Monitor Independent Regulator of NHS Foundation Trusts

Forward Plan Strategy Document for

The Hillingdon Hospitals NHS Foundation Trust

Plan for y/e 31 March 2012 (and 2013, 2014)

1. Strategy

1.1. Introduction

Patient safety and the delivery of high quality services are at the heart of our vision and at the very top of our priorities; they are the main focus of all our efforts. During the last five years, operating in an uncertain environment, the Trust has continued to build a reputation for delivering high quality, innovative and effective patient care while at the same time generating an operating surplus. In summary, we have;

- A good track record of operational performance and are currently one of the best performing general hospitals in London
- A capable board and a well managed organisation
- Good clinical engagement and leadership
- Sound financial management with a record of delivering value for money
- Low reference costs and are the most efficient provider in Northwest London
- A strong community base on which to build membership

1.2. Vision

Our vision is simple, succinct, unifies staff and public, and puts patients at the heart of our purpose; it is, "**To be the best general hospital in the country**."

Regardless of how we shape ourselves as a healthcare provider in the future in response to the challenges and opportunities within the wider strategic environment, we will remain true to this vision and the principle of "being the best" in delivering healthcare, regardless of its setting. We are confident that our vision captures the aspiration for quality, standards and service for The Hillingdon Hospital.

We will strive to provide excellence in:

- Treatment and care which is safe, sensitive and responsive to the individual
- Recruiting, retaining and developing our staff
- Relationships with the people we serve and those with whom we work
- Innovation and improvement
- Financial stewardship

1.3. Strategic Direction

We will use the freedoms that Foundation Trust status offers to respond and shape our services to meet the needs of the local health economy and the opportunities provided in the market place. Key existing services and future developments which underpin the Trust's strategic objectives over the next five years are in summary:

Acute Stroke Services - Expansion of service to a 24-bedded unit, which caters for stabilised stroke patients and "high risk" TIA patients until discharge, with an integrated therapy suite.

Elective Orthopaedics - The intention is to continue to develop a centre of excellence for trauma services at Hillingdon Hospital, transferring elective activity to Mount Vernon Hospital.

Paediatric Oncology Shared Care Unit (POSCU) - the Trust has been selected as one of the providers of this service for North West London.

Maternity services - development of a midwifery led model of care alongside the existing obstetric service to meet the market demand for maternity services.

Integrated Care - working with partners to develop a more integrated approach to delivering healthcare.

The strategic objectives reflect our culture and values and the priorities that will deliver our objectives are set out in our 'Strategy on a Page' represented below:

STRATEGY ON A PAGE – CRITICAL SUCCESS FACTORS				
1	2	3	4	5
DELIVERY OF HEALTHCARE	CONTROL OF THE BUSINESS	CUSTOMER & STAKEHOLDER ENGAGEMENT	COMPETITIVENESS	ORGANISATIONAL DEVELOPMENT & CHANGE
[1.1Provide excellent healthcare which meets or exceeds standards [1.2] Listen, learn & respond to the experience of patients [1.3] Provide a safe and healthy environment for our patients, staff and visitors	[2.1] Optimise and improve the Trust Estate [2.2] Ensure high standards in the integrity, security & overall quality of data and documents [2.3] Maintain a financial risk rating to support viability as a foundation trust [2.4] Deliver best quality care for the best value	[3.1Work with our partners to secure joined up, integrated care [3.2] Grow representative membership [3.3] Reach out to our local communities to shape services responsively [3.4] Develop and support the effective working of the (shadow) Council of Governors [3.5] Reduce the environmental impact of our business activities	[4.1] Position ourselves as a principal healthcare provider over a greater catchment area [4.2] Develop a service portfolio to deliver our Integrated Business Plan [4.3] Be the provider of choice to GPs (Empower the GP in the eyes of the patient)	[5.1] Right people, right place, right skills [5.2] Engage staff to innovate and improve for better care [5.3] Maximise the potential of the workforce

2. External Environment

2.1 Overview

Situated on the western border of North West London, the Trust is the main provider of acute healthcare to the 270,000 residents of the Borough of Hillingdon. People in neighbouring Hertfordshire, Buckinghamshire, Harrow, Ealing and Hounslow bring our immediate resident catchment population for general hospital services to over 350,000.

The Trust is working in a complex and changing environment. In particular, there is currently a level of uncertainty about the implications of London Strategic Reconfiguration strategy in terms of both opportunities to take on extra services and the potential threat to some of the services provided by a general hospital from service reconfiguration. Currently the majority of patient care is commissioned by NHS Hillingdon, NHS Ealing and NHS Harrow.

2.2 Future service delivery in London

Our strategic goal is to provide comprehensive high quality and resilient healthcare services across Northwest London which meet the needs of those who commission healthcare services and those that use them.

We aspire to be one of the trusts in Northwest London that continue to provide inpatient paediatric services and emergency surgery, to provide trauma centre services as part of a trauma network linked to a major trauma centre and to be a designated maternity unit delivering a midwifery led model of care alongside obstetric services. We want to have the potential to maintain our emergency care service receiving patients from other neighbouring Trusts and to continue to provide both acute and rehabilitation stroke services from Hillingdon Hospital.

In pursuit of this we are positioning ourselves to expand, as appropriate, our portfolio of clinical services through developments such as POSCU, a designated stroke unit (24 beds) and improved capacity and capability for maternity services.

Under recent NW London service reconfigurations we have successfully bid to retain and expand services. Our level 2 haemato-oncology service for patients in the borough of Hillingdon now extends to Ealing patients and our capacity in stroke and TIA services has increased from 16 to 24 beds and takes stroke patients from the Ealing conurbation as well as from Hillingdon.

Through a planned quality initiative we expect levels of emergency readmissions to reduce as we work with NHS Hillingdon to ensure that patients requiring care following appropriate discharge from hospital can access this in a primary care setting. The scheduled transfer of our continuing care ward to NHS Hillingdon and working together to improve End of Life Care provides further opportunity for our two organisations to collaborate to ensure that patients are treated in the most appropriate setting.

3. Key Risks

The main risks that the Trust must successfully manage to deliver its vision and strategic objectives are summarised below.

Risks	Mitigation strategy
Failure to achieve the activity levels needed to continue delivering current range of services.	Prudent activity levels modelled. Realistic assessment of capacity to repatriate activity commissioned by NHS Hillingdon supported by clinicians. Detailed market assessments of potential new markets carried out.
Changes in activity as a result of London Strategic Reconfiguration [LSR]/ GP Commissioning/ plurality of providers do not happen at the pace that the Trust anticipated	Prudent & reasonable forecasts made. Service provision is in line with PbR income and PCT agreements on new to follow up ratios etc. Real time monitoring of activity on a daily basis to ensure responsive to changes in activity.
The Trust underachieves on specific efficiency savings targets and fails in financial performance against plan.	Monthly finance meetings with divisional management teams to monitor performance against agreed performance plans. Savings plans agreed before the start of the financial year.
Major Clinical Failure	Risks are managed through the Integrated Risk Management Committee, The Clinical Quality & Standards Committee, Infection Control Committee and the Board. Complaints, Incidents and patient satisfaction surveys are monitored through the CQSC and assurance given to the Board. The Trust has a Serious Incident Policy.
Unforeseen health and safety compliance issues	Risk Management Strategy Programme of assessments and audits to meet statutory obligations
Failing to provide a patient experience in line with vision to be the best general hospital	Existing mechanisms to capture the experience of patients are being strengthened. Divisional Dashboards include patient experience indicators. A 'Listen, Learn and Respond' framework has been agreed by the Board to pull all work strands together comprehensively.

4. Financial plans

4.1. Overview

The Trust's financial plan for the next 3 years builds on the success of the solid foundations laid over the past decade. During this time, surpluses have been generated in all but one year and that was a relatively minor deficit of under £1m. To get to and maintain this position, the Trust has worked consistently to improve the robustness of its financial governance and at the same time its performance management systems.

Key to delivering our financial intentions are planned improvements in managers and clinicians understanding and management of cost in the current business environment where revenues are contested and therefore variable. To develop and enhance these skills the Trust has implemented a patient level costing system. The system is currently being developed further to provide a more clinician focused interface and to make it easily available for use on a day-to-day operational basis. The Trust believes the development of this system will significantly assist divisional management teams to increase future surpluses.

Over the last two years, the Trust has significantly increased its management capacity and support in relation to the delivery of its efficiency savings programme. There is a Programme Office in place led by a Programme Manager to support clinical divisional teams. These teams clearly retain the ownership and accountability for identifying and delivering savings including assessing their impact on clinical quality.

4.2. Income and expenditure

The Trust intends to build on its long-term record of financial success and to use its surpluses to build a robust financial foundation and support achievement of its strategic aims and objectives.

Income & Expenditure Statement	Actual 2010/11 £'000	Projected 2011/12 £'000	Projected 2012/13 £'000	Projected 2013/14 £'000
Commissioning Income	161,962	164,143	162,561	166,278
Non-Commissioning Income	24,656	24,117	24,755	24,968
Total Income	**186,618**	**188,260**	**187,316**	**191,246**
Operating Expenses	(173,492)	(172,768)	(171,502)	(173,353)
Earnings before Interest Tax Depreciation & Amortisation	**13,126**	**15,492**	**15,814**	**17,893**
Depreciation	(7,406)	(7,560)	(7,549)	(7,549)
Interest Payable	(1,604)	(1,689)	(1,610)	(1,785)
Public Dividend Capital	(3,805)	(3,701)	(3,764)	(3,858)
Exceptional Items (Impairments)	(1,969)	0	0	0
Surplus/(Deficit) for the Year	**(1,658)**	**2,542**	**2,891**	**4,701**
Normalised Surplus/(Deficit) for the Year	**311**	**2,542**	**2,891**	**4,701**

Surplus projections for 2011/12, 2012/13, and 2013/14 are consistent with the Trust's Long Term Financial Model (LTFM) submitted as part of our Foundation Trust application. 2011/12 forecasts have been updated for 2010/11 outturn and Commissioning Contract negotiations, all assumptions from 2012/13 are unchanged from the Trust's Foundation Trust application.

During the Foundation Trust application it was assumed that Training & Education funding would be realigned from 2011/12. The Annual Plan now assumes the

realignment will not happen until 2012/13; the loss in 2011/12 has been offset by an increase in the Trust's Market Forces Factor (MFF) in 2011/12. MFF is the adjustment made to national tariffs to reflect the difference in costs relevant to location.

Should the Trust's financial position move adversely compared to the Annual Plan, the Trust Board has identified a potential £8.1m of mitigation strategies that could be implemented, up to £3.5m of which could impact in 2011/12. Each of these strategies has been subject to quality review, but the Board would require a full Quality Impact Assessment before implementation.

4.3. Activity and costs

Activity growth for 2011/12 and beyond has been modelled at an average of 3%, as in the Trust's Foundation Trust application. Demand Management reflects contract negotiations for 2011/12, with assumptions maintained as per commissioner plans reflected in the Foundation Trust application for later years. Costs have been modelled to move with activity using the same assumptions as per the LTFM.

During the Trust's Foundation Trust application it was assumed that the Stroke Unit would expand from 20 beds to 24 beds, and that the Urgent Care Centre (UCC) fronting A&E would repatriate to the Trust from 1st April 2011. Neither of these assumptions are now reflected in the Annual Plan.

Also, within the Foundation Trust application Financial Model it had been assumed that the management of the Continuing Care ward on the Mount Vernon site would transfer to another organisation from 1st April 2011. The Annual Plan assumes management of the ward will remain with the Trust for the period modelled.

4.4. Workforce

The management of bank and agency staff has been identified as a cost improvement programme, with efficiency savings coming through reductions in staffing usage via agencies. The Trust makes use of a highly efficient and effective internal bank for certain staff groups (especially, nurses, midwives and admin and clerical groups) and it has plans to extend this initiative to medical staff.

The cost improvement programme is focussed on improving productivity and will have an impact on the workforce. Sickness and turnover have reduced significantly over the two years. These metrics are regularly monitored and are now included on the new People Dashboard that is reviewed at management and Executive Team Meetings on a monthly basis.

4.5. Balance Sheet and Cashflow

The Balance Sheet as at 31st March 2011 differs from the forecast included within the Trust's Foundation Trust application for the following reasons :

- Revaluation of buildings resulting from movements in the building market reduced non-current assets and revaluation reserve both by £5m;

- Non-Current assets were lower by a further £1.3m because of slippage on capital against plan in 2010/11. The cash released was used to reduce current liabilities and as a result improve net current assets by £1.3m.

- Cash at the year-end was £0.5m, as opposed to £1.0m, to align the Trust to plans agreed with NHS London for 2010/11. This was used to temporarily reduce current liabilities.

- Both other current assets and current liabilities were reduced by £1.6m due to better than anticipated payment of NHS Debtors at year-end.

All Balance Sheet movements from 2011/12 are aligned in the Annual Plan to the Financial Model produced during our FT application, with the exception of reversing the temporary reduction in current liabilities. As a result, planned cash balances at the end of 2011/12, 2012/13 and 2013/14 match the previous projections.

4.6. Prudential Borrowing Limit and Private Patient Cap

The Trust has a Prudential Borrowing Limit (£36.1m) and a Private Patient Cap (1.3%) set as part of our Foundation Trust authorisation.

Within the period of the Annual Plan the minimum balance of the Prudential Borrowing Limit is £11.8m in 2013/14. The Annual Plan assumes our Private Patient Income ratio is 1.3% in line with the Cap, but there is little flexibility against this. The Trust will need to very closely monitor this ratio.

4.7. Cost Improvements

4.7.1. Cost Improvements Schemes 2011/12

a) Emergency Inpatient Pathway and bed reconfiguration - £0.1m

The Division of Medicine, Emergency Care and Rehabilitation are currently redesigning patient pathways in some specialities to facilitate a better patient experience and reducing emergency admissions.

b) Clinical Support Services efficiency improvement - £0.4m

The Operational divisions are working with Clinical Support Services to understand the capacity available to deliver diagnostic services, against ever increasing demand. Clinical Support Services is in the process of introducing a recharging model for Radiology which should encourage better planning of complex diagnosis provision in-house and encourage commissioning Divisions and Clinicians to review the appropriateness of tests ordered. There is also a plan to reduce external fees for tests. A Managed Service Contract will deliver significant pathology savings whilst managing risk.

c) Theatre and Outpatient Utilisation - £0.9m

In November 2010 The Division of Surgery and Anaesthetics reorganised its Trauma and Orthopaedic Department into of two dedicated teams: one to delivery trauma care and one to deliver elective orthopaedic care. The change has led to:

- Improved continuity of care
- Improved time to theatres for patients presenting to Accident and Emergency
- Improved availability and patient access to specialist surgeons
- Improved elective clinic and theatre capacity

The Division of Clinical Support Services is also planning to reduce premium spends for additional outpatient clinics.

d) Procurement and Drug Management - £1.6m

Hillingdon Medicines Management Committee and Pharmacy processes ensure a controlled prescription of existing drugs and managed introduction of new drugs. The Pharmacy team participate in all appropriate consortia arrangements to ensure the Trust gets the best price. Operational Divisions are also reviewing the way in which drugs are administered which could reduce costs. Continuation of the procurement process that has been in place for some time and have consistently delivered procurement savings. The Trust will continue to improve further efficiencies with non-pay contracts.

e) Reduction Clinical Bank and Agency - £0.5m

Better management of Trust staff is resulting in a reduction in the use of Bank and Agency staff. Savings are currently being made by:

- Removal of temporary bank premium rates and tighter controls of authorisation of Bank and Agency staff
- Improved auto rostering
- Limiting Waiting List Payments

f) Medical Staffing - £0.5m

Changes to Medical Training numbers and the move towards a more consultant delivered service means a review of medical staffing is essential. During 2011/12 the medical cover provided at Mount Vernon Hospital will be reviewed, and the use of medical locums reduced through improving sickness management. A new internal doctors locum service will also release savings.

g) Review non-ward based nursing staff, nursing overlap and nursing establishment - £0.4m

The Division of Medicine, Emergency Care and Rehabilitation will pilot this scheme from September 2011, saving one hour during the overlap period on wards operating an early/ late/ night shifts system.

All specialist nurses and midwives job plans are currently being reviewed to ensure all activity is recorded correctly. Divisions are also rostering specialist nurses and midwives to work on wards once a month (where it is possible), which also facilitates skills transfer.

h) Pay efficiency schemes - £0.7m

Action to manage staff costs associated with Agenda for Change: as staff reach the top of the pay scale they cease to incur an incremental drift cost pressure, thereby creating a saving. All Divisions are also working closely with the Divisional HR Advisors to review and manage sickness trends.

i) Estates, Facilities and Utility rationalisation - £1.1m

A Contract Review Group was convened in November 2010 to identify high cost estates and facilities contracts and prioritise in which order to review. The Trust is also currently working with staff internally and GP Practices to reduce the demand on patient transport services.

An estates rationalisation group was convened early 2010 to identify buildings with low space occupancy and prioritise which buildings to take out of use to save rates, utilities and other running costs.

In line with Agenda for Change guidance estates pay enhancements are currently under review. HR advisors are working closely with management to monitor potential impact in respect of recruitment and retention.

j) Other Schemes - £0.5m

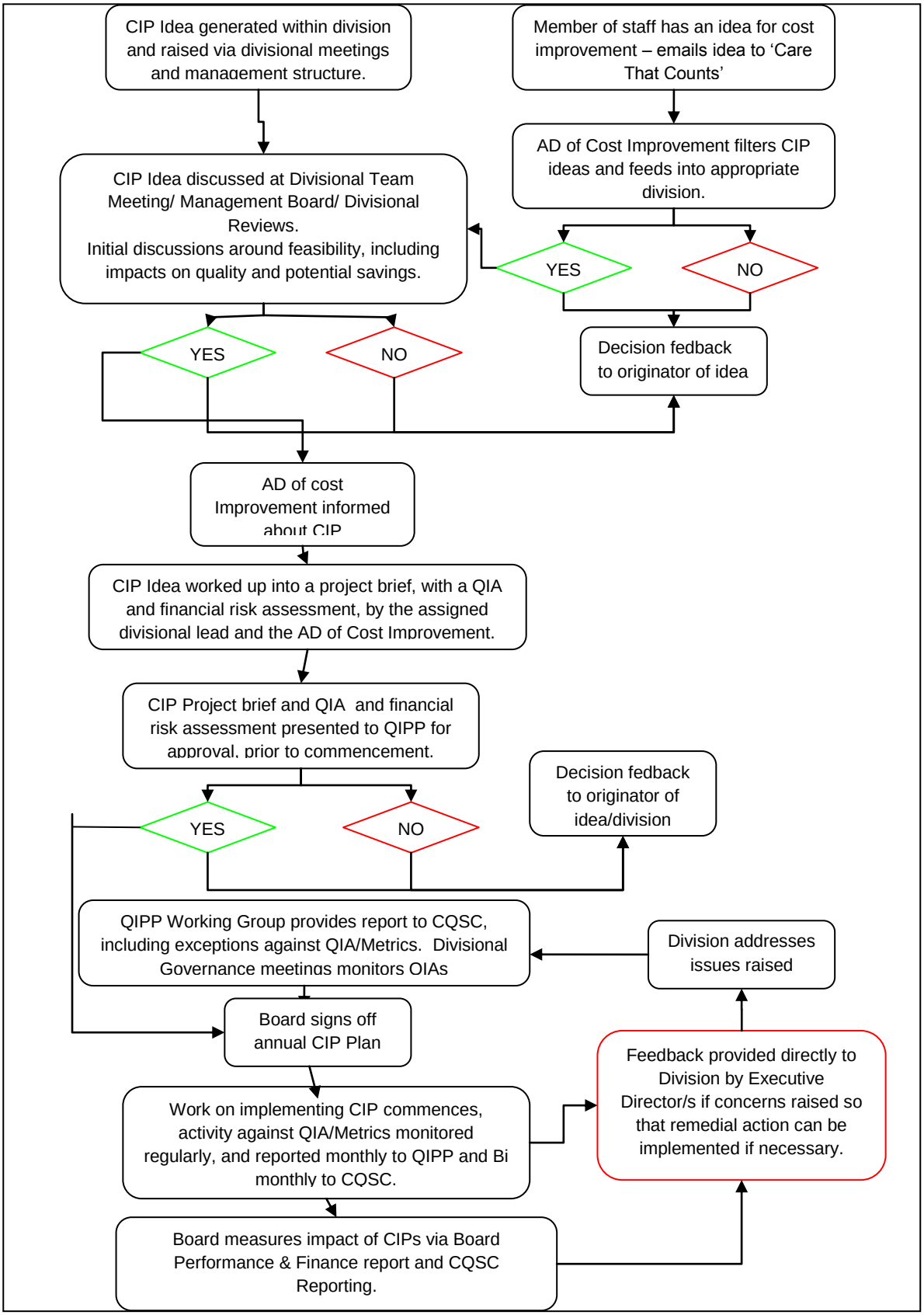
All other savings schemes including termination of a service contract, rationalisation of pay in one of the support services and the centralisation of switchboard has created staffing savings.

4.7.2. Management and Governance of Cost Improvement Projects 2011/12

The process of planning, approval and ongoing monitoring of the impact of CIPs has been agreed by the Trust Board and is well embedded. The process is rigorous and is underpinned by the acknowledgment that the impact of CIP activity on quality is considered at every stage, and monitored by the Board.

The chart below outlines the process for the generation and approval of CIPs.

CIP Generation, Approval and Monitoring Process



4.8. Capital programmes

4.8.1. Estates strategy

The Trust is aware that there are significant health and safety and ongoing maintenance issues facing the estate. Whilst recognising that some work needs to be done in the short term, irrespective of any new estate development, further steps have been taken to better understand the condition of the estate, and specifically the risks associated with the management of the high and significant backlog maintenance.

The Trust will continue to ensure that High risk backlog maintenance is treated as a priority. Additionally, through the current strategy which seeks to more effectively link backlog maintenance and capital expenditure into clinical strategy and site reconfiguration plans (including plans for the long term use or disposal of wards / clinical areas), strengthened strategic planning of the estate capital programme will be achieved going forward.

The Trust Board has agreed that at present there is not an affordable plan for the redevelopment of the Hillingdon site. The Board has decided to take a prudent approach, building surpluses over the next five years to ensure that plans, when agreed, are affordable.

Mount Vernon Hospital occupies a site of approx 23ha to the west of Northwood. Like many hospitals that have grown incrementally over the past 80 years the layout of the hospital is confusing for visitors and the fabric of the buildings is varied, with some in poor and deteriorating condition. As a result of changes in patient management several buildings and large areas of the site are becoming surplus to requirement. If surplus areas of the site are to be sold the value of these areas will be optimised by achieving the best possible planning permission.

4.8.2. Future Capital Investment

Over the 3-year period the Trust is planning to invest £26.9 million, £22.4m will be internally funded, and £4.5m funded through finance leases. The basic principle is that the Trust will fully reinvest cash released through depreciation into its internally funded capital spend from 2011/12. The Trust undertook a significant level of investment in the estate during 2009/10, supported by a £4m loan from the NHS Bank. The table below shows the capital investment programme supporting the Trust's strategic and operational objectives.

Capital Investment Programme			
Internally Funded	Projected 2011/12 £'000	Projected 2012/13 £'000	Projected 2013/14 £'000
Medical Equipment	1,611	1,675	1,745
IT	1,611	1,675	1,745
Estates	4,161	4,160	4,019
Total Trust Funded	**7,382**	**7,509**	**7,508**
Total Lease Funded Medical Equipment	890	527	3,124
Total	**8,272**	**8,036**	**10,632**

5. Clinical Quality plans

5.1. Setting the Annual Quality Operational Plan

The quality cycle detailed in our Clinical Quality Plan allows the Clinical Quality and Standards Committee (a committee of the Board) to analyse all the quality priorities, and following due consideration present recommendations to the Trust Board. The approved priorities will form the backbone of our Clinical Quality Strategy for the forthcoming year, which in turn will provide the framework for the annual Quality Account.

5.2. Quality Strategy Operational Plan for 2011/12

The quality priorities identified in the Clinical Quality Strategy are in line with the areas in which the three domains for quality improvement in the NHS Outcomes Framework are based: Clinical Effectiveness, Patient Experience, and Safety. In these areas we have identified a total of 13 primary action areas which are as follows:

High Quality Care through Clinical Effectiveness

- Achievement of standards set by regulatory authorities, e.g. CQC, NHSLA
- Achievement of National Performance Standards and Targets and those required by Commissioners
- Quality initiatives, stretch targets and projects identified through consultation on the Quality Plan, incidents including SIs, complaints, audits or locally monitored trends
- The Enhanced Recovery Programme, already successful in Orthopaedics, being extended to some Gynaecology and Bowel Surgery patients for 2011/12
- Clinical Pathways to ensure patients with these long term conditions receive the best possible care in the most appropriate place (dementia and diabetes identified for 2011/12)

Enhancing the Experience of our Patients

- For Outpatient Care to improve access, the patient pathway and communication
- For Emergency Care to maintain access and treatment times and improve communication, privacy and dignity and control of pain
- For Inpatient Care to improve patient care (food and drink, cleanliness, privacy, dignity and responsiveness to need) communication, the process around leaving hospital
- For Maternity Care to ensure appropriate choice and access to care, care from a named midwife during labour
- To respond to complaints or issues raised about care in a timely way and with appropriate improvements to service delivery

Providing a Safe Environment for Patients and Preventing Avoidable Harm

- Ensure compliance with all statutory health and safety standards
- Ensure safeguarding measures for children and vulnerable adults are robust and effective and that people with learning disabilities have access to the health care they need

- Reducing the incidence of avoidable harm to patients through the reduction of hospital acquired infections, venous thrombo-embolism, pressure ulcers, falls, harm from surgery, failure to rescue and certain high risk medicines such as insulin and oral anti-coagulants.

Appendix

Detailed Financial Summary £m		2010-11 Actuals	2011-12 Plan	2012-13 Plan	2013-14 Plan
Total operating income		186.6	188.3	187.3	191.2
Employee Expenses		(117.9)	(117.3)	(115.5)	(116.8)
Drugs expense		(10.4)	(10.9)	(11.1)	(11.3)
Supplies (clinical & non-clinical)		(45.1)	(44.6)	(44.9)	(45.3)
PFI expenses		0.0	0.0	0.0	0.0
Other Costs		0.0	0.0	0.0	0.0
Total operating expenses		**(173.5)**	**(172.8)**	**(171.5)**	**(173.4)**
EBITDA		**13.1**	**15.5**	**15.8**	**17.9**
Net Surplus / (Deficit)		**(1.7)**	**2.5**	**2.9**	**4.7**
EBITDA % Income	%	7.0%	8.2%	8.4%	9.4%
CIP% of Op.Exp. less PFI Exp.	%	4.2%	4.1%	4.1%	3.9%
Capital expenditure		(4.1)	(5.3)	(5.3)	(5.5)
Net cash inflow/outflow		**0.1**	**1.4**	**2.4**	**4.2**
Cash and cash equivalents		**0.5**	**1.9**	**4.3**	**8.5**
Liquidity days		**(3.3)**	**27.8**	**32.0**	**39.5**
Net current assets/(liabilities)		**1.4**	**2.5**	**4.5**	**8.2**
Planned borrowings		**23.9**	**23.4**	**23.1**	**25.4**

Cost Improvement Plans (CIPs) Totals Totals	Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012 Value £m	Plan for Year ending 31-Mar-2013 Value £m	Plan for Year ending 31-Mar-2014 Value £m
Analysis of Revenue Generation and Expense CIPS				
Recurring CIPs + revenue generation schemes	7.227	6.848	6.807	6.576
Non-recurring CIPs + revenue generation schemes	0.000	0.000	0.000	0.000
Total (agrees to above)	**7.227**	**6.848**	**6.807**	**6.576**
1 **Short Name or Description** Emergency Inpatient Pathway and bed reconfiguration		**0.100**	**0.546**	**0.318**
2 **Short Name or Description** Clinical Support Services efficiency improvement		**0.406**	**0.270**	**0.169**
3 **Short Name or Description** Theatre and Outpatient Utilisation		**0.940**	**0.666**	**0.091**
4 **Short Name or Description** Procurement and Drug Management		**1.614**	**1.953**	**2.099**
5 **Short Name or Description** Reduction Clinical Bank and Agency		**0.425**	**0.604**	**0.462**
6 **Short Name or Description** Medical Staffing		**0.510**	**0.063**	**0.000**
7 **Short Name or Description** Review non-ward based nursing staff, nursing overlap and nursing establishment		**0.438**	**0.251**	**0.000**
8 **Short Name or Description** Pay efficiency schemes		**0.703**	**0.966**	**1.578**
9 **Short Name or Description** Estates, Facilities and Utility rationalisation		**1.110**	**0.966**	**1.320**
10 **Short Name or Description** Other Schemes		**0.602**	**0.522**	**0.539**

The Hillingdon Hospitals NHS
NHS Foundation Trust

List of Directors, Governors and elections for The Hillingdon Hospitals NHS FT

Directors *(at 31 May 2011 or date of submission, whichever is earlier)*

	Role	Job Title	Name of Director	Tenure	Date appointed
example	*Finance Director*	*Director of Finance and Information*	*Ms Jane Doe*	*Acting*	*01/05/2010*
	Chief Executive	Chief Executive	David McVittie	Permanent	05/03/2001
	Finance Director	Finance Director	Paul Wratten	Permanent	20/03/2000
	Medical Director	Medical Director	Dr Susan LaBrooy	Permanent	01/01/2006
	Nursing Director	Director of Patient Experience & Nursing	Marie Batey	Permanent	01/04/2007
	Other Board Director	Interim Chief Operating Officer	Julie Wright	Interim	07/02/2011
	Other Board Director	Director of Corporate Development	David Searle	Permanent	29/01/2007
	Chair	Chair	Mike Robinson	Permanent	16/07/2009
	NED	Deputy Chair & Non-Executive Director	James Reid	Permanent	01/02/2008
	NED	Non-Executive Director	Katey Adderley	Permanent	01/12/2010
	NED	Non-Executive Director	Alan McLeod	Permanent	01/10/2008
	NED	Non-Executive Director	Craig Rowland	Permanent	01/10/2006
	NED	Non-Executive Director	Patricia Rushton	Permanent	01/12/2003

Governors *(at 31 May 2011 or date of submission, whichever is earlier)*

	Constituency Type	Full Name of Constituency	Name of Governor	Origin	Date appointed/elected
example	*Public*	*North west outtown*	*Mr John Jones*	*Elected*	*01/05/2010*
	Public	North Public Constituency	David Bishop	Elected (Contested)	01/04/2011
	Public	North Public Constituency	Tony Ellis	Elected (Contested)	01/04/2011
	Public	North Public Constituency	Ahmad Mallick	Elected (Contested)	01/04/2011
	Public	North Public Constituency	Rachel Owen	Elected (Contested)	01/04/2011
	Public	North Public Constituency	Alvan Seth-Smith	Elected (Contested)	12/04/2011
	Public	Central Public Constituency	Donald Dakin	Elected (Contested)	01/04/2011
	Public	Central Public Constituency	Barbara Hosier	Elected (Contested)	01/04/2011
	Public	Central Public Constituency	Muriel Hosking	Elected (Contested)	01/04/2011
	Public	Central Public Constituency	Kerstin Rolfe	Elected (Contested)	01/04/2011
	Public	Central Public Constituency	Roger Shipton	Elected (Contested)	01/04/2011
	Public	South Public Constituency	John Coleman	Elected (Contested)	01/04/2011
	Public	South Public Constituency	John Davies	Elected (Contested)	01/04/2011
	Public	South Public Constituency	Asma Jalal	Elected (Uncontested)	01/04/2011
	Public	South Public Constituency	Abid Majeed	Elected (Uncontested)	01/04/2011
	Public	South Public Constituency	Sharda Mohan	Elected (Uncontested)	01/04/2011
	Public	South Public Constituency	Marion Tuplin	Elected (Contested)	01/04/2011
	Staff	Doctors & Dentists	Ronald Langstaff	Elected (Contested)	01/04/2011
	Staff	Nurses & Midwives (including healthcare assistants)	Bev Hall	Elected (Contested)	01/04/2011
	Staff	Nurses & Midwives (including healthcare assistants)	Ann Morling	Elected (Contested)	01/04/2011
	Staff	Nurses & Midwives (including healthcare assistants)	Angela Wilson	Elected (Contested)	01/04/2011
	Staff	Allied Health Professionals	Graham Coombs	Elected (Contested)	01/04/2011
	Staff	Support Staff	Gay Bineham	Elected (Contested)	01/04/2011
	Staff	Support Staff	John Woodford	Elected (Contested)	01/04/2011
	Stakeholder	Hillingdon PCT	Mike Whitlam	Appointed	01/04/2011
	Stakeholder	London Borough of Hillingdon	Philip Corthorne	Appointed	01/04/2011
	Stakeholder	Joint Negotiating & Consultative Committee	Lesley Dixon	Appointed	01/04/2011
	Stakeholder	London Ambulance Service	Peter McKenna	Appointed	01/04/2011

Membership return for The Hillingdon Hospitals NHS FT

Membership size and movements

Public constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	5,829	7,020
	New members	+ve	1,365	480
	Members leaving	+ve	174	200
	At year end (31 March)		7,020	7,300

Staff constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	2,845	2,891
	New members	+ve	1,196	1,150
	Members leaving	+ve	1,150	1,041
	At year end (31 March)		2,891	3,000

Patient constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve		0
	New members	+ve		
	Members leaving	+ve		
	At year end (31 March)		0	0

Analysis of membership at 31 March 2011

Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
	Age (years):		
	0-16	15	5,388
	17-21	211	26,235
	22+	5844	286,782
	Unknown	950	
			318,405
	Ethnicity		
	White	4,616	286,234
	Mixed	217	10035
	Asian or Asian British	1182	81,941
	Black or Black British	250	19347
	Other	105	8353
	Unknown	650	-87,505
	Socio-economic groupings*:		
	ABC1	6,248	176,262
	C2	61	44,816
	D	476	49,883
	E	235	42,540
	Unknown	0	4,904
	Gender:		
	Male	2,840	152,423
	Female	4,180	165,982
	Unknown	0	0

Patient Constituency		31 Mar 2011 members	Eligible membership
	Age (years):		
	0-16		
	17-21		
	22+	0	

Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	2,891	