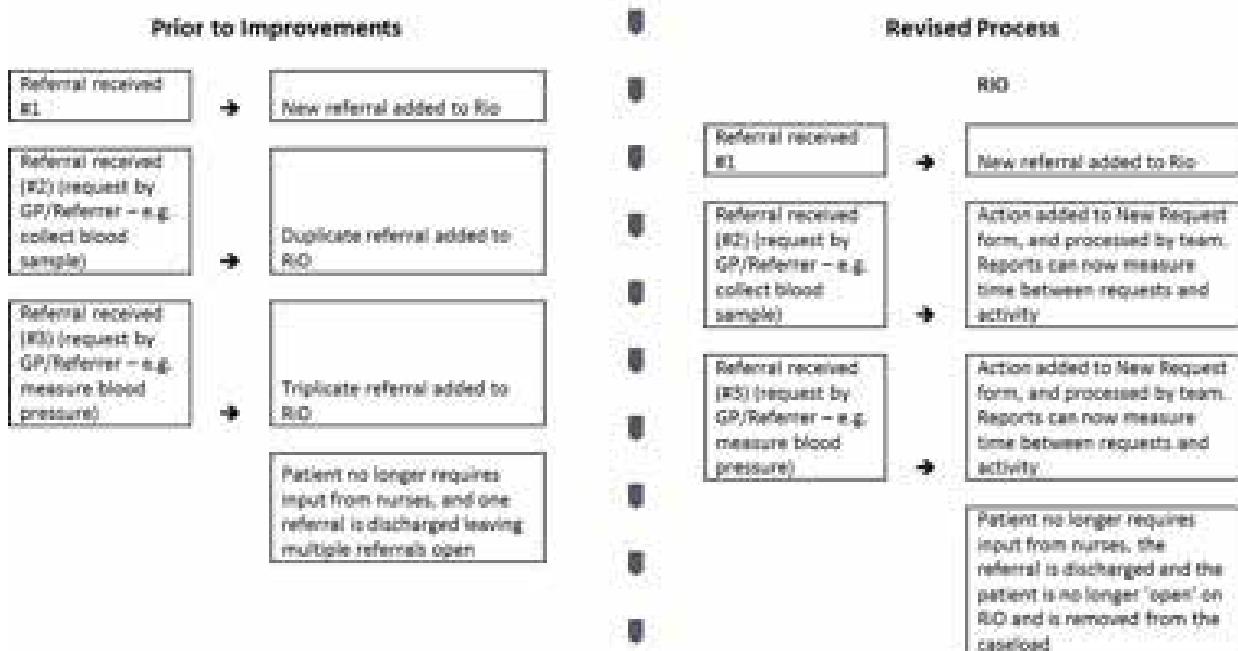


Source: Local Database

The team appointed an informatics lead to develop our community electronic patient information system (RiO) and optimise its potential, to enable better management of referrals and accurate tracking. The development of this system ensures patient records are accurate and up to date, allowing appropriate care delivery and documentation for all patients, and better community case load management through assessment and triage (see Figure 30).

Figure 30

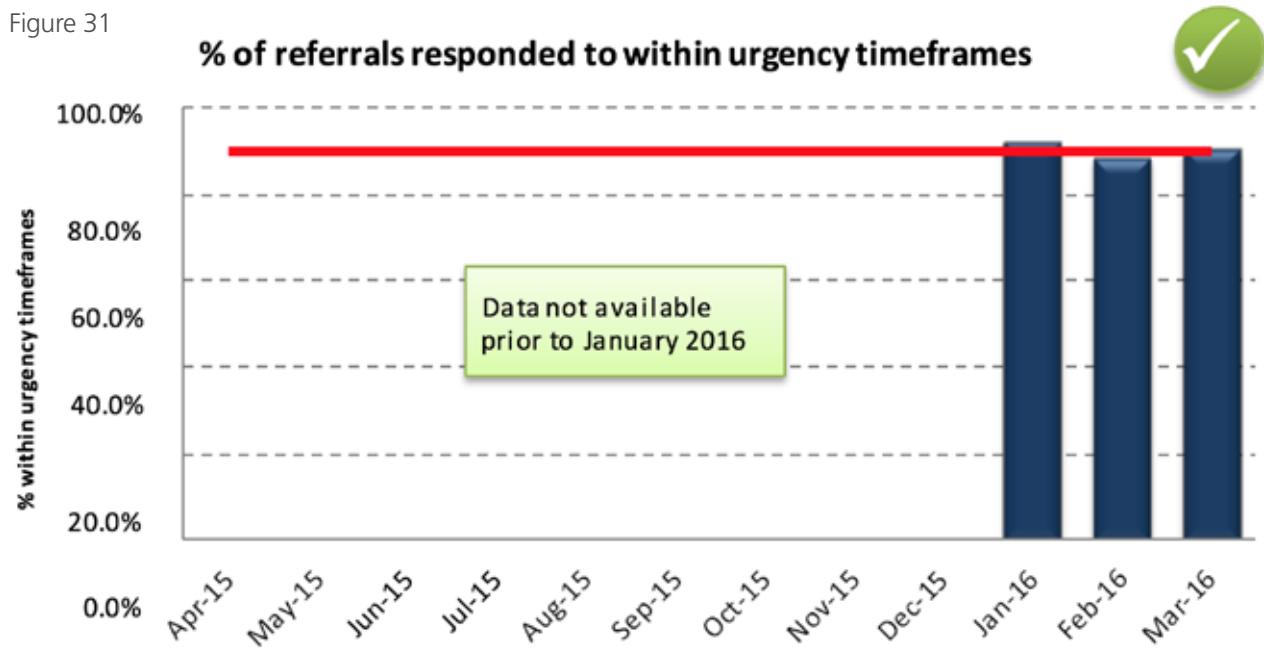
RiO Referrals Process



Quality Account

Whilst the live system was under development, the teams carried out local audits to ensure patients were being reviewed and seen in line with requested urgency; a series of back to back reviews were carried out monthly by each team between 1 January and 31 March 2016, which identified that teams responded appropriately to GP referrals in 90% of cases (see Figure 31 below) achieving our target.

Figure 31



Source: Community Electronic Patient Record (RIO)/ Local database

Historical data is not available due to a new reporting/ recording system being developed to capture this information.

In addition to the RIO modifications we also carried out improvements, such as:

- caseload cleansing has been carried out to remove duplicate referrals, and historical patients.

Together this should mean that the District Nursing caseloads will have only one entry per patient to better reflect the work done by each cluster at any given moment

- extensive work has been carried out to ensure timely completion of appointment outcomes, and to clear backlog of un-outcomed contacts
- a library of care plans and standard correspondence created to ease processes

We can evidence progress through:

- Patient Quality and Safety Board
- Trust Management Board

In 2016/17 we will:

- validate new RIO referral process
- continue to work closely with our GP* practices, to maintain and build on progress made
- further explore developing the RIO system to support roll out of electronic mobile working
- implement mobile working for clusters 2 and 3 with a view to expanding to all clusters.

Priority Six

Effective: Improve integrated pathways between community and acute care



Target fully achieved

Background:

This is a new priority for the Trust and measures are set to ensure that improvements are made to better integrate the care and services provided by our organisation.

What did we say we would do?

We said we would keep our patients well and improve our integrated pathways between community and acute care, focusing on the reablement and intermediate care services (RICS), community paediatric and ambulatory care services to ensure:

- 100% of children have an epilepsy plan (newly diagnosed children only)
- 100% young people (with epilepsy) who are 15 years and under have an individual transition plan
- Integrated Independence Team (IIT*) service fully operational by October 2015 offering a single point of access for health and social care referrers over extended hours, seven days a week

*Please note following a period of consultation the name RICS was replaced by the new name of IIT

What did we do?

Significant progress has been made since April 2015.

The Integrated Independence Team

Following on-going negotiation and consultation the Integrated Independence Team (ITT) launched in October 2015.

This includes a single point of access for referrals, integrated health and social care teams and extended hours for therapy and reablement care seven days/ week. This service is jointly provided by London Borough of Hackney and Homerton, with the Trust being the lead provider.

A new multidisciplinary team of specialists has been launched to support people in their homes and help them maintain their independence. The team works within Homerton to support quicker discharge and where possible prevent hospital admission from the community. The team has specialist input from a range of disciplines to holistically support service users for up to six weeks, in all aspects of health and social care, and help them back to independence.

The team also deliver rehabilitation equipment, and if required, install and make adaptations in order for service users to be treated in their home environment.

A full communication plan has been developed to make sure GPs* are aware of the IIT service.

Quality Account

Improving planned care for children with epilepsy

In April 2015, we launched a new paediatric epilepsy service to provide specialist epilepsy care to children and young people up the age of 16. A paediatric epilepsy nurse specialist (ENS) was recruited to the service on a fixed term contract in June 2015.

The ENS attends all epilepsy clinics providing nursing expertise and support to children and families ensuring written care plans are in place for newly diagnosed children, liaising with tertiary services and supporting the development of the community epilepsy clinics. More specifically the following actions were taken.

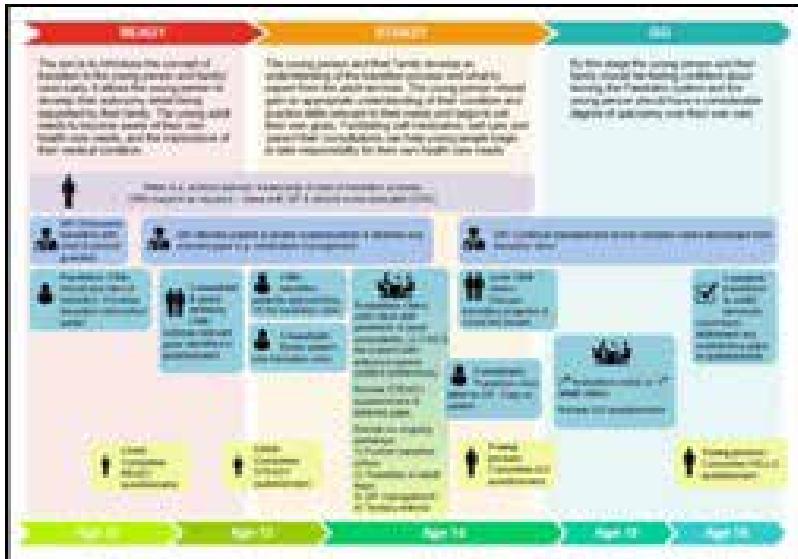
- All care/management plans are shared with the family and are provided with a hand held copy. A copy is sent by post to the GP and there are care plans in place for nurseries, schools are available on RiO and in the school.
- The paediatric ENS is working with both her acute and community colleagues, both health visitors and school nurses to ensure that the care and management plans for the child in the community setting are adhered to, to ensure the safety and well-being of the child or young person.
- The ENS is made aware of any child that comes to children's Accident and Emergency department or is admitted to the ward; this ensures the reaffirming of the care plan/management or the need to provide additional support within the community.
- The ENS will contact families if a child or young person misses an outpatient appointment, to ensure continuity of care and continuance of treatment, and she has implemented a patient/GP* specialist advice line to support families and primary care.

There are 218 children on the ENS epilepsy register, to date care plans have been completed for all newly diagnosed children, and work has commenced for existing children to ensure they have a meaningful plan. Unfortunately, we have not yet achieved our ambition for all children to have an epilepsy care plan, but will continue to work towards this.

During 2015/16, the team have developed an epilepsy change pathway for transition for young people with epilepsy from children to adult services, and have held their first transition clinic for young people. A copy of the pathway can be found in Figure 32.

A training package for health and non-health professionals has been developed and implemented in schools and nurseries. The training programme has been ratified with epilepsy clinical leads and training sessions have commenced with GPs.

Figure 32



This work has helped us to reach our goal and currently 100% of young people with epilepsy now have a transition plan; 15 of 25 will transition this year and 10 of 15 will transition at 18 years as they have complex special needs.

We can evidence progress through:

- IIT implementation was monitored by IMRS
- Implementation of the epilepsy service has been overseen by the divisional management team and the service leads via our service line meetings and paediatric planning and governance meetings.

In 2016/17 we will:

- further develop our IIT service to help keep our patients well at home
- continue to embed and develop our paediatric epilepsy service.

Priority Seven

Effective: Improve quality of dementia care for our patients and carers



Progress towards target achieved

Background:

The Trust continues to prioritise improving the quality of care provided to our patients with dementia and those who care for them. This is strengthened by our on-going participation in the national dementia CQUIN.

What did we say we would do?

We said we would embed the local strategy, and commit to making a difference to people with dementia and those who care for them when they come into our care.

The Trust dementia strategy was launched with an event in May 2015. The event was opened by the Speaker of Hackney, and was well attended by members of the local branch of the Alzheimer's Society, carers, people living with dementia, East London NHS Foundation Trust and members of the Trust from both community and inpatient settings.

We said we would improve our care quality by:

1. improving support for carers
2. ensuring the Abbreviated Mental Test is undertaken on 90% of all patients over the age of 75 entering the hospital
3. showing demonstrable engagement from staff – register of Level 1 training attendance.

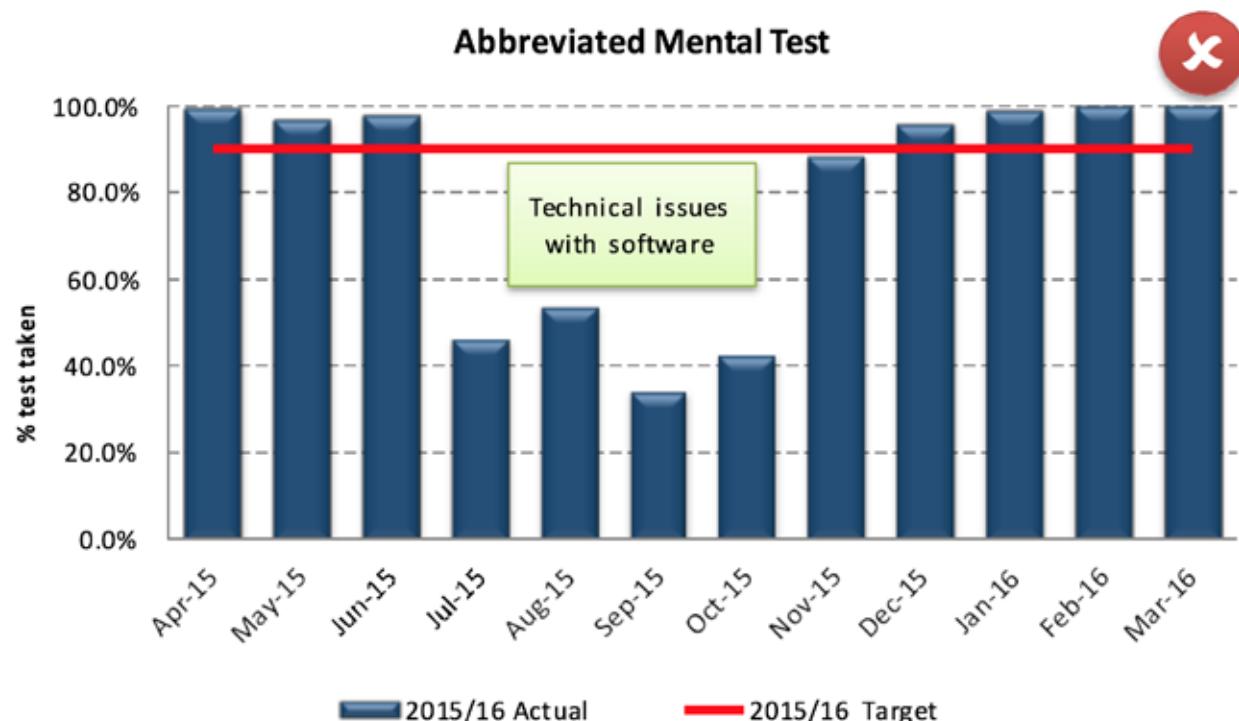
Quality Account

What did we do?

We have carried out partnership working with carers, and have increased the uptake of the carers' questionnaire from three per month during 2014/15, to an average of 10 per month during 2015/16. We did this by looking at the role of the dementia care support workers, to ensure that they were engaging with carers at the point of admission, and taking responsibility for obtaining feedback. We also ensured that where possible, a dementia care support worker was available across seven days to capture as many carers as possible.

We continued with a successful carers group on the Elderly Care Unit (ECU*). The group offer practical and educational advice to those caring for someone with dementia.

Part of the Dementia CQUIN in 2015/ 16 was to ensure at least 90% of eligible patients were screened for dementia, and to ensure that the management of relevant patients was appropriate. The hospital has performed well on this measure historically; however, the revision of our electronic patient record (EPR) system in July 2015 had the unintended consequence of directly impacting on our performance between July and November 2015. The hospital used this problem to further improve the process of identifying and assessing patients with dementia/ delirium, and since December 2015 our data demonstrates a return to the level of previous performance.



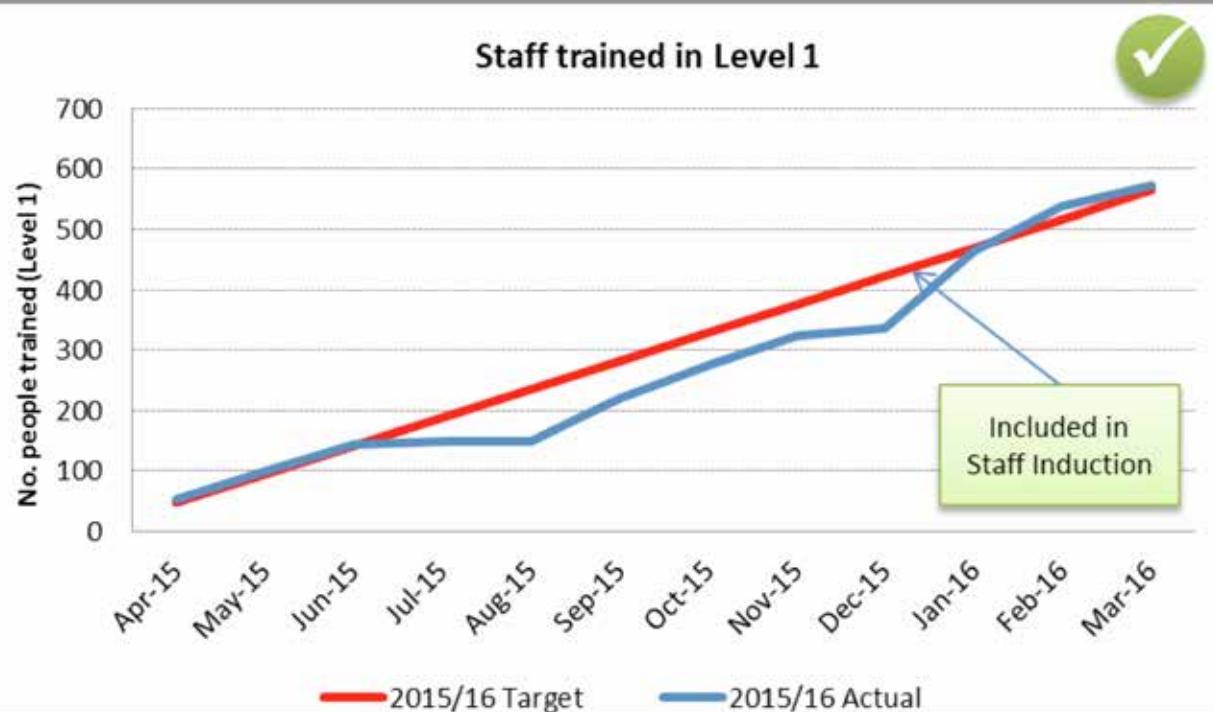
Source: Electronic Patient Record (EPR)

UCL Partners is supporting the NHS to improve health care delivery, by ensuring it has a workforce that is skilled, to provide high quality dementia care at all stages of the condition and able to understand its importance. As the numbers of patients with dementia are expected to continue growing, demand for quality dementia care will increase.

Level 1 training is essential information aimed at all health or social care staff. It provides basic dementia awareness and is relevant to all roles, but those who are in regular contact with dementia patients should have more in-depth training. We set ourselves an ambitious goal to get as many of our workforce trained in dementia awareness. We believed that whether a staff member was a porter, an administrator, a phlebotomist, a nurse, a housekeeper or indeed any employee of the Trust that dementia was and is everybody's business.

Our training is delivered via the Care Certificate, nurses' annual updates, doctors' training and sessions run throughout the Trust; more recently this has been added to the Trust induction programme. This year we have increased the number of champions who deliver dementia awareness sessions from 13 to 25.

In 2015/16, the number of staff trained in level 1 dementia awareness was 573, and increase of 29% compared to 2014/15 (444), exceeding our target of 568.



Source: Electronic Patient Record (EPR)

In addition, our Level 2 training (introduced in 2015/16) has been targeted towards staff who work directly with people who have dementia; this was commissioned from Oxford Brooks University. Staff groups who completed this one day inter-professional simulation training, included 36 nurses, therapists and health care assistants from the Elderly Care Unit (ECU*), The Bryning Outpatient Unit, and the two surgical wards Thomas Audley and Priestly wards and community matrons and district nursing teams.

We can evidence progress through:

- reported quarterly to the CCG and Trust Board on dementia training and six monthly on carers support.

In 2016/17 we will:

- continue to embed the dementia strategy to include regular therapies, support for carers, work to the environment and completing cognitive screening for all those over 75 years old who come into hospital.
- continue to deliver dementia awareness to the workforce, including within corporate induction from January 2016, meaning 100% of all new staff will receive training from January 2016 onwards.
- continue our work with carers by setting up an additional support group at Mary Seacole Nursing Home from January 2016.

Priority Eight

Positive Patient Experience: Improve our end of life care and advanced care planning



Progress towards target achieved

Background:

Despite an increasing focus on End of Life Care (EoLC*) from the Department of Health (DOH 2010) over the past five years, and setting objectives to enable patients to die in their preferred choice of place, more than half of patients in England still die in hospital settings (Office for National Statistics 2011- 2012).

End of life care is at the forefront of the UK government agenda (NHS Care Actions for End of Life Care: 2014-2016 programme). The collective majority reinforce that a good death is deemed as receiving the best standard of care which is “competent, confident and compassionate” with education of all staff to improve outcomes (London End of life care Clinical Network, 2015).

The majority of these deaths occur in acute trusts on busy acute medical and surgical wards, in what can be sub-optimal settings. Despite a decrease over the past 10 years, the number of patients who remain in hospital and are cared for in these settings in last days of their lives, remains high.

Although most people in the UK would prefer to be cared for and eventually die at home, approximately 52% of people in Hackney currently die in hospital and the majority of these at Homerton. Hospitals often struggle to provide best care for patients at the end of life, and 54% of complaints in acute hospitals relate to care of the dying / bereavement care (Healthcare Commission 2007). The care of the dying is therefore the domain of almost every department, and all Trust staff have a responsibility to play their part in the provision of very best care for dying patients and their families. To enhance care of the dying we set out to improve the care we delivered to our patients through individualised care plans.

At the outset of the 2015, clinicians and managers, both at the hospital, and working in primary care, sought to improve the sharing of information for patients who were recognised to be nearing the end of life. It was hoped that by doing this, more patients would have an opportunity to discuss their treatment plans and preferences for future care, before a crisis occurred; this is called advance care planning (ACP*).

The first step in this process is defining the population that would benefit from ACP*. GPs* told us it would be helpful to know about patients where discussions around EoLC* and resuscitation were had during their hospital stay, as this would be a good group of patients to target. To help achieve this, we agreed to undertake an EoLC* CQUIN centred on electronic patient discharge summaries for patients discharged from Elderly Care Unit.

What did we say we would do?

To achieve our objectives we took a two-pronged approach to EoLC*, in order that:

1. Patients known to be dying in hospital have an individualised care plan in place (75% by end March 2016)
2. Communication is improved between secondary and primary care by including more information on discharge summaries, with three aims of this information:
 - i. Inform GP* that discussions about treatment escalation have happened
 - ii. Inform GP* of any blocks/ issues if conversations about treatment escalation have been raised
 - iii. Prompt GP* to action to start a conversation about advance care planning

What did we do?

An EoLC Board is currently operational to oversee management of clinical effectiveness and quality for this specialist patient cohort.

Education has been fundamental to improving EoLC care and planning. The Palliative Care Team have taken several approaches. For example:

- educating all acute ward nursing staff on the new electronic EoLC documentation, that has been created using the 'Five Priorities of Care' principles, which were implemented following the removal of the Liverpool Care Pathway (LCP)
- commenced end of life care (EoLC) training on mandatory clinical update programme for nursing staff
- trial use of bespoke 'Milestones' DVD and training packs; two of our specialist palliative care nurses (SPCN) have attended a 'Train-the-Trainer' course to enable delivery of these bespoke sessions. This pilot has been funded by HENCEL and led by UCL Partners.

The Homerton intranet site has been revised to provide staff with information about the 'Five New Priorities' for the care of the dying person and individualised nursing care plan for the last hours or days of life i.e. compassionate care planning tailored to individual needs, along with decision making algorithms including diagnosing dying, reversible conditions, good practice guidance, and anticipatory prescribing at end of life e.g. symptom control algorithms; it also includes information regarding first-line drugs, PRN (as required) dosing including syringe driver information; and out of hours palliative care service information; and guidelines for communicating significant news.

Despite efforts to improve our end of life care planning, a hospital wide audit of all in-patient deaths recorded in March 2016 found that: 66% of all deaths were expected, of those only 38% of our dying patients had an EoLC plan documented on the EPR system, falling short of our end of year target of 75%.

To support enhanced communication between primary and secondary care, we held several meetings with our EoLC CCG partners to agree discharge summary requirements. It was agreed that, at the very least, it was important to ensure each patient treated on the Elderly Care Unit (ECU) had an opportunity to have a treatment escalation plan, including a resuscitation status decision completed during their inpatient stay, and that all patients who, after discussion with them and their family, had a 'do not attempt cardiopulmonary resuscitation' (DNACPR*) order completed during their stay had this information recorded on their discharge summary. In addition, it was agreed that it would be appropriate for general practitioners to work on developing advance care plans with this patient cohort, and in view of this, it was suggested it would be very useful to have a 'prompt' comment in their discharge summary for the GP* to consider advance care planning.

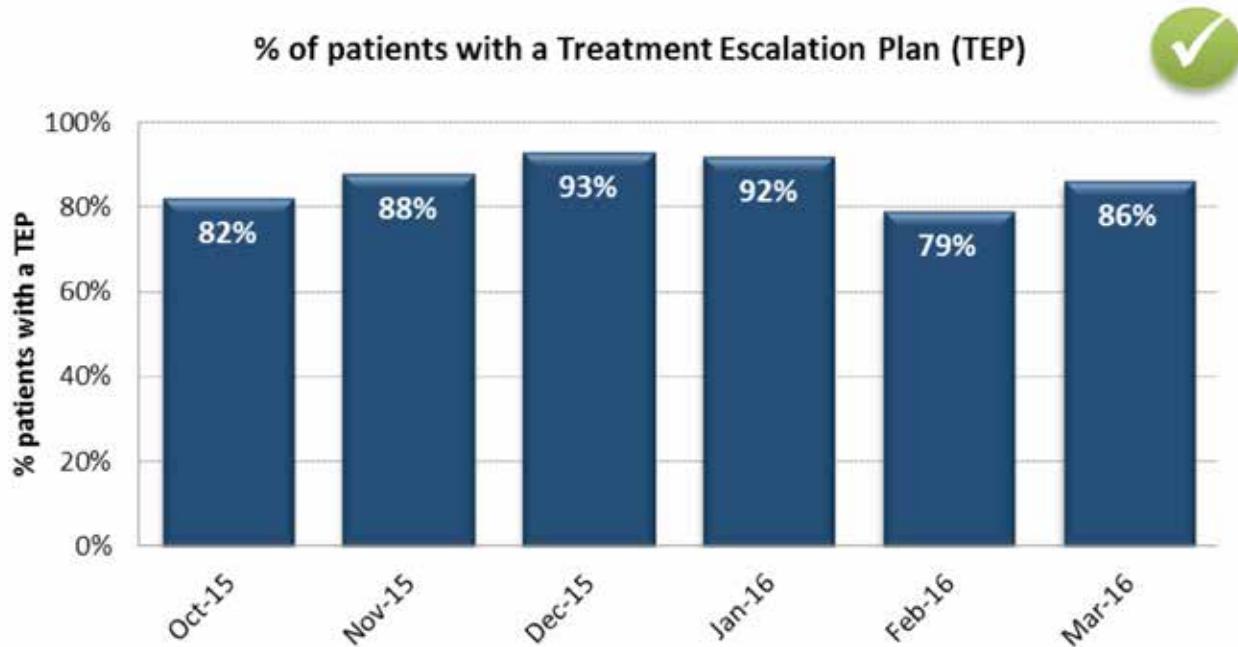
A stepwise roll out was agreed, and we undertook a series of events with junior and senior staff on the ECU* wards to explain the importance of the project.

In October 2015, we implemented monitoring to determine whether or not we were achieving the standards of the CQUIN. Between October 2015 and March 2016 we found clear improvements in the following areas:

- Overall in the second half of the year, 87% of patients on the ECU* had a treatment escalation plan completed during their inpatient stay (see Figure 33)
- 61% of patients who had a DNACPR* order in place during their stay had this fact recorded on their discharge summary
- 57% of patients who had a DNACPR* order in place during their stay had a prompt on their discharge summary for GPs to consider advance care planning if appropriate (see Figure 34)

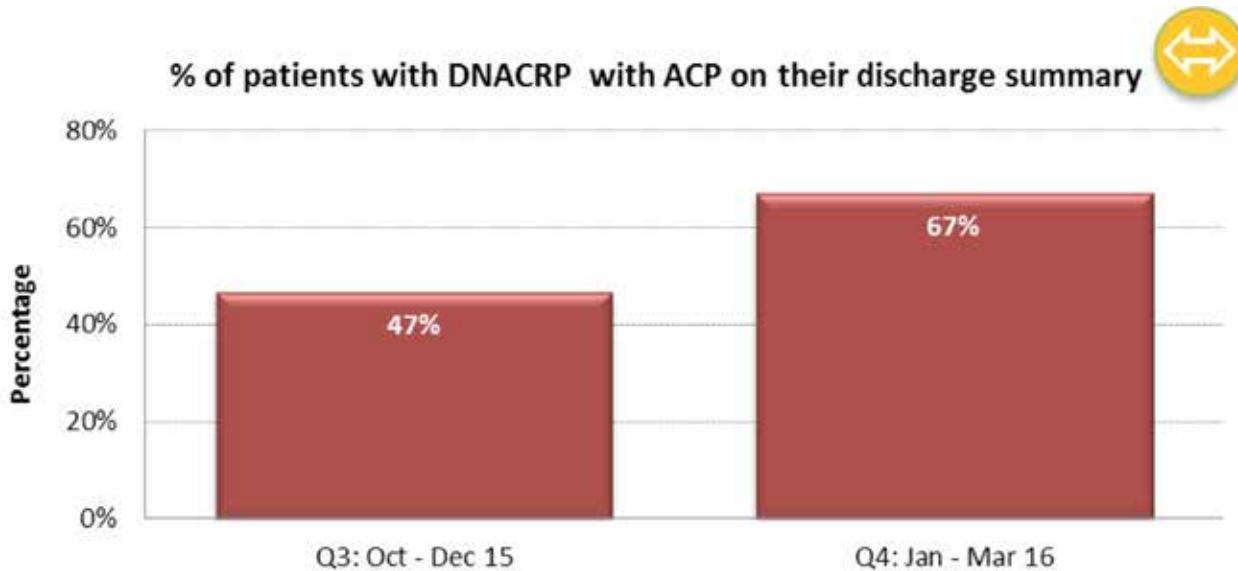
Quality Account

Figure 33



Source: Electronic Patient Record (EPR)

Figure 34



Source: Internal Audit

Although gains have been made and treatment escalation planning was carried out for 88% of our ECU cohort, there is no demonstrable evidence that this information was communicated to the GP in the absence of a DNACPR order or that any blocks or issues were highlighted.

We can evidence progress through:

- the progress has been monitored through the EoLC* Board and Clinical Quality Review meeting

In 2016/17 we will:

Despite progress made, there is still significant room for improvement and for this reason we will carry this work forward as a Quality Account priority for 2016/17. We will seek to improve our end of life care and the effectiveness of advanced care planning, in partnership with our colleagues in primary care by:

- looking at ways to auto-populate the treatment escalation form in the discharge summary and generate an advance care planning prompt
- explore options for communication skills training, to enable our clinicians to discuss wishes and needs in the context of recognising deterioration, and the need to plan ahead
- continue to roll out and expand EoLC education and training
- further explore impact of enhanced GP communication on ACP* in primary care setting.

Priority Nine

Positive Patient Experience: Improve the effectiveness of discharge from our care



Progress towards target achieved

Background:

This work came about as a result of bed pressures the Trust faced during winter of 2014/15, and the feedback from patients which identified a poor discharge experience in a number of cases. In an effort to address this pressing issue, the Improving Emergency Care Project was established, with the intention of improving patient flow and discharge throughout the Integrated Medical Rehabilitation Service (IMRS) directorate.

One of the first actions to be undertaken, was the 'day of care' audit, where all inpatients within IMRS had their health care record reviewed to see if they could potentially be managed in a non-inpatient setting. The audit identified 10 patients who could potentially have had intravenous (IV) drug therapy as an outpatient, suggesting we had further scope for improving our Out Patient Antibiotic Therapy (OPAT) service.

Alongside the 'day of care audit', we also carried out a staff survey, which was sent to consultants and senior nurses within the Trust, with the purpose of trying to identify reasons for potential delays in discharging patients and methods of improving patient flow. The consultant body was unanimous that having planned discharge dates (PDDs) would help improve timely discharge, though the nursing body was less convinced. PDDs were recommended as part of the 'SAFER patient flow bundle', which was developed by NHS England to help improve the process of

Quality Account

patient flow, the patient experience of discharge and reduce length of stay across adult inpatient wards. As a Trust we already used PDDs, although not very consistently or accurately, and therefore, it was decided to place a renewed emphasis on the use of PDDs as a useful and accurate tool to aid effective and timely discharge. This would in turn have a positive impact on patient experience, capacity and bed management and patient flow, which are all dependent on PDDs.

What did we say we would do?

To facilitate our goal, we said we would ensure:

- 100% of patients were given a predicted discharge date (PDD) at admission
- increase the number of bed days saved by the outpatient parenteral antibiotic therapy (OPAT) service by 50% (compared to its first quarter i.e. October - December 2014).

What did we do?

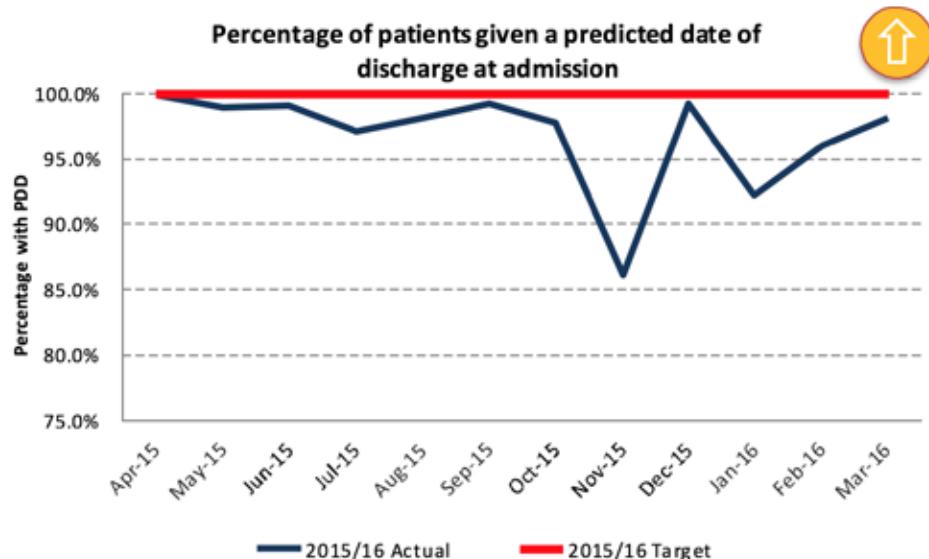
A system has been developed whereby a PDD is assigned to every new patient at the consultant led, multi-disciplinary team meeting (MDT), that takes place every day at 10.30 a.m. on the Acute Care Unit (ACU). Once assigned, this is recorded on the Electronic Patient Record (EPR*) and is displayed on the ward Whiteboard. The purpose is to enable our teams to identify patients that will be able to be assessed, treated and discharged promptly and efficiently from the unit, thus avoiding a transfer of care to another ward. Alternatively, it ensures that patients identified as requiring a longer hospital stay will be transferred to a specialty ward as soon as possible.

The PDD system is also used by specialty wards once patients have been transferred. Within our medical directorate, every ward now has a weekday 'Whiteboard' meeting, where all patients are briefly reviewed by the MDT; PDDs are monitored and evaluated to ensure progress is being made, and where necessary amended to reflect any change in patient status.

During 2015/16 96.4% of our patients were given a PDD on admission. Due to the constantly changing profile of ACU patients, this is never likely to be 100%, as there will always be patients who have arrived on the ward, awaiting full assessment and consultant review.

Although PDD results fall short of the target, the results suggest, the process of allocating PDDs to patients on admission is working well (see Figure 35).

Figure 35



Source: Electronic Patient Record (EPR)

This is a new measure monitored during 2015/16 and no historical data is available

During 2015/16 we successfully increased the number of bed days saved from 201, in the first quarter of the OPAT service, to 408 in the same quarter in 2015 (see Figure 36) and to date we have saved 985. In addition, 56 patients have been facilitated to return to the comfort of their own home rather than have to remain in hospital to receive intravenous antibiotics.

The following work was carried out to facilitate this increase in bed day savings and improvement in patient experience:

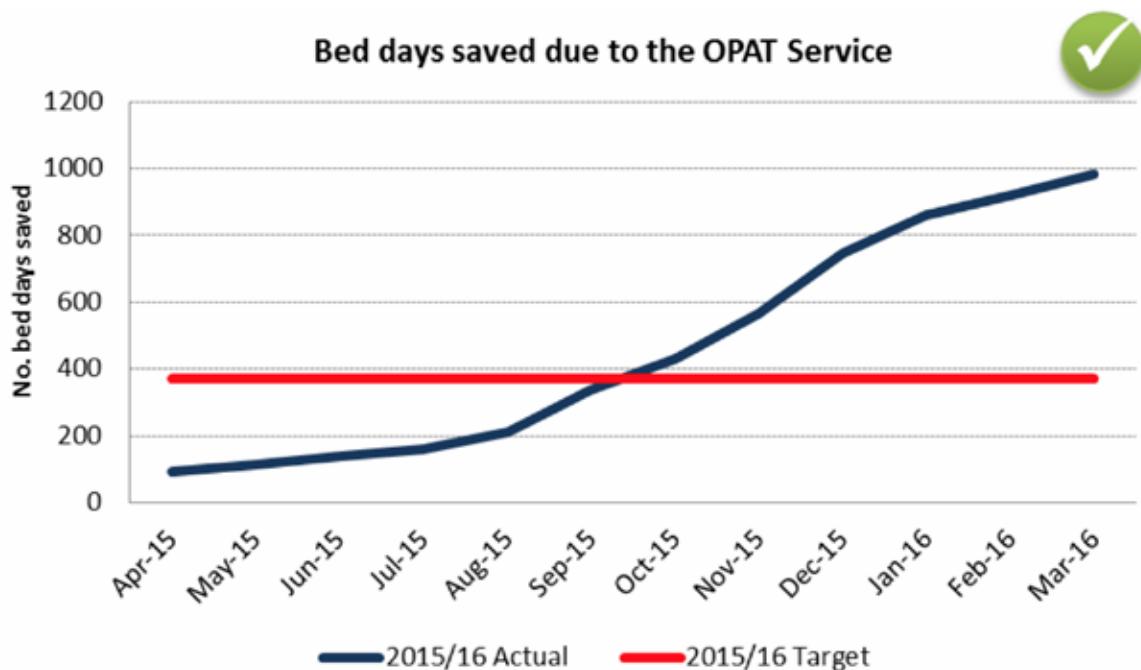
Publicity

The service was publicised through electronic alerts on the Electronic Patient Record (EPR*) System whenever there is an on-going IV antibiotic prescription, and also on daily 'Whiteboard' rounds carried out by the clinical site manager. The safety and effectiveness of the service was presented to the physicians at their medical unit meeting to promote confidence in the service.

Vascular access

An OPAT service can only be successful if there is a good vascular access service to enable the administration of antibiotics into veins. Over the past year we have developed a regular PICC (peripherally inserted central catheter) line insertion service, to allow drugs to be given directly into the veins and have introduced minimally invasive midline catheters that can be easily put into patients on the ward. Additionally, we have trained community nurses to carry out the insertion of peripheral intravenous cannulas (small plastic tube) to enable prompt discharge of patients on short-term intravenous antibiotics.

Figure 36



Source: Local database

This is a new measure monitored during 2015/16 and no historical data is available

We can evidence progress through:

- divisional board and review.

Quality Account

In 2016/17 we will:

- continue to develop the PDD model on all medical wards, working on accuracy as well as completion. Ensuring they are available and transparent to patients and families, to provide a guide to them as well as to staff
- develop a clinical dashboard for PDDs
- further roll out PDDs model to other areas such as Pre-operative Assessment to allow planning to commence pre-admission, and to surgical wards
- amalgamate PDDs work with other discharge management initiatives such as non-medical discharging (i.e. nurses and therapists)
- remain focused on the OPAT, and improve the contingency arrangements for the OPAT/ Vascular Access Team
- develop a teaching programme to enable patients and/ or their carers to administer IV antibiotics and explore the use of elastomeric devices (non-electronic medicine pumps) to aid the outpatient administration of antimicrobials that require multiple daily dosing.

Priority Ten

Positive Patient Experience: Improve the management and control of pain



Progress towards target achieved

Background:

Good acute pain management is regarded by many as central to the provision of good quality of clinical care (Royal College of Anaesthetists, 2014). Pain relief is not only a basic human right, but it can also improve clinical outcomes for patients and reduce spending for health care organisations. However, in 2014, the Picker survey showed that 31% of our patients were not satisfied with pain relief.

What did we say we would do?

Although previous patient feedback demonstrated a reduction in the number of patients reporting pain we still felt satisfaction gains could be made by setting the following goals:

- To monitor number of patients reporting satisfaction with pain relief as measured during anaesthetic first day post op review (aiming to achieve a minimum of 75% reporting satisfaction)
- Inpatients reporting severe pain (i.e. score of 3) report a reduction of at least 1 point on a scale of 0- 3 within 24 hours of first contact with the Acute Pain Team (APT)
- 75% of our patients reporting on our patient feedback system* say, they thought the hospital staff had done everything they could to help control pain
- For those who reported that staff were not able to control their pain adequately, 75% of patients reporting on our patient feedback system* had the reasons explained to them

* Optimum system

What did we do?

We undertook a number of initiatives to improve our management and control of pain to enhance our patients' experiences, and these are set out below.

During 2015/16 the pain team introduced a number of teaching events and projects to increase awareness and knowledge regarding pain relief and its importance. We implemented individual training sessions. Additionally, we held a Trust wide Pain study day in autumn 2015; this was well attended and positive feedback was received by a range of healthcare professionals. As a result of this, we have subsequently organised further dates in 2016/17.

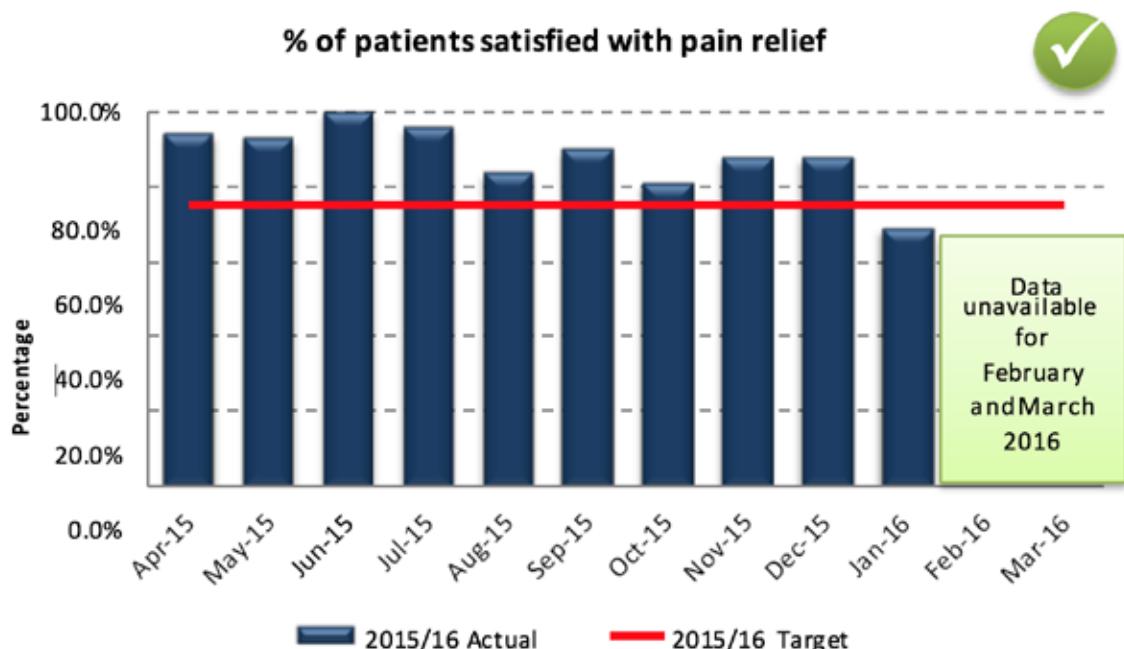
We instigated a formal ward round to review all surgical patients in their first 24 hours post procedure. The rounds were undertaken by doctors trained in anaesthesia, in conjunction with the nurse-led Acute

Pain Team, all of whom are independent prescribers. It was hoped that patients reviewed by staff trained in analgesia methods, would deliver an improvement in the management of pain. All post-operative surgical patients were reviewed (with exception of February and March 2016 due to anaesthetic staffing issues). An assessment of pain scores and associated morbidity (state or symptom) was carried out. Corrective steps were taken immediately when problems were identified - this usually involved changing standard prescriptions to fit individual patient needs, as indicated by their vital signs (e.g. blood pressure) and patient reported symptoms.

A new database was developed to facilitate the recording of information related to the post-operative surgical review, resulting in more reliable patient data being accessible to staff. This enables the APT* to monitor results and report information such as the number of patients reporting severe pain and outcome evaluations on a monthly basis.

Between October 2015 and March 2016 92% of patients reporting severe pain on their first visit from the APT* had their pain reduced within 24 hours of the first contact. We also surveyed patients regarding how satisfied they were with their post-operative pain relief in the first 24 hours. We aimed to achieve that at least 75% of patients would report that they were satisfied with their pain relief. Our survey shows on average 88% of our patients reported complete satisfaction with their pain relief in the first 24 hours after surgery (see Figure 37).

Figure 37



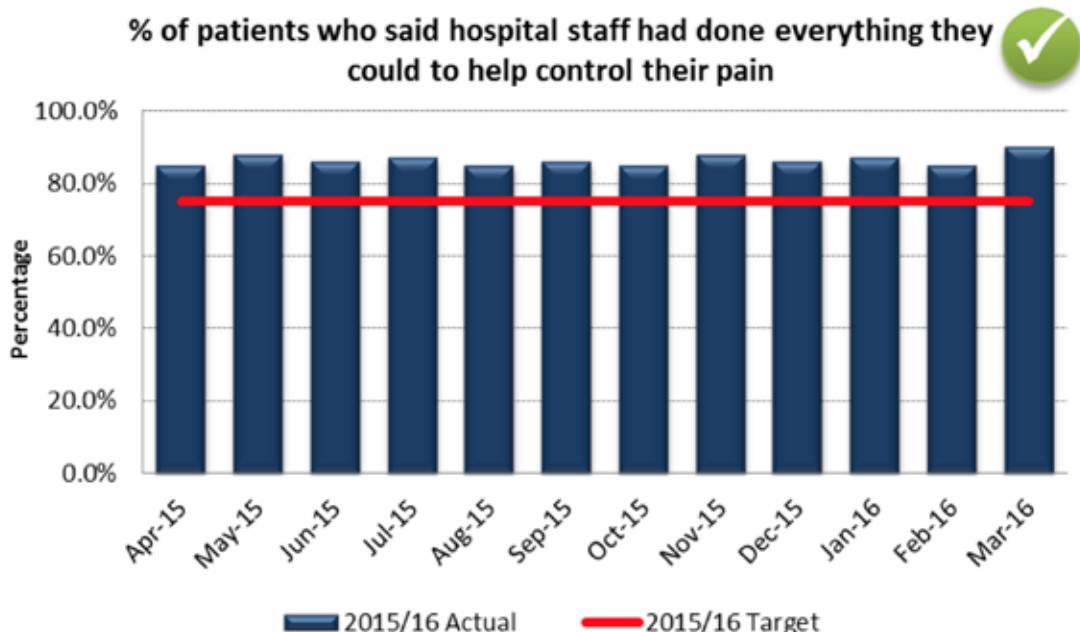
Source: Local database and Electronic Patient Record (EPR)

This is a new measure monitored during 2015/16 and no historical data is available

Quality Account

During 2015/16, 86% of our patients reported that they thought the hospital staff had done everything they could to help control their pain. This exceeded the target of 75% by 11 percentage points (see Figure 38 below).

Figure 38



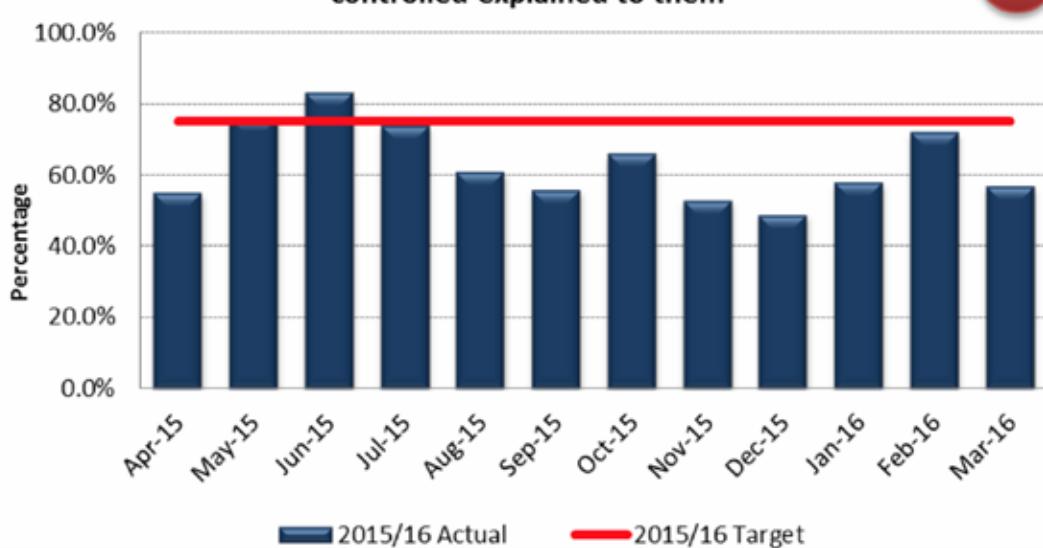
Source: Meridian Reporting System, Optimum Healthcare

Due to changes in reporting system and question definitions, historical data is not available.

However, whilst these results are encouraging, our data does show that there are still improvement gains to be made in the way we communicate about pain control issues with our patients. This is important so that they are provided with a clear explanation as to the reasons why their pain management is problematic, and they fully understand. This is borne out by the fact that only 64% of our patients felt this had been achieved, missing our target of 75% by 11 percentage points (see Figure 39 below).

Figure 39

% of patients who had the reasons for their pain not being controlled explained to them



Source: Meridian Reporting System, Optimum Healthcare

Due to changes in reporting system and question definitions, historical data is not available.

We have shared the data gathered with the anaesthetic department, with the aim to influence on-going changes in practice to maintain high levels of satisfaction.

We can evidence progress through:

- audit data gathered on ward rounds and results presented to the anaesthetic department.

In 2016/17 we will:

- continue to monitor patients in the immediate post-operative period, with a view to continuing the progress and quality improvement
- seek to gather data more efficiently, so as to deliver real time information to anaesthetists, in the hope that constant feedback will drive continual improvement in this area.

[Reference: Royal College of Anaesthetists (RCOA), 2014. www.rcoa.ac.uk/gpas2014 accessed

Priority Eleven

Effective: Improve the way we communicate and ensure respect, dignity and compassion



Target fully achieved

Background:

In 2013, the National Inpatient Survey showed that we needed to improve on treating our patients with respect and dignity, as 34% of patients had identified this as a problem (the national average was 28%).

During 2014/15, driven through the Patient Experience strategy; specific projects were identified to improve the way that our patients are treated, to embed the key principles of respect, dignity and compassion. Additionally, we introduced a new online annual Performance and Development Review (PDR) system which requires staff performance to be assessed against the four Trust Values.

In situ simulation provides training for health care professionals in their everyday environment. It offers a more realistic environment than the simulation lab by introducing real time pressures and everyday distractions. Through the use of familiar equipment in situ simulations have also been shown to identify latent safety threats and improve safety. Likewise, it provides a forum for discussion of hospital systems and protocols. In situ provides opportunities for multi-disciplinary training, facilitating team working and communication skills, which ultimately have an impact on patient experience.

Quality Account

What did we say we would do?

This year we said we would to aim for:

- further role out of Multi-disciplinary in-situ^{*} simulation team (increase from six to 10 areas)
- 85% of staff to have their behaviour assessed as good or better by their manager (where they have completed their annual appraisal on PDR). (See Figure 41)
- 1% improvement in the Optimum question "Do you feel you have been treated with respect and dignity?"
- 1% improvement in the Optimum question on "Do you have the confidence and trust in the staff treating and caring for you?".

What did we do?

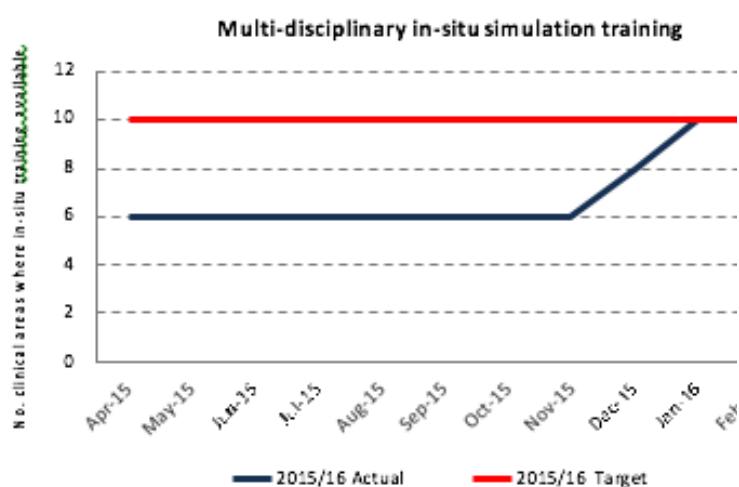
In situ simulation is at the centre of our improvement work to enhance the way we communicate. This training programme offers valuable training to staff with minimal interruption to their daily routines. Initially, some participants were apprehensive that time taken to engage in this training programme would have a negative impact on their clinical duties. However, this perception was quickly dispelled once staff had completed the 'scenario' training and could see the benefits to their own clinical practice.

The opportunity to take part in multi-disciplinary training is particularly beneficial, as this is something which most staff had not previously experienced. The nature of in situ training has the added advantage of identifying latent safety threats, and has produced tangible improvements in clinical areas e.g.

- During early simulation sessions, staff on one ward were unable to locate oxygen connectors and bag-valve-masks, but by the third session these could be located quickly by the participants.
- In a simulation related to a potential Ebola patient presenting to the Emergency Department this identified many of the expected at-risk areas such as deficiencies in personal protective equipment, which were subsequently changed. It also provided the opportunity to see the care provided from a patient perspective, especially privacy and dignity which had not been fully considered during planning. More importantly it demonstrated procedural deficiencies such as a failure to ensure all staff had been educated on the Ebola plan, screening procedures, and the handling of high risk materials in the lab.

This year we expanded our in situ simulation programme training to our community sites, and into more hospital areas. Subsequently, we now offer training in 10 clinical environments (see Figure 40), and for multiple teams. This is good progress on 2014/15 where we were training in six clinical areas. We have focused on training staff in emergency situations, the deteriorating patient, and to improve knowledge of essential protocols.

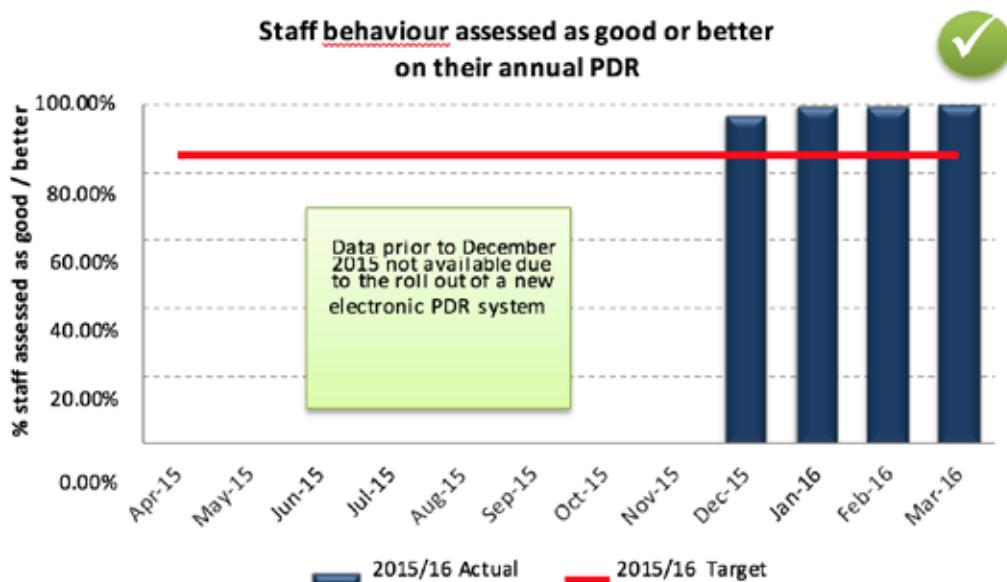
Figure 40



Source: Local Database

This is a new measure monitored during 2015/16 and no historical data is available

Figure 41



Source: PDR Web Based Reporting System

Due to a new reporting system being implemented part way through 2015/16, no historical data is available

This year the use of the Personal Development Review (PDR) system has been encouraged throughout the Trust, and both managers and staff have been offered training and support to adjust to the new process. Intensive training has been provided for individuals and teams in areas of low compliance.

We wish to use PDR for staff appraisal, as it explicitly requires staff to reflect on their values and behaviours, encouraging discussion at appraisal and enabling assessment and evaluation of staff performance against the Trust values.

Our Trust Values

To date, 38% of our staff have had their appraisal using the new system, of which 99.89% have had their behaviour assessed as good or better.

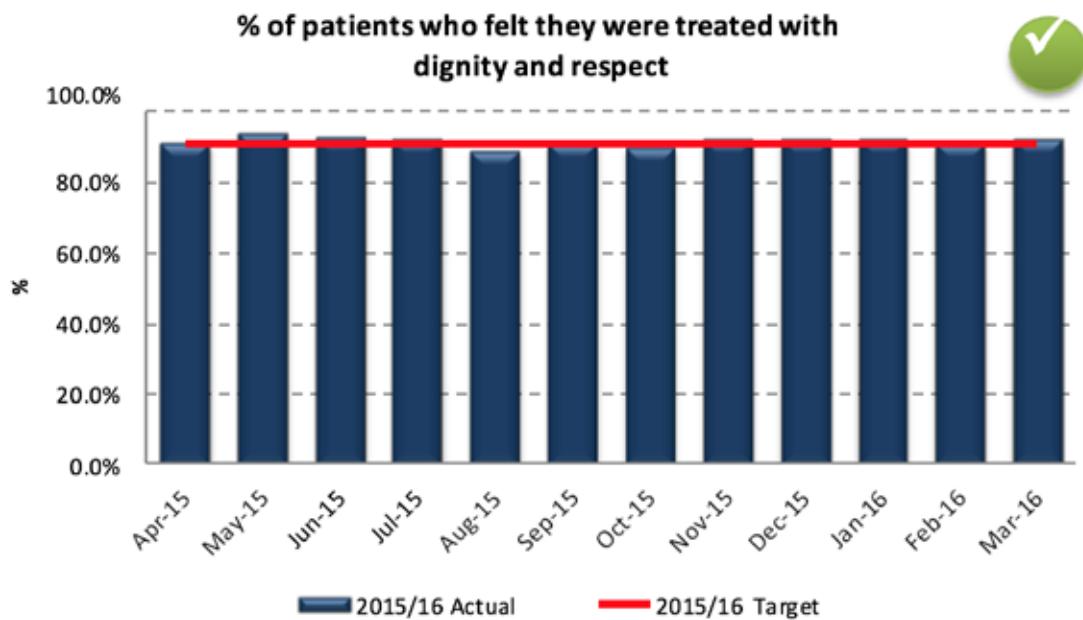
In addition, the Trust has been working in partnership with Hackney Community Voluntary Service and the Community Education Provider Network (CEPN) to develop user-led training modules. This programme aims to train users of services to deliver training about their experiences of using services, to the providers of health and social care services. This year, we have successfully introduced user-experience trainers in our administrative staff development programme; and are currently incorporating user-experience sessions into our student nurse teaching programmes. We have continued to monitor and evaluate the results of our Patient Experience Surveys, and we have seen an improvement in the satisfaction rate for two of our core questions and achieved our one percentage point increase target i.e.

- 92% of patients who felt they were treated with dignity and respect – up from 90% in 2014/15 (see Figure 42)
- 89% of patients who have trust and confidence in the staff treating and caring for them – up from 88% recorded between October 2014 and March 2015 (see Figure 43)



Quality Account

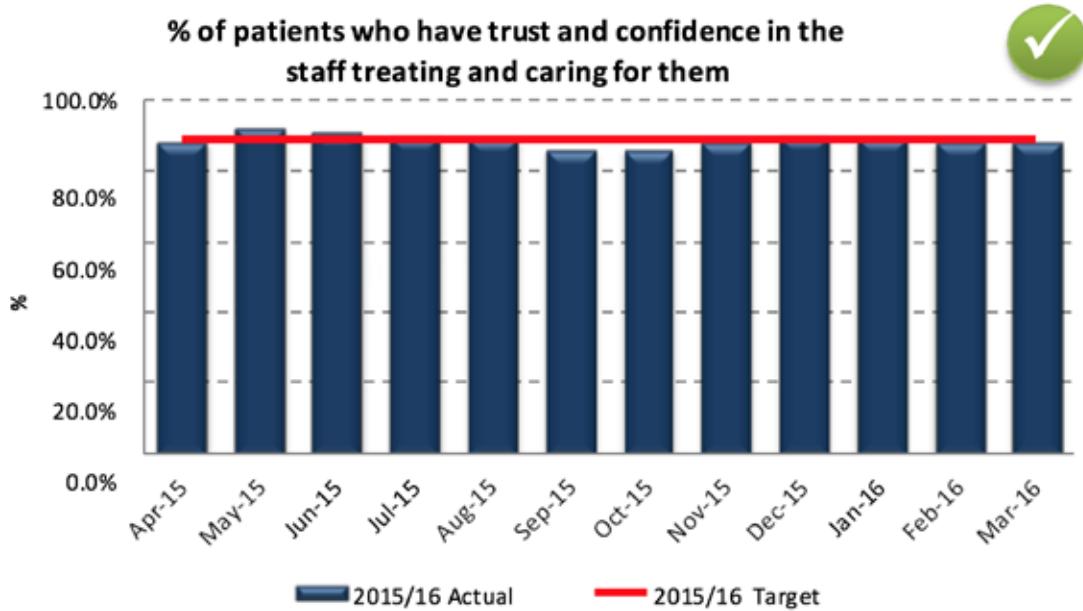
Figure 42



Source: Meridian Reporting System, Optimum Healthcare

Due to changes in reporting system and question definitions, historical data is not available.

Figure 43



Source: Meridian Reporting System, Optimum Healthcare

Due to changes in reporting system and question definitions, historical data is not available.

We can evidence progress through:

- improving Patient Experience Delivery group and forum.
-

In 2016/17 we will:

- continue our rollout programme to additional practice areas and encourage ownership of training by individual clinical areas
- continue to monitor compliance rates of PDR
- map/ evaluate performance outcomes using PDR and take appropriate steps to improve underperforming staff, and to reward high achievers
- continue to monitor and evaluate the results of patient experience surveys
- develop education and training programmes to address concerns, incidents and issues regarding communication, dignity and respect, raised by staff, patients and their families; for example, improving communication about discharge care plans on discharge and increasing staff awareness of threats to dignity
- together with Hackney Community Voluntary Service, we will design and develop new education programmes for staff, specifically concerning the experience of our patients with long-term disabling conditions
- we will develop experiential simulation programmes as well as classroom based sessions, to raise awareness of our patient's experiences.

Priority Twelve

Positive Patient Experience: Improve Health and Wellbeing of Trust Staff and achieve excellence



Target fully achieved

Background:

There is a growing evidence base that staff who feel their employer supports them in their daily work lives and with their personal health and well-being are more likely to deliver better services and higher quality care.

The Healthy Homerton Working group was formed in the summer of 2014 bringing together a multi- professional group with an interest in the health and well-being agenda. The strategic objective was to improve the health and well-being of staff working for Homerton using the vehicle of the Workplace Charter and achievement of 'Excellence' via 'Commitment' and 'Achievement'.

What did we say we would do?

We would achieve 'excellence' in the activity and outcome measures embedded within the London Healthy Workplace Charter i.e. the areas of corporate support for wellbeing; attendance management; health and safety requirement; mental health and wellbeing; tobacco; physical activity; healthy eating; problematic use of alcohol and other substances.

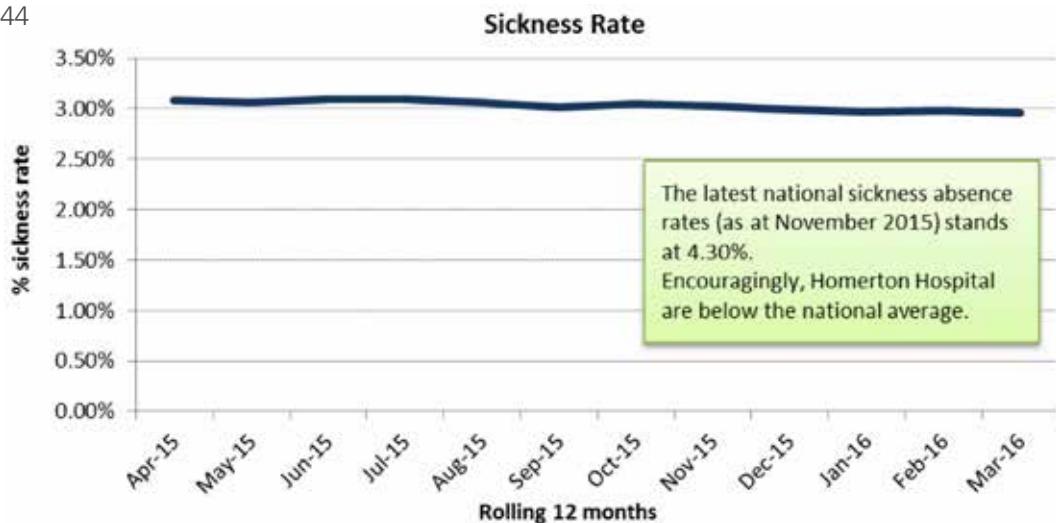
Quality Account

What did we do?

Over several months, the core group worked on identifying areas for improvement following our award of 'achievement' in April 2015, and address and close gaps. In the run up to verification, all evidence was gathered by the Healthy Homerton Team. This information supported the Trust in being awarded 'Excellence'.

In January 2016, members of the Healthy Homerton Core Group attended a certification day at City Hall. The team delivered a presentation, and were interviewed by a panel of four experts in the Health and Well Being field.

Figure 44



Source: HealthRoster, Electronic Staff Record (ESR)

This resulted in 'Excellence' being awarded.

We can evidence progress through:

- the Workforce committee and Trust Board.

In 2016/17 we will:

- the Healthy Homerton Core Group will continue to ensure this work is embedded and progressed
- use assessment panel feedback (when available) to help prioritise our work
- facilitate the Trust to go smoke free, take a targeted approach to sickness and absences, mental health first aid training, alcohol and substances awareness guidance and support
- work on ensuring that the ethos of 'Every Contact Counts' is embedded in the work of the trust, with the aim of contributing to improved health outcomes for the our patients and the wider population we serve.



Annex 1: Statements from commissioners, local Healthwatch and Overview and Scrutiny Committees

The following pages contain statements from our commissioners.



City and Hackney Clinical Commissioning Group

From City and Hackney CCG

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 are also the lead commissioner for other CCGs for the Homerton's services.

NHS City and Hackney CCG welcomes the opportunity to provide this statement on the Trust's 2015/16 Quality Account.

The CCG was pleased to be consulted on new quality priorities for the Trust last year and we welcome the breadth of indicators chosen and reported on in this Quality Account which, for the first time, also includes community services.

We fully endorse the Trust's approach to Quality Improvement with frontline staff asked for ideas to drive improvements, working closely with managers. We think this culture has always served the Trust very well, and is crucial to good patient care. This culture is also reflected in excellent, if slightly declining, staff survey results. The quality improvement program, which the CCG has been funding, is already showing system wide impact and we expect to see improved outcomes from this investment during 2016/17 such as reducing falls and best practice treatment for acute kidney injury.

We warmly welcome the Trust's recognition of the joint work that has taken place to make City and Hackney GPs the highest performers in England for some of their clinical outcomes: this is an excellent example of how primary and secondary care clinicians working together can reduce avoidable morbidity and mortality. The CCG has historically worked closely with Homerton clinicians to develop pathways and up-skill GPs, supporting them to have one of the lowest first outpatient referral rates in London. We are keen to see this work continue and to explore all opportunities to reduce waste and ensure our collective performance benchmarks well against our peers. We are particularly keen to see a greater emphasis on patient information and decision aids and on ensuring that all interventions deliver patient benefit and health gain and are grounded in best practice.

The Trust's investment into updating electronic patient records and enabling electronic drug rounds and automated vital signs recording is also welcome and we hope will be developed further so that paper systems soon become redundant. There are considerable gains to be made to improve safety and reduce costs and our GP colleagues are keen to see better and faster electronic information exchange. We note, however, that once again the Trust has failed to meet the requirements of the NHS Information Governance Toolkit. The new ACE transition was smooth, but there have been problems with the introduction of new referral to treatment and pathology processes.

We congratulate the Trust on their excellent record in participating in national clinical audits and for their local audit program. The Quality Account clearly shows how results are leading to changes in clinical practice such as the new Falls Group. We are keen to continue to ensure that there is a robust, locally agreed audit programme to measure the quality of services across the interface and that action plans are implemented.

We are somewhat disappointed that so many of the Trusts quality priorities are rated amber and many targets have been missed but pleased that the Trust continues to perform extremely well in

terms of national targets for example for cancer and A&E, and maintains a Summary Hospital-level Mortality Indicator (SHMI) below average.

We were disappointed with the results of the CQC inspections of the Trust's maternity services and Mary Seacole Nursing Home but we recognise the huge amount of work that has taken place to address issues highlighted by those inspections. We expect to continue to work closely with the Trust to address concerns raised about maternity services and support the Trust to be the hospital of choice for our residents.

We congratulate the Trust on achieving quality priorities such as increases in harm free care and a reduction in medication errors, and low infection rates especially for C. Diff. infections. Targets for District Nursing were also met and we hope the Trust continues to focus on this vital service for some of our most vulnerable residents, working closely with the One Hackney and the City initiative. Even though most of the targets were missed, significant improvements have been made in maternity services, responding to deteriorating patients, use of Early Warning Scores, early identification and management of sepsis, dementia training, care of children with epilepsy and end of life care planning.

We are encouraged to see the Trust working more closely with other local providers to improve services for patients across pathways and teams. We believe that there is much more that the Trust could do with others in the next year to fully integrate services across providers and, in doing so, demonstrate that there is a collective ambition and responsibility to deliver improved outcomes for our patients and address our local five year priorities

We note some improvements to patient experience scores which remain below the England average for inpatients, and we are aware there is considerable work being undertaken to improve this area which we wholeheartedly support. Whilst we recognise the particular demographics of the local population we want to see the Trust focusing on improving patient experience and learning from patient feedback – we would encourage the Trust to work actively with its patients and local patient groups and fora to both identify issues and involve patients in designing the solutions and monitoring their impact. Staff recommendations continue to be higher than the England or London average and the Trust is to be congratulated for this.

The Trust's Patient Reported Outcome measures are still low but have improved comparative to other Trusts. We hope the Trust will continue to expand its excellent dementia friendly initiatives in wards and the Mary Seacole Nursing Home and spread these wider into community services over the next few years. There is still some way to go to achieve the dementia CQUIN.

We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing quality / performance monitoring discussions and it is accurate in relation to the services provided.

Overall we welcome the 2015/16 quality account and look forward to working in partnership with the Trust to improve safety, effectiveness and patient experience of primary, community and acute services in City and Hackney in the next year.



Dr Clare Highton

Chair, NHS City and Hackney Clinical Commissioning Group

Overview & Scrutiny

Health in Hackney Scrutiny Commission
HSC, Area K, 2nd Floor
Hackney Council
1 Hillman St
London, E8 1DY

Reply to: jarlath.oconnell@hackney.gov.uk

12 May 2016

Ms. Sheila Adam
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Homerton Row
London, E9 6SR

Dear Sheila

RESPONSE TO QUALITY ACCOUNT 2015/16 FROM HEALTH IN HACKNEY SCRUTINY COMMISSION

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2015-16. 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 that about your key achievements over the past year. The Report is an accurate description of the Trust's performance against your quality indicators.

Over the past year our good working relationship with the Trust has continued. We appreciate the willingness of the Trust's representatives to attend the commission meetings. Much of our focus this year has been on the safety of maternity services at the Trust and on holding the Trust to account on some poor CQC inspection reports'. In June we considered reports from the Trust and others on the safety of the maternity service and debated these with key stakeholders. Following the publication of the CQC inspection report we discussed, in some detail, in September and January, how the shortcomings were being addressed and the progress being made in implementing the Joint Action Plan arising from the Maternity Risk Summit. We look forwarding to a further discussion at our July meeting on progress made since the publication of the re-inspection report in February.

In January we also discussed an action plan for Mary Seacole Nursing Home, which fell short in number of respects, following a separate CQC inspection.

In October the Trust contributed to our review on 'Tuberculosis in Hackney' and in our report, published in February, we commended the Trust for its work in reducing TB incidence locally, noting that the Trust's work here was held in very high esteem by the wider health sector.

In December and April we also discussed the Hackney Health and Social Care Devolution Pilot which we hope will be instrumental in transforming the quality of health and social care services in the borough. We will continue to regularly monitor the development of the Pilot.

We wish to make the following specific comments on your draft Quality Account:

- a) The Trust has maintained a solid performance across all the quality indicators. We noted for example that Significant Incidence (SI) management has greatly improved and that the Trust was rated the 2nd highest in London on patient safety incidents.
- b) There is an ongoing concern about the fact that recording of Referral to Treatment Times (RTT) had to be suspended on a few occasions because of poor data quality. This relates to the general 18 week Referral to Treatment Time as well as the both the 6 week and 18 week Referral to Treatment Times for the IAPT Service. We will be pursuing with you how these are being tackled.
- c) In relation to the safety of the maternity service, while we acknowledge that the borough's population has a significant proportion of mothers who are high risk for complications in pregnancy, the shortcomings found in the inspection reports are, nevertheless, not acceptable. The report of the re-visit by the CQC in October has shown some welcome improvement and this has led to the lifting of the three warning notices but the outstanding 'requirement notice' about governance structures in the department remains. The latest patient survey results are also positive which is to be welcomed. We would repeat our general observation about learning not appearing to be going back up the line and the need for good practice to be better embedded. We appreciate however the seriousness with which your Council of Governors' and the senior management team have taken this issue.
- d) We are pleased to see the good performance throughout on CQINs noting however that 'Improving Family and Friends Tests response rates needs to be improved.'
- e) We are pleased that you have appointed a Patient Incident and Liaison Officer to support the delivery of the Duty of Candour regulation which came into effect on 1 April. We hope that by being open and honest with patients and their relatives when things do go wrong and by providing a timely and appropriate communication or apology to those affected, that there should now be a significantly improvement in future on your performance on complaints handling, which has been poor.
- f) We note that there has been a lack of progress in achieving the target of reducing by 10% the number of patients who are readmitted within 30 days of discharge, but acknowledge the challenge here. We

welcome that you have a specific priority on reducing the number of postnatal readmissions.

- g) We are pleased you are carrying forward the Priority on 'improving end of life care and advance care planning' to build on the progress you started to make last year on ensuring GPs are informed about discussions around treatment escalation or advance care planning at the hospital. We look forward to discussing this subject in more detail with you during our imminent review on 'End of Life Care'.

We look forward to taking up these issues with you over the next year as the Trust presents it regular updates.

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, Director of Public Health, City and Hackney

healthwatch

City of London

Healthwatch City of London response to the Homerton University Hospital NHS Foundation Trust quality account 2015/16

Healthwatch City of London is pleased to have been given the chance to comment on this quality account and has spoken to service users and residents over the last year to gather views on the Homerton from the City perspective. The bus routes to the hospital have continued to be a problem for City residents meaning that the hospital is not used as frequently by residents as it could be. Better publicity of the alternative transport links could lead to greater usage of the Homerton by people from the City.

City Healthwatch has had the opportunity to be represented at regular meetings concerned with Trust quality assurance. The commitment to ensuring that appropriate processes are in place is clearly visible and the wide reaching nature of supervision and effective follow-up of problems is apparent. That the meeting is chaired by the Chief Nurse shows the importance that the trust accords to quality. The content of the annual summary is largely determined by supervisory bodies. That said, the earlier part of the statement is written in a refreshingly clear manner. Recurrent problems in many urban trusts with multiple ethnic populations include patients feeling they are not listened to, or sometimes get contradictory messages from the staff. The trust continues to work on these issues, and others highlighted by audit procedures.

Annex 2: Statements 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.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support 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 2015/16 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 2015 to 25/05/2016
 - papers relating to Quality reported to the board over the period April 2015 to 25/05/2016
 - feedback from commissioners dated 11/05/2016
 - feedback from governors dated 12/05/2016
 - feedback from local Healthwatch organisations dated 12/05/2016
 - feedback from Overview and Scrutiny Committee dated 12/05/2016
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2015
 - the 2015 national patient survey January 2016
 - the 2015 national staff survey March 2016
 - the Head of Internal Audit's annual opinion over the trust's control environment dated 20/05/2016
 - CQC Intelligent Monitoring Report dated May 2015
 - the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
 - the performance information reported in the Quality Report is reliable and accurate
 - there are proper internal controls over the collection and reporting of the measures of performance

included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board



Chairman

Date: 25 May 2016



Chief Executive

Date: 25 May 2016

Appendix B: 2015/16 CQUINS

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
1	Physical Health: Acute Kidney Injury Planned Care	250,000			<p>1) Acute Kidney Injury</p> <p>This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below.</p> <ol style="list-style-type: none"> 1. Stage of AKI (a key aspect of AKI diagnosis); 2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment); 3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care); 4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).
2	Physical Health: Sepsis Planned Care	250,000			2a) Sepsis Screening
					<p>The CQUIN seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.</p>
3	Mental Health - Dementia Mental Health	150,000	49,500		2b) Sepsis Antibiotic Administration
					<p>2b relies on administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies.</p>
3	Mental Health - Dementia Mental Health	150,000	49,500		<p>3a) Dementia and Delirium - Find, Assess, Investigate,</p> <p>Refer and Inform (FAIRI)</p> <ol style="list-style-type: none"> i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP*.
					»

Quality Account

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
»		25,000	8,250		<p>3b) Staff training To ensure that appropriate dementia training is available to all staff. Quarterly reporting to Provider Board to include numbers of staff who have completed the training and overall percentage of staff training within each provider.</p>
		75,000	24,750		<p>3b) Supporting carers Ensure carers of people with dementia and delirium feel adequately supported. Carer survey - Commissioners and providers will need to agree on the content of the survey and local processes for surveying carers of people with dementia and delirium which should cover the whole health and social care economy. The findings of the survey to be presented biannually to the Provider Board.</p>
4	Urgent and emergency	100,000			<p>4a) - Supported discharge – Patients over 75 on the ACN caseload, assessed by the service within 48 hours of admission 80% of patients over 75 on the ACN caseload who are assessed by the service within 48 hours of admission in order to develop a discharge plan.</p>
					<p>4b) PART ONE Emergency Care Community Discharge Support % of patients over 75 admitted as an emergency to HUHFT who are on ACN caseload and are contacted either via a home visit or a telephone contact within 48 hours of discharge by ACN service with a report to the GP* within 24 hours of discharge via fax or electronic letter system.</p>
					<p>4c) Care Plans - over 75s Trust will fax the GP* of all patients over 75 who are admitted as an emergency to find out if the patient has a care plan and to request the care plan or the patient summary if there is no care plan available. The Trust may also record where a clinical conversation has taken place with the patient's GP*.</p>

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
		100,000			<p>4d) End of life care Include information on electronic patient discharge summaries (of patients discharged from Elderly Care Unit) on:</p> <ul style="list-style-type: none"> - Inform GP* that discussions about treatment escalation have happened (and to inform GPs* of any blocks/issues if conversations about treatment escalation have been raised) - Prompt GPs* to action: provide information to GP* about secondary care consultant's assessment of whether patient may be entering the last year of life – prompt a discussion about future wishes/ACP* by GP* or other community staff
5	Long term conditions	80,000			<p>5a) Diabetes For all patients admitted for any reason, elective and emergency, with a diagnosis of diabetes to have a face to face and documented assessment by a specialist diabetes nurse within 48 working hours of admission Sunday - Thursday excluding bank holidays, together with a pack where indicated.</p>
		80,000			<p>5b) COPD* For all patients admitted for any reason, elective and emergency, with a diagnosis of COPD*, new diagnoses and existing diagnoses, to have a face to face and documented assessment by a specialist COPD* nurse within 48hrs of admission Sunday - Thursday excluding bank holidays, together with a care bundle or pack where indicated.</p>
		100,000			<p>5c) Heart Failure inpatients seen by specialist nurse For all patients admitted for any reason, elective and emergency, with an established diagnosis of heart failure confirmed by ECHO, to have a face to face and documented assessment by a specialist HF nurse within 48 hrs of admission (Sunday to Thursday, excluding bank holidays and Sundays prior to a bank holiday).</p>
6	Urgent care	120,000			<p>6a) Consultant Review – Over 75s seen by a geriatrician % of all patients over 75 admitted as emergencies seen by a consultant geriatrician within 72 hours and a management plan agreed.</p>
	Planned care	120,000			<p>6b) Consultant Review – ACU % of all ACU A&E admissions to be reviewed by a consultant by 10.30 am the following day. To ensure patients who may benefit from a consultant review are not being excluded inappropriately the Trust will provide a quarterly exception report on patients admitted to the OMU and not discharged within 24 hours (LoS > 24hours).</p>

»

Quality Account

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
»		150,000			<p>6d) Implementation of the National Cancer Survivorship Initiative</p> <ul style="list-style-type: none"> i) Holistic needs assessment ii) Treatment summaries <p>Trust is required to put a system in place to identify and track relevant patients to provide report to commissioner at the end of Q4.</p>
7	Planned care		90,750		<p>7a) IBS Patients</p> <p>IBS patients seen by dieticians trained in FODMAP as part of the community IBS Pathway.</p> <ul style="list-style-type: none"> i. 90% waiting times below 5 weeks ii. DNAs no greater than 15%
8	Medicines management	30,000			<p>8a) Antimicrobials</p> <p>Trust wide plan to ensure adherence to NICE / other National guidelines as well as locally agreed guidelines to reduce inappropriate use of antimicrobials.</p>
		30,000			<p>8b) Safety in Prescribing CQUIN – Opioids</p> <ul style="list-style-type: none"> (i) Develop and implement jointly agreed local protocol for the use of Oxycodone with the Trauma & Orthopaedics department for Total Hip and Total Knee Replacements in relation to inpatient and discharge prescribing. (ii) Audit compliance against the protocol (iii) To reduce proportion oxycodone as percentage of all opioids (and ensuring that reduced usage of oxycodone is not associated with increased use of fentanyl)
		20,000			<p>8c) Improving Process and Assurance of CCG*</p> <p>Commissioned PbR excluded drugs - through use of BluTeq and Audit</p> <p>Providing assurance for compliance to guidelines/guidance relating to PbR Excluded drugs by</p> <ul style="list-style-type: none"> (i) Utilisation of BluTeq for prior approval/notification requests for PbR Excluded drugs - this will be 95% by end of Q4 2015/16 for all new patients initiated from 1st January 2015 onwards. (ii) Submission by 31st December 2015 - of clinician-led audit of use of biologics [to show NICE compliance for initiation and continuation of biologics] used in the Trust.

»

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
»					<p>8d) Improving uptake of LPP negotiated Infliximab pricing - £10k</p> <p>From 1st September 2015, as a minimum all patients being initiated on infliximab should have the Remsima® provided as the preferred biosimilar in line with the LPP negotiated contract.</p>
9	Maternity	185,000			<p>9a) Normal Births</p> <p>Increase the percentage of women delivering in the midwife-led birthing centre and at home to 21%. This target is based on the place of birth studies as well as recent NICE guidance. Current baseline as month 10 2014/15 is 12.87% for birth centre and 2.17% for home births totalling 15.04%.</p>
		70,000			<p>9b) Supporting Mothers to Breastfeed</p> <p>Implementing the international WHO/UNICEF Baby Friendly Initiative (BFI) at Homerton; this is proven to increase rates of breastfeeding. The focus will be on embedding standards across maternity, children's community and neonatal services. The Homerton have previously reached level 1 in 2009. The refreshed scheme has three levels which would normally take a trust three years to complete. In order to show a stretch in performance it is asked that Homerton re-accredit for stage 1 and reach stage 2 by end of 2015/16.</p>
		50,000			<p>9c) Improving Test Response Rates</p> <p>Maternity services have for some years had a family and friend test (FFT) patient survey to establish patient satisfaction levels. This is due to historic poor patient reported experience with these services. The national maternity FFT asks for women's views on their maternity services at three touch points:</p> <p>Maternity dashboard will continue to report monthly but it is expected that the Homerton report quarterly on the CQUIN achievement.</p>
11	Improving Patient Experience Committee	140,000	148,500		<p>11) Patient Experience Decision Making Tool</p> <p>Trust to pilot and evaluate relevant elements of the Making Good Decisions in Collaboration (MAGIC) Programme (The Health Foundation) or similar scheme.</p> <p>2. The Trust will identify at least three specialities, one within long term conditions care and one in surgical care, to pilot use of an appropriate shared decision making tool and evaluate to show impact and how this can be spread to the rest of the Trust</p> <p>3. Trust will provide a plan for roll out of programme across the Trust in 2016/17 and how to embed shared decision making.</p>

Quality Account

Number	National CQUINS	Acute contract Value	Community contract value	NHSE Contract value	Description
12	Public Health LBH	55,000	165,000		<p>12) Smoking</p> <p>The proportion of clinical staff (not including AHP/ supporting clinical staff) trained to deliver very brief advice (VBA) on smoking. The proportion of patients with smoking status recorded. The proportion of patients identified as smokers that have been offered VBA, and referred on to the local smoking cessation service.</p>

	NHSE CQUINS	Acute contract Value	Community contract value	NHSE Contract value	NHSE CQUINS - Early Years/Dental/PH
	B02 Dental	50,000			Quality Dashboard for Dental - tiers 1,2,3 activity and Tiers mapping
	Public Health DESP	140,000	148,500		<p>Immunisations</p> <p>All providers will be targeting all patients and clients who might be part of the commissioned service caseload / cohort.</p> <p>All providers will offer increase staff vaccinations for = 75 – 90% for flu and offer brief intervention, campaigns and sign- post</p>
	Early Years				<p>CHIS Interoperability</p> <p>Antenatal Referrals, Screening and eRedbook function will be activated and implemented by December 2015</p>

	NHSE CQUINS	Acute contract Value	Community contract value	NHSE Contract value	NHSE CQUINS - Specialised
	Acute scheme 2	50,000		85,673	<p>Post bariatric surgery discharge pathway</p> <p>Achievement in line with agreed contract plan:</p> <ol style="list-style-type: none"> 1. Set up an operational group with membership of clinical, commissioner and provider leads from the CCGs* and Trust (CCG* membership based on referral and discharge destination in line with the Responsible Commissioner guidance). 2. Hold minimum of three op group meetings during 2015/16 3. Identify active patient list from the Trust record commencing with 2013/14 admission year up to 2015/16 4. Develop shared care discharge pathway from Tier 4 service after two year of bariatric treatment and care (NICE guidance) 5. Develop shared care protocols between the Trust and CCG* commissioned community services to ensure continuity of care
	Acute scheme 3	140,000	148,500	108,022	<p>Hepatitis C Network</p> <p>Year 1: A national model of Specialised Hepatitis C networks is proposed. This CQUIN is to support the development of partnership working within networks and co-ordination of data collection alongside the procurement process.</p> <p>The CQUIN focuses on developing partnership working across services which treat patients for Hepatitis C; these may be commissioned through NHS England or through other commissioners.</p> <p>Providers across networks are responsible for developing a working group for this CQUIN, map patient pathways and produce a plan to improve partnership working. Implementation of an improvement in partnership working as part of developing the Hepatitis C Operational Delivery Networks (ODN).</p> <p>Year 2: Implementation of an agreed improvement plan for partnership working.</p>
	Acute scheme 4			108,023	

Quality Account

	NHSE CQUINS	Acute contract Value	Community contract value	NHSE Contract value	NHSE CQUINS - Specialised
	Acute scheme 4			108,023	<p>B2) HIV: Reducing unnecessary CD4 monitoring</p> <p>To embed evidence based approach to monitoring CD4 counts for management of HIV treatment, in line with international guidelines (2014 DHHS antiretroviral guidelines).</p> <p>Specifically, it measures the proportion of eligible individuals, who are on ART and have had an undetectable viral load for two years and a CD4 count > 350, who have CD4 counts performed annually or less frequently.</p> <p>The target is for =>90% of eligible patients attending in 2015/16 to have had no more than one CD4 count performed within the last 9 months.</p>
	Acute scheme 5			40,973	<p>Management of Oral Formulation of Systemic Anti Cancer Therapy</p> <p>Implementation of improved prescribing practice aimed at achieving reduction in the level of Oral SACT that is "wasted" (i.e. issued to patients but not taken by patients).</p>
	Acute scheme 6			108,023	<p>To reduce delayed discharges from ICU to ward level care by improving bed management in wards.</p> <p>Provider to identify why delays from ICU to ward based care occur and to identify a scheme to reduce these delays to less than 24 hours after decision to discharge made</p>
	Acute scheme 7			42,836	<p>7) Neonatal Intensive Care</p> <p>7a) Neonatal Community Nursing</p> <p>This scheme is designed to improve community nursing support enabling timely discharge for babies <36 weeks gestation.</p> <p>The scheme should be read in association with the Neonatal Discharge QIPP* Scheme.</p>
				42,836	<p>7b) Neonatal unit admissions</p> <p>Reduce separation of mothers and babies and reduce demand on neonatal services by improving learning from avoidable term admissions (≥ 37wk gestation) into neonatal units.</p>

Appendix C: Glossary of terms and abbreviations

AAC	Augmentative and Alternative Communication (aid)
ABI	Acquired Brain Injury
ACE	Acute Clinical Excellence
ACP	Advanced Care Plan
ACU	Acute Care Unit
AKI	Acute Kidney Injury
Caesarean Section	An operation to deliver a baby
CCG	Clinical Commissioning Group
<i>C.diff</i>	<i>Clostridium Difficile</i>
CEO	Chief Executive Officer
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation
CTG	Cardiotocograph
DNA	Did Not Attend
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoC	Duty of Candour
ECU	Elderly Care Unit
ED	Emergency Department
EDPS	Edinburgh post natal depression score
EoL	End of Life Care
EoLC	End of Life Care
EPR	Electric Patient Record
ESP	Extended Scope Physiotherapy i.e. physiotherapists with skills beyond the scope of a normal physiotherapist e.g. injecting, prescribing, requesting investigations such as MRI scans , blood tests and doing diagnostic ultrasound scanning
GAD 2	Generalized Anxiety Disorder Scale

Quality Account

Glossary of terms and abbreviations continued

GLA	Greater London Authority
GP	General Practitioner
In-situ	In the appropriate position
IV	Intravenous
K2 CTG Training	Cardiotocograph training delivered by specific computer system i.e. K2
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?
LCP	Liverpool Care Pathway
MDT	Multidisciplinary Team
MEOWS	Maternity Early Obstetric Warning Scores
NEWS	National Early Warning Scores
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
PDD	Planned Discharge Dates
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
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures
PUSC	Pressure Ulcer Scrutiny Committee
QI	Quality Improvement
QIPP	Quality, Innovation, Productivity and Prevention (programme)
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'.
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.
RNRU	Regional Neuorological Rehabilitation Unit
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 (http://sepsistrust.org/wp-content/uploads/2015/08/1409314199UKSTAp pendix1RFS2014.pdf)
SLT	Speech and Language Therapy
TB	Tuberculosis
VTE	Venous Thromboembolism
Whooley	Depression screening tool

Independent auditor's report to the council of governors of Homerton University Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Homerton University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Homerton University Hospital NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Homerton University Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Homerton University Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Homerton University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

As detailed on page 55 of the Trust's Quality Report and page 57 of the Annual Report, the Trust has been unable to report upon the following indicator for the year:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

Where the Quality Report does not include a figure for a national priority indicator, Monitor guidance mandates an alternative national indicator for testing and the following indicator was selected:

- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

As a result, the following national indicators for the year ended 31 March 2016 subject to limited assurance are:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to the two above national indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2015 to March 2016;
- papers relating to quality reported to the board over the period April 2015 to 31 March 2016;
- feedback from the Commissioners dated 11 May 2016;
- feedback from the governors dated 12 May 2016;
- feedback from local Healthwatch organisations, dated 12 May 2016;
- feedback from Overview and Scrutiny Committee, dated 12 May 2016;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2015;
- the national patient survey dated 21 May 2015;
- the national staff survey dated 22 March 2016;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;
- Care Quality Commission reports; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated 10 May 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

The annualised Accident and Emergency ("A&E) four-hour wait indicator is calculated as a percentage of the total number of unplanned attendances at A&E for which patients total time in A&E from arrival is four hours or less until discharge, transfer, or admission as an inpatient. We have tested a sample of 24 unplanned A&E attendances during the year. Our testing included testing attendances where an apparent breach of the target had been validated by the Trust's processes, and, following investigation, had been recoded as meeting the target.

Our testing identified that the Trust does not retain an audit trail for adjustments made following validation of apparent breaches. Documentation is not available to evidence rationale for amending individual A&E attendance durations.

As a result there is a limitation upon the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting A&E 4 hour waiting times.

Qualified conclusion

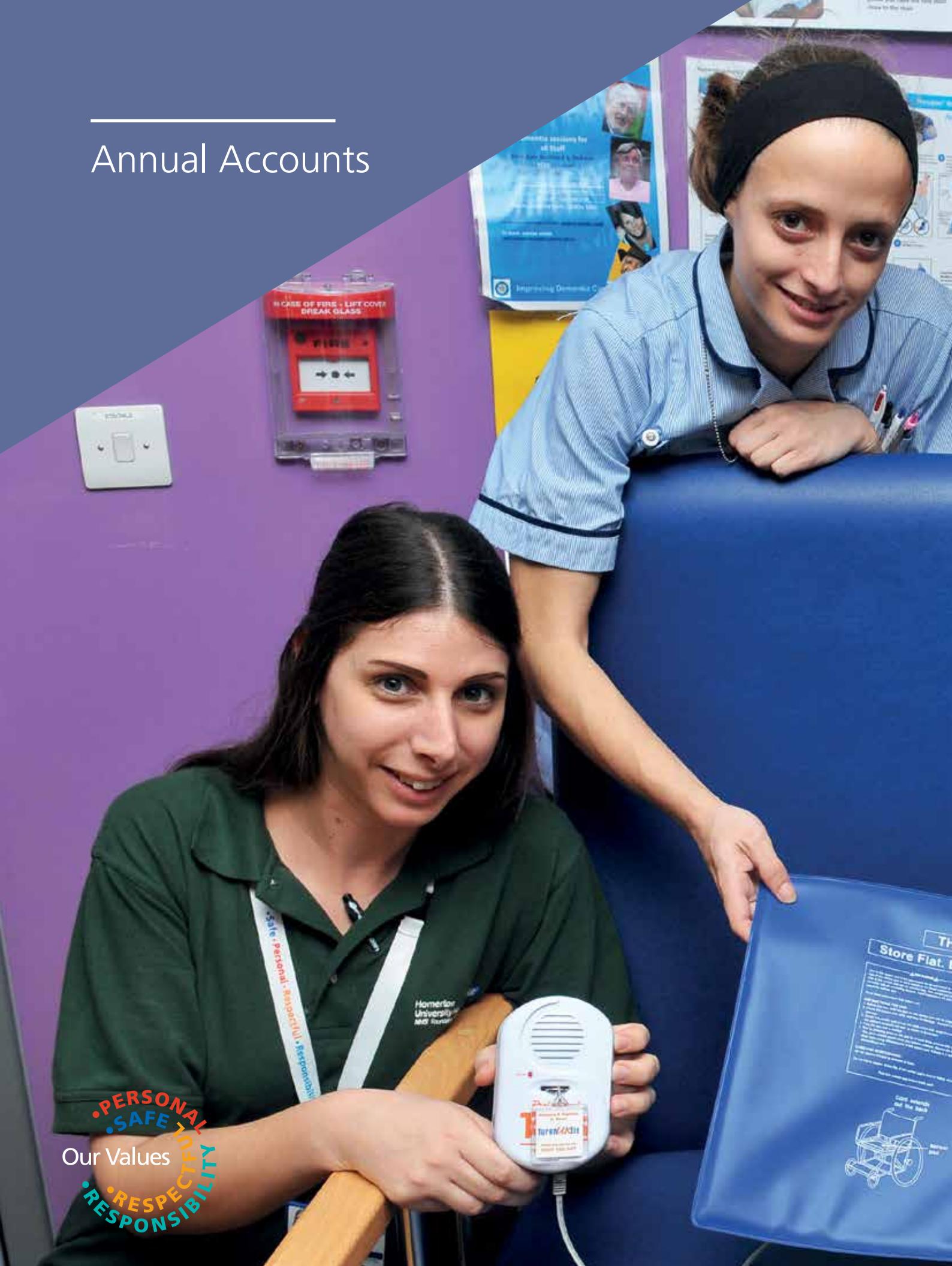
Based on the results of our procedures, except for the effects of matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.



Deloitte LLP
Chartered Accountants
St Albans
26 May 2016

Annual Accounts



Our Values

• PERSONAL
• SAFE
• INTEGRITY
• RESPECT
• RESPONSIBILITY



Annual Accounts

Homerton University Hospital NHS Foundation Trust

Annual Accounts for the year ended 31 March 2016

CONTENTS	Page
Foreword to the Accounts	177
Independent Auditor's Report	178-183
Statement of Comprehensive Income for the year ended 31 March 2016	184
Statement of Financial Position as at 31 March 2016	185
Statement of Changes in Taxpayers' Equity (SOCITE) 2015/16	186
Statement of Cash Flows for the year ended 31 March 2016	187
Notes to the Accounts	188-220

Annual Accounts

Foreword to the Accounts

Homerton University Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2016 have been prepared by Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS

Act 2006.



Tracey Fletcher
Chief Executive

25 May 2016

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Opinion on financial statements of Homerton University Hospital NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements comprise of the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 26. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and Code of Audit Practice.

Going concern

We have reviewed the Accounting Officer's statement on page 8 of the Annual Report that the Trust is a going concern. We confirm that:

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Independence	We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.
Our assessment of risks of material misstatement	The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.
Risk	How the scope of our audit responded to the risk
Recognition of NHS revenue and related recovery of NHS receivables	<p>Total income from activities in 2015/16 was £264.1m (2014/15: £250.1m) as detailed in Note 3.1 of the financial statements. NHS debtors as at 31 March 2016 are £22.8m (31 March 2015: £13.1m). The accrued income as at 31 March 2016 is £2.4m (31 March 2015: £6.1m). These are both detailed in Note 12.1 of the financial statements.</p> <p>There are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:</p> <ul style="list-style-type: none"> • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise; and • the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. <p>The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.</p>
Property valuations	We evaluated the design and implementation of controls over property valuations, and
The Trust holds property assets within Property, Plant and Equipment. The net book	

Risk	How the scope of our audit responded to the risk
<p>value of land and buildings as at 2015/16 was £122.4m (2014/15: £127.0m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.</p>	tested the accuracy and completeness of data provided by the Trust to the valuer.
	We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2016.
	We have reviewed the disclosures in note 1.7 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.
	We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement.
Capital expenditure	
<p>The Trust's capital spend on Property Plant and Equipment and Intangible Assets was £4.2m and £2.7m (2014/15 £10.6m and £2.6m) respectively. This is shown in notes 9 and 8.</p>	We have tested the design and implementation of controls over the capitalisation of costs.
<p>Determining whether expenditure should be capitalised under International Financial Reporting Standards can involve significant judgement in determining whether spend is capital or revenue in nature.</p>	We performed tests of a sample of additions in the year, to assess whether they met the conditions for capitalisation. We performed this testing through scrutinising invoices and other documentation and by inspection of the physical asset.

	<p>audit work and in evaluating the results of our work.</p> <p>We determined materiality for the Trust to be £5.0m (2014/15: £2.6m), which is below 2% of revenue and below 4% of equity (2014/15: below 1% of revenue and below 2% of equity). Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements. We reassessed the percentage used from 1% of revenue in 2014/15 in the context of our cumulative knowledge and understanding the audit risks at the Trust and our assessment of those risks for this year.</p> <p>We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.25m (2014/15 £0.13m), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.</p>
An overview of the scope of our audit	<p>Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices in Homerton directly by the audit engagement team, led by the audit lead.</p> <p>The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.</p>
Opinion on other matters prescribed by the National Health Service Act 2006	<p>In our opinion:</p> <ul style="list-style-type: none"> • the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and • the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.
Matters on which we are required to report by exception	
<i>Use of resources</i>	<p>The Trust has described the following matters in its Annual Governance Statement which we consider to be relevant to the Trust's arrangements to secure economy, efficiency and effectiveness:</p> <p>Financial Performance of the Trust</p> <p>The Trust has recorded a deficit of £11.8m after impairment and £5.5m before impairment. This compares to the Trust's financial plan for the year which showed a planned surplus of £0.5m excluding impairments. The Trust's governance risk rating from Monitor is currently under review following deterioration in the Trust's financial position. These issues are evidence of weaknesses in proper</p>

Annual Accounts

arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Homerton University Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements	An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.
---	--



Jonathan Gooding, FCA
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom
26 May 2016

Annual Accounts

Statement of comprehensive income for the year ended 31 March 2016

	NOTE	2015/16 £000	2014/15 £000
Revenue			
Operating income from continuing operations	3	284,430	269,933
Operating expenses (excluding impairments)	4	(285,092)	(266,458)
Impairments charged to operating expenses	4	(6,354)	(3,188)
Operating (deficit) / surplus		(7,016)	287
Finance costs:			
Finance income	7	35	52
Finance expenses-finance liabilities	7	(278)	(210)
Finance expenses-unwinding of discount on provisions	15	(14)	22
Public dividend capital dividends payable	17	(4,533)	(4,318)
Total finance costs		(4,790)	(4,454)
Movement in fair value of investment property and other investments	10	-	-
Retained deficit for the year		(11,806)	(4,167)
Other comprehensive income			
Net gain on revaluation of tangible assets		-	5,683
Gain arising from transfer by absorption	9.7	4,378	
Total comprehensive income for the year		(7,428)	1,516
Surplus adjusted for impairments			
Retained (deficit) / surplus for the year		(11,806)	(4,167)
Add back: Impairment		6,354	3,188
Retained (deficit) / Surplus for the year before impairments		(5,452)	(979)

Statement of financial position as at 31 March 2016

	NOTE	For the year ending 31 March 2016 £000	For the year ending 31 March 2015 £000
Non-current assets			
Intangible assets	8	5,225	3,230
Property, plant and equipment	9	142,250	146,933
Investments	10	-	-
Total non-current assets		147,475	150,163
Current assets			
Inventories	11	2,523	2,379
Trade and other receivables	12	31,184	24,328
Cash and cash equivalents	13	8,626	17,628
Total current assets		42,333	44,335
Total assets		189,808	194,498
Current liabilities			
Trade and other payables	14	(24,629)	(22,996)
Borrowings	14	(399)	(302)
Provisions	14	(3,172)	(2,373)
Tax payable	14	(6,349)	(6,249)
Other liabilities	14	(4,132)	(3,854)
Total current liabilities		(38,681)	(35,774)
Net current assets		3,652	8,561
Total assets less current liabilities		151,127	158,724
Non-current liabilities			
Borrowings	14	(7,281)	(7,680)
Provisions	14	(872)	(1,007)
Total non current liabilities		(8,153)	(8,687)
Total assets employed		142,974	150,037
Financed by taxpayers' equity			
Public dividend capital	17	90,648	89,471
Retained earnings	SOCITE	14,550	22,348
Revaluation reserve	SOCITE	37,776	38,218
Total taxpayers' equity		142,974	150,037

Statement of Changes in Taxpayers' Equity (SOCITE) can be found on page 186.

The financial statements on pages 184-220 were approved by the Board and signed on its behalf by:

(Chief Executive)

Tracey Fletcher

Date: 25 May 2016

Annual Accounts

Statement of changes in taxpayers' equity (SOCITE) 2015/16

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Total £000
Balance at 1 April 2015	89,471	22,348	38,218	150,037
Changes in taxpayers' equity for 2015/16				
Total comprehensive income for the year:				
Retained deficit for the year	-	(11,806)	-	(11,806)
Revaluations of property, plant and equipment	-	-	(812)	(812)
Gain on transfer by absorption	-	4,378	-	4,378
Transfers between reserves	-	(370)	370	-
New PDC received	1,177	-	-	1,177
Balance at 31 March 2016	90,648	14,550	37,776	142,974

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity 2014/15				
Balance at 1 April 2014	88,755	25,138	32,535	146,428
Total comprehensive income for the year:				
Retained deficit for the year	-	(2,790)	-	(2,790)
Impairments and reversals	-	-	(773)	(773)
Revaluations of property, plant and equipment	-	-	6,456	6,456
New PDC received	716	-	-	716
Balance at 31 March 2015	89,471	22,348	38,218	150,037

Statement of cash flows for the year ended 31 March 2016

	NOTE	2015/16 £000	2014/15 £000
Net cash inflow from operating activities	18	3,121	11,045
Cash flows from investing activities			
Interest received		35	52
Payments for intangible assets		(2,725)	(390)
Payments for property, plant and equipment		(5,515)	(12,976)
Net cash outflow from investing activities		(8,205)	(13,314)
Net cash outflow before financing		(5,084)	(2,269)
Cash flows from financing activities			
Public dividend capital received		1,177	716
Loans repaid to the Department of Health		(271)	(226)
Other loans repaid		(31)	(31)
Interest paid		(265)	(182)
Public dividend capital dividends paid		(4,528)	(4,260)
Loans received from the Department of Health		-	3,700
Net cash outflow from financing		(3,918)	(283)
Net decrease in cash and cash equivalents		(9,002)	(2,552)
Cash and cash equivalents brought forward as at 1 April		17,628	20,180
Effect of exchange rate changes on the balance of cash held in foreign currencies		-	-
Cash and cash equivalents carried forward at 31 March		8,626	17,628

Annual Accounts

Notes to the Accounts

1. Accounting policies

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which has been agreed with the Secretary of State. Consequently, these financial statements have been prepared in accordance with the 2015/16 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 New and revised standards and interpretations

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but are not yet required to be adopted or are not yet effective:

- IFRS 11 (amendment) - acquisition of an interest in a joint operation
- IAS 16 (amendment) and IAS 38 (amendment) - depreciation and amortisation
- IAS 16 (amendment) and IAS 41 (amendment) - bearer plants
- IAS 27 (amendment) - equity method in separate financial statements
- IFRS 10 (amendment) and IAS 28 (amendment) - sale or contribution of assets
- IFRS 10 (amendment) and IAS 28 (amendment) - investment entities applying the consolidation exception
- IAS 1 (amendment) - disclosure initiative
- IFRS 15 Revenue from contracts with customers
- Annual improvements to IFRS: 2012-15 cycle
- IFRS 9 Financial Instruments

The Directors anticipate that the adoption of these standards in future periods will have no material impact on the financial statements. All other revised and new Standards have not been listed here as they are not considered to have an impact on the Trust. Monitor does not permit the early adoption of Accounting Standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified by the revaluation of properties, and, where material, current asset investments and inventories to fair value as determined by the relevant Accounting Standard.

1.3 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 2015/16 on the grounds of materiality. The Charity's accounts can be found at www.homertonhope.org.

1.4 Income measurement

Income is accounted for by applying the accruals convention. Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.5 Expenditure on employee benefits

1.5.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the

extent that employees are permitted to carry forward leave in the following period.

1.5.2 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and the rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Please refer to Note 5.

Employers pension cost contributions are charged to operating expenses as and when they become due. The employer contribution payable in 2015/16 was £17.6m (2014/15 £16.8m, and is estimated to be £17.5m in 2016/17).

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015 updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate

prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

National Employment Savings Scheme (NEST pension scheme)

Employees of the Foundation Trust who are not eligible for the NHS Pension scheme are automatically enrolled into NEST, a defined contribution pension scheme. The amounts charged to the Income and Expenditure account represent the contributions payable by the Foundation Trust during the year.

Defined contribution plans are post-employment benefit plans under which an entity pays fixed contributions into a separate entity (a fund) and will have no legal or constructive obligation to pay further contributions if the fund does not hold sufficient assets to pay all employee benefits relating to employee service in the current and prior years. Under defined contribution plans the entity's legal or constructive obligation is limited to the amount that it agrees to contribute to the fund.

Since the 1 July 2013 all qualifying staff are automatically enroled into the NHS Pension Scheme (NHSPS) unless the employee opts out of the scheme. Any staff not eligible to join the NHS Pension Scheme are automatically enroled into an Alternative Qualifying Pension Scheme (AQPS). The Trust's AQPS provider is National Employment Savings Trust (NEST).

1.6 Expenditure on other goods and services

Expenditure is accounted for by applying the accruals convention. Expenditure on goods and services is recognised when and to the extent that they have been received, and measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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.

1.7.2 Measurement

(i) Valuation

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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the

fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings - Modern Equivalent Asset (MEA) value, as adjusted for wear and tear.

All land and buildings are restated to fair value in accordance with IAS 16 and Monitor guidance, using professional valuations every five years and an interim valuation on an annual basis to ensure that fair values are not materially different from the carrying amounts. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual based on MEA. An interim valuation of land, buildings and dwellings was carried out by DVS Property (Independent Chartered Surveyors). Buildings were valued on a MEA basis as at 31 March 2016.

In order to derive relevant build costs, DVS Property gave regard to the RICS Build Cost Indices in consultation with their own building surveyor. In accordance with the RICS and Treasury's Financial Reporting Manual Valuation Guidelines, an 'instant build' approach was assumed in that the Modern Equivalent Assets would be constructed at the date of valuation without phasing or lead in periods. It also assumes the site is cleared and ready to take the new buildings and therefore there is no allowance for the demolition of any existing buildings or site preparation.

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 (Borrowing Costs) for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

(ii) 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 charged to operating expenses.

(iii) 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 licences - the shorter of 5 years or length of licences

(iv) Revaluation

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

(v) Impairment

Impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. If sufficient revaluation reserve is available a compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- (i) the impairment charged to operating expenses,
- (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.7.3 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.
- The sale must be highly probable i.e.:
 - i) management are committed to selling the asset;
 - ii) an active programme has begun to find a buyer and complete the sale
 - iii) the asset is being marketed at a reasonable price
 - iv) the sale is expected to be completed within 12 months of the date of classification and as 'Held for Sale'
 - v) the actions needed to complete the plan indicate it is unlikely that the plan will be terminated or that significant changes will be made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'.

Annual Accounts

Depreciation ceases to be charged and assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 Donated, Government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are capitalised when they are capable of being used in the Trust's activities for more than one year, and can be valued and have a cost of 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 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.
- 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 five years, whichever is the shorter.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in a manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from valuations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less cost to sell'.

1.8.3 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with consumption of economic or service delivery benefits. Currently intangibles are amortised over five years.

1.9 Government grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups (CCGs) or NHS foundation trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value on a first in first out basis.

1.11 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and on demand deposits and other short term highly liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. These balances exclude monies held in the Trust's bank account belonging to patients (see "third party assets" in note 1.20 below).

Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within payables. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "finance income" and "finance cost" in the periods to which they relate. Bank charges are recorded as operating expenses in the periods to which they relate.

1.12 Financial instruments and financial liabilities

1.12.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements are recognised when the goods or services are delivered.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.12.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.12.3 Classification and Measurement

(i) Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely related' to those contracts are separated out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs charged to the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

(ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: current investments; cash and cash equivalents; NHS receivables; accrued income; and other receivables.

Annual Accounts

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts over the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

(iii) Available-for-sale financial assets

Available for sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'finance costs' in the Statement of Comprehensive Income.

(iv) Other Financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts future cash payments over the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to 'finance costs'. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

(v) Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals and analysis of discounted cash flows.

1.12.4 Classification and measurement (continued)

(vi) Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised, if and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the assets and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of an allowance account/bad debt provision.

1.13 Leases

1.13.1 Finance leases

(i) Lessee

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit

interest rate to the outstanding liability and is charged to 'finance costs' in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

(ii) Lessor

Assets leased to others under agreements, which transfer substantially all the risks and rewards of ownership, with or without ultimate legal title are also classified as finance leases. When assets are held subject to a finance lease the present value of the lease payments, discounted at the rate of interest implicit in the lease, is recognised as a receivable. The difference between the total payments receivable under the lease and the present value of the receivable is recognised as unearned finance income, which is allocated to accounting periods to reflect a constant periodic rate of return.

1.13.2 Operating leases

(i) Lessee

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

(ii) Lessor

Assets leased to third parties under agreements which do not transfer substantially all the risks and rewards of ownership are classified as operating leases. The leased assets are included within property, plant and equipment in the Trust's Statement of Financial Position and depreciation is provided on the depreciable amount of these assets on a systematic basis in accordance with the Trust's policy. Lease income is recognised on a straight-line basis over the period of the lease unless another systematic basis is more representative of the accruing benefit.

1.14 Provisions

The Trust provides for legal and compensation obligations that are of certain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's short (0-5 years), medium (6-10 years) or long (beyond 10 years)

discount rate which are -1.5%, 1.05% and 2.2% respectively, in real terms, except for early retirement provisions and injury benefit provisions which both use HM Treasury's pension discount rate of 2.2% in real terms.

(i) Clinical negligence costs

The NHS Litigation Authority (NHS LA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS LA, which, in return, manages all clinical negligence claims. Although the NHS LA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS LA on behalf of the Trust is disclosed at note 16 but is not recognised in the Trust's Accounts.

(ii) Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling arrangements under which the Trust pays an annual contribution to the NHS LA and in return receives assistance with the cost of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingencies

Contingent assets (that is assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in a note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 20, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control, or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 (Financial Instruments: Presentation).

An amount, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC each year. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- (i) donated assets (including lottery funded assets),
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
- (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The estimated dividend is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

Most activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

Homerton University Hospital NHS Foundation Trust is a Health Service Body under the definition of section 519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this Act. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (section 519A (93) to (8) ICTA 1988). The Trust is not within the scope of corporation tax in respect of activities which are not related to, or

ancillary to, the provision of healthcare, as the profits derived from these activities do not exceed £50,000 per annum.

1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of payment for the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation of the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note in the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual. See note 24 for details.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures

compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The total value and number of special payments is shown in note 26 to the accounts.

1.22 Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had 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. Because of the continuing service provider relationship the Trust has with NHS England and Clinical Commissioning Groups (CCGs) and the way that NHS England and CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. 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 Trust's financial instruments comprise loans, finance lease obligations, provisions, cash at bank and in hand and various items, such as trade debtors and trade creditors, that arise directly from its operations. The main purpose of these financial instruments is to raise finance for the Trust's operations.

1.23 Related parties

Government departments and their agencies are considered by HM Treasury to be 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. These entities are listed in note 21.

The Trust also receives revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund.

The Charity is registered with the Charity Commissioners (Charity Number 1061659) and has its own Trustees drawn from the NHS Foundation Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust based on UK GAAP and Charities SORP).

Although the Trust has no ownership interest in the Charity, the composition of the charity trustees result in it being deemed a subsidiary under IAS 27 (Consolidated and Separated Financial Statements). However, from 2015/16 the Trust has decided not to consolidate the results of the Charitable Fund on the grounds of materiality.

1.24 Partially completed spells

Partially completed spells recognise the value of unfinished treatment episodes for which trusts are entitled to accrue income but would not actually receive funding until the episode is complete.

The estimation is based on the average Healthcare Resource Group (HRG) price by specialty and point of delivery of the fully coded spells in the preceding months.

1.25 Key areas of estimation and judgement

The key areas of estimation and judgement used in the preparation of the accounts have been disclosed within other sections of the accounting policy notes. These include:

- provisions for injury benefit claims, early retirements, impairments of receivables, and others (notes 5, 12 & 15 to the accounts)
- estimates of partially completed patient episodes;
- depreciation rates applied to property, plant and equipment (note 9)
- valuation methodologies and external indices applied to the valuation conducted by the District Valuer (note 9).

1.26 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets transferred is recognised in income/expenses, but not within

Annual Accounts

operating activities. In 2015/16 the Trust received Mary Seacole Nursing Home by transfer from NHS Property Services and this was accounted for as a transfer by absorption.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation / Amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

2. Segmental analysis

All activities of the Trust are considered to be one segment, Health Care. There are no individual reportable segments on which to make disclosures.

3. Operating income from continuing operations

3.1 Income from activities

	2015/16	2014/15 £000
Elective income	24,726	21,944
Non-elective income	31,046	27,023
Outpatient income	41,860	39,223
A&E income	12,161	10,410
Non PbR activity income	95,983	100,066
Community income	42,609	44,176
Private patient income	1,109	1,115
Other non-protected clinical income	14,566	6,150
	264,060	250,107

Other operating income		
Research and development	781	831
Education and training	14,049	14,299
Donated assets / intra group income	102	49
Non-patient care services to other bodies	3,109	1,585
Other income	2,329	3,062
Total other operating income	20,370	19,826
Total operating income	284,430	269,933

Other income includes property rent and leasing income of £1.4m (2014/15 - £1.6m) and staff recharges of £0.96m (2014/15 - £1.4m).

Private patient and overseas income is £1.1m (2014/15 - £1.1m).

3.2 Overseas patient income

Income from overseas patients is £0.5m in 2015/16 (2014/15 - £0.37m). Cash payments received in year relating to overseas patients totalled £0.1m (2014/15 - £0.07m) and amounts added to the provision for impairment of receivables were £0.24m (2014/15 - £0.28m). No receivables relating to overseas patients were written off in the year (2014/15 - £0m)

3.3 Income by source

	2015/16 £000	2014/15 £000
NHS foundation trusts	193	188
NHS trusts	752	761
CCGs and NHS England	241,433	233,879
Health Education - England	14,049	14,299
NHS other	1,020	16
Local authorities	18,068	11,914
Non NHS: private patients	615	793
Non NHS: overseas patients	494	371
NHS Injury Scheme (was Road Traffic Act)	611	511
Other operating income	7,195	7,201
Total	284,430	269,933

NHS Injury Scheme income is subject to a nationally prescribed provision for doubtful debts of 21.99% (2014/15 18.9%) to reflect expected rates of collection. An adjustment has been made to the prior year income analysis to correctly show £3.87m of non-patient related income against other operating income rather than income from NHS foundation trusts.

3.4 Commissioner requested services

	2015/16 £000	2014/15 £000
Commissioner requested services	218,373	212,222
Non - commissioner requested services	66,057	57,711
Operating income from continuing operations	284,430	269,933

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.

Annual Accounts

4. Operating expenses

4.1 Operating expenses by type

	2015/16 £000	2014/15 £000
Services from other NHS foundation trusts	2,003	2,098
Services from other NHS trusts	4,216	3,827
Services from other NHS bodies	187	59
Purchase of health care from non-NHS bodies	1,808	2,738
Directors' costs	1,024	959
Non Executive Directors' costs	124	123
Other Staff costs	193,590	183,990
Supplies and services - clinical (excluding drug costs)	20,356	16,142
Supplies and services - general	8,562	1,852
Establishment	2,586	2,357
Patient Transport	1,458	1,377
Premises	12,292	17,585
Increase in bad debt provision	279	288
Drugs costs	16,369	14,663
Depreciation on property, plant and equipment	6,103	6,064
Amortisation of intangible assets	831	253
Audit fees - statutory audit	114	95
Audit fees - internal audit	102	97
Consultancy	583	539
NHSLA insurance premium	7,321	4,776
Other	5,184	6,576
Total (excluding impairment)	285,092	266,458
Impairments of property, plant and equipment	6,354	3,188
Total (including impairment)	291,446	269,646

4.2 Operating leases

4.2.1 Operating lease rentals

	2015/16 £000	2014/15 £000
Rental of plant and machinery	241	233
Rental hire of building	476	1,855
	717	2,088

4.2.2 Operating lease commitments

	Land and buildings £000	Plant and machinery £000	Other Leases £000	2015/16 Total £000	2014/15 Total £000
Annual commitments on leases expiring:					
Within 1 year	430	190	-	620	2,088
Between 1 and 5 years	430	701	-	1,131	9,460
Greater than 5 years	-	345	-	345	-
Total	860	1,236	-	2,096	11,548

Operating leases relating to buildings are in respect of premises owned by Hackney Community College and NHS Property Services 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. There are no contingent rents payable in respect of these leases and no restrictions relating to dividends, debt or further leasing.

4.3 Salary and pension entitlements of senior managers

a) Remuneration

2015/16	Salary (bands of £5,000)	Taxable Benefits (To Nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Fletcher T - Chief Executive	160-165	-	-	-	75.0-77.5	235-240
Jones D - Chief Operating Officer	115-120	-	-	-	55.0-57.5	175-180
Metcalfe M - Interim Director of Finance (from 13 April 2015)	130-135	-	-	-	47.50-50.0	175-180
Adam S - Chief Nurse and Director of Governance	110-115	-	-	-	37.50-40.0	150-155
Kuper M - Medical Director	180-185	-	-	-	87.5-90.0	265-270
Waldron D - Director of Organisation Transformation	100-105	-	-	-	37.5-40.0	140-145
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

Annual Accounts

2014/15	Salary (bands of £5,000)	Taxable Benefits (To Nearest £100)	Annual Perfomance Related Bonuses (bands of £5,000)	Long Term Perfomance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Fletcher T - Chief Executive	155-160	-	-	-	40.0-42.5	195-200
Jones D - Chief Operating Officer	115-120	-	-	-	22.5-25.0	140-145
Coakley J - Medical Director (until 2 June 2014)	5-10	-	-	-	-	5-10
Farrar J - Director of Finance	130-135	-	-	-	22.5-25.0	155-160
Adam S - Chief Nurse and Director of Governance	110-115	-	-	-	(20)-(22.5)	85-90
Kuper M - Medical Director (from 2 June 2014)	145-150	-	-	-	-	145-150
Waldron D - Director of Organisation Transformation (from 1 June 2014)	100-105	-	-	-	-	100-105
Melville-Ross T - Chairman	40-45	-	-	-	-	40-45
Stewart D - Non Executive Director	5-10	-	-	-	-	5-10
Redmond I - Non Executive Director	0-5	-	-	-	-	0-5
Griffiths C - Non Executive Director	0-5	-	-	-	-	0-5
Gieve Sir J - Non Executive Director	10-15	-	-	-	-	10-15
Treves V - Non Executive Director	10-15	-	-	-	-	10-15
Williams J - Non Executive Director (from 1 May 2014)	10-15	-	-	-	-	10-15
Weitzman P - Non Executive Director (from 1 May 2014)	10-15	-	-	-	-	10-15
Osborne S - Non Executive Director (from 1 May 2014)	10-15	-	-	-	-	10-15
Smith M - Non Executive Director (from 1 November 2014)	5-10	-	-	-	-	5-10

b) Pension Benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 31 March 2015 £000	Real increase in cash equivalent transfer value £000
Fletcher T - Chief Executive	2.5-5.0	2.0-2.5	40-45	115-120	656	588	61
Jones D - Chief Operating Officer	2.5-5.0	0-2.5	15-20	50-55	215	191	22
Metcalfe M - Interim Director of Finance	2.0-2.5	-	0-5	-	27	-	27
Adam S - Chief Nurse and Director of Governance	0-2.5	5.0-7.5	45-50	145-150	1,107	1,044	51
Kuper M - Medical Director	2.5-5.0	2.5-5.0	50-55	140-145	794	734	51
Waldron D - Director of Organisation Transformation	0-2.5	-	10-15	-	126	105	19

Normal Retirement age is dependant upon NHS Pension scheme, for the 1995 scheme normal retirement age is 60, for the 2008 scheme normal retirement age is 65. All of the Trust's Directors are members of the 1995 scheme and their normal retirement age is 60.

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 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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this disclosure note. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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 31 March 2015 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 2016 to calculate the real increase in CETV.

Annual Accounts

c) Director and Governor expenses

In 2015/16 the Trust paid £643 (2014/15 - £155) as expenses to executive and Non-Executive Directors and there were no payments to governors (2014/15 - nil).

d) Tax arrangements of public sector appointees

The tables below summarise the Trust's appointees who fall within the definition of PES(2012)17 published by HMRC in 2012/13.

1 - For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2016	6
---	---

Of which...

No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	3
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

For the six 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.

2 - For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	3
--	---

No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	3
---	---

No. for whom assurance has been requested	3
---	---

Of which...

No. for whom assurance has been received	3
--	---

No. for whom assurance has not been received	-
--	---

No. that have been terminated as a result of assurance not being received.	-
--	---

For the three new engagements or those that reached six months during the year 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.

3 - For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
---	---

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

There were no engagements of board members during 2015/16.

5. Staff costs and staff numbers

5.1 Staff costs

	Permanently Employed	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	135,705	1,699	137,404	131,898
Social Security costs	13,179	-	13,179	12,127
Employer contributions to NHS Pensions Agency	17,575	-	17,575	16,755
Pension cost - other	-	-	-	4
Termination benefits	-	-	-	145
Bank and agency staff	-	26,456	26,456	24,020
	166,459	28,155	194,614	184,949

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	Other	2015/16 Total	2014/15 Total
	Number	Number	Number	Number
Medical and dental	426	15	441	437
Healthcare assistants and other support staff	428	-	428	455
Nursing, midwifery and health visiting staff	1,116	-	1,116	1,082
Nursing, midwifery and health visiting learners	45	-	45	51
Scientific, therapeutic and technical staff	725	-	725	598
Administration and estates	736	-	736	743
Bank and agency staff	-	488	488	363
Other	6	-	6	6
Total	3,482	503	3,985	3,735

5.3 Employee benefits

There are no individual employee benefit costs for 2015/16 (2014/15 Nil).

5.4 Retirements due to ill-health

	2015/16 Number	2015/16 £000	2014/15 Number	2014/15 £000
Early retirements agreed on the grounds of ill-health	3	34	4	188

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.

Annual Accounts

5.5 Staff exit packages

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	6	7
£10,000 - £25,000	1	3	4
£25,001 - £50,000	1	-	1
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
Total number of exit packages by type	4	9	13
Total cost (£'000s)	157	83	240

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

	2015/16 £000	2014/15 £000
Interest on loans and receivables and bank current accounts	35	52
Total	35	52

7.1 Finance expenses - finance liabilities

	2015/16 £000	2014/15 £000
Interest on Loans from the Independent Trust Financing Facility	278	210

8. Intangible assets

All Intangible fixed assets relate to software licences.

8.1 2015/16

	£000
Gross cost at 1 April 2015	3,898
Additions - purchased	2,725
Donations of physical assets (non-cash)	101
Gross cost at 31 March 2016	6,724
Amortisation at 1 April 2015	668
Provided during the year	831
Impairments	-
Disposals	-
Amortisation at 31 March 2016	1,499
Net book value	
- Purchased at 31 March 2015	3,230
- Purchased at 31 March 2016	5,225

8.2 2014/15

	£000
Gross cost at 1 April 2014	1,327
Additions - purchased	2,571
Disposals	-
Gross cost at 31 March 2015	3,898
Amortisation at 1 April 2014	415
Provided during the year	253
Impairments	-
Disposals	-
Amortisation at 31 March 2015	668
Net book value	
- Purchased at 31 March 2014	912
- Purchased at 31 March 2015	3,230

Annual Accounts

9. Property, plant and equipment

9.1. As at 31 March 2016

	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 2015	32,364	114,348	6,041	25,685	119	5,752	1,700	186,008
Transfers by absorption	1,656	2,722	-	-	-	-	-	4,378
Additions - purchased	-	611	647	1,711	(1)	1,158	82	4,208
Additions - donated	-	-	-	-	-	-	-	-
Revaluations	-	3,081	-	-	-	-	-	3,081
Impairments - charged to reserves	(3,892)	-	-	-	-	-	-	(3,892)
Impairments - charged to SOCIE	-	(6,354)	-	-	-	-	-	(6,354)
Reclassifications	-	505	(1,581)	-	-	1,076	-	-
Disposals	-	-	-	(524)	-	-	-	(524)
Cost or valuation at 31 March 2016	30,128	114,913	5,107	26,872	118	7,986	1,782	186,905
Depreciation at 1 April 2015	-	19,665	-	14,011	80	3,964	1,356	39,076
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	3,002	-	2,157	5	863	76	6,103
Other in year revaluation	-	-	-	-	-	-	-	-
Disposals	-	-	-	(524)	-	-	-	(524)
Depreciation at 31 March 2016	-	22,667	-	15,644	85	4,827	1,432	44,655
Net book value								
- Purchased at 1 April 2015	32,364	93,076	6,041	10,101	19	1,788	333	143,722
- Donated at 1 April 2015	-	1,608	0	1,572	20	-	11	3,211
Total at 1 April 2015	32,364	94,684	6,041	11,673	39	1,788	344	146,933
Net book value								
- Purchased at 31 March 2016	30,128	90,931	5,107	10,028	14	3,159	344	139,711
- Donated at 31 March 2016	-	1,315	0	1,199	19	-	6	2,539
Total at 31 March 2016	30,128	92,246	5,107	11,227	33	3,159	350	142,250

9.2. As at 31 March 2015

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2014	29,304	105,645	8,112	23,304	119	4,897	1,529	172,910
Additions - purchased	-	4,507	2,993	2,078	-	855	171	10,604
Additions - donated	-	-	-	-	-	-	-	0
Revaluations	3,060	3,396	-	-	-	-	-	6,456
Impairments - charged to reserves	-	(773)	-	-	-	-	-	(773)
Impairments - charged to SOCIE	-	(3,188)	-	-	-	-	-	(3,188)
Reclassifications	-	4,761	(5,064)	303	-	-	-	-
Disposals	-	-	-	-	-	-	-	0
Cost or valuation at 31 March 2015	32,364	114,348	6,041	25,685	119	5,752	1,700	186,009
Depreciation at 1 April 2014		16,483	-	11,928	75	3,241	1,286	33,013
Provided during the year		3,182	-	2,084	5	722	70	6,064
Disposals	-	-	-	-	-	-	-	0
Depreciation at 31 March 2015	-	19,665	-	14,012	80	3,963	1,356	39,077
Net book value								
- Purchased at 1 April 2014	29,304	87,516	8,112	9,228	22	1,656	228	136,066
- Donated at 1 April 2014		1,646	-	2,148	22	-	15	3,831
Total at 1 April 2014	29,304	89,162	8,112	11,376	44	1,656	243	139,897
Net book value								
- Purchased at 31 March 2015	32,364	93,076	6,041	10,101	19	1,788	333	143,722
- Donated at 31 March 2015	-	1,608	0	1,572	20	-	11	3,211
Total at 31 March 2015	32,364	94,683	6,041	11,673	39	1,789	344	146,933

Annual Accounts

9.3 Assets held at market value

At 31 March 2016 the Trust held land assets at market value for existing use of £28,472,250 (31 March 2015, £32,364,000).

9.4 Valuation of land and buildings

Land has been revalued at 31 March 2016 at market value for existing use.

Both valuations were carried over by the District Valuer (DVS Property) whose address is:
The Westminster Valuations Office, Wingate House, London, W1D 5BU.

The buildings have been valued as at 31 March 2016 using a Modern Equivalent Asset basis of valuation, as discounted for wear and tear.

Buildings have estimated useful economic lives ranging up to 90 years.

9.5 Assets held under finance leases and hire purchase contracts during 2015/16

The Trust did not hold any finance leases or hire purchase contracts during 2015/16.

9.6 Fixed asset investments

There were no fixed asset investments held at 31 March 2016 (31 March 2015 - Nil).

9.7 Property transfers

The Trust received the transfer of Mary Seacole Nursing Home from NHS Property Services on 31st March 2016. The transfer was accounted for under absorption accounting rules, whereby the asset is recognised in the receiving entity's books at the net book value at the date of transfer - this gave rise to a gain on transfer of £4.38m which has been recognised as part of other comprehensive income in the SoCI. The property also had a revaluation reserve associated with it of £0.37m and this has been preserved in the Trust's accounts by a transfer of £0.37m from the I&E reserve to the revaluation reserve.

10. Investments

The Trust held no investments during the financial year 2015/16. In the prior year the value of investments held by the Homerton University Hospital NHS Foundation Trust Charitable Fund were disclosed on the basis that the Charity's results were consolidated with those of the Trust, however in 2015/16 the Trust has taken the decision not to consolidate the Charity's results on the grounds that they are not considered to be material. The Charity's accounts can be found at www.homertonhope.org.

11. Inventories

11.1 Inventories

	2015/16 £000	2014/15 £000
Drugs	1,016	1,002
Consumables	1,462	1,294
Energy	45	83
Total	2,523	2,379

11.2 Inventories recognised in expenses

	2015/16 £000	2014/15 £000
Total Inventories recognised as an expense in the year	14,402	11,821

12. Trade and other receivables

12.1 Amounts falling due within one year:	31 March 2016	31 March 2015
	£000	£000
NHS receivables	22,791	13,099
Non NHS receivables	5,155	4,073
Provision for impaired receivables	(2,877)	(2,598)
Prepayments	1,324	1,135
Accrued income	2,400	6,134
Other receivables	2,391	2,485
Total	31,184	24,328

12.2 Analysis of the provision for impaired receivables

	31 March 2016	31 March 2015
	£000	£000
At 1 April	2,598	2,310
Arising during the year	279	288
Change in discount rate	-	-
Utilised during the year	-	-
Unwinding of discount	-	-
At 31 March	2,877	2,598

	31 March 2016	31 March 2015
	£000	£000
By age:		
Up to three months old	155	65
Three to six months old	1,596	1,597
Over six months old	1,126	936
Total	2,877	2,598

12.3 Age analysis of unimpaired trade receivables

	31 March 2016	31 March 2015
	£000	£000
Up to three months old	15,251	9,439
Three to six months old	4,796	19
Over six months old	5,022	6,091
Total	25,069	15,549

Annual Accounts

13. Cash and cash equivalents

	31 March 2016 £000	31 March 2015 £000
Balance as at 1 April	17,628	20,180
Net change in year	(9,002)	(2,552)
Balance at 31 March	8,626	17,628
Of which:		
Commercial banks and cash in hand	69	43
Cash with the Government Banking Service	8,544	17,567
Other current investments	13	18
Total cash and cash equivalents in the Statement of Cash Flows	8,626	17,628

14. Liabilities

14.1 (i) Current liabilities:	31 March 2016 £000	31 March 2015 £000
Amounts falling due within one year		
NHS payables	5,822	4,019
Non-NHS payables	7,875	8,208
Trade payables - Capital	555	1,862
Other payables	249	230
Accruals	9,958	8,512
PDC Payable	170	165
Trade and other payables	24,629	22,996
Borrowings	399	302
Provisions	3,172	2,373
Tax payable	6,349	6,249
Deferred income	4,132	3,854
Total amounts falling due within one year	38,681	35,774
14.1 (ii) Non current liabilities:		
Payables due after more than one year	31 March 2016 £000	31 March 2015 £000
Provisions	872	1,007
Borrowings	7,281	7,680
	8,153	8,687
14.1 (iii) Total payables	46,834	44,461

14.2 Loans - payment of principal falling due:	31 March 2016 £000	31 March 2015 £000
Within one year	399	302
Between one and two years	399	399
Between two and five years	1,198	1,198
After five years	5,684	6,082
Total	7,680	7,982

Of which:		
Wholly repayable within five years	1,996	1,900
Wholly or partially repayable after five years by instalments	5,684	6,082
Total	7,680	7,982

15. Provisions for liabilities and charges

	Pensions relating to former Directors £000	Pensions relating to former Staff £000	Clinical negligence £000	Redundancy £000	Other £000	31 March 2016 £000	31 March 2016 Total £000
At 1 April	84	998	68	37	2,192	3,379	3,175
Arising during the year	9	26	32	94	2,643	2,804	1,650
Change in discount rate	0	1	-	-	-	1	-
Utilised during the year	(6)	(50)	-	(37)	(1,397)	(1,490)	(542)
Reversed unutilised	-	(151)	-	-	(513)	(664)	(882)
Unwinding of discount	1	13	-	-	-	14	(22)
At 31 March	88	837	100	94	2,925	4,044	3,379
Within one year	7	46	100	94	2,925	3,172	2,373
Between one and five years	26	183	-	-	-	209	208
After five years	55	608	-	-	-	663	798
Total	88	837	100	94	2,925	4,044	3,379

Pension related provisions as at 31 March 2016 consist of £0.6m in relation to Injury Benefits and £0.3m 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 £0.1m 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 £0.094m 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 cessation of an SLA with an external body.

Other provisions include £2.1m relating to potential data challenges from CCGs relating to clinical contract income, £0.7m relating to the estimated value of untaken annual leave owed to Trust employees as at 31 March 2016 and £0.1m relating to the Trust's obligations under the Carbon Reduction Scheme.

16. Clinical negligence liability

The amount provided by the NHTSA in respect of clinical negligence liabilities of the Trust as at 31 March 2016 is £114,155,033 (2014/15 - £63,521,627).

Annual Accounts

17. Movement in Public Dividend Capital

	2015/16 £000	2014/15 £000
Public Dividend Capital as at 1 April	89,471	88,755
New PDC received	1,177	716
Public Dividend Capital as at 31 March	90,648	89,471

The dividend payment for the year was £4.5m (2014/15 £4.3m). 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	2015/16 £000	2014/15 £000
Total operating (deficit) / surplus	(7,017)	1,664
Depreciation and amortisation	6,934	6,316
Impairment	6,354	3,188
(Increase) in inventories	(144)	(498)
(Increase) in receivables	(10,703)	(4,865)
Increase in payables	6,882	3,967
Increase in other liabilities	278	284
Other movements	537	989
Net cash inflow from operating activities	3,121	11,045

18.2 Reconciliation of net cash flow to movement in net funds	2015/16 £000	2014/15 £000
Decrease in cash in the year	(9,002)	(2,552)
Cash outflow from new debt	-	(3,700)
Cash inflow from debt repaid and finance lease capital payments	302	257
Decrease in net funds resulting from cash flows	(8,700)	(5,995)
Net funds at 1 April	9,646	15,641
Net funds at 31 March	946	9,646

18.3 Analysis of changes in net debt

	At 1 April 2015 £000	Cash changes in year £000	At 31 March 2016 £000	At 31 March 2015 £000
GBS cash at bank	17,567	(9,023)	8,544	17,567
Commercial cash at bank and in hand	43	26	69	43
Debt due after one year	(7,680)	399	(7,281)	(7,680)
Debt due within one year	(302)	(97)	(399)	(302)
Current investments	18	(5)	13	18
Total	9,646	(8,700)	946	9,646

19. Contractual Capital Commitments

There were £0.5m of commitments under capital expenditure contracts as at 31 March 2016 (31 March 2015 - £0.7m).

20. Contingent liabilities

	2015/16 £000	2014/15 £000
Other	-	-
Liabilities to Third Parties Scheme (LTPS) members' contribution	57	40
	57	40

Annual Accounts

21. Related party transactions

There were no related party transactions with individuals during the financial year (2014/15 £8k income from London Borough of Ealing. Martin Smith, Non Executive Director was CEO of the London Borough of Ealing in 2014/15).

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	4,449	624	411	106
Barts Health	NHS Trust	665	4,932	1,495	2,934
Health Education England	Special Health Authority	13,725	-	24	-
Department of Health	Department of Health	195	363	-	53
NHS England	Commissioner	43,026	109	4,909	81
NHS City And Hackney CCG	Commissioner	151,874	78	7,379	503
NHS Waltham Forest CCG	Commissioner	12,805	-	865	125
NHS Newham CCG	Commissioner	6,415	167	2,021	53
NHS Tower Hamlets CCG	Commissioner	4,494	-	928	18
NHS Islington CCG	Commissioner	4,161	-	927	9
NHS Redbridge CCG	Commissioner	3,996	-	1,203	22
NHS Barking And Dagenham CCG	Commissioner	1,784	-	495	6
NHS Enfield CCG	Commissioner	1,911	-	208	3
NHS Haringey CCG	Commissioner	4,141	-	300	18
NHS Litigation Authority	Other NHS Whole of Government Accounts Bodies - Insurer	-	7,325	-	1
HM Revenue & Customs - VAT	Central Government WGA Body	-	-	567	-
NHS Pension Scheme	Central Government WGA Body	-	17,575	-	2,506
HM Revenue & Customs - NI Fund & PAYE	Central Government WGA Body	-	13,179	-	3,843
London Borough of Hackney	Central Government WGA Body - Local Authority	15,514	1,204	1,472	3,936

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 2016 £000	At 31 March 2015 £000
Fixed rate	-	-
Floating rate	8,626	17,628
Non-interest bearing	29,292	22,439
Total	37,918	40,067

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 2016 £000	At 31 March 2015 £000
Fixed rate	7,679	7,680
Floating rate	-	-
Non-interest bearing	28,506	26,513
Total	36,185	34,193

Financial liabilities consist of current and non-current liabilities less deferred income, payments received on account, tax and PDC payable.

Annual Accounts

23.3 Analysis of financial instruments

23.3 (i) Financial assets (book and fair value)	At 31 March 2016 £000	At 31 March 2015 £000
Cash	8,613	17,610
Receivables within one year	29,292	22,439
Receivables after one year	-	-
Other current investments	13	18
Total	37,918	40,067

23.3 (ii) Financial liabilities (book and fair value)

Payables within one year	27,634	25,506
Provisions over 1 year	872	1,007
Provisions under contract over one year	-	-
Loans	7,679	7,680
Total	36,185	34,193

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 2.2% in real terms (2014/15 - 2.2%).

24. Third party assets

The Trust held £956 of patients' monies at 31 March 2016 (31 March 2015 - £1,574). 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	Payables: amounts falling due within one year
	At 31 March 2016 £000	At 31 March 2016 £000
English NHS Foundation Trusts	898	1,615
English NHS Trusts	1,837	3,119
Department of Health	-	223
Public Health England	8	7
Health Education England	24	-
NHS England & Clinical Commissioning Groups	22,360	149
Other NHS Whole of Government Accounts bodies	3	840
Other Whole of Government Accounts bodies	2,967	10,310
Total	28,097	16,263

25.2 Income and expenditure values for the year

	Income Year Ended 31 March 2016 £000	Expenditure Year Ended 31 March 2016 £000
English NHS foundation trusts	5,510	3,043
English NHS trusts	1,004	5,466
Department of Health	195	363
Public Health England	1,133	40
Health Education England	13,725	-
NHS England & Clinical Commissioning Groups	241,967	353
Other NHS whole of Government accounts bodies	-	9,269
Other whole of Government accounts bodies	18,095	33,244
Total	281,629	51,778

Annual Accounts

26. Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases £000	Total number of cases	Total value of cases £000
LOSSES:				
1. Losses of cash due to:				
Other losses - pharmacy expired / damaged stock	-	-	-	-
2. Fruitless payments and constructive losses	-	-	-	-
3. Bad debts and claims abandoned	-	-	-	-
4. Damage to buildings, property etc. (including stores losses)	-	-	-	-
TOTAL LOSSES *	-	-	-	-
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	-	-	-	-
6. Extra contractual to contractors	-	-	-	-
7. Ex gratia payments in respect of:				
Loss of personal effects	5	-	2	2
Personal injury with advice	7	36	6	72
other	5	2	6	3
8. Special severance payments	1	3	1	30
9. Extra statutory and regulatory	-	-	-	-
TOTAL SPECIAL PAYMENTS *	18	41	15	107
TOTAL LOSSES AND SPECIAL PAYMENTS *	18	41	15	107

* Losses and Special Payments have been calculated on an accruals basis but exclude provisions for future losses.



Homerton University Hospital
Homerton Row
London E9 6SR
Tel: 020 8510 5555

