Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING AGENDA

Wednesday 30th January 2013
10.45am – 1.00pm

Hammersmith Conference Centre
Maple & Ash Suite
Hammersmith Hospital Site
Du Cane Road W12 0NL

1.	**General Business**			
		Paper	**Presenter**	**Time**
1.1	Chairman's Opening Remarks	Verbal	Chairman	5 minutes
1.2	Apologies	Verbal	Chairman	1 minute
1.3	Minutes of the Previous Meeting	1	Chairman	2 minutes
1.4	Matters Arising and Action Log	2	Chairman	2 minutes
1.5	Chief Executive Report	3	Chief Executive	10 minutes

2.	**Quality and Safety**			
2.1	Report from the Director of Nursing • National A&E Patient Survey Results • Family and Friends Test Implementation • Care Quality Commission (CQC) Inspection reports	4 5 6	Director of Nursing	15 minutes
2.2	Report from the Medical Director • Infection Prevention and Control Report • CQC Clinical Alert: Perinatal Conditions • Never Event	7 8 Oral	Medical Director Director of Infection Control and Prevention Medical Director Professor Sir Anthony Newman Taylor	15 minutes

3.	**Performance**			
3.1	Performance Report • Month 9 Report	9	Chief Operating Officer	10 minutes
3.2	Finance Report • Month 9 Report	10	Chief Financial Officer	10 minutes
3.3	Single Operating Model	11	Chief Financial Officer	10 minutes

4.	**Strategy**			
4.1	Cerner Implementation Update Report	12	Chief Information Officer	10 minutes

5.	**Governance**			
5.1	Education Update Report	13	Director of Education	10 minutes

6.	**Papers for information**			
6.1	Report of the Audit and Risk Committee	14	Sir Gerald Acher, Chair Audit and Risk Committee	10 minutes
6.2	Report of the Quality and Safety Committee	15	Medical Director	
6.3	Midwifery Local Supervisory Report	16	Director of Nursing	
7	**Papers for Ratification**			
7.1	Management of Concerns and Complaints Policy	17		

7.	**Any Other Business**			
			Chairman	2 minutes

8.	**Date of Next Meetings**
Trust Board meeting in Public – Wednesday 27th March 2013, New Boardroom, Charing Cross Hospital, Fulham Palace Road, Hammersmith	

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 28th November 2012
Staff Dining Room, QEQM Building,
St Mary's Hospital, Paddington

Present:
Sir Richard Sykes, Chairman
Sir Thomas Legg, Non-Executive Director
Dr Rodney Eastwood, Non-Executive Director
Professor Sir Anthony Newman Taylor, Non Executive Director
Dr Martin Knight, Non-Executive Director
Mr. Jeremy Isaacs, Non-Executive Director
Sir Gerald Acher, Non-Executive Director
Mr. Mark Davies, Chief Executive
Professor Nick Cheshire, (Acting) Medical Director
Ms Janice Sigsworth, Director of Nursing
Mr. Steve McManus, Chief Operating Officer

In Attendance:
Professor Dermot Kelleher, Principal of the Faculty of Medicine, Imperial College Director
Ms Anne Mottram, Director of Governance & Corporate Affairs
Mr. Sam Armstrong, Head of Corporate Services (Minutes)
Mr. Marcus Thorman, Director of Operational Finance (for Bill Shields, Chief Financial Officer)
Mr. Justin Vale, Director, CPG2 (item 2.2.2)
Dr Julian Redhead, Director, CPG1 (item 5.1.1)
Ms Pippa Nightingale, Head of Midwifery (item 5.1.2)

1. GENERAL BUSINESS

1.1 Chairman's Opening remarks

The Chairman opened the meeting at 10.45 a.m. and welcomed all present and in particular Professor Sir Anthony Newman Taylor and Professor Dermot Kelleher attending their first Board meetings.

1.2 Apologies

An apology was received form Mr. Bill Shields, Chief Financial Officer.

1. 3 Minutes of Previous Meeting

The minutes of the meeting held on 26th September 2012 were approved.

1.4 Actions

The action sheet was noted.

1.5 Chief Executive's Report

Mr. Mark Davies presented the report. Congratulations was noted for Ms Anne Mottram for retaining level 3 NHSLA risk management for acute trusts and Ms Pippa Nightingale for achieving level 3 for NHSLA CNST for maternity services. These results place the Trust in the top 15% in the country.

Key appointments were highlighted. Professor Nick Cheshire has been appointed Medical Director of the Trust. Ms Anne Mottram has been appointed Director of Operations for the Imperial Academic Health Science Centre. A new Director of HR has been appointed, Ms Jayne Mee, who has extensive experience in the private sector.

The Trust Board noted the Chief Executive Report.

2.1 Report from the Director of Nursing
2.1.1 Nursing and Midwifery Strategy
Ms Janice Sigsworth presented the Nursing and Midwifery Strategy. It was noted that it builds on the current strategy and looks toward Foundation Trust (FT) authorisation for the Trust. An attempt has been made to incorporate views of the new Chief Nurse. In response to a question from the Chairman, Ms Janice Sigsworth stated that the strategy focuses on providing the basic aspects of care; it now introduces performance measures and has a stronger focus on supporting and developing staff. To a follow up question, she confirmed that the Trust had engaged its education partners in developing the strategy. The potential for specialist nurses to take on additional responsibilities was discussed.

The Trust Board noted the Nursing and Midwifery Strategy.

2.1.2 Clinical Risk Management of Cost Improvement Programme (CIP) Schemes
Ms Janice Sigsworth presented the paper. It was noted that the management of clinical risks associated with CIPs is very important to the Trust and to the National Quality Board: the Trust process is broadly on track. The Francis Report will be reviewed once published. Further work is being conducted to embed processes with Clinical Programme Groups (CPGs) via the CIP Board and a series of spot check will be undertaken. The Medical Director and Director of Nursing are the gatekeepers and guardians of the process. In response to a question from the Chairman, Ms Janice Sigworth stated she believes the system is robust. Sir Thomas Legg stated the Governance Committee had reviewed this and the system appeared sensible. Sir Gerald Acher stated the process will be discussed at the upcoming Audit and Risk Committee.

The Trust Board approved the risk management process.

2.1.3 Clinical Governance Review
Ms Janice Sigsworth provided a verbal update. It was noted that the review had been commissioned by NHS London and the Commissioners and was conducted as a two-stage review: a desktop review followed by a series of interviews. The draft report has now been received by the Trust and will be signed off with NHS London after a meeting between them and the Trust on 13th December 2012. The report found no cause for concern, however it did raise issues regarding to patient transfers. There are a small number of actions from the report. The Board will receive the final report. Comments pertaining to culture below CPG Board level were noted.

Action: Final Clinical Governance Review to be presented to the Board.

The Trust Board noted the report.

2.2 Report from the Medical Director
2.2.1 Infection Prevention and Control Report
Mr. Steve McManus presented the report for Professor Alison Holmes. It was noted that the year-to-date performance is good with three cases of Trust attributable MRSA compared to a threshold of seven and annual ceiling of nine cases and 53 cases year-to-date of C. difficile compared to a threshold of 63 and annual ceiling of 110 cases. The winter period is expected to be challenging and vigilance will be needed to maintain this good position.

The benefits of aseptic non touch technique (ANTT) were noted. Staff training numbers have plateaued and will become a focus of attention at CPG Performance Reviews. In answer to a question from the Chairman, Mr. Steve McManus stated that a combination of screening and ANTT was thought to have contributed to lowering cases of MRSA. To a follow up question he added that many other types of infections are monitored not just MRSA and C.difficile. Mr. Mark Davies stated that the Trust must remain vigilant to keep infection rates low. In answer to a question from Sir Gerald Acher, Ms Jancie Sigsworth stated that ANTT is used for interactions that have higher risk of infection and not for more general care given to patients. In answer to a question from Sir Gerald Acher, Mr. Steve McManus stated that approximately 2000 of the 6000 patient facing staff have had flu vaccinations to date.

The Trust Board noted the Infection Prevention and Control Report

2.2.2 Cancer Survey Implementation Plan

Mr. Steve McManus presented the plan. It was noted that the Trust is not where it would like to be in terms of its performance in this area. The remedial plan has been put together from internal reviews, work with the Intensive Support Team and work undertaken with the Commissioners. There has been engagement with clinical and administrative staff. In answer to a question from the Chairman, Mr. Steve McManus stated that the cancer patient tracking list (PTL) had been reconstructed during the reporting break; the IST has signed off on this as a robust system and data quality KPIs have been developed. In answer to a follow up question, he added that the new Somerset system (the Trust's new cancer information system) will manage patient pathways and will go live in January 2013. In answer to a question from Sir Gerald Acher, Mr. Steve McManus confirmed he was responsible for the action plan. To a follow up question from Dr Rodney Eastwood, he stated that he personally oversees weekly reviews of tumour site leads to review pathways and a weekly breach report. In answer to a question from Dr Rodney Eastwood, Mr. Justin Vale said that whether someone is or isn't a cancer patient is now mandatory information for the imaging department. He further stated that teamwork is the key to improving these results and there is a psychologist working with the leads to improve teamwork.

In answer to a question about cancer strategy, Mr. Steve McManus stated that a completion date hasn't been set yet. Professor Dermot Kelleher asked that the College be engaged with any development of strategy. Professor Sir Anthony Newman Taylor reiterated the importance of the College and Trust working together on this issue. Mr. Mark Davies stated he would set up a group to look into this. Mr. Jeremy Isaacs suggested creating a social media strategy. Mr. Steve McManus stated the Trust is working with MacMillan to further develop communications. The Chairman emphasised the seriousness of the situation to the Trust and stated it was important in the short term to control the situation and that in the long term the Trust must work closely with the College to improve outcomes. Cancer has to be a critically important area for the Trust.

Action: Mr. Mark Davies to establish cancer strategy working party.

The Trust Board noted the report.

2.2.3 Quarter 2 Patient Safety and Service Quality Report

Professor Nick Cheshire presented the report. It was noted that there had been a visit by the Care Quality Commission to Charing Cross Hospital to inspect privacy and dignity and more recently two planned inspections in support of registration at the Western Eye Hospital and Hammersmith Hospital. The Trust remains registered across all sites without conditions. Incident reporting has increased; the Trust is closer to peer average. In response to a question from Sir Gerald Acher, Ms Anne Mottram stated that the Trust's level of complaints were low at 0.48 complaints per 100 admissions; work continues to reduce themes of complaints. It was noted that the Trust has a very low amount of complaints reopened by the ombudsman.

Incidents reported relating to staff levels increased, however over 80% were graded as 'no harm'. Although there were no never events in quarter 2, in October there was an instance of a retained vaginal swab, the findings of the investigation will be presented to the Board.

Action: Findings from October retained swab incident to be reported to the Trust Board.

The Trust Board noted the report.

3.1 Performance Report
Mr. Steve McManus presented the report. It was noted that the Trust is performing well in Venous Thromboembolism assessment rates, elimination of mixed sex accommodation and national waiting times for non-admitted patients on incomplete pathways. The Trust is underperforming A&E type 1, 18-week waits and cancer performances, achieving four out of eight standards. Work continues on all underperforming areas. Ms Janice Sigsworth explained the new harm free care measures, which the Trust has recorded over the 95% target since records began in July 2012. In answer to a question from Dr Rodney Eastwood, Ms Janice Sigsworth stated that this data is available and presented in clinical areas.

The Trust Board noted the Performance Report.

3.2.1 Finance Report
Mr Marcus Thorman presented the finance report. It was noted that the Trust had an in-month surplus of £2m, of which £1.5m non-recurrent income is relating to a windfall from the disposal of Acton Hospital. There is an overall £0.5m favourable variance to plan in month and a year-to-date favourable variance of £3.3m from a £5.1m surplus. CIP delivery is £1.4m ahead of plan year-to-date, however a higher percentage of CIP are back loaded and planned to be achieved late in the year.

CPG performance against historic budget and expenditure is reducing over time. Mr. Marcus Thorman stated he was confident of achieving overall CIP by year-end. Monthly CPG monitoring meetings continue. Cash is above plan due to payments to suppliers and payroll payments being lower than planned. R&D income was paid earlier than expected and IT scheduled capital expenditure under achieved, however it is expected to be fully utilised by year-end. The Trust's overall Monitor risk rating is 3 based on results in October.

The Trust Board noted the Finance Report.

3.2.2 Single Operating Model (SOM)
Mr. Marcus Thorman presented the SOM. It was noted that two areas are rated red due to performance. Discussions are occurring for the Trust's FT dates to come forward. In answer to a question from the Chairman, Mr. Mark Davies stated that it's about TDA confidence in the Trust's future performances. It is hoped that by demonstrating a positive trajectory the start date will be moved forward.

The Trust Board approved October SOM declaration.

4.1 Management of Waiting List Action Plan
Mr. Steve McManus presented the action plan. It was noted this had been produced from four reviews by: Deloitte, Intensive Support Team and the two external reviews presented to the September Trust Board. Actions have been grouped together under themes and where they have not been completed a timeline is in place. Two key areas are data quality and waiting list management. An audit review has been agreed with Parkhill, the Trust's internal auditor. The Chairman pointed out that there are lots of initiatives occurring in the Trust at once, including CERNER. In response, Mr. Steve McManus stated that CERNER training will be used to

embed the improved data quality processes. Mr. Marcus Thorman pointed out that Deloitte will be conducting value for money audit again this year and data quality remains an area of focus.

The Trust Board approved the plan.

5.1 Chair's Action

5.1.1 Endoscopy Full Business Case

Dr Julian Redhead presented the business case. In answer to a question from Dr Martin Knight, Dr Julian Redhead stated there were few significant risks and it is unlikely related activity will decrease. To follow up question, he added that costs have been investigated and the endoscopy unit opened at Hammersmith Hospital on budget. JAG accreditation could be at threat if this business case doesn't go ahead. The gastroenterology service overall, of which endoscopy is a part, showed a positive EBITDA of 30% in 2011-12. In response to a suggestion by Professor Nick Cheshire relating to business partner with private firms, the Chairman stated the Board were content to approve the business case, however Professor Nick Cheshire's suggestion should also be pursued.

The Trust Board approved the business case.

5.1.2 Maternity Risk Management Strategy

The Trust Board ratified the strategy.

5.2 Service Quality and Patient Safety Annual Report – Executive Summary

The report was taken as read.

The Trust Board noted the report.

5.3 Report of the Quality and Safety Committee

The report was taken as read.

The Trust Board noted the report.

5.4 Summary of the Governance Committee

The report was taken as read.

The Trust Board noted the report.

6.1 Any other Business

There was no other business.

Questions from members of the Public

A member of the public raised the closing of the hydro pool at Charing Cross Hospital and asked if this planned change had been assessed for equality and diversity. Mr. Steve McManus offered to take the member of the public's contact details to discuss the issue fully.

The meeting concluded at 1.00 p.m.

TRUST BOARD MEETING: 30th January 2013 **PAPER NUMBER: 13/01/30 – 2**

ACTION SHEET FROM TRUST BOARD
PUBLIC MEETING – 28 NOVEMBER 2012

Agenda Item	Action	Responsible	Completion Date
Item 2.1.3	Final Clinical Governance Review to be presented to the Board.	Ms Janice Sigsworth	March 2013 Board
Item 2.2.2	Cancer strategy working party to be established.	Mr. Steve McManus	February 2013
Item 2.2.3	Findings from October retained swab incident to be reported to the Trust Board.	Ms Anne Mottram	January 2013 Board (item 2.2.3)

ACTION SHEET FROM TRUST BOARD
PUBLIC MEETING – 26 SEPTEMBER 2012

Agenda Item	Action	Responsible	Completion Date
Item 2.2.3	A report on Perinatal clinical alert to be presented to the Trust Board	Dr David Mitchell	Revised January 2013 Board (item 2.2.2)
Item 3.2.1	Mr Steve McManus to present trajectories for all cancer standards in performance report to the Board	Mr. Steve McManus	January 2013 Board
Item 6.11	Report on CERNER implementation to be presented to the Trust Board	Mr. Kevin Jarrold	Revised January 2013 Board (item 4.1)

ACTION SHEET FROM TRUST BOARD
MEETING – 30 MAY 2012

Agenda Item	Action	Responsible	Completion Date
Item 3.2.1	Report on private patients to be presented to a future Trust Board.	Mr. Bill Shields	Revised March 2013 Board

Imperial College Healthcare NHS
NHS Trust

Chief Executive's Report

30th January 2013

1 TRUST BUSINESS

1.1 CLINICAL

1.1.1 Cancer Update

The Trust has been awarded £584,000 from the Department of Health (as part of a competitive bidding process) to buy two Intensity Modulated Radiotherapy (IMRT) machines which will significantly improve utilisation, reduce side effects for patients and allow us to exceed the government target of 25%. We are currently treating 25-30% of the target patient group (prostate, brain, head and neck and some breast) with the old kit, but could achieve up to 50% with the implementation of the new Rapid Arc IMRT. Other cancers will continue to receive the NCAT recommended radiotherapy treatment, standard radiotherapy, IGRT etc. The team is intending to run research programmes using the equipment to look at extending IMRT techniques for lung, pancreas, gynae and oesphageal cancers to ensure we are able to deliver cutting edge cancer treatments.

Lead Director – Steve McManus, Chief Operating Officer

1.1.2 Saville Allegations

The Saville allegations have been widely covered in the media. In December 2012 David Nicholson (NHS Chief Executive) asked that organisations review with their Boards arrangements and practices relating to vulnerable people. At the same time NHS London required Trusts to provide assurance that systems had been checked and action plans had been put in place to address any gaps. The Trust response confirmed that systems and processes are in place at ICHT to protect vulnerable people and there are policies and procedures in place to listen to and act on patient concerns.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.3 NHS Constitution

The Department of Health is seeking views on proposals to strengthen the NHS constitution. In particular, in ten key areas: Patient involvement; Feedback; Duty of candour; End of life care; Integrated care; Complaints; Patient data; Staff rights, responsibilities and commitments; and Dignity, respect and compassion (for more detail see: www.dh.gov.uk/nhsconstitution). ICHT has submitted a response broadly supporting the proposals.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.4 Equality Delivery System (EDS)

The Equality Delivery System (EDS) is a systematic way of meeting the Public Sector Equality Duty (PSED) comprised of equality outcomes assessed over a four year period. The EDS requires evidence for each outcome to be presented to a stakeholder group to grade

performance. For 2012/13 the Trust selected four EDS outcomes for delivery, two service-focused (1.2 Health needs assessment and 2.1 Access to services) and two workforce focused (3.2 Equal pay and 3.5 Flexible working). The workforce focused-outcomes were graded as 'achieving' at a stakeholder event held in December and the service-focused outcomes will be graded at an event on 23 January 2013. The PSED results will be published on the Trust website by 31 January 2013.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.5 Clinical Governance Review

A letter (please refer to appendix A) confirming the main outcomes of the Clinical Governance Review has been sent from Dr. Andy Mitchell, Medical Director for NHS London. The letter confirms that the review identified a number of positive aspects and acknowledges the action plan that the Trust has put in place to implement stronger systems.

Lead Director – Janice Sigsworth, Director of Nursing and Nick Cheshire, Medical Director

1.1.6 HASU Performance

The Hyper-Acute Stroke Unit (HASU) has been ranked first among the 150 stroke units in England, according to the Royal College of Physicians (RCP). The most recent results reflect consistently high performance by the HASU at Imperial, which has maintained a high score across the quality indicators (88% since 2011). The HASU treats over 150 patients per month – in many cases this is life-saving.

Lead Director – Nick Cheshire, Medical Director

1.1.7 Safety Thermometer

The Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It is also a great example of how nurses make a difference. During the first four months of this programme, the Trust has performed extremely well against peers and has one of the best rates of Harm Free care in comparison to the Shelford Group. From July 2012 data collected using the NHS Safety Thermometer was part of the (CQUIN) payment programme. The 2013/14 CQUIN relating to the Safety Thermometer will focus on reductions in pressure ulcer prevalence.

Lead Director – Janice Sigsworth, Director of Nursing

1.2 PEOPLE

1.2.1 Deputy Medical Director and Director of Cancer and External Clinical Relationships Appointed

As a highly experienced clinician and healthcare leader, Dr. Chris Harrison will join Imperial from The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe, where he has been medical director since 2006. He has for the past two years also been clinical director for cancer for NHS London. He will support Professor Nick Cheshire and play a pivotal role in developing external clinical relationships. The experience he brings, both from cancer and his background in public health, will be invaluable to the Trust as we seek to improve cancer services and build strong external relationships that will enable us to improve our patients' journeys both in and out of hospital.

1.2.2 Non-Executive Director Commences in Post

Sarita Patel joined the Trust in January as a Non-Executive Director. A proven leader in international business, Sarika's experience includes leading large multi-sited teams, corporate development and finance, acquiring, integrating and developing businesses, and company restructuring and turnaround. Her experience and knowledge of both public and private sectors will bring the highest level of expertise to benefit the Trust in our commitment to delivering excellent standards of patient care

1.2.3 Director of People and Organisation Development

Jayne Mee has been appointed as the Director of People and Organisation Development and will be joining the Trust on 18th March 2013. Jayne is a highly experienced human resources and organisation development professional who has held senior appointments in a wide range of businesses, most recently Barratt Developments PLC and prior to that Spirit Group Ltd as well as Royal Mail Group. Jayne brings a wealth of experience to this role, combining private sector expertise and business skills with an excellent grasp of the business challenges faced by public sector organisations.

2 PERFORMANCE

2.1 Month 9 Performance Summary

The Trust continued to sustain good performance in all of the Quality Performance Indicators particularly venous thromboembolism assessments, infection control and stroke care and continues to report no mixed sex accommodation breaches.

The Trust successfully delivered on the Referral to Treatment standards in November and December for admitted, non-admitted and incomplete patients. This was the first time that this target had been achieved since the reporting break.

The 4 hour maximum waiting time in Accident and Emergency for the 'type 1' target of 95% was missed by 1.5% in December, with Charing Cross and St Mary's Hospitals falling below target. All sites achieved over the 95% target for 'all types'.

The Trust achieved 5 of the 8 national standards for cancer waiting times, including maintaining its performance in the 2 week wait for urgent cancer referrals. The Trust has a robust plan in place to enable continued performance improvement for all cancer standards.

Lead Director – Steve McManus, Chief Operating Officer

3 FINANCE

3.1 Month 9 Financial Summary

The Trust has achieved a surplus of £8.3m at the end of quarter 3 (December 2012); a favourable variance against the plan of £5.9m. This is based on a surplus in month of £2.9m. The forecast outturn for the year has been revised to £11.5m. This revised forecast has been achieved by receiving additional non-recurrent income and through releasing the contingency that was required as part of the plan, but is not necessitated due to cost control in year. This is reflected by the over-achievement of the cost improvement plan, which is expected to deliver £54m in year savings, £2m more than the plan requires. The continued focus on cost improvement is required into 2013/14, despite the over-achievement in year.

Lead Director - Bill Shields, Chief Financial Officer

4 NWL BUSINESS

4.1 "Shaping a Healthier Future" Consultation

The Joint Committee of PCTs (JCPCT) is meeting on Tuesday 19 February to make a decision. The Trust continues to work closely with the commissioners in support of Option A.

Lead Director – Mark Davies, Chief Executive Officer

4.2 West Middlesex University Hospital NHS Trust (WMUH)

The Trust's expression of interest was presented to the WMUH Board in December and a decision is awaited.

Lead Director – Mark Davies, Chief Executive Officer

5. AHSC – AHSN BUSINESS

5.1 Academic Health Science Partnership (AHSP) Development

The Partnership was interviewed on 3 December by the panel assessing the bids that have been submitted for designation by the Department of Health & NHS Commissioning Board as an Academic Health Science Network (AHSN) to improve the health and healthcare of the 2 million people living in North West London. The Partnership anticipates being informed formally of the outcome of the designation process in March, along with all the other Networks. The AHSN designation will be for 5 years.

Adrian Bull, currently CEO at the specialist Queen Victoria Hospital, has been selected after a rigorous recruitment process to be the first Managing Director and will start on 1 April 2013. Further details of his appointment are available at: http://www.imperial.nhs.uk/aboutus/news/news_037972 . A small permanent core team will be appointed to drive forward its development. The Trust and AHSC continue to play an active role in ensuring the AHSN is successfully established, and good progress is being made to expand the membership of the Partnership to include all the provider trusts in North West London and primary care and Commissioners.

Lead Director – Mark Davies, Chief Executive Officer

5.2 Academic Health Science Centre Development

Professor David Taube, the AHSC Director continues to consult with Trust and College colleagues on how best to take forward the development of the Imperial AHSC. He is in the process of building a small dedicated team at the Hammersmith Hospital to push forward implementation and prepare for an AHSC re-designation process anticipated during 2013.

The relationship between the College and the Trust has now been formalised through a signed Joint Working Agreement, including critical issues such as joint posts, Intellectual Property, a Trade Mark Licence and new Terms of Reference for the AHSC Strategic Partnership Board and the AHSC Joint Executive Group.

Lead Director – Mark Davies, Chief Executive Officer

6. IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

6.1 Staff Business

The Charity has recruited two new members of staff to fill two vacancies within the team. Josephine Job is set to join the team as its new fundraising director, having worked as the head of corporate and major donor fundraising at the charity RNIB, where she has been since 2007. The charity will also be joined by Gillian McKay who will take the position of finance director in the team. Gillian has spent a number of years working for the consultancy and audit firm Sayer Vincent.

6.2 Grants Business

The Charity agreed funding for nine projects across the trust hospitals in December 2012 which come to a total of £578,000. Examples of projects include one that looks at the ways smartphone applications can provide antimicrobial support to staff prescribing medicines. Another project aims to train 50 healthcare professionals to provide lower-back pain support to patients in hard to reach demographic areas and one project aims to reduce hospital admission by providing older patients with same day diagnosis and a care management plan for delivery into the community.

6.3 Fundraising Business

The opening of the new CT scanner and its scanner room following a donation of £660,000 by Mr and Mrs Williamson will take place on the evening of January 28th 2013 at Charing Cross Hospital's imaging department.

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Appendix A – Clinical Governance Review, feedback from NHS London Chief Executive, December 2012

NHS London

Southside
105 Victoria Street
London SW1E 6QT

www.london.nhs.uk

Tel: 020 7932 3700
Fax: 020 7932 3800

Sent via Email

20 December 2012

Mark Davies
Chief Executive
Imperial College Healthcare NHS Trust
The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

Dear Mark

Clinical Governance Review

Last weeks meeting provided an important opportunity for the Trust, NHS London, NHS North West London and CCGs to consider and discuss key findings from the Clinical Governance Review.

Notes of the meeting will follow, however I wanted to confirm the main outcomes of the meeting and what we see as next steps. In summary, the review identified many positive aspects of the Trust's systems and processes for quality governance as well as highlighting areas where these need to be strengthened. This relates in particular to developing the medical leadership, including more visible involvement in quality governance; building capacity and further embedding systems and processes to promote the quality culture across the organisation and support Board to ward to Board arrangements. Stronger systems are also needed to identify and disseminate learning in a more systematic way, particularly in relation to serious incidents. It is important to also acknowledge that the review identified several examples of good practice that the Trust can build on.

You outlined action already in train and planned. Acknowledging the number of reviews carried out in the last year the aim now is to consolidate action and delivery through an integrated plan. In taking this forward we identified benefits in the Trust and CCGs working more closely together to improve understanding of the impact of initiatives by sharing intelligence and learning from different parts of the system, and to further develop relationships. There was agreement that measures of improved patient experience should be a key indicator of progress and area of focus in the next year.

From NHS London's perspective this review process is now closed and ongoing work with the Trust will be led by CCGs. The one area that I would like to discuss further with you relates to inter hospital transfers, which was also picked up in the review and I will be taking this on with other Medical Directorates providing you are in agreement.

In conclusion, I would like to reiterate our appreciation of the open and transparent way in which you and your staff have engaged in this process and your commitment to act on and learn from findings of reviews that have taken place. I will of course continue to be available to offer support and advice where helpful.

Yours sincerely,

Dr AT Mitchell
Medical Director

Cc: Caroline Alexander, Chief Nurse, NHS London
Dr Anne Rainsberry, Chief Executive, NHS North West London
Dr Mark Spencer, Medical Director, NHS North West London
Jonathan Webster, Director of Nursing, NHS North West London
Simon Weldon, Director of Performance, NHS North West London
Daniel Elkeles, Chief Officer, CWHH, Clinical Commissioning Groups

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TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 4**

Report Title: 2012 Care Quality Commission National A&E Survey Results

To be presented by: Ms Janice Sigsworth, Director of Nursing

Executive Summary: The 2012 National Accident & Emergency Survey results were published by the Care Quality Commission on 6 December 2012. The survey is based on the results from 246 patients that attended Accident & Emergency Departments in March 2012 from 850 patients that were sent questionnaires. This equates to a response rate of 30%.

This is the first National A&E Survey since 2008. The strategic aim for the National A&E Survey was to form the baseline (as it has been a significant time since the last survey). This has now been achieved.

It is not clear at this stage when the next National A&E Survey will take place, but there will be significant focus on A&E patient experience through the Friends & Family test implementation.

The report includes the following:
i) Scoring methodology
ii) Key messages relating to performance.
iii) Comparison to previous performance.
iv) Comparison to peer Trusts (London, Shelford & teaching)
v) Next steps

Key Issues for Discussion:
i) Consider the implications of the Policy guidance.
ii) Consider the options, recommendations and action plan.

Details of Legal Review, if needed: Not required.

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve, improving patient safety and satisfaction.
2. Provide world-leading specialist care in our chosen field.
3. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective: Patient Experience programme

Purpose of Report

a. For Decision √
b. For information/noting ☐

Imperial College Healthcare NHS Trust
CQC National Accident & Emergency Survey
Trust Board on 30 January 2013

1. Background

The 2012 National Accident & Emergency Survey results were published by the Care Quality Commission on 6 December 2012. The survey is based on the results from 246 patients that attended Accident & Emergency Departments in March 2012 from 850 patients that were sent questionnaires. This equates to a response rate of 30%.

This is the first National A&E Survey since 2008. The strategic aim for the National A&E Survey was to form the baseline (as it has been a significant time since the last survey). This has now been achieved.

It is not clear at this stage when the next National A&E Survey will take place, but there will be s significant focus on A&E patient experience through the Friends & Family test implementation.

2. Scoring Methodology

The scoring and reporting method has changed in line with the National Inpatient Survey as follows:

i) There is no longer a Red, Amber and Green rating based on the top 20%, middle 60% and bottom 20%
ii) A funnel plot methodology has been used to calculate questions that are significantly better or worse that the average expected for the number of responses
iii) The score for each question and category is scored out of 10 (rather than 100) and to one decimal point only. This leads to significant bunching of scores and small differences can account for significant variation in benchmarking.

3. Key Messages Relating to Performance

The key messages are as follows:

i) ICHT was amongst the highest performing Trusts for the Leaving A&E section of questions
ii) ICHT performed more poorly than similarly performing organisations on the sections on Travelling by Ambulance and Hospital Ward and Environment
iii) The Trust scores deteriorated since the last survey on Doctors and Nurses Talking over Patients and Waiting Times questions.

4. Comparison to Previous Performance

In comparison to the 2008 National A&E Survey, the performance was as follows:

i) Improvement on 14 questions

ii) Reduction on 7 questions
iii) No change on 3 questions
iv) 13 new questions.

5. Comparison to Other London Trusts

As above, there is significant bunching of scores in the A&E Survey, with most Trusts in London achieving similar levels of performance. ICHT was fourth equal across London, with an average score of 7.53 (the same score as King's and the Homerton. Chelsea & Westminster were the top performing in London, Guy's & St. Thomas' second and Ealing third. The detailed scores are shown in Appendix B.

6. Comparison to Other Shelford Trusts

ICHT performed fifth equal out of the Shelford Trusts included in the benchmarking. University Hospitals Birmingham FT, Newcastle Upon Tyne FT and Cambridge University Hospitals FT were the top performing Shelford Trusts and are grouped together ahead of all other Trusts. The detailed scores are shown in Appendix C.

7. Comparison to Other Teaching trusts

ICHT performed fifth equal out of the 22 Teaching Trusts included in the benchmarking. University Hospitals Bristol was the top performing teaching hospital. The other highest performing teaching hospitals were the top three Shelford Trusts, as well as Royal Devon and Exeter FT and Royal Liverpool and Broadgreen FT. The detailed scores are shown in Appendix D.

8. Next Steps

The proposed next steps are to:

- Review the A&E I track survey in the light of the enclosed results
- Share the results with partner organisations that have a shared responsibility in providing a good A&E experience, such as the London Ambulance Service
- Review Medical & Non Medical Induction to ensure that the key patient experience messages are incorporated, including the importance of not talking over patients
- Consider if there are any modifications to the environment that could be improved to provide a better experience
- Begin to collect the Friends & Family Test in A&E Departments.

APPENDIX A: COMPARISON OF 2012 NATIONAL

No.	2012 ACCIDENT & EMERGENCY SURVEY	Comparison to Previous Survey							
		2008	2012	Difference	Better	Worse	New	No Change	Total
4	How well do you think the ambulance service and A&E staff worked together?		9.1				1		
5	How long did you wait with the ambulance crew before your care was handed over to the A&E staff?		8.5				1		
6	Were you given enough privacy when discussing your condition with the receptionist?	6.1	6.9	0.8	1				
7	How long did you wait before you first spoke to a nurse or doctor?	6.4	6.6	0.2	1				
8	How long did you wait before being examined by a doctor or nurse?	6.1	6.2	0.1	1				
9	Were you told how long you would have to wait to be examined?	4.5	4.1	-0.4		1			
10	Overall, how long did your visit to the A&E Department last?	6.8	6.1	-0.7		1			
11	Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.3	8.5	0.2	1				
12	Did a doctor or nurse explain your condition and treatment in a way you could understand?	8.1	8.1	0				1	
13	Did the doctors and nurses listen to what you had to say?	8.8	8.9	0.1	1				
14	If you had any anxieties or fears about your condition or treatment did a doctor or nurse discuss them with you?	6.6	7.3	0.7	1				
15	Did you have confidence and trust in the doctors and nurses examinining & treating you?	8.4	8.4	0				1	
16	Did doctors or nurses talk in front of you as if you weren't there?	8.7	8.0	-0.7		1			
17	Did your family or someone else close to you have enough opportunity to speak to a doctor?		7.5				1		
18	How much information about your condition or treatment was given to you?	8.8	8.6	-0.2		1			
19	Were you given enough privacy when being examined or treated?	8.9	9.1	0.2	1				
20	If you needed attention, were you able to get a member of medical or nursing staff to help you?		7.6				1		
21	Did a member of staff say one thing and another say something different?	8.6	8.3	-0.3		1			
22	Were you involved as much as you wanted to be in decisions about your care & treatment?	7.7	7.5	-0.2		1			
28	Do you think the hospital staff did everything they could to help control your pain?	6.5	7.6	1.1	1				
29	Did a member of staff explain why you needed these test(s) in a way you could understand?		8.1				1		
30	Before you left the A&E Department, did you get the results of your tests?		7.8				1		
31	Did a member of staff explain the results of the tests in a way you could understand?		8.9				1		
32	In your opinion, how clean was the A&E Department?	7.5	8.0	0.5	1				
30	How clean were the toilets in the A&E Department?	6.9	6.8	-0.1		1			
31	While you were in the A&E Department, did you feel threatened by other patients or visitors?		9.2				1		
32	Were you able to get suitable food or drinks when you were in the A&E Department?		5.8				1		
35	Did a member of staff explain the purpose of the medications you were to take home in a way you could understand?	9.1	9.1	0				1	
36	Did a member of staff tell you about medication side effects to watch for?	4.6	5.4	0.8	1				
37	Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	3.7	6.0	2.3	1				
38	Did hospital staff take your family or home situation into account when you were leaving the A&E Department?		47				1		
39	Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	5.3	6.2	0.9	1				
40	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department?	6.4	7.3	0.9	1				
41	As far as you know, was your GP given all the necessary information about the treatment or advice that you received in the A&E Dept?		9.0				1		
42	Overall, did you feel you were treated with respect and dignity while you were in the A&E Department?	8.5	8.7	0.2	1				
43	Overall... (on a scale from 0-very poor to 10-very good experience)		7.6				1		
44	While in the A&E Department, did you ever see any posters or leaflets explaining how to complain about the care you received?		3.8				1		
	Total				**14**	**7**	**13**	**3**	**37**

APPENDIX B: COMPARISON TO OTHER LONDON TRUSTS

2012 NATIONAL ACCIDENT & EMERGENCY SURVEY - COMPARISON TO OTHER LONDON TRUSTS									
TRUST	**AVERAGE TRUST SCORE**	**Travelling by ambulance**	**Reception & waiting**	**Doctors & nurses**	**Care and treatment**	**Tests**	**Hospital env. & facilities**	**Leaving the A&E**	**Overall Rating**
Chelsea & Westminister NHS FT	7.93	9.20	6.60	8.60	8.50	8.60	8.10	6.80	7.00
Guys & St Thomas' NHS FT	7.59	9.10	6.10	8.30	8.30	8.10	7.70	5.90	7.20
Ealing NHS Trust	7.58	9.10	6.00	8.10	8.10	8.30	7.90	6.30	6.80
Imperial College Healthcare NHS Trust	7.54	8.80	6.00	8.10	8.10	8.30	7.50	6.80	6.70
Kings College NHS FT	7.54	9.10	5.90	8.10	8.20	8.30	7.80	6.20	6.70
Homerton NHS FT	7.54	9.10	5.90	8.20	8.00	8.10	8.00	6.30	6.70
Whittington Hospital NHS Trust	7.51	9.10	6.20	8.00	8.10	8.00	7.80	6.00	6.90
UCLH NHS FT	7.48	8.90	5.90	8.20	8.00	8.50	7.60	6.00	6.70
Barnet & Chase Farm Hospitals NHS Trust	7.46	9.40	5.60	8.00	7.90	8.40	7.80	5.80	6.80
Epsom & St Helier NHS Trust	7.45	9.10	5.70	8.20	8.10	8.40	7.60	6.00	6.50
Whipps Cross NHS Trust	7.44	9.20	5.60	8.00	8.00	8.10	7.60	6.30	6.70
Royal Free London NHS Trust	7.40	8.90	6.10	8.10	8.00	7.70	7.60	6.10	6.70
St Georges' Healthcare NHS Trust	7.36	9.00	5.40	8.20	8.10	8.40	7.40	6.10	6.30
South London NHS Trust	7.14	9.30	5.50	7.80	7.70	8.00	7.20	5.50	6.10
North Middlesex NHS Trust	7.14	8.80	5.70	7.70	7.60	8.00	7.10	5.90	6.30
North West London NHS Trust	7.14	8.80	5.70	7.70	7.60	8.00	7.10	5.90	6.30
West Middlesex NHS Trust	7.11	8.80	5.70	7.70	7.50	8.40	7.20	5.30	6.30
Hillingdon Hospitals NHS FT	7.10	9.20	5.60	7.50	7.40	7.90	7.40	5.70	6.10
Kingston NHS Trust	7.05	9.00	5.10	7.70	7.60	8.20	7.40	5.00	6.40
Croydon NHS Trust	7.04	8.60	5.00	7.70	7.70	8.20	7.30	5.50	6.30
Newham NHS Trust	6.98	8.70	5.50	7.60	7.60	7.60	7.20	5.40	6.20
Lewisham NHS Trust	6.96	8.50	5.70	7.70	7.50	7.30	6.90	5.80	6.30
Barking, Havering & Redbridge NHS Trust	6.86	8.70	5.20	7.30	7.40	7.70	7.40	5.30	5.90

Bart's & the London could not be rated as data was missing.

Leeds Teaching Hospitals could not be rated as data was missing.

APPENDIX C: COMPARISON TO OTHER SHELFORD TRUSTS

2012 NATIONAL ACCIDENT & EMERGENCY SURVEY - COMPARISON TO SHELFORD TRUSTS									
TRUST	**AVERAGE TRUST SCORE**	**Travelling by ambulance**	**Reception & waiting**	**Doctors & nurses**	**Care and treatment**	**Tests**	**Hospital env. & facilities**	**Leaving the A&E**	**Overall Rating**
University Hospitals Birmingham NHS FT	7.91	9.60	5.90	8.50	8.40	8.70	8.70	6.40	7.10
Newcastle Upon Hospitals Tyne NHS FT	7.89	9.40	6.30	8.20	8.50	8.60	8.50	6.50	7.10
Cambridge University Hospitals NHS FT	7.81	9.00	6.20	8.50	8.40	8.10	8.50	6.80	7.00
Guys & St Thomas' NHS FT	7.59	9.10	6.10	8.30	8.30	8.10	7.70	5.90	7.20
Imperial College Healthcare NHS Trust	7.54	8.80	6.00	8.10	8.10	8.30	7.50	6.80	6.70
Kings College NHS FT	7.54	9.10	5.90	8.10	8.20	8.30	7.80	6.20	6.70
Sheffield Teaching NHS FT	7.51	9.20	6.20	8.00	8.00	8.10	8.00	5.90	6.70
UCLH NHS FT	7.48	8.90	5.90	8.20	8.00	8.50	7.60	6.00	6.70
Oxford University Hospitals NHS Trust	7.43	9.00	5.90	8.00	8.00	8.10	8.40	5.60	6.40
Central Manchester NHS FT	7.23	8.90	5.80	7.90	7.70	7.90	6.90	6.10	6.60

APPENDIX D: COMPARISON TO OTHER TEACHING TRUSTS

2012 NATIONAL ACCIDENT & EMERGENCY SURVEY - COMPARISON TO OTHER TEACHING TRUSTS									
TRUST	**AVERAGE TRUST SCORE**	**Travelling by ambulance**	**Reception & waiting**	**Doctors & nurses**	**Care and treatment**	**Tests**	**Hospital env. & facilities**	**Leaving the A&E**	**Overall Rating**
University Hospitals Bristol NHS FT	**7.98**	**9.00**	6.40	8.60	8.60	8.60	8.50	6.90	7.20
University Hospitals Birmingham NHS FT	**7.91**	9.60	5.90	8.50	8.40	8.70	8.70	6.40	7.10
Newcastle Upon Hospitals Tyne NHS FT	**7.89**	9.40	6.30	8.20	8.50	8.60	8.50	6.50	7.10
Royal Devon & Exeter NHS FT	7.84	**9.50**	6.20	8.20	8.30	8.40	8.40	6.80	6.90
Cambridge University Hospitals NHS FT	**7.81**	**9.00**	6.20	8.50	8.40	8.10	8.50	6.80	7.00
Royal Liverpool & Broadgreen NHS Trust	**7.78**	9.40	6.30	8.20	8.40	8.50	7.60	6.70	7.10
Guys & St Thomas' NHS FT	7.59	9.10	6.10	8.30	8.30	8.10	7.70	5.90	7.20
Imperial College Healthcare NHS Trust	**7.54**	8.80	6.00	**8.10**	**8.10**	**8.30**	**7.50**	**6.80**	**6.70**
Kings College NHS FT	**7.54**	9.10	5.90	8.10	8.20	8.30	7.80	6.20	6.70
Sheffield Teaching NHS FT	**7.51**	9.20	6.20	8.00	8.00	8.10	8.00	5.90	6.70
University Hospital of Southampton NHS FT	**7.51**	**8.90**	6.00	7.90	8.00	8.50	8.10	6.20	6.50
UCLH NHS FT	**7.48**	8.90	5.90	8.20	8.00	8.50	7.60	6.00	6.70
Oxford University Hospitals NHS Trust	**7.43**	9.00	5.90	8.00	8.00	8.10	8.40	5.60	6.40
Nottingham University Hospitals NHS Trust	**7.41**	**9.20**	6.10	7.80	8.00	8.30	7.90	5.30	6.70
Royal Free London NHS Trust	7.40	8.90	6.10	8.10	8.00	7.70	7.60	6.10	6.70
University Hospitals South Manchester NHS FT	**7.38**	**9.10**	5.90	8.10	7.90	7.50	7.70	6.10	6.70
St Georges' Healthcare NHS Trust	**7.36**	9.00	5.40	8.20	8.10	8.40	7.40	6.10	6.30
Norfolk & Norwich NHS FT	**7.30**	8.30	5.70	7.70	7.80	8.10	8.10	6.40	6.30
Central Manchester NHS FT	**7.23**	8.90	5.80	7.90	7.70	7.90	6.90	6.10	6.60

Bart's & the London could not be rated as data was missing.

Leeds Teaching Hospitals could not be rated as data was missing.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 5**

Report Title: Update on Friends & Family Test (FFT) Implementation

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary: On 25 May 2012 the Prime Minister announced the introduction of the Friends and Family Test (FFT) with the aim of improving patient care and highlighting best performing hospitals in England. From 1 April 2013, Standard NHS Contracts will include a requirement for FFT to be included by providers of all NHS funded acute inpatient services and A&E departments.

Following publication of the initial guidance, a paper was presented to the Management Board on 20 November 2012. Since the Management Board, further details have emerged. The final guidance had been expected in December 2012, but this has been significantly delayed and is now due to be published in February 2013.

The paper includes the following:

i) Policy context
ii) Questions to be implemented
iii) Scope of the FFT
iv) Implementation requirements
v) Planned Implementation Approach
vi) Action plan.

Key Issues for Discussion:

i) Consider the implications of the Policy guidance
ii) Consider the approach and action plan.

Details of Legal Review, if needed: Not required.

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve, improving patient safety and satisfaction.
2. Provide world-leading specialist care in our chosen field.
3. Achieve outstanding results in all our activities.

Assurance or management of risks associate with meeting key objective: Planned implementation approach, monthly reporting

Imperial College Healthcare NHS Trust
Friends & Family Test Implementation
Trust Board on 30 January 2013

1. Background

On 25 May 2012 the Prime Minister announced the introduction of the Friends and Family Test (FFT) with the aim of improving patient care and highlighting best performing hospitals in England. From 1 April 2013 Standard NHS Contracts will include a requirement for FFT to be included by providers of all NHS funded acute inpatient services and A&E departments.

Following publication of the initial guidance, a paper was presented to the Management Board on 20 November 2012. Since the Management Board, further details have emerged; the FFT Unify Reporting Guidance has been published; the letter from Sir David Nicholson has been circulated to all Trusts and NHS London has been co-ordinating weekly conference calls. The final guidance had been expected in December 2012, but this has been significantly delayed and is now due to be published in February 2013.

This paper provides an updated implementation plan.

2. Policy Context

The implementation of the Friends & Family Test is going to be very high profile. This has been evident since the publication of the guidance and is re-enforced in the correspondence from Sir David Nicholson. The NHS Commissioning Board will be supporting the implementation of the Policy and NHS Development Authority will be tracking implementation progress.

The FFT will be incentivised through a National CQUIN. The value of the CQUIN has not yet been confirmed. It is likely that this may be in three parts:

i) Implementation of FFT
ii) Improvements in FFT
iii) Performance in the staff rating of FFT.

3. Questions to be Implemented

As in the previous presentation to the Management Board, the following question and responses have been specified in the guidance: *How likely are you to recommend our ward / Accident & Emergency Department to friends and family if they needed similar care or treatment?*

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Extremely unlikely
- Don’t know

The scoring of the responses is expected to be included in the 21 January guidance.

4. Scope of the FFT

The scope for FFT continues to be all inpatient areas (excluding day cases, maternity and paediatrics). FFT is to be extended to maternity in October 2013 and other services thereafter (details have not yet been confirmed).

5. Implementation Requirements

As above, it is mandated that the Trust adheres strictly to the following guidance:

i) The standard question and responses are used for both Inpatients and A&E
ii) The question must be asked first on the survey
iii) The question is preceded by the standard framing text
iv) The test includes a follow-up question to determine the reason for the rating
v) All patients should be asked if they would like to take part
vi) The required response rate is 15% (but it is anticipated that in areas it will be much higher)
vii) The method must enable reporting at ward level
viii) The method should include the capture of demographic information
ix) Patients should be surveyed on the day of discharge or within 48 hours of discharge
x) The method should allow for the question to be transferred into different languages.

6. Planned Implementation Approach

The options for implementation have been explored and the intention is to add a specific FFT mini – survey into I track. The aim is that this will meet all aspects of the guidance whilst enabling fully automated reporting.

7. FFT Action Plan

	Action	**Deadline**	**Lead**
i)	Include FFT as a stand-alone question / survey	22 January	HoPM
ii)	Begin collection of FFT question.	23 January	CPG HoNs
iii)	Add in language options.	31 January	HoPM
iv)	Add in free text option.	31 January	HoPM
v)	Establish FFT Task & Finish Group.	21 January	HoPM
vi)	Establish FFT Communications Plan.	21 January	Comms. Team
vii)	Confirm compliance with reporting requirements.	21 January	HoI
viii)	Begin monthly reporting of FFT.	1 February 2013	HoI
ix)	Implementation of Communications Plan.	As per plan	HoM
x)	Convert FFT Scoring Reasons to pick-list.	1 March 2013	HoPM
xi)	Identify areas with implementation risks.	1 March 2013	HoPM / CPGs

HoPM - Head of Performance Management
CPG HoNs – CPG Heads of Nursing
HoI – Head of Information
HoM – Head of Marketing

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 6**

Report Title: Care Quality Commission Inspections at Imperial College Healthcare NHS Trust

To be presented by: Ms Janice Sigsworth, Director of Nursing

Executive Summary:

The Care Quality Commission (CQC) has now visited all of the Trust main sites and two renal satellite units. All of the sites inspected were found to be compliant with the Essential Standards of Quality and Safety, in line with the Trust's own compliance submission. There are no outstanding actions. The outcomes of a number of these inspections have been previously reported to the Board as part of the quarterly Patient Safety and Service Quality Report from the Governance Department. Below is a list of the outcomes inspected per site.

Reports of the inspections are included in the supporting papers file.

St. Mary's Hospital

In response to an increasing number of never events reported, CQC visited St. Mary's Hospital in May 2012. They inspected against Outcome 4: care and welfare of people who use services; outcome 14: supporting staff and outcome 16: assessing and monitoring the quality of service provision. CQC were satisfied with the measures that had been put in place to strengthen the swab count procedure through the implementation of new policies, processes and training. They acknowledged that this work was ongoing but that the Trust was alerted to this and was monitoring their own progress through action plans and audit programmes.

Charing Cross Hospital

A planned inspection was conducted as part of the follow up to the National Dignity and Nutrition work in August 2012. They inspected against outcome 1: respecting and involving people who use services; outcome 5: food and nutrition; outcome 7: safeguarding; outcome 13: staffing and outcome 21: records. CQC reported that patients were happy with the care they had received and felt they treated with dignity and respect by staff. They noted that staff were seen to be interacting positively with patients and provided assistance to those that required it. Staff were knowledgeable on safeguarding matters and confident in how they would address safeguarding concerns.

Western Eye Hospital

A planned inspection was conducted in October 2012. They inspected against outcome 1: respecting and involving people who use services; outcome 4: care and welfare of people who use services; outcome 6: cooperating with other providers; outcome 8: cleanliness and infection control; outcome 14: supporting staff and outcome 16: assessing and monitoring the quality of service provision. CQC highlighted the positive patient feedback they received, with patients reporting that staff were professional, they felt they were well informed and that the hospital was clean. CQC noted some operational issues with patients having to stand in the A&E waiting area and not always receiving accurate information re: waiting times. These areas are currently being reviewed by the Trust and some improvements have already been made.

Hammersmith Hospitals

A planned inspection was conducted in November 2012. They inspected against outcome 2: Consent to care and treatment; outcome; outcome 4: care and welfare of people who use

services; outcome 11: safety, availability and suitability of equipment; outcome 13: Staffing and outcome 21: records. The inspection report concluded that patients generally had a positive experience at the hospital. CQC did note that some patients did not enjoy the food and that they were sometimes moved between wards, which they found unsettling. Overall patients were positive about their experience and felt they were well informed about all surgical procedures they had. CQC reported that the Trust had clear processes for assessing people's capacity to consent and how to support them if they needed it.

Queen Charlotte's and Chelsea Hospital

A planned inspection was conducted in December 2012. They inspected against outcome 4: care and welfare of people who use services; outcome 8: cleanliness and infection control; outcome 13: staffing and outcome 16: assessing and monitoring the quality of service provision. CQC quoted several positive patient comments in the report, confirming that patients found staff to be supportive, were happy with the care they received and found the environment to be clean. CQC followed up on concerns from a previous responsive inspection conducted in December 2011 and were satisfied with the improvements that had been made. These included staff recruitment and increased staff morale.

St. Charles & Hammersmith Renal Centres

Although registered as two locations, both locations were inspected at the same time in January 2013 and a joint report has been published. They inspected against outcome 1: respecting and involving people who use the services; outcome 4: care and welfare of people who use services; outcome 8: cleanliness and infection control; outcome 13: staffing and outcome 17: complaints. The report highlights the positive patient experience with patient's giving examples of how they felt involved in their own care and how clean the environment was. Staff were knowledgeable about infection prevention and control.

Key Issues for discussion:

To note the positive outcomes for all of the inspections over the past year, the continued need to sustain this and the ongoing need for participation in the Leadership Walkarounds.

Legal Implications or Review Needed

a. Yes ☐
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities

Assurance or management of risks associated with meeting key objective: risk management processes and external assurance on standards

Purpose of Report

a. For Decision ☐
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 7**

Report Title: Monthly Infection Prevention Summary

To be presented by: Professor Alison Holmes, Director of Infection and Prevention Control

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Executive Summary: This report includes the Trust's monthly mandatory reports of HCAI for December 2012.

It includes an update on selected activities and indicators and it highlights local infection prevention and patient safety issues.

Key Issues for discussion:

- There were no Trust-attributable MRSA blood stream infections (BSI) in December, the total number YTD is four. The annual set objective is nine
- There were seven cases of *C.difficile* in December, the total YTD is 66. The annual set objective is 110
- The Trust is below YTD thresholds for both MRSA BSI and *C. difficile*
- Norovirus activity

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction

Assurance or management of risks associated with meeting key objective: Infection prevention and control as a core aspect of patient safety, hospital management and excellence in clinical care. The ongoing programme of infection prevention and control.

Purpose of Report

a. For Decision ☐
b. For information/noting √

Monthly Infection Prevention and Control Summary

January 2013
(December data)

Key Indicators

December 2012

	Month 12: December			CPG						
	Threshold	Trust		1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	0	0		0	0	0	0	0	0	0
MSSA BSI (>48hrs)	0	6		4	0	1	1	0	0	0
Clostridium difficile (>72 hrs)	9	7		4	0	1	2	0	0	0
Hand hygiene compliance	100	98%		98%	98%	97%	99%	98%	96%	100%

Year to Date 2012/13

	YTD 2012/13				CPG											
	Threshold		Cases													
	Year	YTD	Trust		1		2		3		4		5		6		PPs	
MRSA BSI (>48hrs)	9	7	4		2		0		0		2		0		0		0	
MSSA BSI (>48hrs)	0	0	29		6		4		6		5		5		1		2	
Clostridium difficile (>72 hrs)	110	83	66		34		6		8		13		5		0		0	
Hand hygiene compliance	100%	100%	98%		98%		98%		97%		98%		97%		97%		99%	

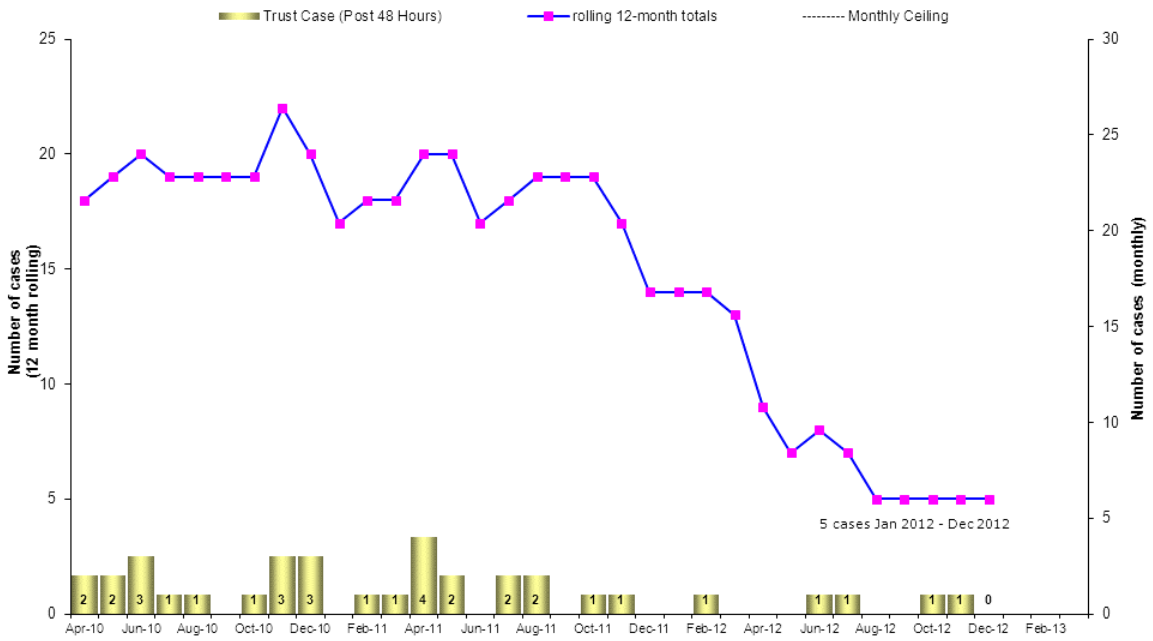
n/a = Not applicable

1. Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

For 2012/13 our 'MRSA objective' has been set at nine Trust-attributable cases of MRSA BSI. In December there were zero Trust acquired MRSA BSI cases reported. Year to date we have reported four Trust-attributable cases; the first associated with a temporary vascular access device for dialysis, the second related to biliary tract interventions and the third related to thoracic intervention for the management of a pleural effusion. The source of infection for the fourth case could not be determined.

Update on key elements of the MRSA BSI prevention action plan:
The plan is underpinned by professional and personal accountability for all groups of staff through Clinical Programme Groups (CPGs) and by the promotion of local ownership at CPG, ward and unit level supported by information provision, communications and detailed RCA investigations.

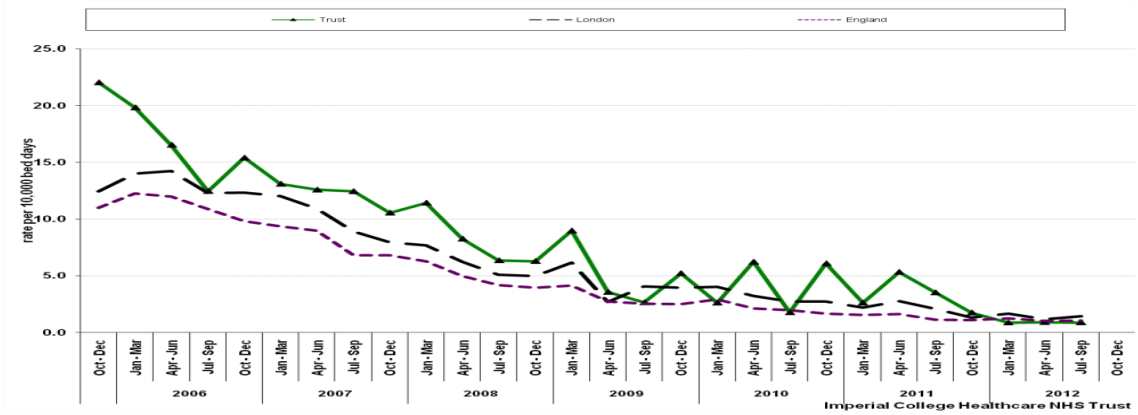
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



Benchmarking Trust-attributable MRSA BSI rates

Provisional data presented by the Health Protection Agency (HPA) in figure 2 shows that the Trust had a quarterly rate of 0.88 per 100,000 bed compared to a regional rate of 1.39 and national rate of 1.02.

Figure 2: Trend in the Trust-attributable MRSA BSI rate compared to the national & London Region rates (rate/100,000 bed days)

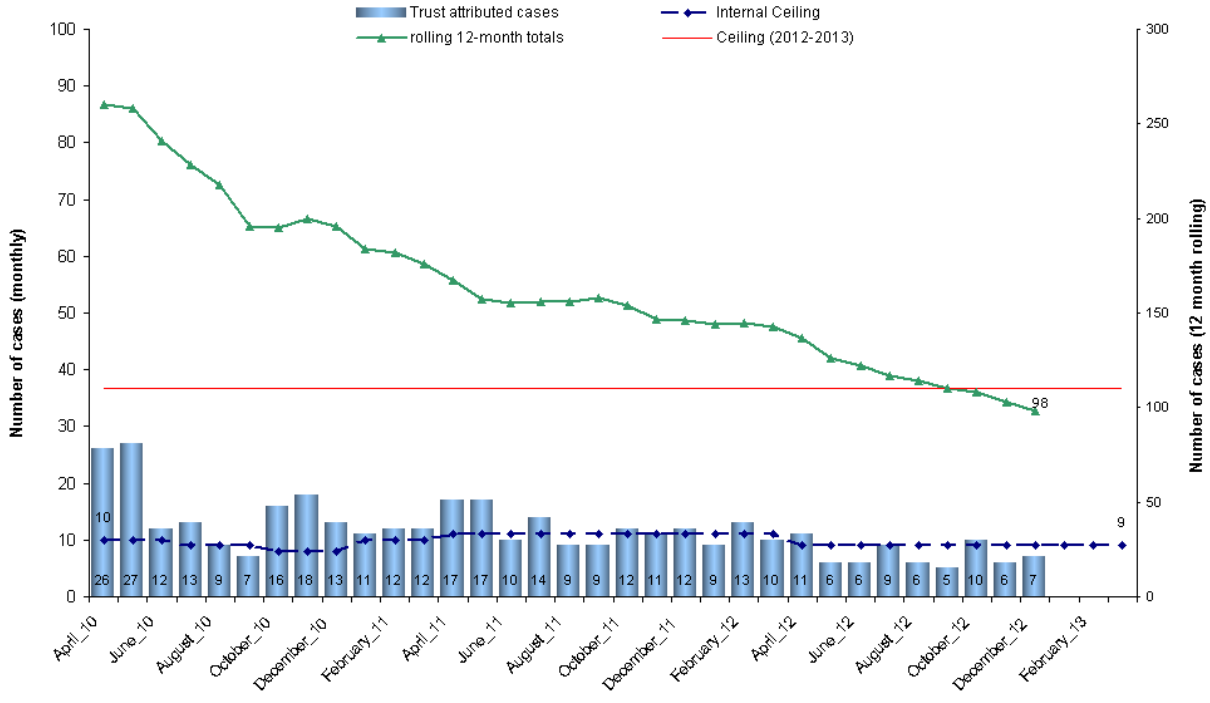


Source: HPA Trust reports Nov 2012

2. *Clostridium difficile* infections

For 2012/13, the Department of Health (DH) annual ceiling for the Trust is 110 cases of *C. difficile* infection (CDI). Year to date there have been 66. In December, 13 cases of CDI were reported to the HPA of which seven cases were Trust attributable.

Figure 3: Trust attributable C.*difficile* infections and 12 month rolling total April 2010 – March 2013



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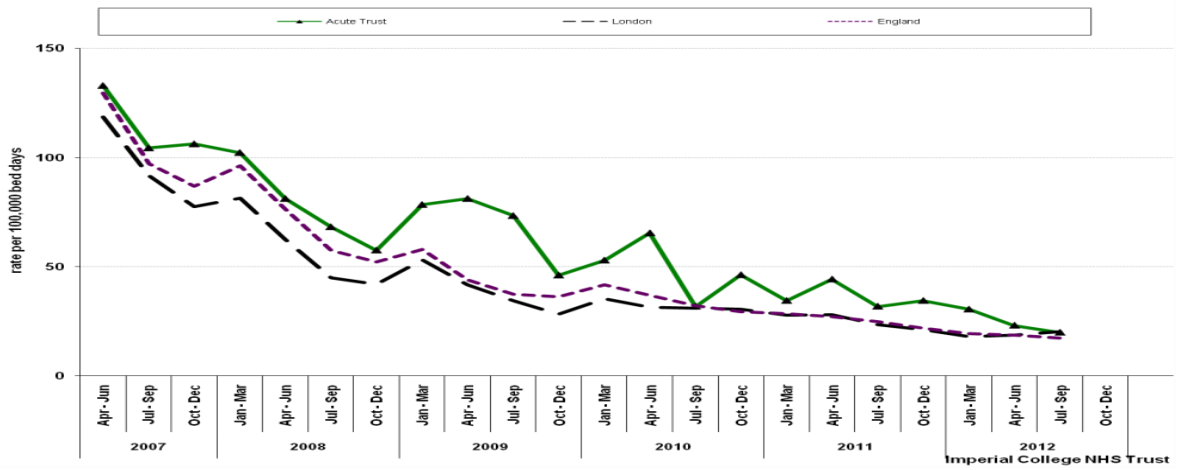
Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by the HPA in figure 4 shows that the Trust had a quarterly rate of 19.9 per 100,000 bed days compared to a regional rate of 20.2 and national rate of 17.4.

Figure 4: Trend in Trust-attributable CDI rate compared to national & regional rate (in 100,000 bed days)



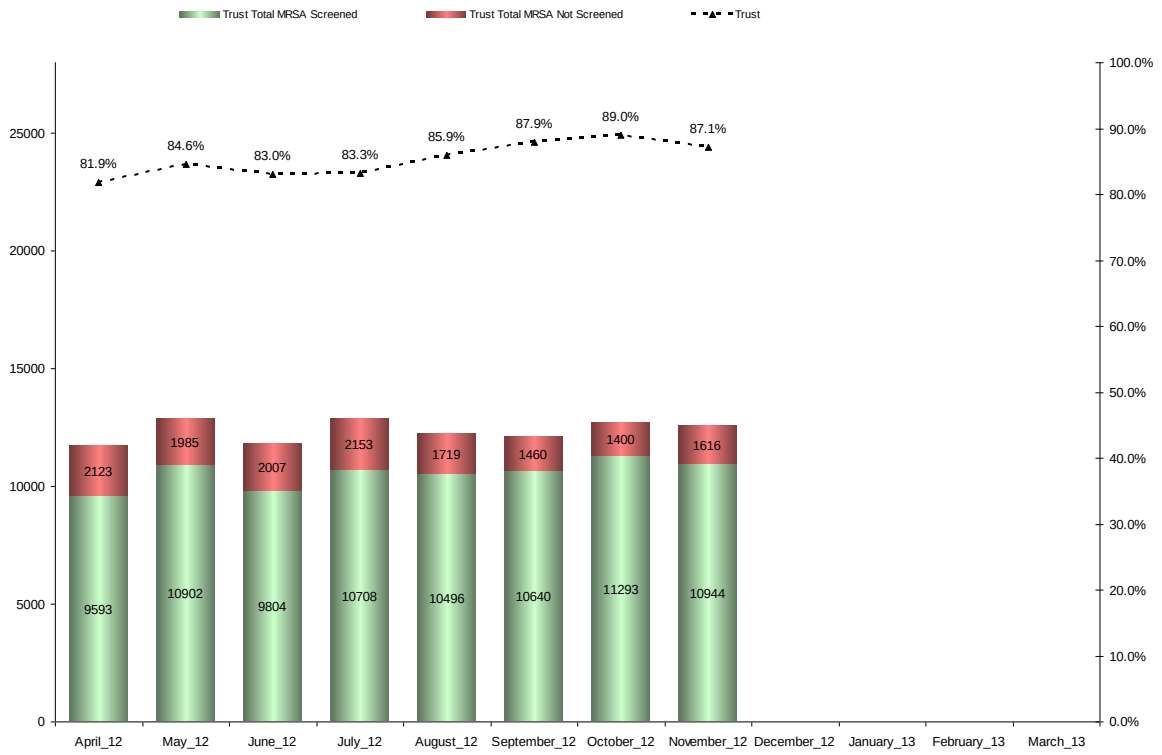
Source: HPA Trust reports Novemeber 2012

3. MRSA Screening

The Trust remains compliant with the DH population screening requirements. Analysis at an individual patient level in November identified 12,560 patients admitted who required screening of which 10,944 (87.1%) were screened.

There has been a steady increase in screening rates since the start of this financial year, consistently above 82 percent.

Figure 5: Trust MRSA screen percentage (individual patient level)



4. Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

Figure 6a: Monthly MSSA BSI cases

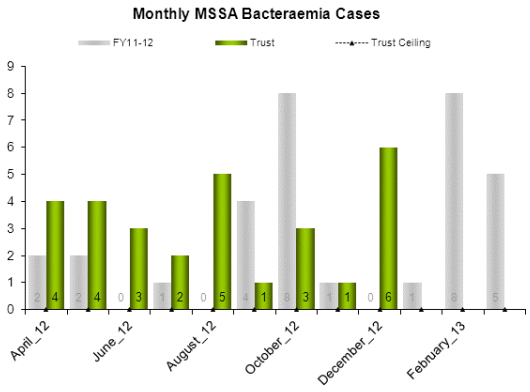
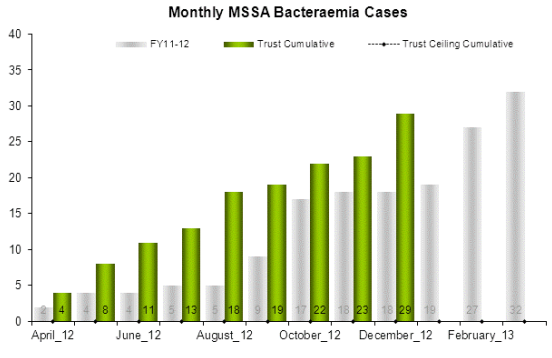


Figure 6b: Cumulative MSSA BSI cases



There is no threshold for this indicator at present. There were 15 cases of MSSA BSI reported to the HPA in December 2012, of which 6 were Trust attributable and 9 were non-Trust attributable. Of the Trust attributed cases reported, three occurred at Charing Cross Hospital, in three separate wards, and three at Hammersmith Hospital.

5. *Escherichia coli (E. coli)* BSI

Mandatory surveillance of *E. coli* bloodstream infections commenced in June 2011.

There is no threshold for this indicator at present. There were 16 cases of *E. coli* BSI reported to the HPA in December 2012, of which three were Trust attributable cases (i.e. post 48 hours of admission), one case at Hammersmith hospital, two cases at Charing Cross hospital and 13 non-Trust attributable cases.

Figure 7a: Monthly Trust-acquired *E. coli* BSI cases

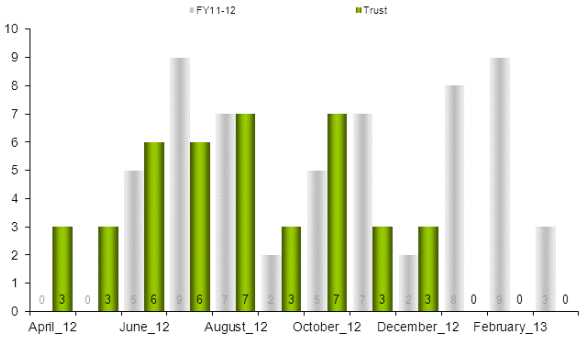
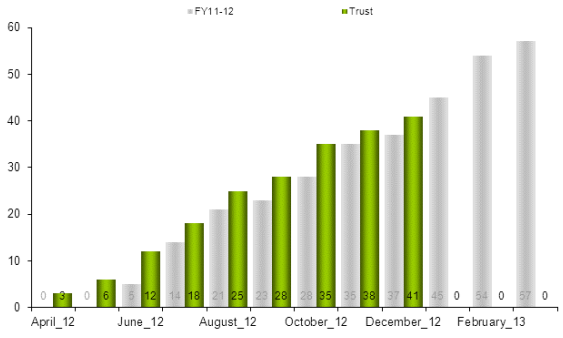


Figure 7b: Cumulative Trust-acquired *E. coli* BSI cases



6. Monitoring contaminated blood cultures

Blood culture contaminants are related to the technique in obtaining the sample. They give rise to significant unnecessary processing in the laboratory as well as to unnecessary antibiotic prescribing. In December, 3552 blood cultures were taken in the Trust, 333 grew an organism, in 81 of these it was considered to be a contaminant from a surveillance perspective. Therefore the percentage of total blood cultures contaminated was 2 percent (total of positive blood cultures contaminated was 28.8 percent). It is recommended that no more than 3 percent of blood cultures should be contaminated.

The rate of contamination of blood cultures specimens has been estimated from microbiology laboratory data using standard methods, by counting the number of sets of cultures in which skin micro-organisms have been identified in one or more bottles. For the month of November 2012 the microbiology registrars collected clinical data on every positive blood culture across the Trust and recorded a judgement for each as to whether it was clinically significant or not clinically significant (potential contaminant). Overall, the proportion of contaminated blood cultures was 2.5 percent (66/2641). The clinical areas with the greatest numbers were particularly in the A and E's. These clinical areas will now be the focus of interventions to improve the quality of blood cultures taken. Blood culture contaminants will be monitored through the Vascular Access Group.

7. Aseptic non Touch Technique (ANTT)

The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at CPG level as part of the infection prevention plan, with all junior medical staff and trainers being assessed by the vascular access team.

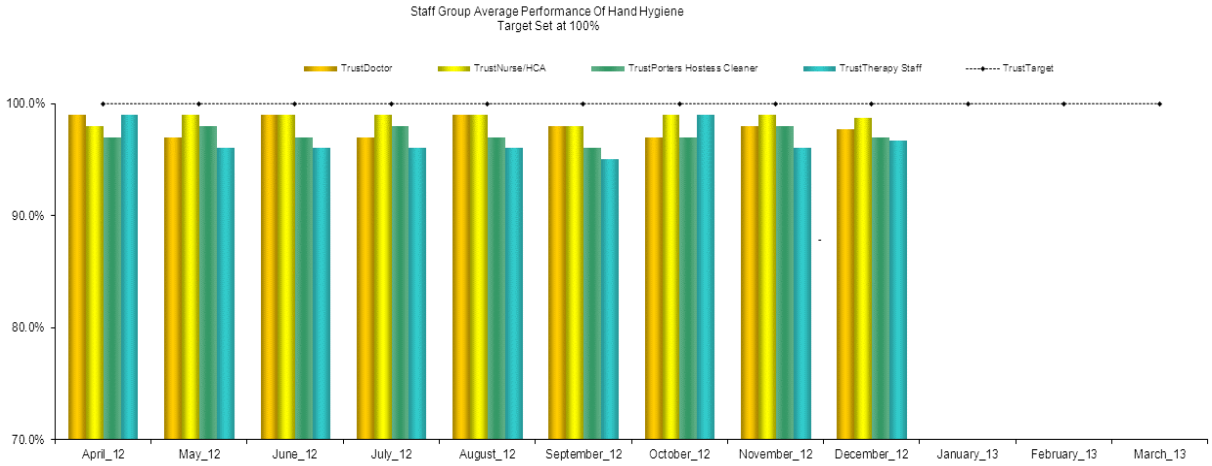
The number of assessments carried out per month has gradually plateaued, there is a refocus with individual CPG's to ensure that all staff assessed are entered onto the OLM system to support accurate monitoring of staff trained. Training is supported by information on how to arrange competency assessments and a DVD on ANTT is on *The Source.*

8. Hand hygiene compliance

In December, 85.7 per cent of clinical areas submitted a total of 5980 observations.

Hand hygiene compliance (as measured by the current Trust audit procedures based on a minimum of ten observations per ward) was 98.3 percent, and compliance with bare below elbows was 98.5 per cent.

Figure 8: Staff group average performance of hand hygiene practice



9. Other matters

9.1 Norovirus

An outbreak of confirmed norovirus occurred at Charing Cross hospital which led to two ward closures in January. This affected both patients and staff and resulted in two wards being closed to admissions and transfers until symptoms had resolved. The outbreak was recognised promptly and infection prevention and control measures implemented rapidly to control and limit the outbreak. All patients were managed appropriately and symptoms resolved as expected. Affected staff were excluded from work for 48 hours following the resolution of their symptoms as per Trust policy. The outbreak was reported to the Health Protection Agency via the norovirus outbreak in hospitals reporting scheme.

9.2 Pertussis

A lookback exercise has taken place following the diagnosis of a child with pertussis in December 2012. This identified one patient who had been in contact with the child who has been followed up by the Health Protection Unit. Healthcare staff that had contact with this patient have been followed up by Occupational Health and their immunity assessed.

9.3 Tuberculosis lookback

The mother of a baby born at another hospital but transferred to the Trust post delivery was diagnosed with miliary tuberculosis in November 2012. The mother had visited her baby whilst he/she was an inpatient during November. The IPC team in liaison with the NW London Health Protection Unit, TB and neonatal teams undertook a risk assessment and investigated potential contacts that had had close contact with the mother during her visits to the unit. National experts have advised that the risk of transmission is low but that screening processes will be offered to those identified as being in contact and are being followed up appropriately.

9.4 CQC inspections

The CQC carried out an unannounced visit to the Queen Charlottes and Chelsea hospital site on the 13th December 2012. The purpose of this visit was to assess the Trusts compliance against four standards including cleanliness and infection control. An initial report has been sent to the Trust stating that they were meeting all four standards. They found that people were cared for in a clean, hygienic environment and were protected from the risk of infection because appropriate guidance had been followed.

9.5 Integrating Infection Services

Following the external review of the infection services in April 2012 by the Royal College of Pathologists (commissioned by the Medical Director), Professor Alison Holmes was asked to lead on the development and implementation of the restructure of Infection services through a merger of Medical Microbiology, Virology, Infectious Diseases and Infection Prevention and Control. Following the Management Board in December 2012 it was agreed that the integration should be implemented with a new integrated services model in a combined directorate led by Alison Holmes, reporting to the Chief Operating Officer. This model will be able to adapt to the changing landscape of the Trust and the AHSC.

9.6 Innovation and Applied Research Initiatives

Health Foundation Shared Purpose Update 'Workforce analysis for Safer Care'

The six-month setup phase for the programme is complete and the two-year implementation phase commenced in Jan 2013. During the setup phase, data workshops were held with ICU and PICU, an epidemiologist/health economist was recruited to the project and meetings were held with key stakeholders from within the Trust and external partner organisations.

Over the next six months, the plan is to recruit the statistician and data analyst, access and collate data for the project and undertake the statistical analysis to inform the development of a toolkit. Qualitative work will involve exploring staff perceptions' of risk and safety in relation to staffing levels, skill mix and clinical scenarios.

CIPM Annual Scientific Research Meeting

The UKCRC funded National Centre for Infection Prevention and Management's 3rd Annual Scientific Research Meeting will take place on 3 July 2013 at the Hammersmith Campus and will showcase the work of the Centre and its collaborators.

Innovations for Tackling Antibiotic Resistance

CIPM was invited to the Sanford School of Public Policy, Duke University; Program on Global Health and Technology Access, to discuss 'Finding Breakthrough Innovations for Tackling Antibiotic Resistance'. Esmita Charani and Dr. Eimear Brannigan attended, leading sessions on optimising infection prevention and control and antimicrobial prescribing behaviours

Health Foundation Spotlight Award

In December a team from Imperial and University of Leicester were awarded a grant from the Health Foundation to conduct a Spotlight report on Healthcare-Associated Infections. The report will bring together evidence from a range of sources on a particular topic to positively illustrate how practice in the UK could be improved.

The Foreign and Commonwealth Office's Global Partnership Fund, Singapore and CIPM

The Institute of Infectious Diseases & Epidemiology, Tan Tock Seng Hospital won a grant as a "UK-Southeast Asia Partners in Science Collaboration Award" to develop collaborations with CIPM. This was awarded by the British High Commission, Singapore from the Foreign and Commonwealth Office's Global Partnership Fund. The purpose of the grant is to enable researchers to spend time with potential partner institutions to gain an in-depth understanding of their research and formulate proposals for collaborative research, which can then be put to funding bodies. Leads from Singapore will be visiting CIPM from 31st January - 1st February 2013.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 8**

Report Title: Care Quality Commission Clinical Alert: Perinatal Conditions

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary:
The Trust was notified by the Care Quality Commission that its performance in regard to neonatal mortality appeared to be higher than expected.

An initial external data review was completed, including cases analysis. The review highlighted the important of comparing the Trust service with relevant clinical comparators, such as those which provide specialist services to high risk populations, to ensure accuracy in benchmarking of outcomes.

The neonatal unit has been involved for a number of years in an international benchmarking network with other large neonatal units, and compares favourably in terms of outcomes within this specialist group.

The accuracy of Trust coding in this patient group was also highlighted as an area in need of focus.

A further detailed review of this year's activity has been commissioned and results will be presented at the meeting of the Board.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective: Assurance on accuracy of clinical outcome data

Purpose of Report

a. For Decision ☐

b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 9**

Report Title: Performance Report – Month 9

To be presented by: Mr. Steve McManus, Chief Operating Officer

Executive Summary:

This report for the Trust Board summarises the Trust's Performance against key indicators. Accompanying this report is the Month 9 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.

In December 2012 the Trust achieved good performance in:
- National 18 week referral to treatment waiting time target for admitted, non-admitted patients and patients on incomplete pathways.
- Maintaining year to date position of having zero mixed sex accommodation breaches.
- Achieving above target for providing national care standards for stroke and maternity patients.
- Achieving venous thromboembolism assessment rates.
- Achieving the national diagnostics waiting time target.
- Sustained good scores for patient feedback.
- Maintained position below the maximum trajectory for MRSA and Clostridium Difficile cases.

Areas identified as underperforming are:
- The A&E 4 hour wait for type 1 monthly performance in December was 93.5%, against the 95% target however for all types performance was 96.8% against the 95% target.
- The Trust maintained achievement of 5 out of the 8 national Cancer targets for November (Cancer targets reported one month in arrears).

Against the Department of Health 2012-13 Acute Trust Performance Framework The Trust continued to be defined as 'performing'. Against the Monitor Compliance Framework for December the Trust is 'amber-green' (1.7) compared with 'amber-red' (2) in November.

The Performance scorecard is included in the supporting papers file.

Key Issues for discussion:
To note the performance in month 9.

Legal Implications or Review Needed

a.	Yes	☐
b.	No	√

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective: Performance monitoring framework

Purpose of Report

a. For Decision ☐
b. For information/noting √

Executive Performance Report

Imperial College Healthcare NHS Trust

Month 9:December 2012 | **Paper:**

Quality	
Mortality The Trust continues to have one of the lowest mortality rates in England, based upon the Hospital Standardised Mortality Rate and Standardised Hospital Mortality Indicator.	**Scorecard Page 3**
Patient Experience The Trust continued to receive positive feedback. Patient experience results and improvement plans at ward level are discussed in detail during the monthly Clinical Programme Group Performance Reviews and progress is monitored by the Trust's Patient Experience Team.	**Scorecard Page 4**
Infection & Prevention Control For 2012/13 the Trust MRSA objective set by the Department of Health is a maximum of 9 Trust attributable cases in a year. MRSA incidents are escalated to the most senior management level in the Trust and are treated as a priority by the Infection Control and Prevention team. No cases of Trust acquired MRSA infection were reported in December, the year to date total remains at 4 cases, compared with 12 cases being reported at the same time last year 2011/12. The Trust remains within its trajectory to stay below the maximum 9 MRSA cases for the year. For Clostridium Difficile there were 7 cases reported in December 2012 bringing the year to date total to 66. The Trust remains within its trajectory to stay below the maximum 110 cases for the year.	**Scorecard Page 5**
Eliminating Mixed Sex Accommodation (EMSA) In December the Trust sustained its year to date achievement of zero mixed sex accommodation breaches.	**Scorecard Page 6**
Stroke Care The Trust achieved above both national stroke care targets in December 2012. This performance has been sustained since the beginning of the financial year and the Trust expects this to be maintained.	**Scorecard Page 7**
Venous Thromboembolism The Trust achieved above the target of 90% for the 9th consecutive month, achieving a score of 90.2% in December 2012. The Trust expects to sustain this performance.	**Scorecard Page 8**
Research and Development The quarter two results reported by the Joint Research Office show enrolment of patients onto clinical trials increased 11% from the same period last year. This is significantly above the initial target of a 1% increase set by the Trust at the beginning of the year.	**Scorecard Page 9**
Safety Thermometer The Trust continues to perform extremely well against peers and has one of the best rates of Harm Free care in comparison to the Shelford Group with 96.2% of patients reported as 'harm free' in December.	**Scorecard Page 10**
Operations	
Accident & Emergency - 4 Hour maximum waiting time	

The 4 hour maximum waiting time in Accident and Emergency for the 'type 1' was 94.3% below the 95% target, with Charing Cross Hospital below target at 90.4% and St Mary's Hospitals below target at 94.4% and Hammersmith Hospital above target at 95.3%. The Trust did not meet the 'type 1' target for quarter three however YTD remains above 95%. The 4 hour maximum waiting time in Accident and Emergency for 'all types' was 96.8% above the 95% target, with YTD at 97.6%. All sites were above the 95% target with St Mary's Hospital at 96.8%, Hammersmith Hospital at 98.1% and Charing Cross Hospital at 95.9%. To ensure patients are seen within the maximum waiting time the Trust's A&E teams are focussing on ensuring timely decision making and careful management of inpatients to reduce delays in A&E and improve patient experience and outcomes. The Trust secured £514k of additional funding for quarter four to support the following actions in relation to increase seasonal demand: - Increase out of hours consultant cover in the Accident and Emergency department - Increase consultant locum cover for ward level patient review - Increase medical bed capacity at Hammersmith Hospital - Increase therapy support for discharges - Increase weekend pharmacy cover - Increase opening hours for the St Mary's Hospital Urgent Care Centre	**Scorecard Page 11**
Accident & Emergency - Clinical Quality Indicators The A&E teams have been working to deliver the A&E Performance Improvement Plan which is intended to support delivery of A&E performance through Quarter four and seeks to address areas such as capacity, response by specialty teams and time to treatment. Work on ambulatory care pathways continues with the development of both clinical and operational groups and the Trust has also joined the national Ambulatory Emergency Care Network.	**Scorecard Page 12**
Cancer Waiting times In December the cancer waiting time standards for November were published showing the Trust maintained 5 out of the 8 National cancer standards, including maintaining performance of the 2 week wait for urgent cancer referrals, 2 week wait for breast symptomatic and the 31 day wait for chemotherapy, radiotherapy and for subsequent surgery. The 3 standards not met were 31 and 62 day wait from diagnosis to first treatment for all cancers and the 62 day wait for first treatment from consultant screening that failed by only 0.5% of a breach. A number of the cancer remedial action plan initiatives have been implemented. Performance is improving but it remains volatile with a trajectory for sustained achievement of all 8 measures by end of quarter four. Early indication for the December submission is an improvement with 6 of the 8 National standards being met, however further validations are still being undertaken.	**Scorecard Page 13**
Elective Access - Referral to Treatment The Trust maintained all three standards for December sustaining November's performance. The admitted performance for December was 90.5% against the 90% target for patients waiting less that 18 weeks on admitted pathways, 96.8% against the 95% target for patients waiting less than 18 weeks on non-admitted pathways and 92.2% against a target of 92% for patients waiting less than 18 weeks on incomplete pathways. The number of patients waiting over 52 weeks rose slightly from 30 in November to 32 in December 2012 and the overall admitted 'backlog' of patients waiting over 18 weeks rose slightly from 1,054 in November to 1,060 in December related to the decreased activity carried out in December. Seasonal pressures has resulted in a number of elective surgery cancellations and although RTT performance is expected to be maintained in January the admitted 'backlog' of patients waiting over 18 weeks and the number of patients waiting over 52 weeks may not reduce.	**Scorecard Page 14**
Diagnostic Waiting times The Trust maintained its year to date performance in December achieving over 99% performance, with 7	**Scorecard**

reported waiting time breaches out of 6,717 diagnostic pathways. The breaches were in urodynamics, audiology and cystoscopy.	**Page 15**
Maternity The maternity service continued to achieve the 90% target for pregnant women see a midwife within 12 weeks and 6 days of pregnancy, at 96.2% in December 2012.	**Scorecard Page 16**
Delayed Transfer of Care The Trust remain below the 3.5% threshold for patients whose transfer of care was delayed in quarter two. This indicator is reported quarterly, with quarter three reported next month.	**Scorecard Page 17**
Quality, Innovation, Productivity and Prevention The Cost Improvement Programme is driving the delivery of savings as a result of improved efficiencies in key productivity indicators, including staffing, diagnostic demand management, theatre and bed utilisation and outpatient productivity.	**Scorecard Page 18**
Workforce	
Progress against the Workforce key performance indicators are in the Performance Report.	**Scorecard Page 19**

Trust Board Performance Report
Report Period Month 9
(to end December 2012/13)

Trust Board on 18th January 2013

Contents

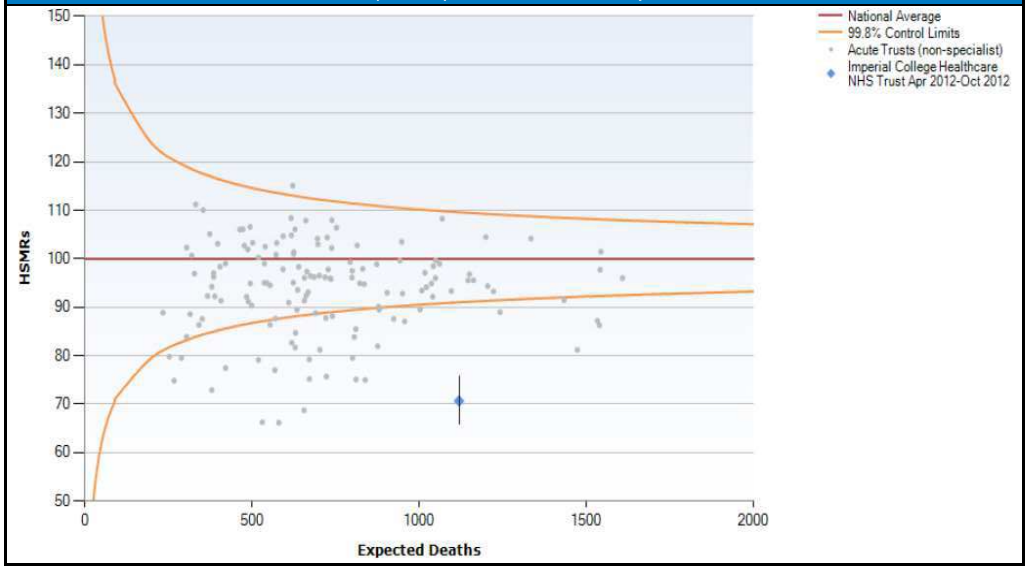
QLTY 1: Mortality - **Supports compliance with Care Quality Commission Outcome 4**

Domain	Indicator	National average	Unit	April - October 2012	Year to date
Mortality	Hospital Standardised Mortality Rate (HSMR) (*)	100	number	71	71

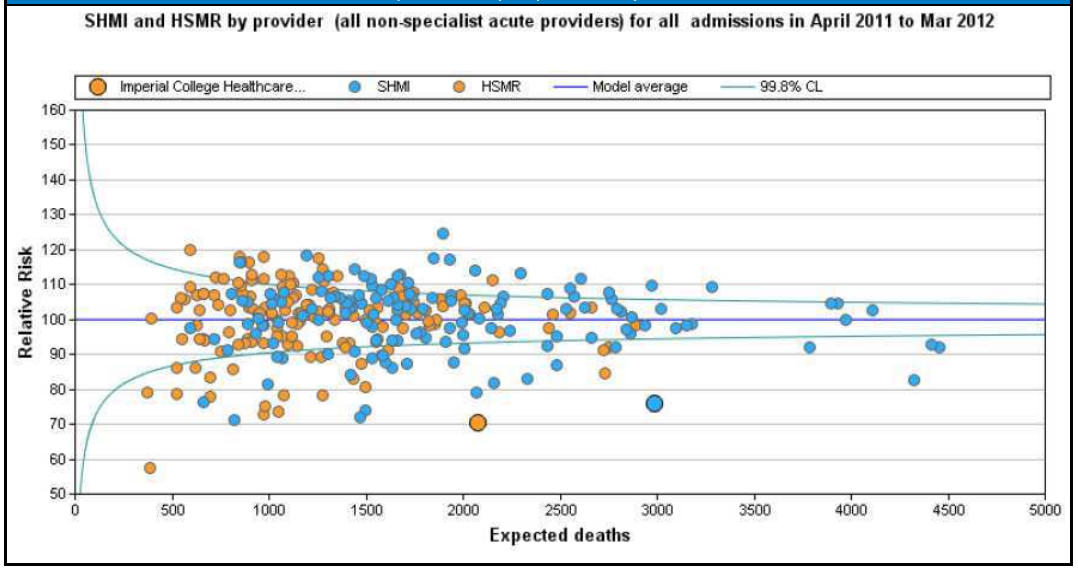
Indicator	National average	Unit	2011-12 Year end
Summary Hospital Mortality Indicator (SHMI)	100	number	75.8

(*) - Data available to Month 6

Graph 1: Hospital Standardised Mortality Rate



Graph 2: Summary Hospital Mortality Indicator

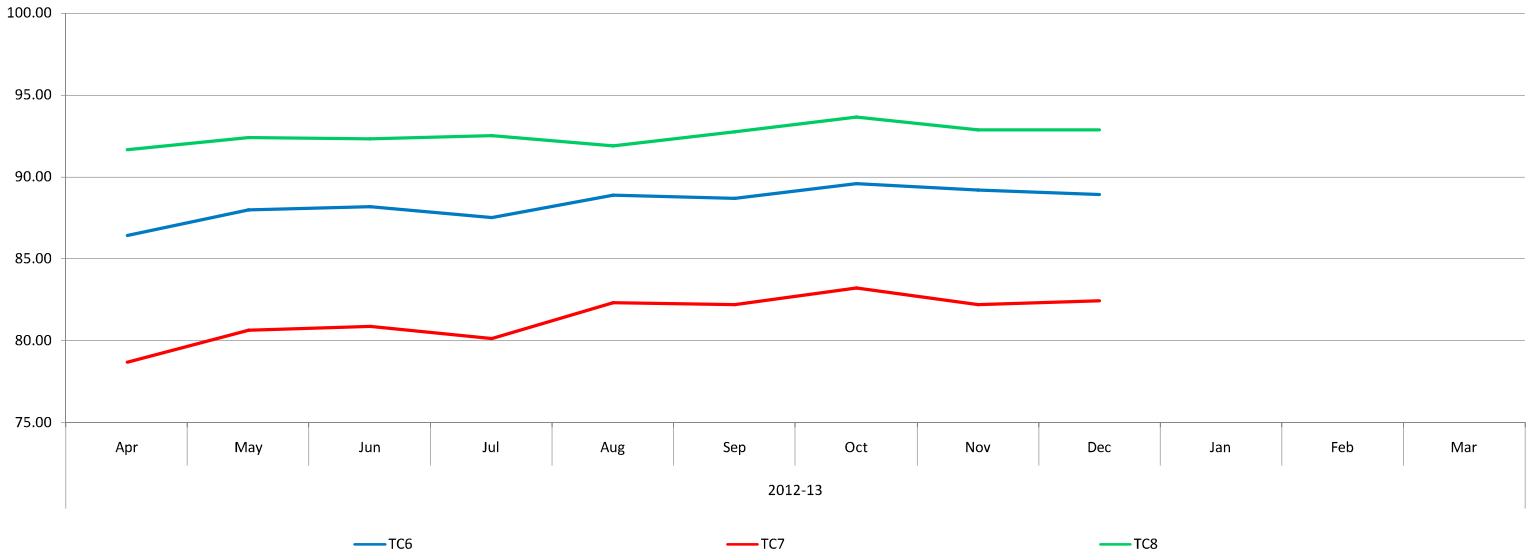


Source: Dr. Foster Intelligence

QLTY 2: Patient Experience - key questions from National Survey - **Supports compliance with Care Quality Commission Outcome 16 and 17**

Core Question	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	86.4	88.0	88.2	87.5	88.9	88.7	89.6	89.20	88.93			
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	78.7	80.6	80.9	80.1	82.3	82.2	83.2	82.19	82.42			
TC8: Were you given enough privacy when discussing your condition or treatment?	91.7	92.4	92.3	92.5	91.9	92.8	93.7	92.88	92.89			

Graph 3: Patient Experience - key questions from National Survey by month

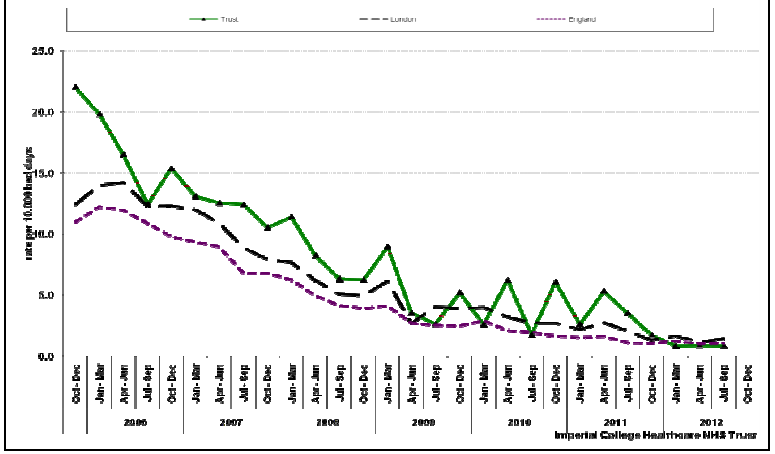


Source: iTrack

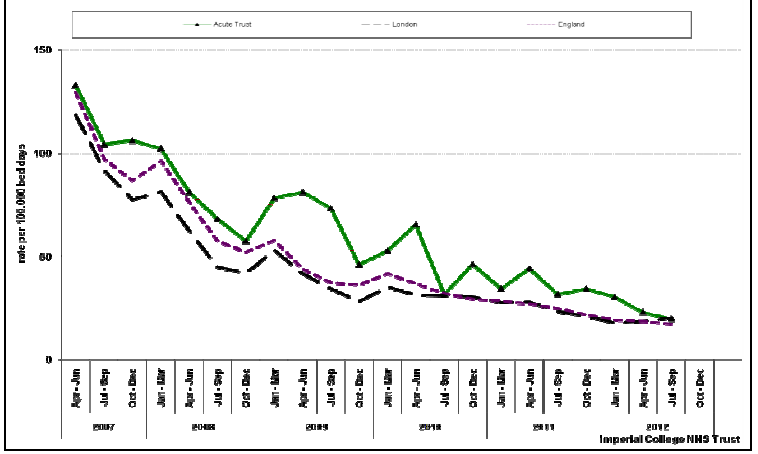
QLTY 3: Infection Prevention Control - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 8**

Domain	Indicator	Annual Trust Ceiling	Unit	Month 9		Year to date	
Infection Prevention and Control	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection (BSI) Bacteraemias	<=9	Cases	0	●	4	●
	Clostridium Difficile (C-Diff) post 72 Hours - Enzyme Immuno-Assays (EIA) - (Nationally Monitored)	<= 110	Cases	7	●	66	●

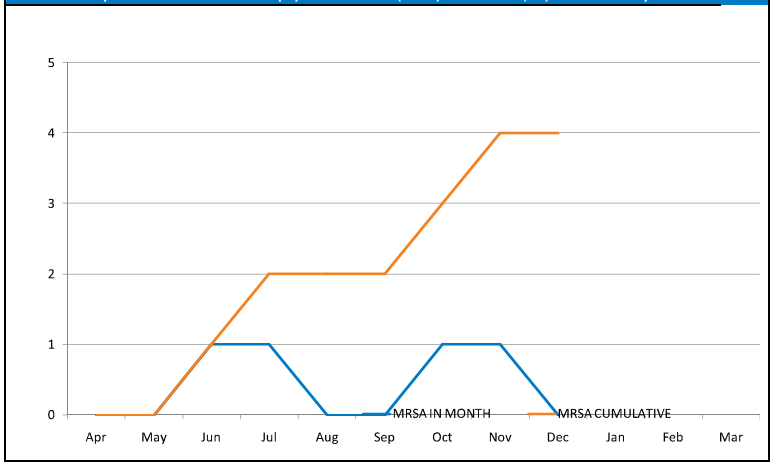
Graph 4:MRSA BSI/100 000 bed days at ICHNT compared to rates in London and England Trusts



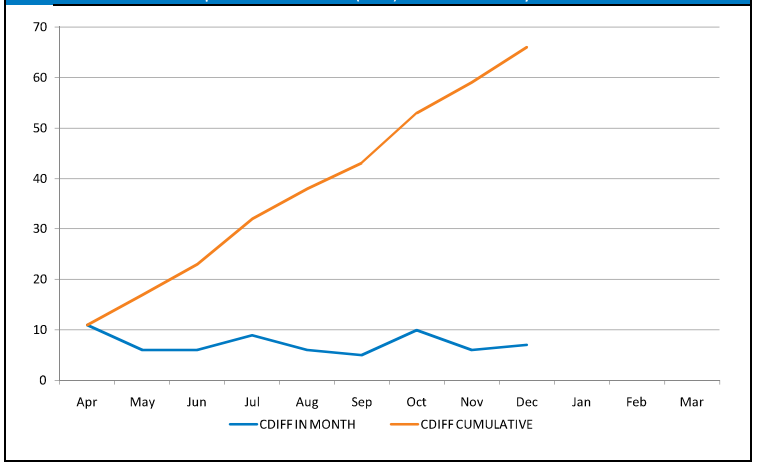
Graph 5: Clostridium Difficile cases/100 000 beddays at ICHNT compared with Trusts in London and England



Graph 6: Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream (BSI) Bacteraemias by month



Graph 7: Clostridium Difficile (C-Diff) Post 72 Hours - EIA by month

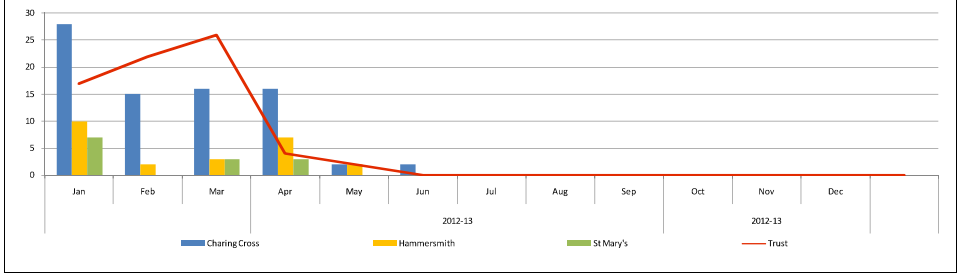


Source: Health Protection Agency & Infection Prevention Control Team

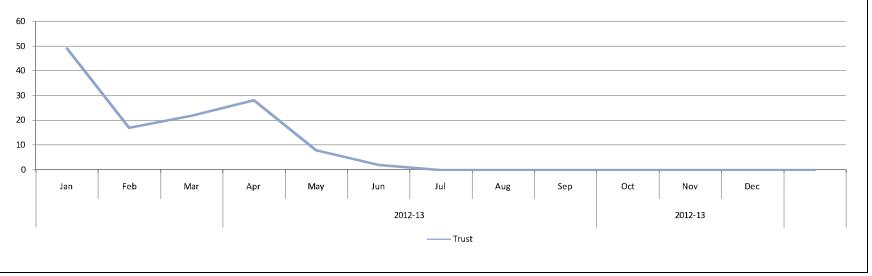
QLTY 4: Eliminating Mixed Sex Accommodation - EMSA - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9		Year to date	
Eliminating Mixed Sex Accommodation	Trust - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Charing Cross- Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Hammersmith - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	St Mary's - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●

Graph 8: Number of monthly Non-Clinical/Unjustified Level 0/1 Beds



Graph 9: Trust Total Breach Days

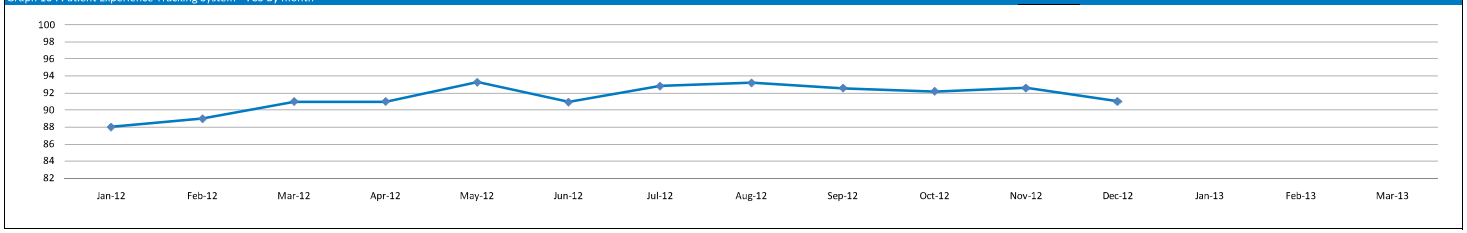


Source: Information Team

Patient experience (data take from iTrack - Trust's Patient Experience Tracking System)

TC3: When you were first admitted to a bed on this ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex? This table shows the % of patients who thought that they did not share a sleeping area with a member of the opposite sex on admission.		Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
	Trust	88	89	91	91	93	91	93	93	93	92	93	91			

Graph 10 : Patient Experience Tracking System - TC3 by month

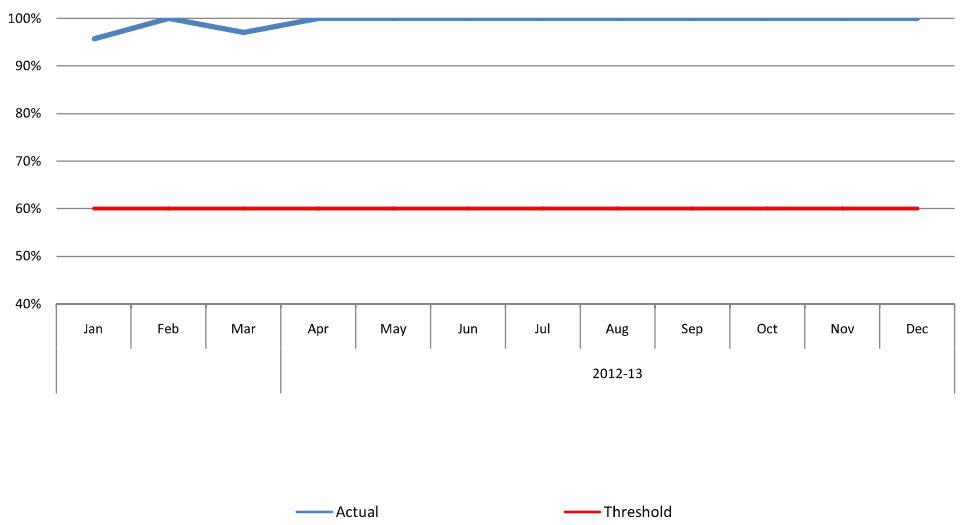


Source: iTrack

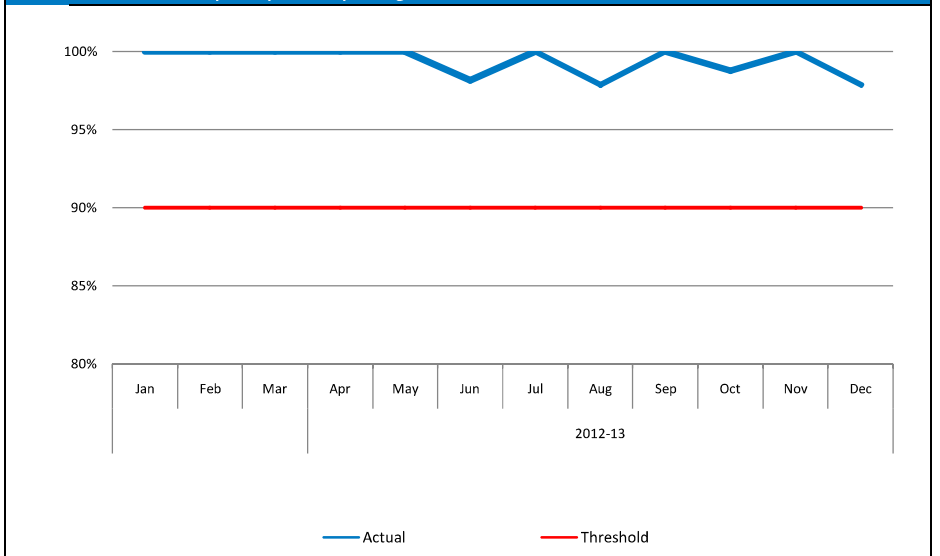
QLTY 5: Stroke Care - **Supports compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9	Year to date
Stroke Care	Patients with high risk of Stroke who experience a TIA and are assessed and treated within 24 hours	60.0	%	100.0 ●	99.4 ●
	Patients who spend at least 90% of their time in hospital on a Stroke Unit	90.0	%	97.9 ●	99.4 ●

Graph 11: TIA patients assessed and treated within 24 hours



Graph 12: patients spending at least 90% of their time on a Stroke Ward

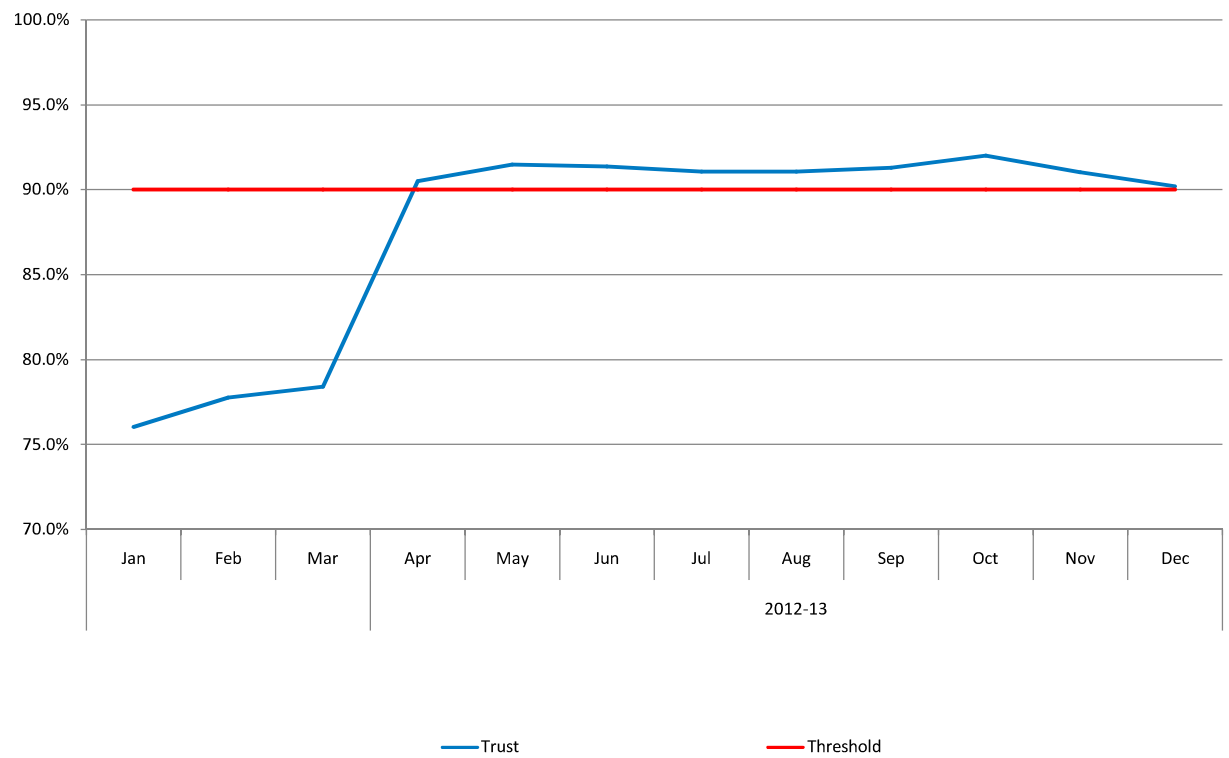


Source: Information Team

QLTY 6: Venous Thromboembolism - **NHS Performance Framework 2012/13 Indicator & Supporting Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9	Year to date
Venous Thromboembolism (VTE) Risk Assessment	Adult Inpatients who have had a Venous Thromboembolism (VTE) Risk Assessment	90.0	%	90.2 ●	91.1 ●

Graph 13: Venous Thromboembolism (VTE) Risk Assessment - Monthly Performance



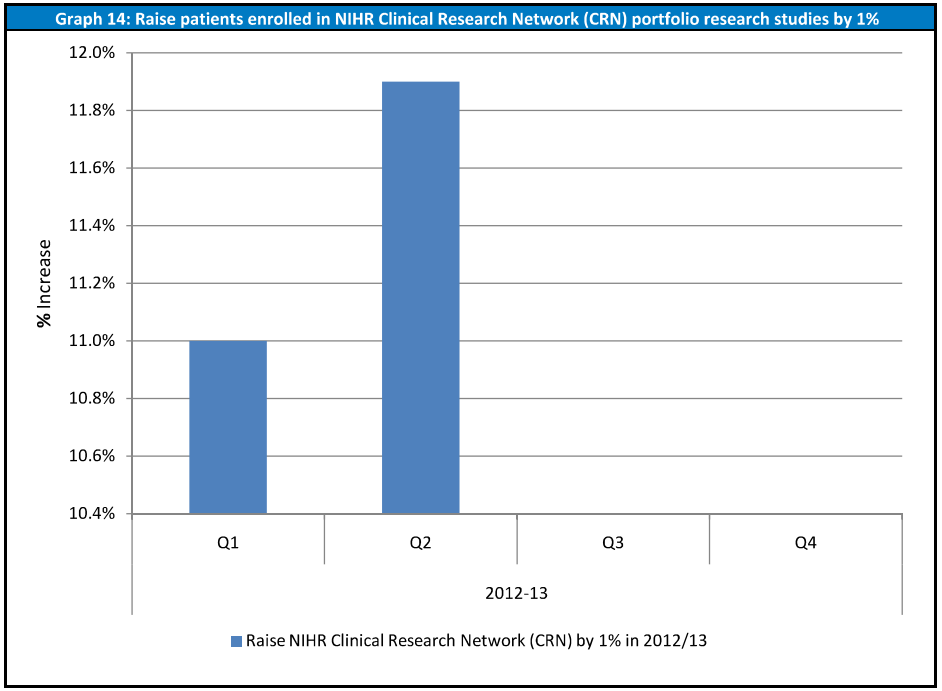
Source : Information Team

QLTY 7: Research & Development - **Supporting Compliance with Care Quality Commission Outcome 14**

Domain	Indicator	Target	Unit	Quarter 2	Year to date
Research & Development	Raise the proportion of patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%	Increase by 1% from 11/12	%	12.0 •	11.5 •

(*) Q3 data available in M10

Graph 14: Raise patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%



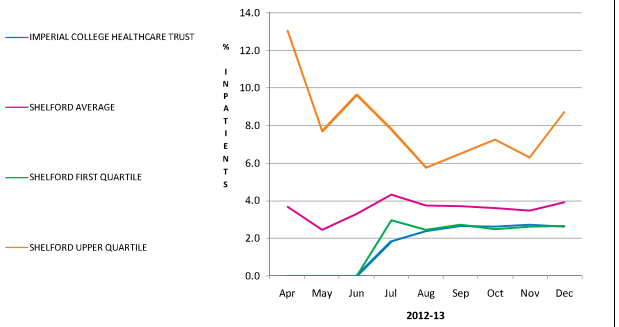
Source: Joint Research Office

QLTY 8: Safety Thermometer - **Supports Compliance with Care Quality Commission Outcome 4**

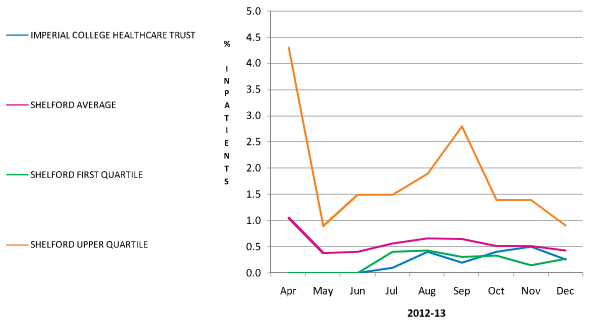
Domain	Indicator		Threshold	Unit	Month 9	Year to Date
Safety Thermometer	Harm free	-		%	96.2%	96.21
	Pressure Ulcers - All	-		Number	30	162
	Pressure Ulcers - New	-		Number	3	20
	Falls with Harm	-		Number	2	10
	Catheter's & UTI	-		Number	5	45
	Catheter's & New UTI	-		Number	2	23
	New VTE's	-		Number	3	14

(*) - The Safety Thermometer is based on a point prevalence survey exacted the first Wednesday of each month

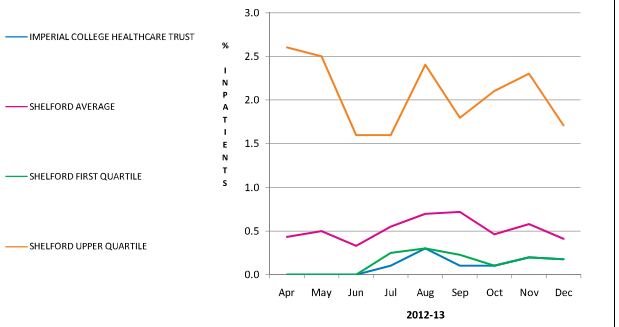
Graph 15: % of Inpatients with Pressure Ulcers (All) - by Month



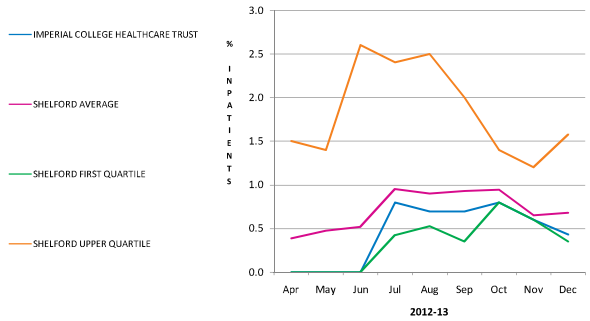
Graph 16: % of Inpatients with Pressure Ulcers (New)- by Month



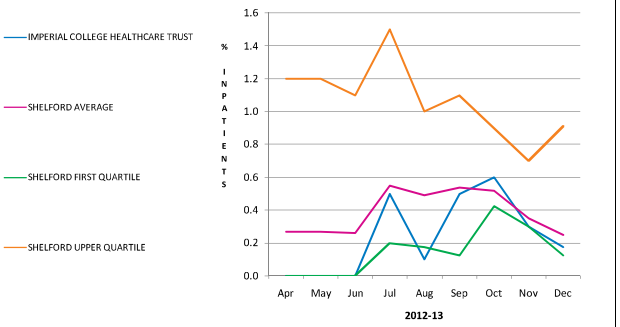
Graph 17: % of Inpatients with Harm Falls - by Month



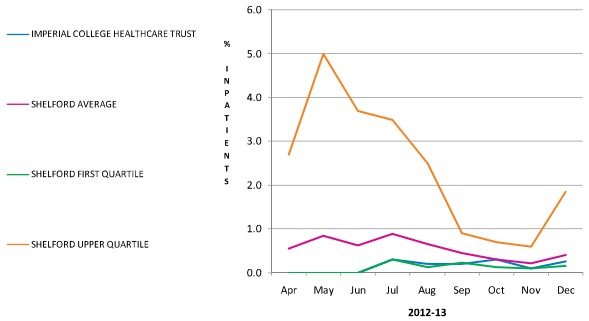
Graph 18: % of Inpatients with a Catheter and UTI (old and new) - by Month



Graph 19: % of Inpatients with a Catheter and a New UTI - by Month



Graph 20: % of Inpatients with a New VTE - by Month



OPS 1: Accident & Emergency - 4 hour maximum waiting time - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

Domain	Site and type		Threshold	Month 9		Year to date	
4 hour maximum waiting time In Accident & Emergency	Trust	All (Type 1,2,3)	95.0%	96.8%	●	97.6%	●
	Trust	Type 1	95.0%	93.5%	●	95.2%	●
	Hammersmith	Type (1,2,3)	95.0%	98.1%	●	98.2%	●
	Charing Cross	Type (1,2,3)	95.0%	95.9%	●	97.8%	●
	St Mary's	Type (1,2,3)	95.0%	96.8%	●	97.0%	●
	Hammersmith	Type 1	95.0%	95.3%	●	96.5%	●
	Charing Cross	Type 1	95.0%	90.4%	●	96.3%	●
	St Mary's	Type 1	95.0%	94.4%	●	95.2%	●
London Ambulance Service (LAS) Handover	London Ambulance Service Patient Handover - within 60 Minutes		100%	100.0%	●	99.9%	●
	London Ambulance Service Patient Handover - within 30 Minutes		95.0%	99.0%	●	98.5%	●
	London Ambulance Service Patient Handover - within 15 Minutes		85.0%	91.9%	●	93.9%	●
	London Ambulance Service Breaches Handover > 60 Min		0		●		●

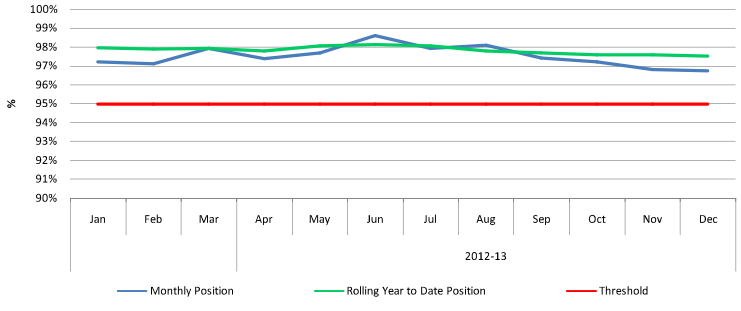
Key

Type 1 = A consultant led 24 hour service with full resuscitation facilities (known previously as 'Majors') ie those patients who attend the main emergency departments across all 3 sites

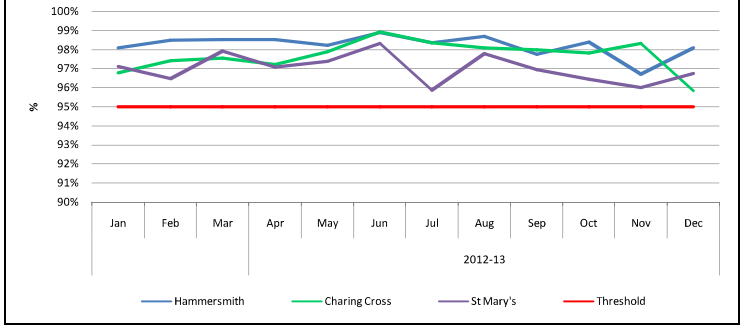
Type 2 = A consultant led single specialty accident and emergency service ie Western Eye for Ophthalmology patients

Type 3 = Other type of A&E/minor injury units (MIUs), Urgent Care Centre. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community

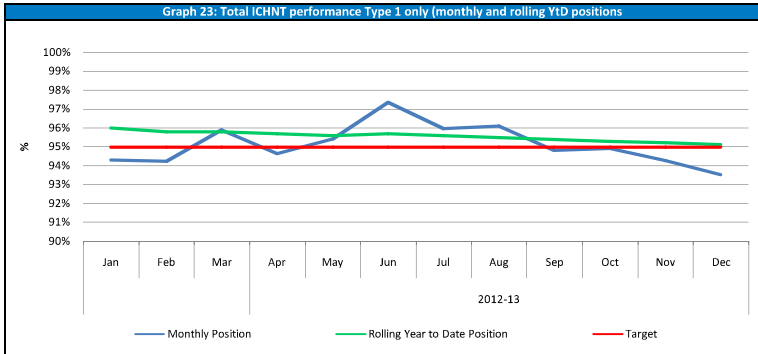
Graph 21: Total ICHNT performance (monthly and rolling YtD positions)



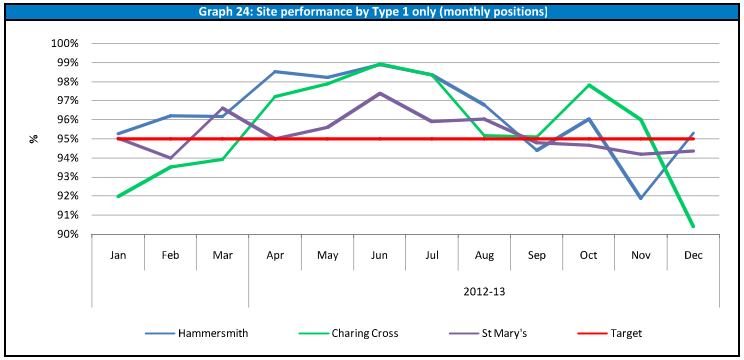
Graph 22: Site performance by All (Type 1,2,3) (monthly positions)



Graph 23: Total ICHNT performance Type 1 only (monthly and rolling YtD positions



Graph 24: Site performance by Type 1 only (monthly positions)



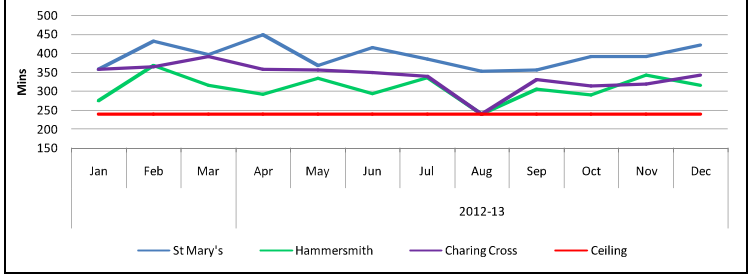
Source: Emergency Medicine

OPS 2: Accident & Emergency - Quality Indicators - **Supports Compliance with Care Quality Commission Outcome 4**

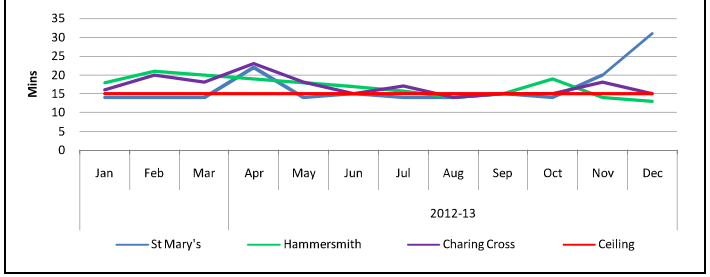
Domain	Indicator	Ceiling	Unit	St Mary's Month 9	St Mary's Year to date	Hammersmith Month 9	Hammersmith Year to date	Charing Cross Month 9	Charing Cross Year to date
Accident & Emergency - Quality Indicators	**Unplanned re-attendance at A&E within 7 days (*)**	5	%						
	Total time spent in A&E								
	Admitted - Median Time	240	Minutes	235	235	232	227	231	216
	Admitted - 95th Percentile	240	Minutes	436	403	317	329	421	343
	Admitted - Longest Time	360	Minutes	955	955	596	768	985	985
	Non-Admitted - Median Time	240	Minutes	130	134	84	84	92	106
	Non-Admitted - 95th Percentile	240	Minutes	238	238	235	234	236	230
	Non-Admitted - Longest Time	360	Minutes	995	1248	427	568	782	836
	Left Department Without Being Seen Rate	5	%	3.63%	3.99%	0.97%	0.96%	1.24%	1.70%
	Time To Initial Assessment (ambulance cases only)								
	Median Time	15	Minutes	5	4	2	3	4	4
	95th Percentile	15	Minutes	19	15	14	15	19	16
	Longest Time	15	Minutes	190	254	58	169	73	192
	Time To Treatment In Department								
	Median Time	60	Minutes	76	74	52	58	48	61
	95th Percentile	60	Minutes	185	182	162	168	164	180
	Longest Time	60	Minutes	440	522	295	395	325	447

(*) - Type 1 indicators for Re-attendance are pre validated prior to April 2012
(**) Type 1 Unvalidated for November 2012

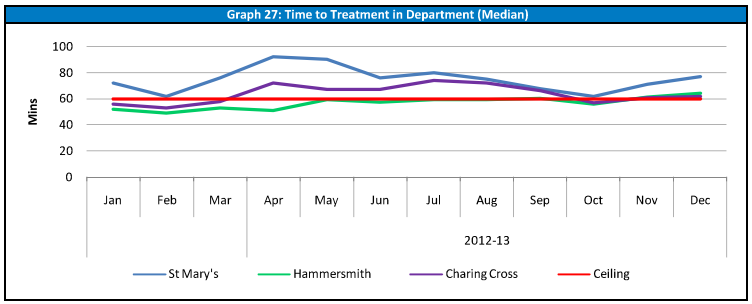
Graph 25: Total time in A&E (Admitted 95th Percentile)



Graph 26: Time to Initial Assessment (95th Percentile)



Graph 27: Time to Treatment in Department (Median)



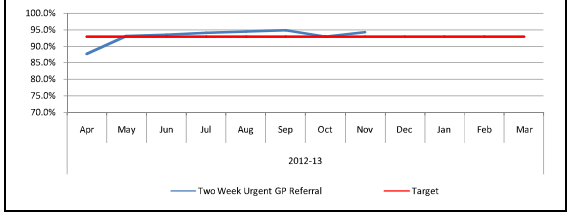
Source: Emergency Medicine

OPS 3: Elective Access - Cancer Waiting Times - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

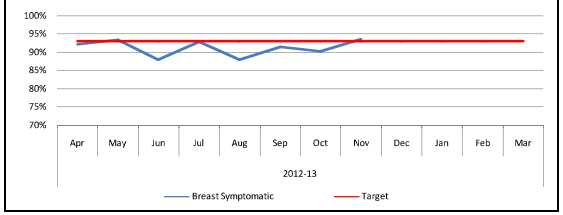
Domain	Indicator	Target	Unit	Month 8	
Elective Access - Cancer Waiting Times (*) (**)	All Cancer two week wait	93	%	94.4	●
	Two week GP referral to 1st outpatient - Breast Symptoms	93	%	93.6	●
	First Definitive Treatment within one month (31 days) of a Cancer Diagnosis	96	%	93.6	●
	31 day Standard to Subsequent Cancer Treatments - Surgery	94	%	95.8	●
	31 day second or sebsequent treatment - Drug	98	%	100.0	●
	Proportion of patients waiting no more than 31 days for second or subsequent cancer Treatment - Radiotherapy Treatment	94	%	99.2	●
	All Cancer Two Month Urgent Referral to Treatment wait	85	%	77.0	●
	62-Day wait for First Treatment following referral from an NHS Cancer Screening Service	90	%	84.6	●

* Cancer data reported one month in arrears as shown on Open Exeter

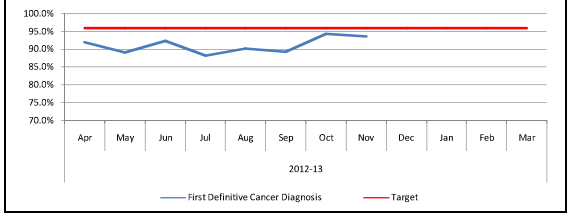
Graph 28: All Cancer two week wait



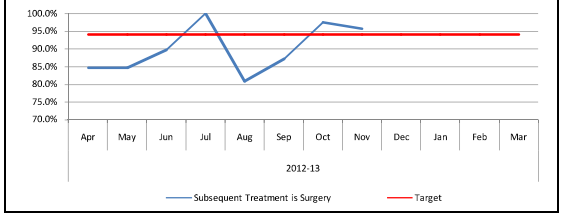
Graph 29:Two Weeks of an Urgent Referral for Breast Symptoms



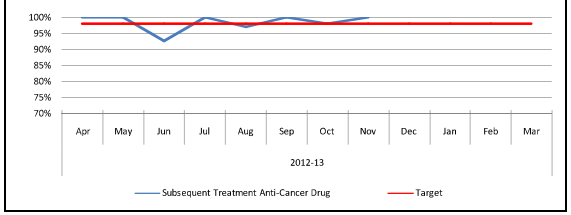
Graph 30: First Definitive Treatment within one Month (31 days) of a Cancer Diagnosis



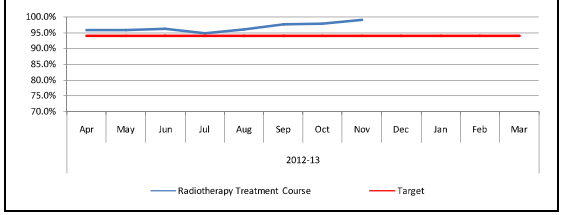
Graph 31: 31 day Standard to subsequent Cancer Treatments - Surgery



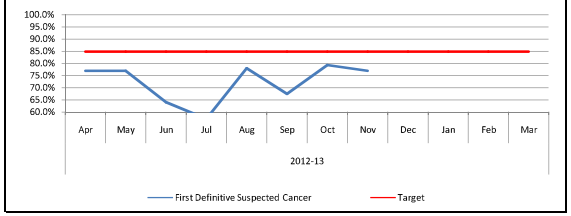
Graph 32: 31 day second or sebsequent treatment - Drug



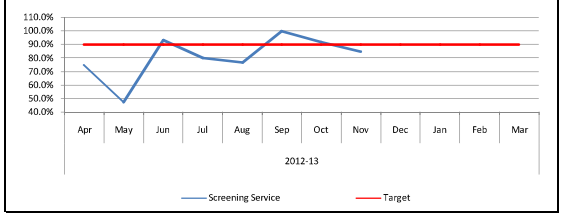
Graph 33: Treatment within 31-Days that Treatment is a Radiotherapy Treatment



Graph 34: All Cancer Two Month Urgent Referral to Treatment wait



Graph 35: 62-Day wait First Treatment following Referral - NHS Cancer Screening Service

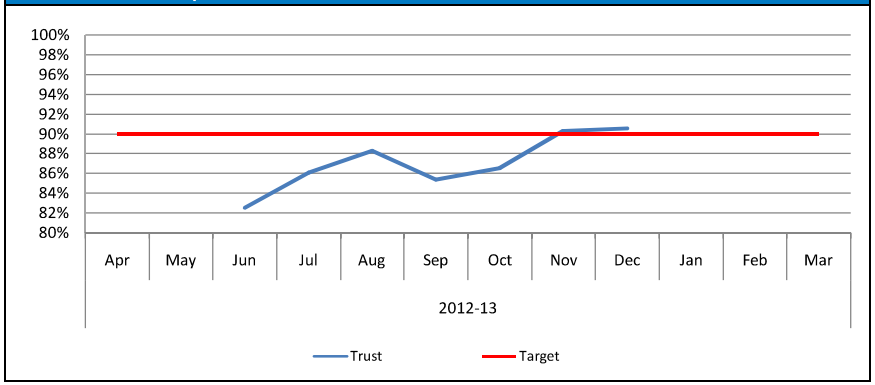


Source: Cancer Services

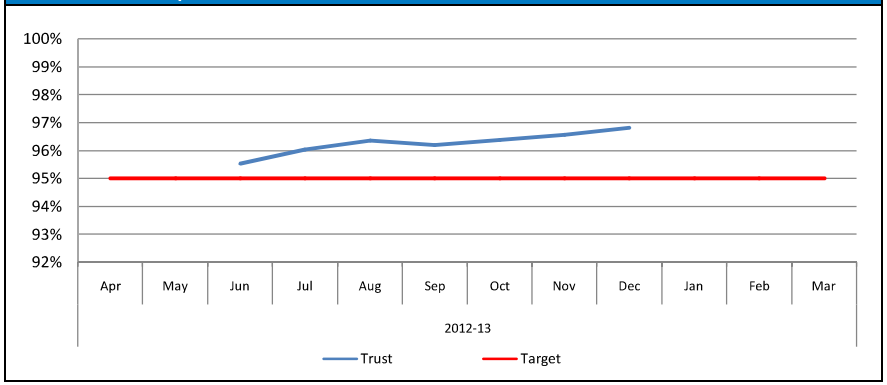
OPS 4: Elective Access - Referral To Treatment - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9	Treatment Functions Not Achieving Target M8
Elective Access - Referral To Treatment	Total number of completed Admitted pathways - waiting 18 weeks or less	90.0	%	90.54	3
	Total number of completed Non-Admitted pathways - waiting 18 weeks or less	95.0	%	96.80	6
	Incomplete pathways where patients waiting less than 18 weeks	92.0	%	92.24	5
	Number of Treatment functions where standards are not delivered (admitted, non-admitted and incomplete pathways)	<=20	Number	-	14

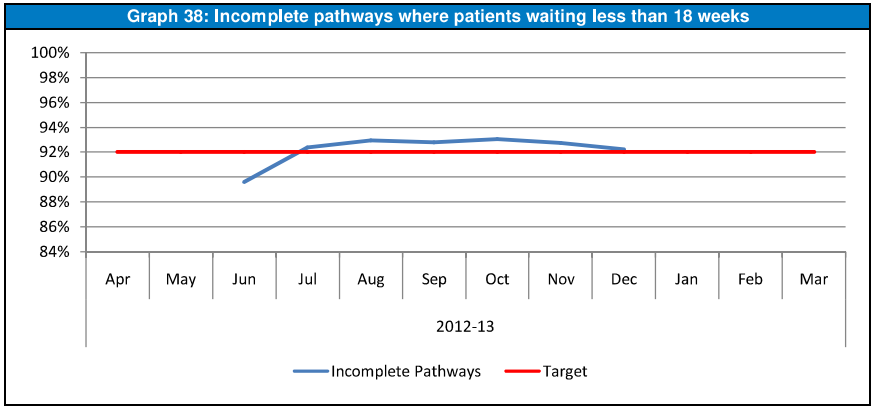
Graph 36: Patients Seen Within 18 Weeks For Admitted Treatment



Graph 37: Patients Seen Within 18 Weeks For Non-Admitted Treatment



Graph 38: Incomplete pathways where patients waiting less than 18 weeks

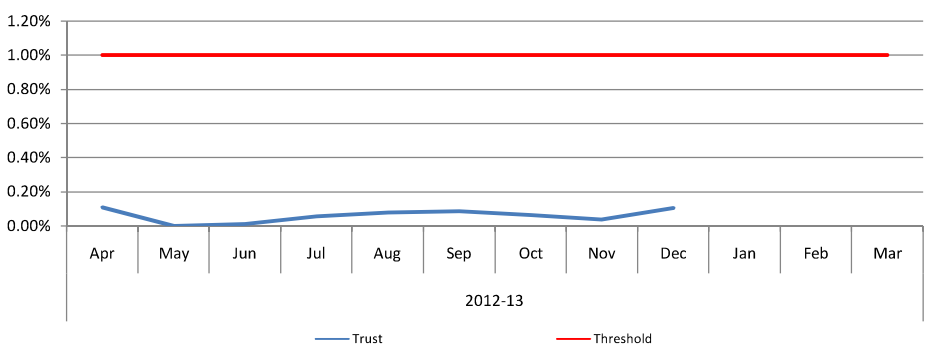


Source: Information Team

OPS 5: Elective Access - Diagnostics - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9
Elective Access - Diagnostics	Patients waiting 6 weeks or more for a diagnostic test	<1	%	0.10

Graph 39: Patients waiting 6 weeks or more for a Diagnostic Test



Source: Information Team

Diagnostic waiting list and Breaches waiting more than 6 weeks

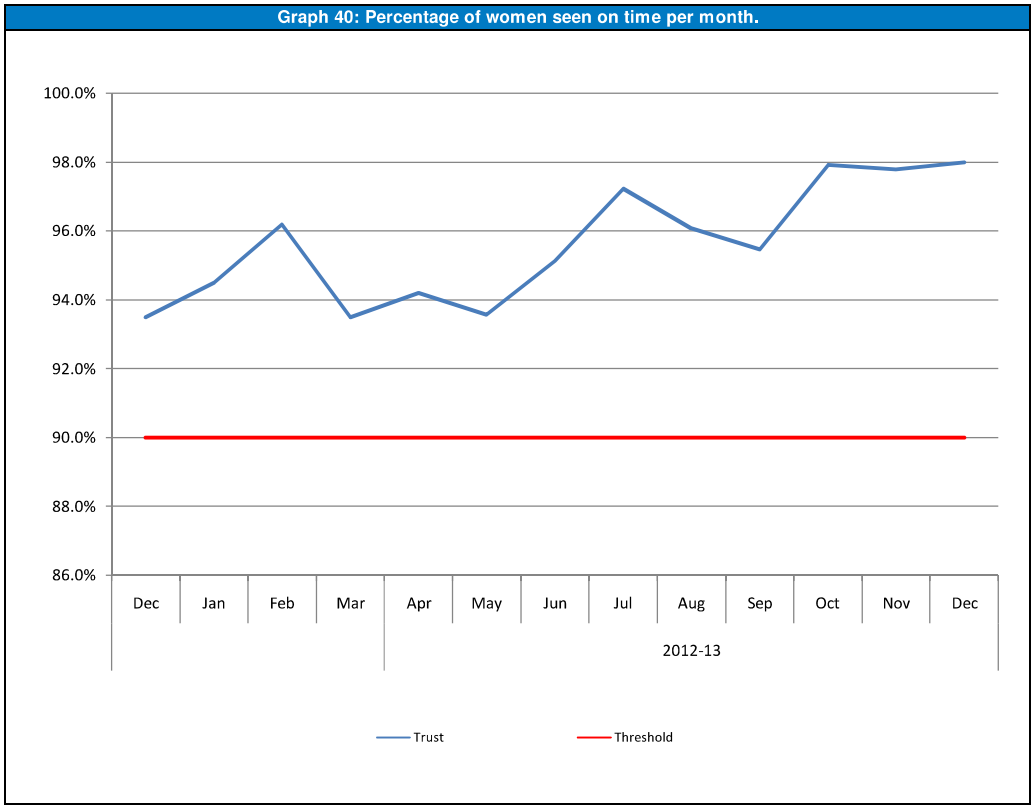
April		May		June		July		August		September	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7379	8	7393	3	7287	3	7237	4	7632	6	7057	6

October		November		December		January		February		March	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7978	5	7745	3	6717	7						

OPS 6: Maternity - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 9	Year to Date
Maternity access - by 12 weeks and 6 days	Women who have seen a Midwife by 12 weeks And 6 days of pregnancy who were referred on time	90.0	%	98.0 ●	96.2 ●

Graph 40: Percentage of women seen on time per month.



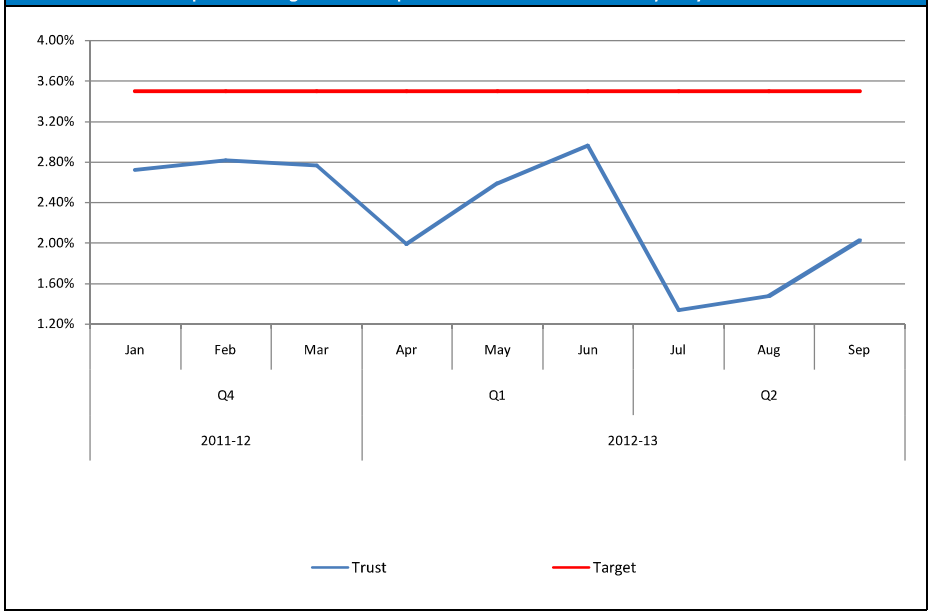
Source: Information Team

OPS 7: Delayed Transfer of Care - **NHS Performance Framework 2012/13 Indicator & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Quarter 2	Year to date
Delayed Transfer of Care	Average number of Acute patients (aged 18+) per day whose transfer of care was delayed (*)	3.5	%	1.62 •	2.07 •

(*) Q3 data not available for submission

Graph 41: Average number of patients whose transfer was delayed by month

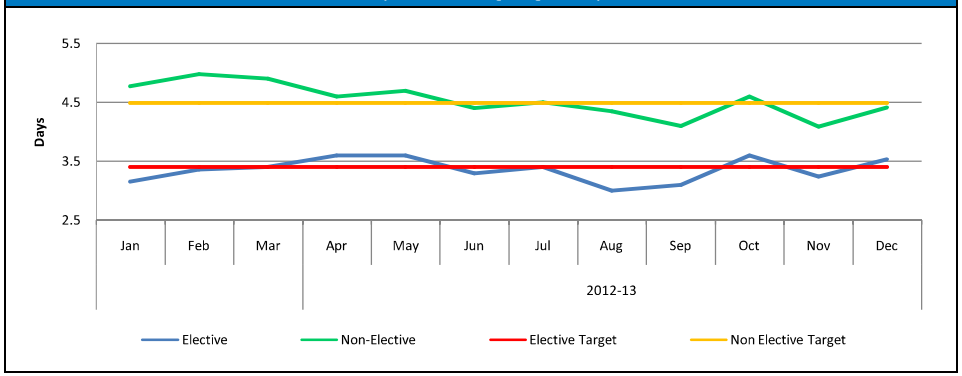


Source: Discharge Team, Clinical Site Management Team & Information Team

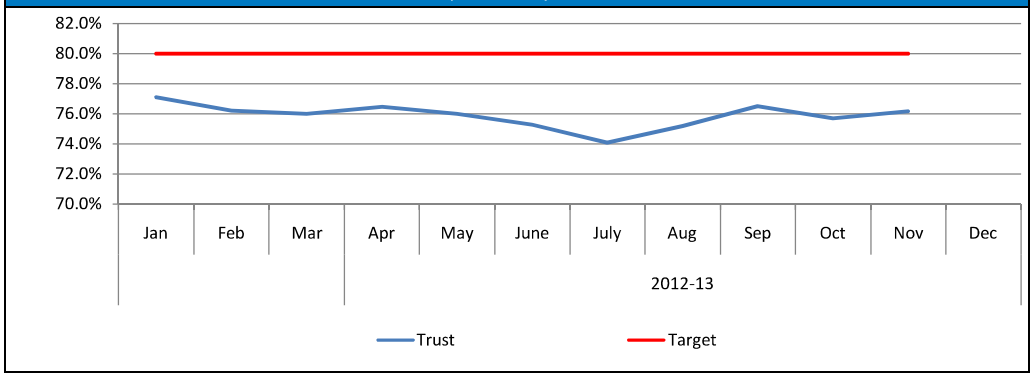
OPS 8: Quality, Innovation, Productivity and Prevention - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Target	Unit	Month 9	Year to date
Productivity	Average Elective Length of Stay	3.40	Days	3.54 ●	3.34 ●
	Average Non-Elective Length of Stay	4.49	Days	4.42 ●	4.30 ●
	Daycase Rate	80.0	%	76.2 ●	75.7 ●
	New to Follow Up Outpatient Ratio	1.67	Ratio	2.36 ●	2.41 ●
	Theatre Utilisation Rate	>= 81	%	78.84 ●	78.7 ●

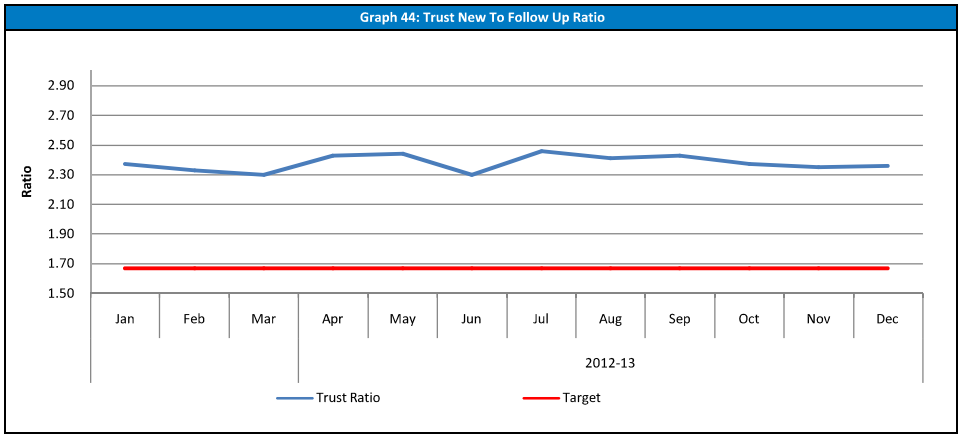
Graph 42: Trust Average Length Of Stay



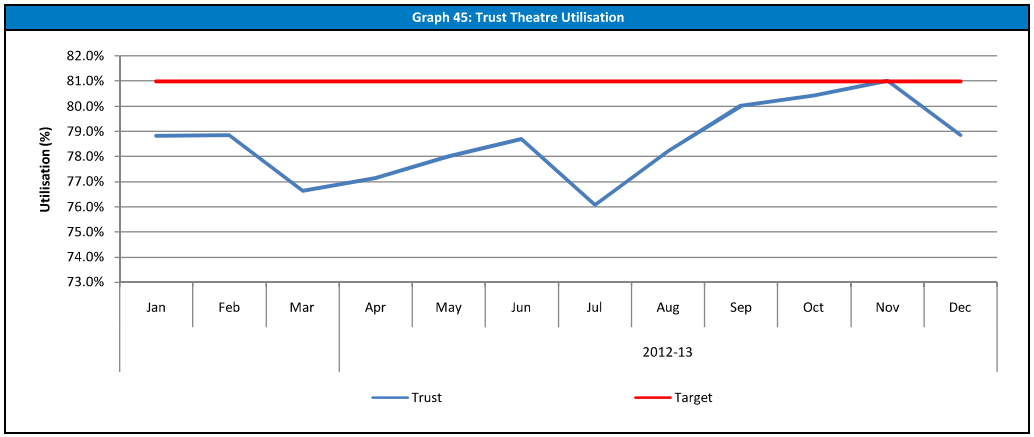
Graph 43: Trust Daycase Rate



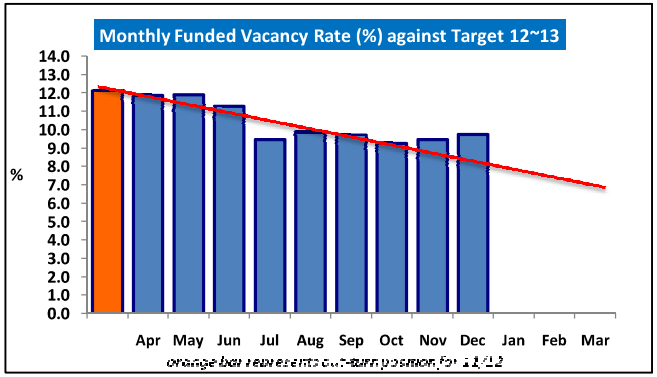
Graph 44: Trust New To Follow Up Ratio



Graph 45: Trust Theatre Utilisation

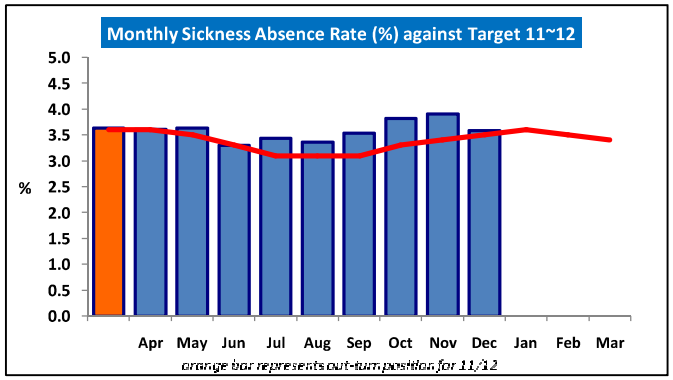


Source: Information Team, Finance Team & Theatre's Team



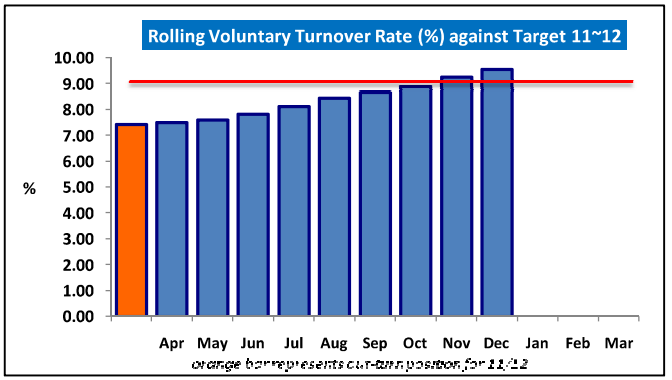
VACANCY RATE TARGET (YEAR-END)	<7.0%	
In month POSITION against target	9.8%	●

vacancy rate derived from GL WTE and ESR staff inpost WTE



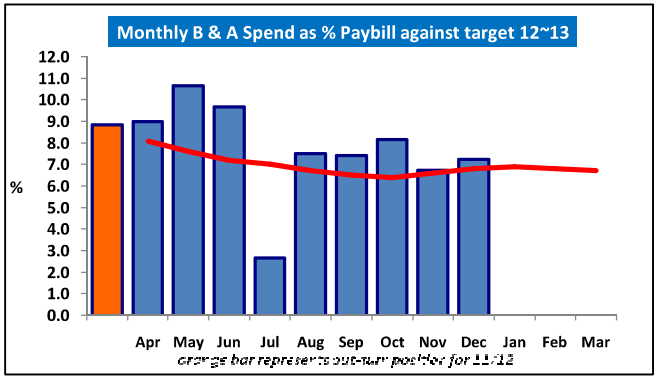
SICKNESS RATE TARGET (YEAR-END)	<3.4%	
CURRENT in-month POSITION against target	3.6%	●
12 Month Rolling POSITION	3.7%	●

sickness rate respresents % of contracted hours lost to sickness

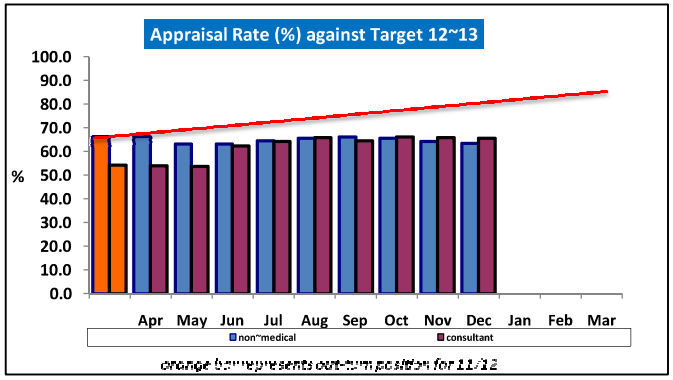


TURNOVER RATE TARGET (YEAR-END)	<9.0%	
12 Month Rolling POSITION against target	9.6%	●

note that from April 2012, 'retirement' is now included in voluntary turnover

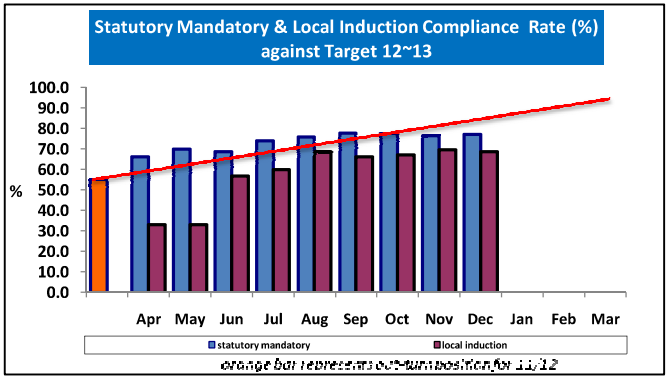


B&A SPEND as% PAYBILL TARGET (YEAR-END)	<7.0%	
CURRENT in-month POSITION against target	7.2%	●
12 Month Rolling POSITION	7.8%	●



APPRAISAL RATE TARGET (YEAR-END)	>85.0%	
NON~MEDICAL STAFF ~ CURRENT POSITION	63.4%	●
CONSULTANT APPRAISAL ~ CURRENT POSITION	65.7%	●

% of current staff who have had an appraisal in the last 12 months



EWTD COMPLIANCE RATE TARGET	>95.0	
STATUTORY MANDATORY ~ CURRENT POSITION	77.1%	●
LOCAL INDUCTION ~ CURRENT POSITION	68.7%	●

Staff Numbers: Substantively employed staffing numbers at the end of December were 8674 WTE; this is 229 WTE fewer than at the end of March 2012 (2.57% reduction). Within the staff groups, this reduction is seen as follows; A&C/Snr.Mgr = 98 WTE,
Forecast Pay Spend & Staffing WTE: Forecast numbers for both pay spend and staffing WTE (including bank and agency) are now included; taken from the salary forecast template. At present these are showing a favourable year-end variance of £7.38m for pay
Bank & Agency Spend: YTD bank and agency spend accounts for £27.90m or 7.4% of the total YTD paybill, against a full-year target of 7.0%. Of the spend in Month 9, £1.70m is attributable to agency spend with £1.28m attributable to bank spend. When comparing
Pay Expenditure: Total pay expenditure in Month 9 was £41.19m against a pay budget of £41.98m, giving an underspend of £791k. The YTD pay spend against budget position is a favourable variance of £6.68m. In month, the total paybill reduced by £233k;
Vacancy: The vacancy rate against the funded WTE establishment (as stated on the general Ledger) was 9.75% at the end of November, the equivalent of 938 WTE; the majority of which are covered by temporary staffing leaving 163 unfilled (1.70% of the total
Turnover: There were a total of 90 voluntary leavers in December, bringing the 12-month rolling position to 9.55%; above the 9.0% target for the year. With the ending of enforced retirement at 65, retirees have been included in the voluntary turnover figures since
Sickness: Recorded sickness absence decreased in December from 3.91% to 3.59%. This equates to a total of 51,047 working hours lost; equivalent to 313 WTE. Of the December recorded sickness, 26% is attributable to long-term illness. Against target, the 12-month
Appraisal: The non-medical appraisl rate was at 63.4% at the end of December ranging from 46 to 81% across the CPG's and 0 to 89% across the Corporate Directorates. The Consultant appraisal rate stands at 65.7% ranging from 44 to 85% across the CPG's.
Statutory Mandatory & Local Induction: Statutory Mandatory training compliance for non-medical staff is currently at 77.1% with Local Induction compliance at 68.7%; both measures are below the in-month target of 83%.

* the figures and information contained in this analysis relates to CPG/Corporate/Private Patients only

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 10**

Report Title: Finance Report

To be presented by: Mr. Bill Shields, Chief Financial Officer

Chief Financial Officer's message:

The Trust has achieved a surplus of £8.3m at the end of quarter 3 (December), a favourable variance against the plan of £5.9m. This is based on a surplus in month of £2.9m.

The forecast outturn for the year has been revised to £11.5m. This revised forecast has been achieved by receiving additional non-recurrent income and through releasing the contingency that was required as part of the plan, but is not necessitated due to cost control in year. This is reflected by the over-achievement of the cost improvement plan, which is expected to deliver £54m in year savings, £2m more than the plan requires. The continued focus on cost improvement is required into 2013/14, despite the over-achievement in year.

Key Issues for discussion:

Continued improvement required in future months through improved performance against CIPs.

Legal Implications or Review Needed

a. Yes ☐
b. No ✓

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objective

5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision ☐
b. For information/noting ✓

Building world class finance

innovation respect care achievement pride

FINANCE REPORT - DECEMBER 2012

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st December 2012.

1.2 The narrative report is intended to provide a more focussed statement of the main drivers of the financial performance and direct the audience to the appendix for further explanation.

1.3 This month's finance report includes the agreed forecast surplus of £11.5m with NHS London. The forecast Income & Expenditure figures reflect the 3rd quarter accounts submitted to the Department of Health.

2 Overview of Financial Performance (Pages 1, 2, 3)

2.1 **Statement of Comprehensive Income (I&E Account)** - The Trust's financial position for the month is a **surplus** of £2,897k, with a year to date surplus of £8,245k.The Trust achieved a **favourable variance** of £3,038k in month.

2.2 **PCT Service Level Agreement (SLA) Income**–The PCT SLA contract monitoring report for the month of December was calculated using the month 8actual data and adjusted for the new planned monthly profile within the SLA.

2.3 **Other Income**- Other Income includes funding from the SHA for Cerner. Project Diamond of £8.1m has been confirmed and as result additional £1.5m income has been included this month; the plan was for £6m.

2.4 **Expenditure**- Pay expenditure shows a **favourable** variance of £6,144k year to date. Total pay expenditure, after adjusting for the income reclassification, demonstrates a reduced expenditure run rate across most pay categories of £1m when compared to the previous month. Non pay expenditure for drugs and clinical supplies is showing a **favourable** variance year to date of £13,358k, this mainly relates to a favourable variance for non-PbR drugs. The adverse variance on Other Non-Pay relates to provisions for additional anticipated cost pressures and the re-mapping of pay recharges.

3 Monthly Performance (Page 4& 5)

3.1 The performance of the CPGs and Corporate Services reflects the agreed budget allocations. The focus is on the forecast outturn and reducing run rates of expenditure rather than just the position against the plan. However, this month the CPGs underspent against the plan and delivered an improved run rate.

3.2 There needs to be continued focus on CIP delivery thereby reducing unit costs and securing a reduction in the current expenditure run rate, which is key to delivering the financial plan for the year.

3.3 The Corporate Directorates' expenditure is, on the whole, in line with the plan. CIP phasing is, however, more heavily weighted towards the end of the year; continued focus is required to ensure expenditure reduction in line with CIP achievement.

4 Cost Improvement Plan (Page 6)

4.1 The CIP plan for the year is £52.1m, (full year effect £62m). Expected forecast outturn is £54m.

4.2 Actual achievement of new CIP schemes in December was £5.4m (year to date £37.4m) of which £3.1m relates to central schemes. To date there is a favourable variance of £2.1m.

4.3 The CIP Delivery Board is closely monitoring the position and further plans are being developed to ensure delivery of the 2012/13 target. In addition, work is progressing on the schemes for 2013/14.

5 Statement of Financial Position (Balance Sheet -Page7)

5.1 The overall movement in balances when compared to the previous month is £2.9m.

5.2 The most significant movement on the balance sheet is an increase in cash of £12.4m relating to the change to invoicing arrangements for specialist clinical services and the Trust owing a number of PCTs £8.7m which is being reclaimed either by refund or deduction from SLA payment over the next three months.

6 Capital Expenditure (Page 8)

6.1 Expenditure in month was £1.7m (£9.9m year to date) which is a favourable variance to the plan.

6.2 Expenditure is behind plan by £3.9m due to backlog maintenance and IT projects both starting more slowly than planned.

6.3 Clinical Chemistry relocation and St Mary's site power are likely to come under budget due to unrealised contingencies.

7 Cash (Page 9)

7.1 The cash profile has been set out as per the plan to NHS London. Cash is ahead of plan at month 9 due to payments to suppliers (including capital) and payroll payments being lower than the year to date plan and money owing to PCTs.

8 Monitor metrics – Financial Risk Rating (Page 10)

8.1 The Trust's overall financial risk rating is a FRR of 3based on the results in December. All risk metrics were on plan for December. A score of 3 is mandatory for Foundation Trust status.

9 Conclusions & Recommendations

The Board is asked to note:

- The surplus of £2,897k for the month of December, the cumulative surplus of £8,245k and the favourable variances, in month and cumulatively, of £3,038k and £5,889k respectively.
- Actual achievement of new CIP schemes in month 9 was £5.4m which is now above the average monthly run rate required of £4.4m to achieve the full year target of £52.1m.
- This month's finance report includes the agreed forecast surplus of £11.5m with NHS London.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Director of Operational Finance

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 11**

Report Title: Department of Health Single Operating Model

To be presented by: Mr. Bill Shields, Chief Financial Officer

Executive Summary:
As part of the Foundation Trust application process the Department of Health introduced the Single Operating Model (SOM) earlier this year. The SOM supports and assures Trusts through their Foundation Trust (FT) applications by drawing on best practice to introduce one common set of tools, processes and guidance for FT development and application, which is more closely aligned with Monitor's authorisation approach. It will also support transition to management by the NHS Trust Development Authority and operational delivery and planning for 2013/14.

As part of the compliance with Part 2 of the SOM the Trust is required to submit self-certification templates to NHS London on a monthly basis in line with their timetable. The SOM model requires that self certification templates are approved by the Trust board before submission.

The rationale and purpose of the Oversight process is to focus on developing self awareness and self management of issues by Trust Boards. NHS Trusts are required to become self governing autonomous organisations when they commence an FT application and the Oversight approach develops the organisational capabilities that will be tested in detail as part of the assessment for FT status and what will be required once authorised.

The process sits alongside and complements the development and assurance of FT applications and is to be viewed as an ongoing process rather than a 'set piece' review like other elements of the FT pipeline, such as Historical Due Diligence (HDD) and the Board Governance Assurance Framework (BGAF).

The last submission, covering the month of November 2013, was made on January 17th 2013 using the templates provided by NHS London. The next submission, covering Trust performance in the month of December 2012, will be made on February 19th 2013 and is enclosed for discussion by the Board.

Following discussion the document will be signed off on behalf of the Trust Board by the Trust Chair and Trust Chief Executive Officer, or appointed deputies, before sign off of the TFA milestone section by NHS North West London submission to NHS London.

Legal Implications or Review Needed
a. Yes
b. No

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective: Risk Management Processes

Purpose of Report

a. For decision and approval ☐
b. For review/noting ✓

SELF-CERTIFICATION RETURNS
Organisation Name:
Imperial College Healthcare NHS Trust
Monitoring Period:
December 2012
NHS Trust Over-sight self certification template

Returns to som@london.nhs.uk by the last working day of each month

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Imperial College Healthcare NHS Trust	Period:	December 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	AR
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :		Print Name :	Sir Richard Sykes
on behalf of the Trust Board	Acting in capacity as:	Chairman of the Board	
Signed by :		Print Name :	Mark Davies
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer	

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**Underperformance against admitted RTT standard**
Action :	**Agreed performance trajectories and remedial action plans with commissioners**

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**Underperformance against mandatory IG Training target and behind plan for anonymisation**
Action :	**Implementing agreed IG action plan with staff incentives and reviewing anonymisation plan**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Imperial College Healthcare NHS Trust

December 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Mark Davies**	
Chair		**Sir Richard Sykes**	

QUALITY

Information to inform discussion meeting

Imperial College Healthcare NHS Trust

Insert Performance in Month

	Criteria	Unit	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Board Action
1	SHMI - latest data	Score							76.0	76.0	76.0	70.0	75.8	75.8	
2	Venous Thromboembolism (VTE) Screening	%							91.08	90.93	91.3	92.03	91	90.2	
3a	Elective MRSA Screening	%													
3b	Non Elective MRSA Screening	%													
4	Single Sex Accommodation Breaches	Number							0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number							6	5	9	10	4	4	
6	"Never Events" occurring in month	Number							0	0	0	1	0	0	
7	CQC Conditions or Warning Notices	Number							0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number							0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number									4	4	4		All improvement areas are being addressed and overseen by local midwifery teams, led by the Director of Nursing who is an Executive Board member. Both St. Mary's and Queen Charlotte's are outliers for consultant cover and in recognition of this a proposal to increase consultant presence on both labour wards to 98 hours a week in the first instance, over a phased implementation period is being prepared for consideration in early 2013. This will be considered by the Investment Committee, chaired by the Chief Financial Officer.
10	Falls resulting in severe injury or death	Number							0	0	0	0	0	0	
11	Grade 3 or 4 pressure ulcers	Number							2	1	0	4	2	0	Detailed root cause analysis completed and reported to the Quality and Safety committee which in turns reports to the Governance committee and Trust Board. Monthly Pressure Ulcer Improvement Group reviews all grade 2-4s with representation from all CPGs, and feeds into the Nursing and Midwifery Professional Practice Committee
12	100% compliance with WHO surgical checklist	Y/N							N	N	N	N	N	N	
13	Formal complaints received	Number							87	70	66	79	54	52	Timescales for measuring compliance TBC
14	Agency as a % of Employee Benefit Expenditure	%								7.5	7.4	8.2	6.7	7.2	Each quarter the Board receives a Quality and Service Report that details key learning outcomes and service improvements following a formal complaint investigation. The top three themes are also reviewed by site to help generate a risk profile. The Quality and Service Report is reviewed by the Clinical Risk Committee and the Trust Quality and Safety Committee before it is presented to the Board. In addition to this learning from complaints is shared at the complaints forum. The Trust's response rate to formal complaints has been above the internal target of 90% for each month and complaints are not considered an area of underperformance.
15	Sickness absence rate	%							3.4	3.4	3.5	3.8	3.9	3.6	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

FINANCIAL RISK RATING

Imperial College Healthcare NHS Trust

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	4	4	4	
Weighted Average		**100%**						**3.5**	**3.5**	**3.5**	**3.5**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	Unplanned breach of PBC	No				
2	One Financial Criterion at "1"					
3	One Financial Criterion at "2"					
1	Two Financial Criteria at "1"					
2	Two Financial Criteria at "2"					

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	No	
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Payment due for R&D MFF awaiting confirmation from DH, income not deemed to be at risk
5	Creditors > 90 days past due account for more than 5% of total creditor balances		Yes	Yes	Yes	Yes	Yes	Yes	There are some invoices being disputed and separately a company has gone into administration whereby the Trust is awaiting for confirmation from the company administrator
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No	No	No	
9	Capital expenditure < 75% of plan for the year to date	No	No	Yes	Yes	Yes	Yes	Yes	Slow start of IT projects, however confirmed with the Chief Information Officer that the total will be spent in year.
10	Yet to identify two years of detailed CIP schemes	No	No	No	No	No	No	No	

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	N/a	N/a	No	No	Yes	Yes	No	Trust Board maintains firm grip on performance against RTT access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief of Operations is held to account.
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	N/a	N/a	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	N/a	N/a	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	N/a	No	No	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	N/a	No	No	No	No	No	No	Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief of Operations is held to account. Cancer data reported one month in arrears therefore November data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	N/a	No	No	No	No	No	No	Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief of Operations is held to account. Cancer data reported one month in arrears therefore November data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	N/a	No	Yes	No	Yes	Yes	No	Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief of Operations is held to account. Cancer data reported one month in arrears therefore November data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	**1.0**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	**1.0**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	As per the Compliance Framework of March 2012 Appendix B on Cdiff "If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied" - the Trust therefore is achieving this target and so has stated yes in both boxes to ensure the score is not applied as per the spreadsheet calculation.
			Is the Trust below the YTD ceiling	*110*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	**1.0**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*9*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	**2.0**	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	No	No	No	No	No	No	No	
			TOTAL			**0.0**	**3.0**	**3.5**	**3.0**	**1.5**	**1.5**	**3.0**	
						G	AR	AR	AR	AG	AG	AR	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
Overriding Rules - Nature and Duration of Override at SHA's Discretion													
i)		Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters			Yes	No	No	No	No	No	No	
ii)		Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.			Yes	No	No	No	No	No	No	
iii)		RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter			N/a	N/a	N/a	N/a	N/a	N/a	N/a	
iv)		A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.			No	No	No	No	No	No	No	
v)		Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter			N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vi)		Ambulance Response Times	Breaches: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter			N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vii)		Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter			N/a	N/a	N/a	N/a	N/a	N/a	N/a	
viii)		Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.										
			Adjusted Governance Risk Rating			**4.0**	**3.0**	**3.5**	**3.0**	**1.5**	**1.5**	**3.0**	
						R	AR	AR	AR	AG	AG	AR	

CONTRACTUAL DATA

Information to inform discussion meeting

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The London SCG SLA remains unsigned. The Trust and the SCG are working through the final parts of the contract following a response from the SCG on the comments submitted by the Trust. Out of London SLAs will form part of this SLA in 2012/13
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No	Yes	No	Yes	The Trust has planned for £7m income in relation to Cerner. The London SHA agreed the plan and gave assurances about a minimum of £3m to the Trust in 2012/13, although payment to date has not yet been received. Separate transitional funding has been received but this falls within the terms of the block contract for 2012/13
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
6	Might the dispute require third party intervention or arbitration?	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
7	Are the parties already in arbitration?	No	No	No	No	No	No	No	
8	Have any performance notices been issued?	No	No	Yes	No	No	No	No	Performance notice in Q2 12/13 for cancer performance breaches, patient experience in cancer and application of the non PbR marginal rate
9	Have any penalties been applied?	No	Yes	No	No	No	No	No	Penalty in Q1 12/13 for Never Events

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Jan-13

Imperial College Healthcare NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Board Action
1	Trust returns FY final accounts (deficit position)	Jun-12	Fully achieved in time	
2	Trust letter of support to NWL Cluster re public consultation	Jun-12	Fully achieved in time	
3	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-12	Fully achieved in time	
4	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-12	Not fully achieved	Board maintains clear oversight of financial and performance issues through regular finance and performance scorecard reports and hold responsible Executive Directors to account. Team leading remedial plans to turn around cancer performance and Elective Access programme for RTT report directly to Chief Operating Officer (Executive Board member). Executive Board members participate in monthly review of performance with each CPG as preparation for Board reporting.
5	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-12	Will not be delivered on time	Board maintains clear oversight of financial and performance issues through regular finance and performance scorecard reports and hold responsible Executive Directors to account. Team leading remedial plans to turn around cancer performance and Elective Access programme for RTT report directly to Chief Operating Officer (Executive Board member). Executive Board members participate in monthly review of performance with each CPG as preparation for Board reporting.
6	JCPCT decision on NWL Shaping a healthier future consultation	Jan-13	On track to deliver	NWL PCT reconfiguration programme remains on track to make decision in February 2013
7	Board Governance Assurance Framework commences	Feb-13	On track to deliver	Chief Financial Officer (lead director for FT application) has sought guidance on BGAF requirements under transition from NHS London to NTDA and is supporting the internal team in building its capacity to deliver a baseline assessment of the Board governance function to report to the Trust Board in February
8	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-13	On track to deliver	
9	Trust returns FY13 final accounts (financially balanced position)	Jun-13	On track to deliver	Board and Finance Committee maintain firm grip on financial performance through receipt of monthly finance report and holding Chief Financial Officer, Director of Operational performance and responsible senior managers to account
10	NWL Shaping a healthier future OBCs complete (assuming no appeal)	Jul-13	On track to deliver	NWL PCT reconfiguration programme remains on track to make decision in February 2013
11	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-13	On track to deliver	
12	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-13	On track to deliver	
13	NWL Shaping a healthier future FBC complete (assuming no appeal)	Dec-13	On track to deliver	NWL PCT reconfiguration programme remains on track to make decision in February 2013
14	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-13	On track to deliver	
15	Board sign off first draft of IBP and LTFM	Apr-14	On track to deliver	
16	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-14	On track to deliver	
17	Historic Due Diligence part 1 (HDD1). To be completed May-June 14	Jun-14	On track to deliver	
18	Trust returns FY14 final accounts (financially balanced position)	Jun-14	On track to deliver	
19	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-14	On track to deliver	
20	NWL Shaping a healthier future FBC approved by Treasury (assuming no appeal)	Sep-14	On track to deliver	NWL PCT reconfiguration programme remains on track to make decision in February 2013
21	Historic Due Diligence part 2 (HDD2). To be completed September-October 14	Oct-14	On track to deliver	
22	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-14	On track to deliver	
23	IBP/LTFM submitted to NHS TDA	Dec-14	On track to deliver	
24	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-14	On track to deliver	
25	Board to Board	Jan-15	On track to deliver	
26	FT application submission to Secretary of State	Apr-15	On track to deliver	
27	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-15	On track to deliver	
28	Trust returns FY15 final accounts (financially balanced position)	Jun-15	On track to deliver	
29	Monitor and working capital review commences	Jun-15	On track to deliver	
30	Quarterly review of finance (including achievement trajectory on CIPs (15/16)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-15	On track to deliver	
31	Quarterly review of finance (including achievement trajectory on CIPs (15/16)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-15	On track to deliver	
32	Anticipated FT authorisation date	Nov-15	On track to deliver	
33				
34				
35				
36				
37				
38				
39				
40				

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 12**

Report Title: Cerner Phase 1 Implementation Update Report

To be presented by: Mr. Kevin Jarrold, Chief Information Officer

Executive Summary:
The purpose of this paper is to provide the Trust Board with an update on progress with the implementation of Cerner Phase 1. Building on Phase 0 which involved the implementation of electronic ordering and results reporting for pathology and radiology, this next phase of the programme will see the Trust replace the existing patient administration system (PAS) and maternity functionality with modules of the Cerner Millennium system. The implementation of a new patient administration system is the most complex system change that a hospital can undertake. The implementation is impacting on all parts of the organisation and is being treated as a clinical transformation programme rather than an IT project. Development of the functionality for clinical documentation for doctors, nurses and allied health professionals and for electronic prescribing is being developed alongside the PAS and maternity functionality and this will be rolled out on an incremental basis once the PAS and maternity functionality has bedded in. By the time that the implementation of Phase 1 has completed, the Trust will have in place the key components of an electronic patient record and a firm foundation on which to develop additional functionality to support more specialised applications in line with the wider corporate strategy.

Key Issues for discussion:
The Trust Board are asked to note the progress that has been made to date.

Legal Implications or Review Needed

a. Yes	☐
b. No	√

Details of Legal Review, if needed: N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve, improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high calibre workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective: Project governance

Purpose of Report

a. For Decision	☐
b. For information/noting	√

Imperial College Healthcare NHS Trust
Update on Progress with the Implementation of Cerner Phase 1

Introduction

The purpose of this paper is to provide the Trust Board with an update on progress with the implementation of Cerner Phase 1. The phased approach to the implementation of Cerner can be summarised as follows:

Cerner Phase 0 - Electronic Ordering and Results Reporting.

This phase of the Cerner implementation went live in August 2011. It was one of the most complex implementations of order communications ever undertaken in the UK due to the size of the organisation and the number of feeder systems that had to be integrated – two radiology information systems and four pathology systems (where typically there would be one of each). There has been very good clinical adoption of the system and it is now well used across the organisation. In total the system now processes around 2.4m results per month.

Cerner Phase 1 – Patient Administration System, Maternity, Clinical Documentation and Electronic Prescribing

This phase of the Cerner implementation involves replacing the existing Patient Administration System and the maternity functionality. The development of the functionality for clinical documentation for doctors, nurses and allied health professionals is being run in parallel and will be implemented incrementally across the organisation following a period of stabilisation. Cerner Phase 1 will provide the Trust with the main components of an electronic patient record. It will also provide the foundation on which to develop functionality to support more specialised applications in line with the wider corporate strategy.

Programme Governance

The Cerner Programme Board is chaired by Steve McManus (Chief Operating Officer) who is the Senior Responsible Owner for the programme. Meetings of the Cerner Programme Board are attended by representatives from BT, Cerner and the London Programme for IT. The Hospital Management Board takes weekly updates on progress. The Programme Team is led by Kevin Jarrold (Chief Information Officer) and progress is tracked across a series of functional and technical work streams. A number of clinically led steering groups have been established to ensure there is end user engagement in the programme and design decisions are signed off by the Clinical Advisory Board to the Cerner programme that is chaired by consultant anaesthetist Sanjay Gautama who is also the clinical lead for IT.

Overview of the Key Components of Cerner Phase 1

At a high level the main components of the implementation of Cerner Phase 1 comprise:

- Ensuring that we fully understand the way in which the new functionality that is being provided will work and developing the operational procedures that staff will need to follow in their routine workflows.

- Creating a virtual hospital within Cerner that reflects the clinics, departments, wards, and staff that exist within the real hospital.

- Migration of data from the existing PAS to Cerner – this includes patient demographic information, some historical data on previous attendances, future outpatient appointments that have already been booked and so on.

- Familiarisation of staff with the new system and delivering training that has to cover both the technical issues around how the system is used as well as the process change issues that mean staff will need to follow different workflows. For example, the Cerner system is designed to work in real time. In the past patient admissions, discharges and transfers may not have been recorded on the existing PAS until sometime after the event.

- The Cerner system is linked to the national spine – which means that users have to be issued with a Smart card to access the system. It also means that the first port of call for patient demographic information is the national Personal Demographic Service rather than a local database. This link to the spine improves the security of the system and helps ensure that we have better data quality.

- The current PAS feeds data to a host of other systems across the Trust and the interfaces that enable this flow of information have to be modified to work with the Cerner system.

- The PAS is the primary source of data on patient activity and ensuring that we have in place, a robust set of reports to support operational management, income recovery and reporting against national targets, as well as producing national returns, is an important priority.

- The cutover process of managing the transition from the old system to the new - as we turn from using one system to the other - is a significant project in its own right. As the final stages of data migration process are brought to a conclusion users will not be able to access either system and the Trust will revert to collecting data on paper that will then need to be keyed in as we bring the new system on line.

Key Challenges

The team have been working to address the following challenges:

- The Trust was the first in the UK to implement the Cerner order communications and results reporting functionality, in advance of the PAS. The logic for doing this was that it delivered clinical benefit at an earlier stage in the cycle and this benefit has been successfully realised. However, data from the order communications solution has to be transferred to the larger Cerner system that will deliver the PAS functionality. This has added to the data migration challenge.

- The Trust will be the first to implement a new reporting solution from Cerner based on their Power Insight Enterprise Date Warehouse and this requires fully testing.

- There has been excellent engagement from the team in maternity with the implementation of the Cerner Maternity module. As the team have progressed it has

become clear that there is significant benefit in linking medical devices into Cerner so that there is a direct transfer of data from foetal monitors without the need to re-key the information. The way in which this functionality can be delivered is being explored but it will not be available at go live.

- The Trust has been undertaking a series of trial loads as part of the data migration process. A number of not unanticipated challenges have emerged with historic data that have to be addressed as we move forwards.

- User validation – in order to ensure that the virtual hospital is an accurate replica of the real hospital a detailed validation process has been undertaken. This has involved clinicians in validating that their clinics have been created accurately.

Setting the Go Live Date

The implementation of Cerner Phase 1 is a very complex implementation and it is important to ensure that all preparations have been completed to a satisfactory standard before taking the system live. Experience from elsewhere has shown that taking the system live when the organisation is not ready can have significant adverse consequences. For this reason the decision was taken not to set a premature go live date. The working assumption has been that the go live date will be set when pre-agreed criteria have been met 16 weeks before go live. This allows six weeks for the booking of training (allowing for the adjustment of staffing rotas) and ten weeks to deliver the training.

The Executive Team will be reviewing progress against the criteria for setting the go live date over the next few weeks.

Conclusion and Summary

The purpose of this paper has been to provide the Trust Board with an update on progress with the implementation of Cerner. Any hospital replacing its patient administration system faces a challenging and complex transition that will impact on every aspect of the hospital. The Programme is making good progress and with some excellent clinical and operational engagement and this will need to continue to ensure that the implementation is a success.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 13**

Report Title: Education Update Report

To be presented by: Dr Jeremy Levy, Director of Education

Executive Summary: Education and Training should be core activities of ICHT: income generated exceeds £60 million, and a large number of (award winning) innovative training programmes underway at ICHT. ICHT remains the first choice location for many training programmes. ICHT should also be the key focus for undergraduate teaching for ICL in NW London. Many consultants and multi-professional staff are deeply committed to teaching and training. Currently, however, service commitments and financial pressures are often seen to override training and teaching, we fail to meet our contracts with ICL and NHSL for teaching and training and need to demonstrate this can be improved in order to maintain our position. Postgraduate medical training is not as good as it should be. The coming year will see major changes in commissioning of training and a further reduction in NHS funding for training and education, and ICHT needs to be clear this is a key activity.

Key Issues for discussion: The Trust Board should be aware of achievements and initiatives to drive up the quality of education, together with the increasing challenges across all professional groups. Key decisions need to be made over commissioning of postgraduate medical training and whether ICHT should continue to bid to be a "Lead Provider" of postgraduate medical specialty training, and about the resourcing of teaching for medical students from ICL using existing SIFT monies and provision both of teaching space and consultant time.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction: *Our aim is to integrate patient safety and education, working across boundaries and professional groups.*

4. Attract and retain high calibre workforce, offering excellence in education and professional development : *We aim to provide excellent development and educational opportunities for all staff and create an environment in which educational innovation thrives*

5. Achieve outstanding results in all our activities. *It has been a year during which we won a few educational awards and raised significant funds to progress educational initiatives.*

Purpose of Report

a. For Decision ☐
b. For information/noting √

Overview

The year has been marked by notable achievements in improving educational quality, cementing educational partnerships, raising educational income and driving innovation.

- We have established our reputation as Lead Provider for postgraduate medical education across a number of medical specialties and leveraged education partnerships to deliver innovative programmes across NW London.
- While we have minimised the overall impact of reduced undergraduate medical education income, the risks remain significant for the future.
- The new Imperial GP Scheme, our early work on education in integrated care, the education contribution to *Shaping a Healthier Future* and our key role in the emerging North West London Local Education Training Board (LETB) summarise our work across boundaries within the sector.
- We have maintained our dominance in terms of the NIHR academic fellowships awarded nationally
- We continue to drive up quality of postgraduate medical education with improved outcomes in the GMC national trainees' survey and a generally excellent GMC inspection at the end of 2012.
- We have embedded our undergraduate partnership working with Kings College London who now provide all our pre-registration midwifery education, as well as pre-registration nursing education for the St Mary's site.
- We have established two academic posts with Bucks New University: a Professor of Nursing and a Reader.

However, despite often being the first choice of training location for postgraduate medical trainees, they still report poorer support and satisfaction than in comparable trusts, consultant supervisors and trainers feel education is not valued as highly as it should be, and we continue to fail to meet our contractual obligations with Imperial College London for teaching undergraduates in terms of teaching space and provision of teaching and examining time from consultant staff. Delivering increased service, with similar or reduced staff levels, and higher acuity of patient care with shorter lengths of stay, has had an impact on releasing staff for training across all professional groups. While staff are committed to the Trust financial processes, delays with the processing of externally funded study leave orders/invoices, by cumbersome processes, has severely hampered training opportunities and in some instances has affected attrition.

Key issues for the coming year will be: an expectation that we deliver enhanced training in integrated care or across the primary and secondary care divide, with inevitable impact on the time available of such staff for purely hospital work; working with the emerging LETB (local education and training board) as it determines priorities for spending funding on training; and the need to decide if we should bid to manage medical training across all remaining specialties and if so to ensure it is properly supported.

[ICHT as a "Lead Provider" refers to our role leading postgraduate medical training across NW Thames in place of the London Deanery for a number of specialties, won as a result of a competitive process, due to be continued in 2013 for remaining specialties]

Governance and creating a learning environment

During this year, the Healthcare Education Board and the North West London Lead Provider Committee have become more focussed and effective in the quality monitoring role, with much better involvement of Heads of Education from several of the CPGs. This year has seen the delivery of the Education Strategy with Key Performance Indicators (KPIs) which are being tracked both centrally and via CPGs. We will try and identify those KPIs that are sensitive markers of educational quality.

A year after taking over core medical and core surgical training in NW London, there has been notable improvement in training and trainee feedback; core surgical training was highlighted positively in the recent GMC visit to the Trust. In August 2012, we became the Lead Provider for postgraduate medical education for nine medical and surgical higher specialties in NW London, several of which have already recorded significant improvements. We have, however, offered to provide enhanced training in simulation, patient safety and leadership, but are hindered in this significantly by lack of educational space in which to deliver training.

We embarked on an exercise of financial transparency to improve accountability for delivery of education and disseminated the SIFT placement allocation to CPGs to further drive up our performance in undergraduate medical education. We need to ensure real time use of quality data on quality of undergraduate teaching (SOLE) to improve undergraduate teaching, but have not had this in place as yet. This is planned for 2013. There have been some concerns over teaching within some departments, for example dermatology and oncology, but more significantly challenges of providing adequate clinical experience at ICHT as patient turnover is high and length of stay continues to reduce. Service reorganisations have had a significant impact on ability to deliver teaching in its current form. For example the movement of general and vascular surgery and acute orthopaedics to St Marys has had significant impact on undergraduate teaching and departments have been poor at informing ICL in sufficient detail and with sufficient notice. We have developed a new process to ensure this improves. An area of excellent practice is the use of the ICHT pharmacy teaching sessions for third year medical students, which is now used throughout North West London. The pharmacists have also run a pilot of providing a "buddy" for the medical students during their placements. There continues to be a major challenge over teaching space for medical students at St Mary's, with losses of teaching space to clinical service which has not been replaced.

Postgraduate medical education continues to improve gradually, evidenced by recent inspections and a large reduction in the number of red flags (poor performance) in the GMC survey, although we continue to perform less well than comparator trusts. However, to ensure that issues with training are identified and dealt with in real time, the Directors of Medical Education have just launched an on-line internal trainee survey which will be repeated regularly. There is a separate stream of work to address the issue of undermining, highlighted in the GMC survey, despite the fact that it was notably less than in previous years. ICHT has been criticised in Deanery inspections about some junior doctor training posts for lack of support with phlebotomy and other routine non-medical work still being undertaken by doctors in postgraduate training. The other area of improvement that needs support is the explicit acknowledgement of Education Programmed Activities (EPAs) in Consultant job plans, and service changes impacting on education for which no educational planning is undertaken.

In our attempt to further improve the quality of postgraduate medical education, a project is underway which will provide CPGs with data on the income streams for postgraduate education (mostly doctors' salaries) together with an indication of potential income brought in by our trainee doctors. This is possibly the first time an exercise of this nature has been undertaken in the country.

This year we launched our new Nursing and Midwifery Strategy 2013-16 'Everyone counts' which includes a work stream on supporting and developing our staff; as well as embedding our Nursing and Midwifery Research and Education strategy 2011-14. To help increase research capacity and capability we jointly established two academic posts with Bucks New University, a Professor of Nursing and a Reader and we cemented our undergraduate partnership working with Kings College London which now provides all pre-registration midwifery education, as well as pre-registration nursing education for the St Mary's site. Both King's College London and Bucks New

University were successful in an NHS London tender to deliver pre-registration adult nurse education and at any one time the Trust supports circa 700 student nurses and midwives of whom half are in practice. We held an away-day with the senior team from Bucks New University and the new Chief Nursing Officer Jane Cummings, who spoke about her vision and strategy, focusing on care and compassion; and in line with the Francis Inquiry we sought and received feedback from our partner universities on improving practice. We have delivered six cohorts of theTrainee Nursing Assistant Development programme to prepare unregistered staff to work at the bedside, and four cohorts of a bespoke internship programme for newly qualified nurses. Finally, we increased the number of N&M with degrees from 35% in 2010/11 to 42% in 2011/12, and those with a master's degree from 5% to 7%. Currently ten of our nurses and midwives have a PhD or Doctorate and a further nine are studying for one.

The Trust passed all the mandatory training requirements for NHSLA3 and increased mandatory training compliance from 47% in Nov 2011 to 76% in Nov 2012. We have provided vocational training for Bands 1-4, funded through the Joint Investment Framework (JIF) funding. The large apprentice programme increased retention rates and the Trust featured as 'base practice site' at the NHS London Apprentice conference.

Education Income

Total education income is £59.3 million through the Learning and Development Agreement (LDA) and this will need active protecting in the new world of LETB's management of education and training funding. A major risk is the movement of funding out of London and potential destabilisation of our workforce and HEIs providing CPPD. We prioritised the spend of Continuing Personal and Professional Development expenditure equitably across staff in bands 5-9 and for certain strategic priorities. The Lead Provider function income is an additional £5.9m, which mostly covers the salaries of doctors in postgraduate training.

Area of education income	Total income (£)	Income (£)
Medical And Dental Education Levy (MADEL) - Postgraduate medical education	**19,892,801**	
Lead Provider (1&2)	**5,871,729**	
Service Increment for Teaching (SIFT)- Undergraduate medical education	**30,907,292**	
Placements		3,340,882
Facilities and other		27,566, 410
Non Medical Education & Training (NMET)	**2,642,042**	
TOTAL	**59,313,864**	

Whilst there may be an opportunity to increase Lead Provider income, it is difficult to undertake the activities required within the funding moved from the SHA and Deanery, and the Trust should consider whether it wishes to invest in training and support it appropriately.

There are significant risks to undergraduate medical education income. Apart from the gradual removal of our significant SIFT facilities income over the next few years (national policy), curriculum changes and the resulting decrease in weighting, together with our inability to support undergraduate medical education for some areas at CXH and HH and failure to meet our contract with ICL for St Mary's (eg teaching space) has resulted in income being lost to other trusts in

North West London. There is a significant risk this will continue unless we can improve our integration of undergraduate education as a core activity within CPGs.

Access to educational resource for other professionals has improved management of the funding for nurses and midwifery-prioritised resources to enable staff to attain degree and masters awards, and of the nurses and midwives wishing to achieve this status, 100 per cent received funding for higher education fees. Allied Healthcare professionals (AHPs) continue to develop a learning environment that is supportive of CPD for all staff. They have developed a suite of e-learning courses on Moodle as well as NVQ Apprenticeships for Therapy Assistants. They have been successful in obtaining one NIHR AHP Clinical Academic Training Pathway (CATP) doctoral fellowship and three NIHR AHP CATP MRes scholarships and one Alice Cory fellowship. Healthcare scientists have achieved five Specialist Portfolios this year in cellular pathology. They have set up of a training committee, with a robust training system which is audited to demonstrate equity. Their staff are engaged in BSc, MSc and PhD/PDoc funded through the SHA monies and Imperial Charity. The healthcare scientists are currently launching a unified competency assessment method across ICHT, but cross Pathology coordination/ standardisation of training remains a challenge.

Other investment has been a range of programmes provided by the leadership team to support particular needs of the Trust including:

- Completion of first cohort of Imperial College healthcare Manager Award
- Launch of new enhanced ward manager development programme “Leading to Green”
- Expansion of I Care Customer care programme to include nationally recognised “Sage and Thyme” training tailor made for staff dealing with emotionally distressed patients.

During 2012-13, we raised an additional **£1,228,677** through various external bids for simulation, technology enabled learning and leadership projects of which £263,400 was for our role as Lead Provider of postgraduate medical training. This has provided unique opportunities to innovate, enhance the quality of education and our reputation as an education provider.

Offering excellence in education and professional development for our workforce

We continue to obtain the largest number of academic NIHR fellowships awarded in the country. We have invested in enhancing research skills for nurses and the first cohort of Nursing MRes students graduated in May 2012. However, there is a serious threat to this progress for non-medical professions due to the increase in fees for Masters published by Imperial College in 2012.

While education for integrated care is still in its infancy, ICHT have launched some of the early work in this field, in particular *Learning Together* outreach clinics which are a joint initiative between paediatricians and local GPs to learn alongside each other whilst managing patients' care closer to home. We expect much of this to be further developed through the work of the new NW London LETB. There are also a number of projects undertaken from various departments through the NW London CLAHRC which have significant patient involvement and work across primary and secondary care.

We have explicitly linked patient safety and medical education through several initiatives this year. Two of them were the *Lessons Learnt* project for Foundation Doctors and embedding simulation as a mandatory part of the trainee’s curriculum in areas such as insertion of chest drain based on patient safety data. The pharmacists now run a FY1 prescribing skills workshop and have developed a range of e-learning modules for Trust nursing staff. Mandatory communication courses aimed at developing advanced communication skills are another attempt

at working across professional boundaries and delivering a better patient experience through education. All new radiographers are sent to the 'red dot' course to improve pattern recognition of subtle injuries which they mark on A&E images so junior doctors are alerted to potential pathology that may have been previously missed further reducing risk. We have not yet been in a position to explicitly link SUIs and critical incidents to training, but are in an excellent position to do this if resourced.

Radiography has made remarkable strides in flexing their training to meet emerging service need and reducing dependence on consultant staff. MRI staff are trained in cannulation and managing reactions to contrast and others are sent to CT colonoscopy courses. With elevation to ILS training level, they have been able to introduce new evening MR contrast lists without need for consultant/SpR cover. The Ultrasound lead has been equipped through a MSK (musculo-skeletal) Ultrasound course to allow delivery of increased diagnostic MSK capacity leaving MSK consultants to focus on rapid increase in interventional MSK demand. Designated MR radiographers have attended the Cardiac MRI course in preparation for starting Cardiac Stress MR service at ICHT which is subject to SLA request from Watford and Ealing for the service.

ICHT have gained a reputation within London for our leadership programmes linked to quality improvement with *Paired Learning* which was highly commended at the BMJ Awards and *Today's Drs Tomorrow's Leaders* highly commended for the Deanery Elizabeth Paice award. The real commendation is not the awards but the impact these programmes continue to have on participants.

Infrastructure and creating an environment where innovation thrives

We established the first AHSC- based GP training programme (Imperial GP Scheme) with various innovations. This has enabled us to provide more GP-centric clinical rotations, while harnessing some of the opportunities within the academic department of Primary Care at Imperial College. The GP trainees have started participating in projects with commissioners and work across the primary-secondary-third sector interfaces.

During the year, YODEL was launched as the on-line booking system for all training courses and Moodle as the virtual learning environment for many Trust wide courses. We have piloted the use of Quick Read (QR) codes in clinical areas to improve just-in-time learning. Several apps are in development and a group is being established to manage the governance of this rapidly growing area. An app that was co-produced with adolescents who have sickle cell disease is being used as a training tool for paediatric trainees while the process of co-production has been an educational experience for staff and trainees of all the professions involved.

The number of simulation initiatives has proliferated with an additional 20 programmes starting in 2012-13. Some of these initiatives are dependant on more facilities being available and currently several of our programmes across the sector are being housed at other Trusts. Our in-situ Multidisciplinary Paediatrics Centre for Training via Simulation (iMPaCTS) won an Excellence in Education Award in Dec 2012. This training activity is significantly hampered by lack of dedicated space for delivering simulation and team based training. We are the only large Trust in London not to have a dedicated simulation centre.

Delivering educational initiatives across NW London in partnership and enhancing our reputation

The success of our Lead Provider role has hinged on our educational partnerships across NW London. One of the outstanding achievements this year has been the establishment of a faculty development programme jointly with Central and North West London NHS Foundation Trust for which we won the London Deanery Elizabeth Paice Education Excellence Award for 2012. This

programme has developed educational and clinical supervisors for postgraduate medical training across all specialities and sites across the sector, the success and penetration of which has surprised both us and the London Deanery. Education across professions and organisations continues, multi-disciplinary trauma training being an eminent example. Apart from attending major trauma study days, the teams attend the Pan London Trauma forums to further improve learning and adopt best practice.

The pharmacists have started working with the Joint Programme Board, a collaboration of nine universities in South East, East & South England, to redesign their postgraduate diploma in general pharmacy and their summative assessments. The links with a range of universities that offer pharmacy degree courses continue and they offer clinical placements and joint project placements. ICHT continue to provide clinical placements to some overseas pharmacists studying the postgraduate MSc Clinical Pharmacy, International Practice & Policy and through the Erasmus programme.

We continue to play a critical role in the emerging North West London Local Education Training Board (LETB) that will change the shape of education commissioning from April 2013. Dr Levy had been appointed as Director of Education and Quality for the NW London LETB, which will in future control all education and training funding streams in the sector.

Conclusion:
Education and Training need to remain a priority for the Trust. There are a large number of initiatives ongoing but there is a real risk that these will come under increasing pressure in the coming year. ICHT needs to demonstrate high quality training to maintain its role as an AHSC and attract and retain staff, and influence commissions from the new LETB. ICHT needs to be clear if it wishes to bid to manage postgraduate medical training in round 3 of the commissioning process due to start in February 2013. If we do not then it is likely UCLP will manage training within ICHT.

Challenges and risks:

- potential future reduction in education spend across all professions,
- reduction in posts for doctors in postgraduate training: we need to show excellence to ensure posts are not lost from ICHT.
- the exclusion of education requirements within the CCG service tendering process: CCGs will commission new services outwith any education or training planning
- internal re-configuration of services must take into account training and education at all levels.
- ICHT failure to provide adequate facilities for ICL for teaching (space) and currently failing to meet out educational contact despite receiving > £30 million funding pa.
- Failure to provide simulation facilities as contracted with ICHT as Lead Provider of medical training
- Failure to win bids for postgraduate medical training for remaining specialties (30+) based on our lack of apparent investment in training: in this circumstance UCLP will manage training within ICHT and the training posts.
- Necessity to clearly demonstrate time within consultant job plans for training and education
- Maintaining effective learning environments during a time of change
- Internal and external service re-configurations impact on training and education

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 14**

Report Title: Summary of the Audit and Risk Committee Meeting held 3 December 2012

To be presented by: Sir Gerald Acher, Non-Executive Director and Chair of the Audit and Risk Committee

Executive Summary:

External Audit Report
It was noted that the Audit Commission has not yet issued guidance for auditing of the national quality Accounts, however it is anticipated to be similar to 2011/12 procedures. The audit will cover the whole of the year therefore some challenges are expected in relation to cancer waiting performances.

Losses and Special Payments Register Quarter 2 Report
In relation to overseas patient write offs, it was clarified that the Trust is obligated to provide emergency treatment to overseas patients. The situation will be monitored and every effort is made to recover funds. Suggestions were made to improve management control. It was confirmed that the relevant policy had been updated in time for the Olympic Games and added that much of what was presented in the report was a backlog. The Chair stated that the policy needs to be implemented fully, to ensure medical tourism does not occur. A review of the policy and its implementation is needed. The Trust should examine best practise in other hospitals.

Private Patient Practice Review
The review was discussed. It was pointed out that the review needs a management response with detailed actions. The Chief Financial Officer is the responsible owner for the work. It was noted that medical staff need to be involved in developing plans for private patient activities. It was interesting that this review should come to the Audit and Risk Committee as many aspects of it were of a direct operational nature and more appropriate for the Trust Board. The Chair stated the Audit and Risk Committee will keep an eye on this issue with a follow up report to the Board.

Internal Audit Progress Report
The Internal Audit Progress Report was discussed. Limited assurance audits were noted. Safeguarding vulnerable adults: work has been done and actions are in place. Clinical coding: Capita will support the Trust in January with work around data assurance. The Audit Commission have commissioned Capita to conduct the work annually and duplication will be avoided. The Chair stated it was sensible to reallocate the days for Internal Audit. The delivery plan was noted.

Counter Fraud Progress Report
Arti Patil presented the progress report. It was noted that three induction and training sessions on counter fraud and bribery had been held in the last quarter and 14 policies had been reviewed. Five investigations are currently open and seven have been closed: related sanctions were noted. In answer to a question from the Chair, it stated the Trust's performance was comparable to other trusts.

Harm Free Care Report
It was noted that the report had been modified from the last meeting to include month-on-month trends with RAG ratings. The report aims to bring together various indicators and create an early warning system. The Committee interrogated this report in some detail.

Report from the Medical Director
It was noted that junior doctor inductions are an area of focus. Junior doctor inductions are managed by the Education Directorate and should be conducted within 24 hours of staff moving to a new area. Handover at nights from shift to shift is important and work is being done through the Medical Directorate to improve these processes. The Chair expressed concern that if there was poor compliance in this area there would be implications for others parts of the organisation. Good compliance and good discipline are fundamentals to managing risk.

Board Level Risk Register
The CERNER implementation update was reviewed. It was noted that the risks of the project are reviewed regularly by the CERNER Programme Board. The assurance process was noted. The exact implementation date remains under careful review and the action ratings are reviewed at Management Board. The Committee asked to see how actions are progressing and to be kept updated with timely reports.

An update on retained swab never events was presented. An event had occurred in October and preliminary investigations have been completed; it was noted that these incidents have multi-factorial root causes.

An example of the risk assessment process for cost improvement programmes (CIPs) was given. It was noted the process has improved over the last six months. CPGs are invited individually to review all CIP schemes at the CIP Board.

Elective Access Waiting Times
An update was provided on waiting list management issues. The action plan was noted and much work had been completed.

Clinical Audit 6 Monthly Progress Report
It was noted that the Trust achieved level 3 for clinical audit standards in the recent NHSLA assessment. Internal Audit had recently conducted a review and found adequate assurance.

The Trust has requested assurance on involvement in all 42 currently active National Clinical Audits on the DH Quality Account list. This has been received for all but three projects and immediate representations are being made for further clarification. The 2011/12 CPG Annual Priority Clinical Audit Plan achieved a completion rate of 96.3%. The 2012/13 CPG Annual Priority Clinical Audit Plan is under way, and although some audits have extended beyond their initial anticipated deadline, all are expected to complete before the end of the financial year.

Committee Reports
The reports from the Quality and Safety Committee and the Finance Committee were noted.

Register of Interests and Hospitality Declarations Quarter Update
The registers were noted and further work agreed by internal audit.

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction

5. Achieve outstanding results in all our activities. **Assurance or management of risks associated with meeting key objective:** Risk management processes

Purpose of Report	
a. For Decision	☐
b. For information/noting	√

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 15**

Title of Report: Summary of the 3rd December 2012 meeting of the Quality & Safety Committee

To be presented by: Professor Nick Cheshire, Medical Director

Action log of the previous meeting

The items on the action log were reviewed and the following items had been closed:

- A summary of ANTT and Antibiotic Stewardship now features in the Control of Infection Summary Report;
- CPGs updated on outstanding actions from serious incidents. In particular, CPG4 had closed Zachary Cope ward following three failure to rescue incidents and were working on improving aspects of junior doctor working; and CPG3 were still working on a number of actions relating to failure to rescue. CPGs 1, 2 and 5 had completed their actions;
- Mrs Newton reported that the Trust is compliant in relation to the storage of IV fluids in corridors and that a new contract for IV fluid deliveries will start in early 2013
- Mr Jones had invited Sue Boyle to the meeting and forwarded remaining NCEPOD actions relating to failure to rescue to Ms Powls.

Monthly Control of Infection Summary Report (including Antibiotic Stewardship and ANTT)

As of October 2012, the Trust had had 3 MRSI BSIs in the year to date, against a threshold of 7, with a further case in November. There had been 53 C Difficile cases in the year to date, against a threshold of 63, with 5 further cases in November. MRSA screening is at 89%. ANTT training figures are beginning to plateau and a focus has been placed on CPGs in order to improve uptake. Professor Cheshire added that the University of Manchester had advised the Trust on hand hygiene and ANTT training was part of this advice, asking if this would continue in the Trust. Mrs Whittaker-Axon replied that competency training is being incorporated into Statutory and Mandatory Training schedules. Professor Cheshire requested that training data be sent to CPG Directors and this was agreed. Regarding Antibiotic Stewardship, compliance with Trust anti-infective prescribing policy was at 92%, documentation of indication is at 88% and documentation of stop/review dates is at 64% - all having a target of 90%. Professor Sigsworth asked whether the MRSA BSI in November is Trust-attributable and Mrs Whittaker-Axon confirmed this to be the case, with Dr Redhead in agreement as it had occurred in CPG1. Professor Sigsworth felt that these were becoming a concern, though Mrs Whittaker-Axon noted that Imperial compares well with other London trusts. Dr Redhead noted that a 41% contamination rate seemed high. Mrs Whittaker-Axon replied that there are two measurement techniques and that Dr Brannigan would include more detail in the February report.

ACTION:

- **Mrs Whittaker-Axon to forward ANTT training data to CPG Directors.**

Monthly Pressure Ulcers Report

There had been 3 Grade 3 ulcers in October and panels are being convened on these shortly. The Pressure Ulcer Reduction Group meets monthly and work is being undertaken, notably in ICUs, to reduce pressure ulcer incidence. Ms Heywood added that she is Chair of this group and there is a programme of work on mini root cause analyses of Grade 2 ulcers being started. A zero tolerance approach for hospital-acquired Grade 3 and 4 ulcers will be taken. A CQUIN target is anticipated for 2013/14, though this is not yet finalised. Professor Sigsworth noted that the Tissue Viability Nurse team was 1.4 WTE for the whole Trust and that a future business case will be linked to this CQUIN. Professor Cheshire asked where this information is triangulated. Professor Sigsworth replied that it is also addressed via the Harm Free Care Report and the Safety Thermometer and that the Establishment Review Group also reviews the data, adding that Heads of Nursing would

escalate any concerns noted through CPG governance structures. Ms Heywood reported that improvement plans are being produced for each CPG. Ms Truscott and Ms Powls confirmed that these improvement plans are being implemented. Professor Cheshire asked whether this information also needs to come to Management Board and whether the Committee is assured that the data is reviewed and acted upon. Mr Edmonds felt that this work should remain with CPGs to address and that he is assured the work is being done in CPG5, adding that a purported 50 % reduction in pressure ulcers would be a challenging CQUIN target. Professor Sir Anthony Newman Taylor stated that reassurance is need at a higher level that pressure ulcers are being addressed.

Monthly (October 2012) Quality & Safety Scorecards

- **CPGs to report by exception**

Incident reporting rate is at 6.61%, an improvement for the Trust though still slightly lower than the 6.9% national average. Near miss reporting in particular is felt to be in need of improvement. There had been fewer SIs in October, including one Never Event. Falls are still below national average and Being Open compliance is at 92%. There had been 9 reported failure to rescue incidents in October, 4 at SMH, of which 3 had resulted in patient harm. The CPG breakdown was provided.

Nursing & Midwifery Harm Free Care Report

The paper summarised areas of concern by CPG and drills down to ward level. Workforce incidents will be considered more closely in the next report. Ms Mottram noted that vacancy rate at SMH ran at 10% and asked whether local plans were in place. Ms Heywood replied that the data ended in October and that there has been a lot of work in this area more recently, resulting in much lower vacancy rates now. Professor Sigsworth added that it is occasionally difficult for bank to fill all vacancies and that there are fewer staff members to draw upon, resulting in further pressure on bank. Work is being undertaken particularly on vacancies in the bands 2 to 6 area.

Flu Vaccination Programme

Flu vaccination rates for staff stood at 24.4% up to the end of October and continues to rise, with 150 being vaccinated in the last week. Staff can be vaccinated up to the end of January 2013 and uptake has improved greatly on last year, though lower than would be preferred.

Mental Health Group Annual Report

Key priorities and actions taken were summarised. The work has strong links with both the Safeguarding Adults and Dementia agendas. Awareness of Deprivation of Liberties Safeguards (DoLS) needs to improve, as does rights reading for patients being managed under Mental Health Act 2007 provisions. Steve McManus is leading on work relating to psychiatric liaison support for trusts. Ms Mottram asked whether there is enough support for training in these areas. Dr Jones replied that the approach to training is being organised to link with Safeguarding Adults and Dementia. Ms Heywood added that the Safeguarding Adults assessment had been completed and that gaps have been noted in training there also, so there is work to group agendas.

Professional Education and Development Annual Report

The report reviewed actions undertaken following the GMC trainee survey. These actions are in every department and assurance has been received that these departments are addressing the actions. A re-survey is being undertaken in January 2013. Ms Mottram suggested that an Internal Audit review may help to ensure departments deliver on their actions. Professor Cheshire asked whether the current structures are robust enough to allow for a firmer chasing of actions with consultants. Dr Levy replied that this was the case and that implementation could be challenging, the structures for the actions reside in the CPGs. Mr Edmonds commended the report, noting that the detail is much improved.

Failure to Rescue Report

Ms Mottram presented the report, which included a systematic analysis of both the historic and the current position. Incidents primarily occur out of hours or at the weekend. Involvement of junior doctors is a recurring theme, with reports that local induction of medical staff requires attention. Actions listed included ward visits, addressing medical rotas and discussions with medical education leads. An update has been requested on the reconfiguration of Critical Care Outreach.

Failure to rescue is recognised as the key clinical risk.

Professor Sigsworth replied that she has asked the Site Team to make ward rounds and bed visits, adding that additional funds for Site Team have been agreed and wards have been prioritised for close observation. Ms Powls reported that the in-hours ward round model at Valentine Ellis Ward has been changed and the Ward Manager conducts a twice-daily ward round. Handover has also been formalised and Critical Care Outreach visits the ward at the weekend. The Critical Care Outreach bleep now re-directs to the Site Team out of hours and SBAR education has been increased. For CPG4, Ms Truscott noted actions included consultant ward rounds and daily failure to rescue ward rounds, with SBAR also being trialled. Mrs Oke confirmed that actions had also been taken in CPG2. Professor Sigsworth noted that these areas cover all the high risk locations at SMH site and asked whether junior doctor handover problems had now been addressed. Professor Cheshire added that he will be addressing this issue.

ACTIONS:

- **Professor Cheshire to write a notice as Medical Director stating that FY1 solo cover of wards is not acceptable and that more senior medical cover is necessary.**
- **Ms Mottram to forward final SI reports related to failure to rescue to Dr Levy, for information.**

Medication Safety Review Group – near-miss medication errors report

A summary of guidance and a report template was provided. Detailed data is presented at Drugs & Therapeutics Committee. Around 1000 medication incidents are reported each year and degree of harm categorisation has been challenging, particularly as most are near misses. Themes are examined regarding significant harm incidents, as graded by CPGs. A checklist for storage of medications is being launched. Ms Mottram stated that the Committee needs to understand the data via a high-level report.

ACTIONS:

- **Mr Jones to invite Neil Chapman to attend Quality & Safety Committee.**
- **Ms Heywood and Ms Mottram to discuss the medications incident data needs of the Quality & Safety Committee.**

Minutes of sub-committees

The minutes of the Clinical Risk Committee of the 18th October 2012 and the Clinical Standards Committee of the 26th October 2012 were noted. Ms Mottram asked for a progress update on the work to address the large number of out of date clinical guidelines on the Trust Intranet. Dr Fox summarised the position, focussing on the need to both obtain accurate expiry dates and to update out of date guidance. Mr Jones and Dr Fox are working to firm up escalation and removal processes, for implementation in January 2013 and reporting at the February meeting, as per the existing action on the Committee Action Log. Professor Sigsworth asked about the degree of clinical risk attached to out of date guidelines. Dr Fox replied that this is difficult to quantify but that no clinical incidents have ever been found to have resulted from application of an out of date clinical guideline.

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 16**

Report Title: Midwifery Supervision Annual LSA Report

To be presented by: Ms Pippa Nightingale Head of Midwifery

Executive Summary: An overview of the annual midwifery supervisors LSA report.

The Nursing and Midwifery Council (NMC) sets the rules and standards for the function of the Local Supervising Authorities (LSAs) and the supervision of midwives. The function of the Supervision is to ensure that statutory supervision of midwives is in place to ensure that safe and high quality midwifery care is provided to women.

All practising midwives in the United Kingdom are required to have a named Supervisor of Midwives (SoM). A Supervisor of Midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 11 NMC). Each supervisor oversees approximately 15 midwives and is someone that midwives may go to for advice, guidance and support (Rule 12). The Supervisor of Midwives will monitor care by meeting with each midwife annually, auditing the midwives record keeping and investigating any reports of problems/concerns in practice. They are also responsible for investigating any serious incidents and reporting them to the LSA MO (Rule 15).

The LSA audit the provision and quality of Supervision in all units annually. This audit comprises of 4 standards and was undertaken at Imperial in October 2012.

Standard	**Title**	**2012 results**
Standard one	The Interface of Statutory Supervision Of Midwives with Clinical Governance	Compliant
Standard two	The Profile and Effectiveness of Statutory Supervision of Midwives	Not met due to high caseload of 1:30
Standard three	Team working leadership & development	Compliant
Standard four	Supervision of Midwives & Interface with Service Users	Compliant

Key Issues for discussion:

Recommendations

Eight recommendations were set by the LSA which were largely around strengthening the SoM visibility and involvement in the organisation and external education providers.

The strongest recommendation was that the Trust should urgently address its low supervisor numbers as currently it is not compliant with the NMC recommendation of 1:15. There are education plans in place to train further Supervisors and currently four midwives are in training; however it will take until 2014 to establish this 1:15 ratio. The recommendation was made that

the consideration is given to recruit a full time SoM for the interim to rectify this position of non-compliance.

In summary the audit was complimentary and commented that the SoM team have undertaken some high quality pieces of work during the year despite having such reduced numbers which they felt was commendable. The audit was a vast improvement on the 2011 audit which demonstrates the effectiveness of the supervision team at Imperial. The Midwifery management team will work in partnership with the SoM team to create an effective business plan to enable to appointment of a full time SoM so the team can gain compliance and function effectively.

Legal Implications or Review Needed

a. Yes ☐
b. **No** √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

This report provides assurance that the SoM team have been effective and proactive within the last year and have contributed to the development of staff and the provision of high quality care.

The risk of having a non compliant ration of Supervisors needs to be addressed with a immediate and long term plan to ensure this work continues effectively.

Summary of the report attached

Purpose of Report

a. For Decision ☐
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 30th January 2013 **PAPER NUMBER: 13/01/30 – 17**

Report Title: Concerns and Complaints Policy

Executive Summary:
It is a Department of Health requirement that the Concerns and Complaints policy be reviewed and presented to the Trust Board.

The policy has been reviewed and alterations and updates have been detailed in the Document Version Table on pages 2 and 3 of the policy. The updated policy was approved by Chairman's actions in November 2012 and the Board is asked to note the amendments as presented and ratify the updated policy.

Key Issues for discussion:

Approval of the reviewed policy.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
n/a

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve, improving patient safely and satisfaction.

Assurance or management of risks associated with meeting key objective:
Compliance with legislation through local policies and procedures.

Purpose of Report

a. For Decision √
b. For information/noting ☐

Imperial College Healthcare NHS
NHS Trust

Imperial College Healthcare NHS
NHS Trust

Concerns and Complaints Policy

2013

Authors:	Anne Mottram, Director of Corporate Affairs and Governance Keith Ingram, Acting Associate Director of Service Quality Christine Cornell, PALS Manager Simon Shields, Senior Complaints Co-ordinator Laura Newman, Complaints Manager, Medicine
Contact Details:	keith.ingram@imperial.nhs.uk christine.cornell@imperial.nhs.uk
Date written:	March 2011
Approved by:	Procedural Approvals Group and JNCP
Date Approved:	22 March 2011, revised November 2012
Ratified by:	Trust Board
Date Ratified:	30 March 2011, Chairs actions November 2012
Date Policy becomes Live :	01 April 2011, Revised November 2012
Next due for revision:	Thee years after ratified or sooner if required by the NHS
Target Audience:	All staff, Bank, Locum and agency workers, honorary contract holders, volunteers, contractors' staff, Trust workers, and the representatives of professional organisations and trades unions within the Trust, and employed by other employers on Trust property.
Location of Policy:	Trust Intranet – Policies
Related Policies:	Risk Management Strategy Being Open Policy Serious Untoward Incident Policy Risk Assessment Procedure Disciplinary Policy and Procedure

	Complaints Regulations (statutory instrument) 2009 Data Protection Act Freedom of Information Act Human Rights Act Equalities Act Access to Medical Records Act Environmental Information Regulation Grievance Procedure Bullying & Harassment Policy Equality and Human Rights Policy

Document Version Numbering

Version no.	Updated by	Updated on	Description of Changes
2	SGS / KI	Feb 2011	**3.1 to 3.7** Several staff roles modified to accommodate the duties of the Complaints Manager (post unfilled).
2	SGS / KI	Feb 2011	**3.8** Investigating officer role amended to include statutory requirement to contact complainants and agree timescales for responding. Requirement for collaborative working across CPGs added.
2	SGS / KI	Feb 2011	**3.11** All staff now required to send complaints correspondence to the Complaints Office on the same day it is received.
2	SGS / KI	Feb 2011	**4.3** Definition of 'complainant' expanded to include potential patients (as required by statute).
2	SGS / KI	Feb 2011	**4.4** Consent procedure expanded to include details of how to handle exceptional circumstances.
2	SGS / KI	Feb 2011	**5.3** Procedure for registering verbal complaints clarified.
2	SGS / KI	Feb 2011	**5.7** Procedure for acknowledging complaints revised to ensure that certain requests, such as for access to medical records, are promptly dealt with. Section regarding template letters altered as different letters may be necessary for certain situations (such as SUIs).
2	SGS / KI	Feb 2011	**5.8 & 5.9** Clarified role of Heads of Nursing / Directorate lead in tackling delays in providing responses.
2	SGS / KI	Feb 2011	**7** Alterations to the recording of action points / service improvements to make better use of DATIX and reduce paperwork.
2	SGS / KI	Feb 2011	**9** Process for internal second stage review of complaints detailed.
2	SGS / KI	Feb 2011	**10** New process for managing persistent and unreasonable complainants (previously termed 'vexatious complainants') detailed (explained in full in Appendix F)
2	SGS / KI	Feb 2011	**11** Clarified process for managing cross-border complaints.
2	SGS / KI	Feb 2011	**13** Compensation section clarified and new process for small payments under £20 added.
2	SGS / KI	Feb 2011	**15** The management of complaints that involve/trigger an SUI investigation is explained in more detail.

2	SGS / KI	Feb 2011	**17** Amended policy regarding rights of access under DPA / FoI to ensure requests are appropriately managed by senior complaints staff.
2	SGS / KI	Feb 2011	**Appendix B** Revised pathway for the management of MP complaints.
2	SGS / KI	Feb 2011	**Appendix C** Revised complaint acknowledgement template letter.
2	SGS / KI	Feb 2011	**Appendix D** Substantially revised complaint response template letter – adds section on service improvements.
2	SGS / KI	Feb 2011	**Appendix F** New process to help manage vexatious complainants.
3	KI/CC	Nov 2012	**5.2.1** Process for reporting trends and gaps in service identified by PALS leading to service improvement included
3	KI/CC	Nov 202	**5.4** Complaints Coordinator tracker added so low risk grade complaints Handed to PALS can be monitored
3	KI/CC	Nov 2012	**19** Process of monitoring service improvements as a consequence of PALS identifying trends and gaps service
3	KI/CC	Nov 2012	**Appendix A** Amended to reflect complaints are now acknowledged within 3 working days

Contents

Appendices

1 Introduction

The Imperial College Healthcare NHS Trust (the Trust) has a responsibility to ensure that users of the services provided by the Trust have easy access to information about how to raise a concern or make a complaint and that the issues are responded to promptly, fairly and justly without prejudice to the care and treatment of the service user. At the same time the Trust will also respect the dignity of the service user and its staff.

The Trust is committed to ensuring that the complaints procedure can be accessed on a fair and equal basis by all patients regardless of race, language, culture, disability, religion or belief, age, gender and sexual orientation. The Trust is mindful of its obligations under equality legislation and endeavours to identify and minimise any barriers faced by patients and their relatives when using the Trust's complaints process.

The Concerns and Complaints Policy is the Trust-wide, integrated policy that embraces both the Patient Advice and Liaison Service (PALS) and the formal complaints process and strengthens integrated working between the two teams. This policy provides the framework to achieve this.

2 Purpose

This document describes the means by which patients or their representative can raise a concern and make formal a complaint. It outlines the responsibilities of the staff involved and offers guidance on good practice at each stage of the process. It ensures that the Trust listens and learns from concerns and complaints and is committed to changing practices as a consequence of these.

The Trust endorses unamended, **The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Statutory Instrument No. 309)** as its overarching policy in the management of complaints. The Concerns and Complaints Policy also fully endorses complainants' rights to have their complaint dealt with efficiently and properly investigated. This policy fully supports complainants' rights as described by the **NHS Constitution.**

Guidance has also been obtained from the following documents to ensure this policy reflects current thinking regarding good practice of complaint management within the NHS:

- The Principles of Good Complaint Handling (Parlimentary and Health Service Ombudsman, 2008)
- Listening, improving, responding: a guide to better customer care (DH, 2009)
- NHS Litigation Authority guidance about complaints
- Being Open – communicating patient safety incidents with patients and their carers (NPSA, 2009)

3 Duties, roles and responsibilities of stakeholders

3.1 The Chief Executive retains overall responsibility for the complaints process and signs all letters to Members of Parliament (MPs) and high risk grade complaints; however, responsibility for managing the requirements of this policy is delegated to the Director of Corporate Affairs and Goverance.

3.2 The Director of Corporate Affairs and Governance has delegated responsibility for concerns and complaints handling and management and oversees the performance management aspects of the process. The Director of Corporate Affairs and Governance is responsible for the analysis of complaints and concerns, as part of the Trust's commitment to learning from all forms of adverse events.

3.3 The Associate Director of Service Quality is accountable to the Director of Corporate Affairs and Governance and is responsible for ensuring that systems are developed, implemented and monitored throughout the Trust to meet the regulations.

The Associate Director of Service Quality will:

- Produce complaints reports and other submissions as required by the Trust and Clinical Programme Groups (CPGs).
- Advise the Governance Risk Committee of learning and service change as a consequence of a formal complaint.
- Ensure there is an effective performance mechanism in place to track and follow up all complaints not responded to within 25 days so that all complaints are answered within an acceptable timeframe.
- Ensure that processes are in place to effectively monitor and evaluate access to the complaints process by all patient groups and to agree actions to mitigate any barriers identified by the Equality Monitoring Form.
- Quality-assure at least five per cent of all complaint responses that are not deemed high risk.
- Review all high risk responses and MPs correspondence.
- Manage correspondence and the process concerning the Health Service and Parliamentary Ombudsmen and ensure that the Trust demonstrates compliance with relevant directives and recommendations.
- Lead on all 'second stage reviews' of complaints.
- Review all the complaint questionnaires returned once every six months to ensure continuous improvement for the complaint service.
- Put appropriate steps in place to ensure vital functions are appropriately delegated during periods of leave/absence.

3.4 The Senior Complaints Co-ordinator is accountable to the Associate Director of Service Quality and is responsible for monitoring and supervising the formal complaints handling process.

The Senior Complaints Co-ordinator will:

- Line-manage the Complaints Co-ordinators.
- Sign all formal complaint responses that are low or medium risk-graded.
- Monitor and supervise the first stage of the formal complaints process.
- Co-ordinate the handling of further / re-opened complaints.
- Chair the Complaints Forum and share service improvements implemented subsequent to formal complaints.
- Lead on training related to complaints handling and management.
- Produce the Weekly Complaints Performance Report and the Monthly Complaints Response Rate Performance Report for all CPGs/corporate directorates
- Read all formal complaints and quality-assure responses to all formal complaints.
- Be mindful of the need to offer complainants additional support or reasonable adjustments to meet disability-related or other support needs and to compensate for any barriers arising from language or cultural differences.
- When a formal complaint concerns a number of CPGs, review the complaint and allocate responsibilities appropriately and clearly so that the Trust can respond in a complete and timely manner. Such cases may require the appointed lead to arrange for the relevant medical notes to be obtained, copied and distributed appropriately, oversee the collation of various responses to review or undertake the drafting of a response letter.
- Ensure that DATIX is updated by the appropriate investigating officer when a formal complaint is upheld or partly upheld and to ensure it reflects the learning and service improvements following the complaint investigation. Confirm the integrity of the electronic data stored used for complaint reporting.
- Ensure all final response letters are copied to the relevant CPG complaints lead(s) within three working days of the complaint response letter being signed.
- Ensure relevant service improvements are reported in the Risk and Patient Safety Report.

- Ensure complaint response satisfaction questionnaires are sent to complainants approximately six weeks after their final complaint response. Such questionnaires will not be sent to complainants who it is considered would find receiving this distressing or who are presently engaged in further stages of the complaints process.

- Ensure a robust filing system is in place for complaint files.

- Provide advice to Trust staff regarding the complaints process.

- Delegate the above responsibilities appropriately during periods of leave / absence.

3.5 The Complaint Co-ordinators are accountable to the Senior Complaints Co-ordinator.

The Complaint Co-ordinators will:

- Acknowledge all formal complaints within three working days of receipt by the Trust, enclosing a ICAS leaflet to ensure we support all complainants. Log all complaints and relevant documentation accurately and completely onto DATIX.

- Track the progress of the complaint and prompt relevant staff when deadlines are approaching and a full response has not yet been received.

- Maintain the individual complaint file and collect all supporting documentation, which should be stored on DATIX.

- Refer queries, concerns and low risk-grade complaints that are suitable for informal resolution to PALS promptly.

- Analyse all formal complaint responses to ensure that all issues raised by the complainant have been addressed and that service improvements are clearly documented in the response.

- Maintain DATIX and respond to enquires from complainants, patients, representatives and staff, recording these appropriately.

- Draft complaint responses when the complaint concerns a number of CPGs by collating the appropriate information from various investigating officers. After completing the draft response, ensure each investigating officer agrees with the draft response so that it can be put forward for review by the Senior Complaints Co-ordinator.

- Refer all requests for any form of compensation to the Senior Complaints Co-ordinator for further consideration.

- Ensure that requests for copies of health records and any requests made under the Data Protection Act and Freedom of Information Act are responded to and handled promptly and effectively.

- Produce simple reports regarding complaints. Assist in the production of other reports as requested.

- Refer any complaints that raise issues that could be classified as a Serious Incident to the Associate Director of Quality and Safety immediately for further consideration.

- Refer any draft responses that appears to admit clinical or other form of negligence promptly to the Associate Director of Service Quality.

3.6 The Head of Nursing for each CPG or the nominated lead in each corporate directorate is responsible for the thorough and robust investigation of all concerns and formal complaints that involve their area of responsibility. The Head of Nursing or lead member of staff generally delegates this duty to a responsible officer, whilst providing support for cases that need to be escalated to senior staff**.**

The Head of Nursing/corporate lead will:

- Review and act on reports from PALS and the Complaints teams.
- Ensure that lessons are learnt from concerns and complaints and appropriate service improvements are implemented when a complaint is upheld or partly upheld. Ensure all service improvements as a consequence of a complaint are accurately recorded on DATIX within two weeks of the date of the response letter. Details of the person responsible for implementation and a completion date for actions should be entered onto DATIX as soon as an action has bee agreed.
- Ensure their area has robust systems in place to respond to all concerns and formal complaint correspondence promptly.
- Provide regular reports for their local forums and the Complaints Forum detailing trends and learning from concerns and formal complaints.
- Ensure that complaints investigations that reveal clinical governance concerns are dealt with at their clinical governance meeting.

3.7 The Investigating Officer has delegated responsibility for the investigation of formal complaints that involve their area of responsibility.

The Investigating Officer will:

- Liaise with the complainant, negotiate timeframes, agree desired outcomes and keep the complainant and the central complaints team informed of the progress of their investigation.
- In cross-CPG/directorate complaints, a ‘lead’ CPG/directorate will be nominated by the Senior Complaints Co-ordinator (in accordance with where the majority of and/or most serious concerns relate to). The lead CPG/directorate will be responsible for being the main point of contact for the complainant during the investigation into their concerns/complaint.
- Update DATIX on a regular basis as their complaint investigation progresses. This includes updating DATIX after each conversation with

the complainant and especially after their first telephoning the complainant to establish how they want their investigation to proceed.

- The acknowledgement letter confirms the central complaints team's understanding of the complaint and must be fully responded to unless the investigating officer has had a discussion with the complainant agreeing to alter these and made a file note that has been shared with the central complaints team.
- Be mindful of the need to offer complainants any additional support or reasonable adjustments to meet disability-related or other support needs and to deal with any barriers arising from language or culture.
- Undertake a though investigation into each issue raised by the complainant. Prepare a draft response letter written to the complainant, which is sent to the complaints team with supporting documentation. If the complaint concerns a number of CPGs, the investigating officer will be responsible for sending their draft that relates only to their CPG (together with supporting documentation).
- When complaints cross several CPGs / corporate directorates, the Investigating Officer will work collaboratively with other colleagues in the relevant areas, as necessary.
- Organise meetings as required to resolve informal concerns and formal complaints.
- Within two weeks of resolution of the complaint, update DATIX with the learning and service improvement(s) following the complaint investigation, together with the action taken to help ensure the Trust does not receive further complaints about the same issue.

3.9 The PALS Manager is accountable to the Associate Director of Nursing and will monitor and supervise the informal process of responding to concerns and any low risk-grade complaints that the enquirer agrees can be resolved through this route.

The PALS Manager will:

- Line manage the PALS Officers
- Ensure the PALS service is identifiable and accessible, providing information, advice and a first point of contact for those who have queries about or are unhappy and wish to raise concerns and complaints about Trust services
- Ensure that on-the-spot help is provided to service users and, where possible, will negotiate immediate solutions or speedy resolution of problems where possible so that concerns do not escalate
- Identify those issues that require a formal complaint investigation and refer these to the central complaints team (unless the person raising the concern explicitly requests that they do not do so)
- Ensure service users are sign-posted to appropriate independent advice and advocacy support from local and national sources
- Be mindful of the need to offer complainants any additional support or reasonable adjustments to meet disability-related or other support needs and to deal with any barriers arising from language or culture
- Produce PALS data for monthly Trust scorecard and data for joint monthly Complaints and PALS report for all CPGs/corporate directorates. Provide regular reports to CPG Heads of Nursing to help identify trends from concerns and feedback to PALS
- Lead on staff training and induction.

3.10 PALS Officers are accountable to the PALS Manager. Their role is to provide advice, support and information to clients. They help clients to resolve any concerns about Trust services where appropriate. They provide information and support to clients who need help to make a formal complaint.

PALS Officers will:

- Receive, log and respond to comments and concerns about Trust services.
- Facilitate the speedy resolution of concerns by listening, providing information, liaising and negotiating with staff colleagues as appropriate.

- Identify issues requiring a formal investigation and support service users to access the formal complaint process (unless they explicitly request that they do not wish to make a formal complaint).

- Provide information to patients in alternative formats as required; including an easy-read guide for people with learning disabilities and in other formats/languages as appropriate.

3.11 All staff within the organisation have a responsibility to:

- Respond to concerns and complaints raised directly with or reported to them promptly, apologise for any distress or inconvenience caused and try to provide an immediate resolution.
- Forward any complaint letter they receive to the central complaints team on the same day that they receive it (by email or fax), or hand deliver to a Duty, Site, Service or equivalent manager who will ensure it is received by the central complaints team.
- Signpost patients or their representatives to PALS where issues cannot be resolved locally.
- Take appropriate steps to implement any actions agreed in response to complaints to the best of their ability.
- Be familiar with the processes available to patients or representatives for raising concerns and complaints.
- Co-operate with the PALS and Complaints teams to facilitate resolution of concerns or formal complaints in a timely manner.
- Provide a signed, dated, written statement about their involvement in any matter subject to an informal concern or a formal complaint within five days of request by either the Investigating Officer, PALS or a member of the central complaints team.
- Respond to other queries for information in relation to a concern or complaint promptly, openly and honestly.

4. Definitions

The boundary may not be clear between a concern brought to PALS and a complaint. PALS and Complaints processes offer flexibility and choice that adapt to the needs and wishes of service users and the severity of each particular issue.

Issues raised will be managed in accordance with the wishes of the enquirer and the risk assessment of the concern or complaint. There are two methods of resolution.

4.1 Informal resolution occurs when an investigation and response is possible within five working days after the enquirer has consented to this process. Where a complaint is graded as low risk, enquirers will be offered this process unless they explicitly request a formal investigation.

4.2 Formal resolution occurs when the complaint requires a written response following a formal investigation. All low risk-grade complaints that will take longer than five days to respond to and all complaints assessed as medium or high risk grade will be investigated formally. Please see Appendix A.

4.3 A complainant may be a potential, existing or former patient ('patient') or a person acting on behalf of a patient with consent.

4.4 Consent must normally be obtained to start any formal investigation if the complainant is not the patient. Consent can be given by the legal guardian of a patient under 16 years of age. In cases where the patient has died, consent can be given by the next of kin / their closest living relative. In cases where a patient is unable to give consent because of incapacity, advice should be sought from the Associate Director of Service Quality.

Complainants may also include visitors and other users of Trust facilities; however, complaints that do not relate to a patient will be considered outside of the scope of the Complaints Regulations.

Complaints involving MPs will be handled in accordance with the MP Complaints Pathway. See Appendix B.

5. Policy detail and process

Patients have a right to raise concerns or make a complaint. Information on how to raise concerns and complaints about Trust services will be available and displayed throughout the Trust and on the Trust website to inform service users, their representatives and the general public.

Any complaint concerning non-NHS service providers, operating on the Trust premises, will also be investigated under this policy.

5.1 Verbal concerns

Where concerns are raised in person or over the telephone directly with Trust staff, the relevant ward or department staff should make all reasonable efforts to resolve the situation promptly, in accordance with the complainant's wishes. They should request the assistance of the departmental or service manager. Appendix C details the process for managing a complaint or concern directly and supports immediate resolution to prevent unnecessary escalation. Where prompt resolution is not possible and the complainant remains dissatisfied, they should be referred to PALS.

In some circumstances, for example out-of-hours, it may be appropriate for staff to write a brief note of the concern raised by a patient or their representative and to forward this with relevant patient details (including their contact details, hospital and/or NHS number) to the PALS email account **pals@imperial.nhs.uk**. This must be done on the day of receipt so that the PALS team can contact the complainant promptly.

The PALS team is available weekdays from 9 am to 5 pm and service users can raise their concerns in person, by telephone or email.

At other times, appropriate senior staff can be contacted for advice and support including: Ward Managers, Matrons / Lead Nurses, Consultants and Site Managers.

5.2 Informal resolution procedure

- PALS staff will take the patient/enquirers details and provide the client with their name and contact number

- PALS will listen to concern/complaint expressed by patient/representative and clarify and record details of the issue as reported

- PALS will discuss actions that PALS could take and offer to negotiate options for resolution as appropriate. PALS will ascertain whether the client is willing for PALS to seek to resolve the query informally

- PALS aim to deal with issues within 48 hours; however, because of the nature and complexity of some cases involving in-depth or multiple staff contact resolution may take longer. An expected timescale for resolution or for reporting back progress will be agreed with the client where possible

- If appropriate, PALS staff will verbally request permission to access electronic patient information to deal with an enquiry. Verbal consent will be obtained to share information and contact the relevant staff in an attempt to resolve the query.

- PALS staff will identify and then make contact with the relevant staff member(s), who will be able to investigate and respond to the concerns reported

- PALS staff will feed back actions and a response to the patient / representative. In some cases, another member of staff may offer to speak directly to the patient/representative in response to concern. PALS staff will follow up contact with the client and/or the member of staff to ensure the issue is resolved satisfactorily

- Where the client is not satisfied with the outcome, they should be asked if they wish PALS to continue to be involved or if they wish the matter to be dealt with through the formal complaints procedure.

- All relevant details, action, interventions and outcomes will be logged on PALS DATIX. Each team member can access the recorded information and progress an enquiry as necessary in the absence of a colleague

- PALS refers clients to the formal complaints procedure

  - Where a service user explicitly indicates a wish to follow this route
  - When there is an allegation of a serious nature and issues of risk are identified.

- When it is decided that informal resolution is not possible and/or appropriate for the concern(s) reported.

- PALS will provide information about the formal complaints process, including options for redress.

- PALS can acknowledge the complaint raised with PALS and assist the complainant in formulating the statement of complaint or help the complainant access appropriate independent advocacy services for this purpose and facilitate referral.

- Pass the complaint to the relevant staff for investigation.

5.2.1 Process for improvement and learning as a result of concerns being raised

PALS will ensure that any learning or service improvement reported to PALS during the course of an informal complaint investigation is noted on DATIX in the outcome field.

Any trends or gaps in services identified as a result of the volume of concerns to PALS will be reported by PALS to the appropriate CPG or corporate directorate who will report the action taken to help improve their service annually at the Complaints Forum. Service improvements will also be included int eh annual service quality and safety report which provides an overview of key learning outcomes and service improvements. This is reviewed by the Clinical Risk Committee and then reported to the Trust Quality and Safety Committee and the Board.

5.3 Formal complaints resolution procedure

Formal complaints must be made in writing or verbally. Complaints made verbally will be transcribed within two working days by either PALS or another member of staff for confirmation and signature (where possible) by the complainant. The transcribed complaint must be sent on the day of transcribing to the Complaints Office by email to complaints@imperial.nhs.uk, or by fax to 020 331 21548. The transcription of the complaint must be signed and returned to the Complaints Office. The Senior Complaints Co-ordinator can waive the requirement for the complaint transcription to be signed if the circumstances justify this. The complaint will be classed as being received on the date that either a written complaint is received or the date that a signed transcription of a verbal complaint is received.

All formal complaints will be risk assessed by the Complaints Office to identify the level and type of investigation using DATIX's risk matrix and then follow the appropriate pathway as below:

5.4 Low risk grade complaints

Low risk grade complaints that have no significant learning opportunities for the Trust will be sent to PALS so that the complainant is offered the option of an informal and speedy resolution where appropriate.

When a complaint is passed to PALS by the Complaints Office to explore informal resolution, PALS will contact the complainant within two working days. PALS will verbally acknowledge receipt of the complaint, apologise and negotiate options for a speedy informal resolution of the issues raised. PALS will explain the difference between the PALS informal process and formal process, including timescales.

Where the complainant is happy for PALS to seek to resolve the issue informally, details of the concern will be logged on PALS DATIX and the PALS procedure as outlined above will be followed. PALS will aim to resolve the concerns within five working days or return the complaint to the Complaints Office, unless the complaint agrees to a new timescale. When a complainant is not satisfied and issues cannot be resolved informally, the complaint will be investigated through the formal process.

Any complaint investigated under this process will be tracked by the appropriate Complaint Coordinator to ensure resolution occurs by completion of their PALS Tracker.

5.5 Medium and high risk-grade complaints

All other complaints will be managed through the formal resolution procedure detailed below.

5.6 Out of Time Complaints

Normally, a complaint should be made within twelve months from the incident that caused the problem, or within twelve months of the date of discovering the problem. Issues relating to an event of more than a year ago may be difficult to investigate, due to the time that has elapsed. The relevant Head(s) of Nursing should be consulted and may decide to investigate a complaint that has not been made within twelve months. In the event a complaint is judged as 'out of time', the complainant has the right to request a review of that decision with the Parliamentary and Health Service Ombudsman. A refusal to take on a complaint due to it being 'out of time' must be proportionate and reasonable.

5.7 The complaints co-ordinators will:

- Date stamp and log complaints onto DATIX and ensure consent has been received (if appropriate).

  If the Trust has not received consent with the complaint, this must be obtained before the investigation starts, or authority from the Associate Director of Service Quality must be obtained to commence the complaint investigation. However, the complaint will be passed to the relevant CPG upon receipt to ensure they receive complainants' feedback about our services as soon as possible. If the patient has died before consent has been sought, the next of kin or closest living relative will be asked to give consent.

- Carefully read the letter of complaint and extract a 'statement of complaint'. This will be a succinct summary, preferably in bullet points.

Action any requests from the complainant that require immediate action including requests for medical records, Freedom of Information Act requests and Data Protection Act requests.

- Determine which CPG(s) are responsible for each element of the complaint and forward the complaint to the relevant investigation investigating officer(s) by email or fax. The date the draft response is due back should be noted in the email/fax. If the complaint concerns more than one CPG, the Complaints Co-ordinator will discuss it with the Senior Complaints Co-ordinator, who will decide if it is appropriate to obtain and copy the health records for the relevant Investigating Officers.

- Acknowledge the complaint within three working days, indicating that a full response will be sent within 25 working days unless agreed otherwise. The template for the formal acknowledgement is at Appendix D, however further templates may be used for particular circumstances (such as SUIs, consent cases, etc). All acknowledgements will include an ICAS leaflet.

- Receive the CPG(s) draft response(s) and ensure that the response adequately addresses the issues raised and that any remedies, learning and action points proposed are sufficient. Ensure that appropriately-worded apologies are included where things have gone wrong. The response should be proof read for consistency, spelling, grammar and style and be jargon-free.

- Where necessary, contact the relevant CPG(s) to ask for further information for inclusion in the response.

- Where significant changes have been made to the original draft response letter, return it to the CPG for approval.

- Report concerns about late and/or poor quality responses to the Senior Complaints Co-ordinator.

- Help manage complaints that concern a number of CPGs/directorates. Amalgamate draft responses from various CPGs to create final response letter, which must be reviewed by the Senior Complaints Co-ordinator and approved by the relevant investigating officers.

- Ensure the draft response is sent to the relevant signatory before the due date and that all responses to high risk grade complaints are reviewed by the Associate Director of Service Quality.

- Track all Local Resolution Meetings (LRM) on DATIX to ensure that they are held within 50 days of notification. Obtain the agenda and post LRM action letter for the complaint file. Escalate any delays or concerns to the Senior Complaints Co-ordinator for action.

- Photocopy signed response letters for the complaint file, save electronically on DATIX and email them to the relevant investigation officer(s) within three working days of the response letter being signed.

Collect all supporting documentation for the complaint file and ensure it is saved within DATIX.

5.8 The CPG investigating officer will:

Make contact with the complainant and confirm how they would like their complaint investigated, what outcome they are looking for and confirm the time scale for the investigation. Provide their name and contact details and co-ordinate the investigation of the complaint after consultation with the complainant, and record this conservation on DATIX in accordance with guidance issued by the central complaints team.

- Offer advice and information to the complainant about advocacy, including the Independent Complaints Advocacy Service (ICAS).

- Consider whether the complainant has learning disabilities or special needs and establish what support / adjustment, if any, is required. It may also be more appropriate to offer a local resolution meeting rather than written correspondence to ensure that certain complainants are treated fairly and not excluded from the complaints process. Advice may be sought from the Equality and Human Rights Lead or the lead for vulnerable adults / children.

- Consider if the complaint may have an impact on equality and fairness and contact the Equality and Human Rights lead for support if required

- If the investigation will take longer than 25 working days, or the original date agreed, renegotiate a new response date with the complainant. Request the central complaints team to send an extension letter and record the conversation with the complainant on DATIX.

- Send the response letter to the Complaints Office ten working days before the deadline for responding to the complainant and save any relevant supporting documentation on DATIX.

- Request and review relevant electronic and paper health records and other necessary sources of information that will facilitate the complaint investigation.

- Identify the staff involved in the complaint and any others able to assist in the investigation or from whom information or an explanation is necessary.

- Advise all relevant staff of the complaint and of their part in its resolution.

- Obtain accurate, signed and dated accounts from all relevant staff involved in the patient's care at the time in question, informing them that their account must be returned within five working days. If the member of staff has left the Trust, reasonable efforts must be made to locate them and obtain a statement.

- If a junior doctor is asked for comments as part of any investigation, their consultant must also be informed in order that the details can be verified

- In the event of people experiencing difficulty in the production of a report/ statement themselves, support should be sought from their line manager; however, they must sign and date any such document personally. If supporting documentation and/or statements are not made available within 5 days, escalate to the staff member's manager and copy in the relevant Head of Nursing or equivalent senior staff. Further delays in the provision of statements must be escalated to the relevant Head of Nursing (or equivalent) who will take action themselves to ensure the problem is resolved.

- Advise the appropriate consultant(s) and lead nurse(s) and obtain a medical / nursing opinion where necessary.

If inconsistent clinical opinions are obtained, seek the views of an alternative clinical expert from within the Trust e.g. the Clinical Director.

- Analyse the evidence gathered and draft a response letter to the complainant, using a Trust response template letter. Medical terminology should not be included unless accompanied by a clear explanation or unless the complainant has demonstrated knowledge of the relevant terms within their complaint letter. The template for the formal response is at Appendix D.

- Confirm the implementation of any actions and service improvements following a complaint. When the complaint has been upheld in full or in part, update DATIX under the 'Investigations' section to reflect learning and service improvement(s), together with the actions taken to ensure the learning is embedded.

- Confirm the risk grading of the complaint and amend DATIX if necessary on completion of the investigation.

- Where it has not been possible to reply within agreed timescales, the investigating officer will advise their Head of Nursing, who will take appropriate action themselves as necessary to ensure clinicians or other relevant staff responsible for providing information to the investigating officer do so without further delay.

5.9 The head of nursing/directorate lead will:

- Ensure the draft response letter covers all the points raised by the complainant and help identify where any changes need to be made as a result of the complaint investigation. If there is a reason why a specific issue cannot be addressed, this should be explained.

- Take a proactive approach to resolving the complaint whenever possible. This could include arranging a meeting with the complainant and those

involved in their care, with the Head of Nursing acting as a Chair. It is the Trust's preferred option to record these meetings and then send a letter summarising the outcomes and actions.

- Support their investigating officer so that draft responses are produced within the agreed timescale with the complainant. This may include reminding clinicians and other staff groups of their responsibility to provide information in a timely manner.

- Escalate to the Clinical Programme Group Director and / or the Head of Operations when an unacceptable delay has occurred in the provision of information to the investigating officer.

6. Local Resolution Meetings

Some complaints are best resolved by providing the complainant with an opportunity to meet with representatives of the clinical staff involved in the patients care. This is particularly the case when our initial written response(s) do not satisfy the complainant. The CPG investigating officer may consider offering this instead of a written response. The following applies to Local Resolution Meetings:

- The investigating officer will organise the meeting and will set the agenda in collaboration with the complainant. At least 10 days before the meeting, the agenda will be confirmed in writing to the complainant together with details of the meeting location, time, who will be attending, and confirmation that the meeting will be recorded. A copy of this letter must be sent to the Complaints Office and any advocate supporting the complainant. If the complainant decides that they do not wish their meeting to be recorded, they should be informed that the Trust will not provide full minutes of the meeting.

- Ensure that appropriate arrangements are agreed and in place for complainants with disabilities or cannot communicate verbally in English. This could include providing an interpreter, providing documents in an appropriate format (for example in easy read format or community languages), adapting the space and format of the meeting to ensure that the process is accessible and culturally appropriate.

- The relevant CPG Head of Nursing, or Corporate Lead, will chair the meeting or if necessary delegate this role to another senior member of staff.

- Where two CPGs/directorates are involved, the chairmanship will be determined by the Heads of Nursing involved. In the event that no lead can be agreed, one will be nominated by the Associate Director of Service Quality.

- Staff who are the subject of a complaint will normally be represented by their clinical lead or line manager.

- Complaint meetings will be recorded by the Trust's audio recording equipment. At the start of the recording each person present must be asked to identify themselves by name and role, so that their voice can be recognised throughout the recording. At the end of the meeting, the complainant will be given a copy of the CD. The other copy must be sent to the Central Complaints Team and placed with the complaint file. In the event of equipment failure, an appropriate apology should be given and the notes of the meeting used to provide a written summary of the discussion.

- A letter is sent by the relevant CPG Head of Nursing within two weeks of the meeting confirming the action points agreed, who will be responsible for each action point and the timescale involved. A copy of this letter must be sent to the Complaints Office, the complainant and any advocate.

- Details of learning, action points and service agreements, should be added to DATIX.

7. Process for improvement and learning following a formal complaint investigation

The Investigating Officer will ensure all actions and any learning and service improvement from a complaint is noted on DATIX, under the 'Investigations Tab' within one week after the final response letter has been sent to the complainant. Any service improvement that has occurred as a consequence of a complaint is shared and discussed at the following meetings to ensure Trust-wide learning can occur:

- **Trust Board: Quarterly**
- **Governance Committee: Quarterly**
- **Quality & Service Committee: Quarterly**
- **Clinical Risk Committee: Quarterly including high risk complaints**
- **Ombudsman learning recommendations as they arise together with the presentation of Ombudsman National Reports**
- **Complaints Forum: Quarterly at each meeting, each CPG / corporate area will share service improvements from their complaint investigations and good practice regarding complaint investigations, reporting to the Clinical Risk Committee after each meeting.**

8. Further correspondence

In the event of further correspondence being received from the complainant, it will be processed following a similar process as described under the formal resolution procedure.

The investigating officer may consider verbally answering questions from the complainant, recording this conversation on DATIX, provide another response letter or offer a local resolution meeting. If the Trust receives an

unreasonable amount of complaint correspondence from the same complainant, advice should be sought from the Associate Director of Service Quality.

9. Second Stage Review

If the complainant remains dissatisfied after exhausting the remedies in sections 5 and 6 of this policy, they are entitled to state the reasons for their dissatisfaction and request a review of how their complaint was handled.

The Complaints Office will formally acknowledge the second stage review, confirm why the complainant remains dissatisfied and obtain the appropriate consent to share information with any independent complaint assessor(s) who may be involved in the review.

The Senior Complaints Coordinator will review the complaint file and prepare a report on the complaint for the Associate Director of Service Quality who will convene a panel of a minimum of three members of Trust staff, including the independent complaint assessor, within one month. The number of panel members will depend on the expertise needed and the complexity of the complaint. As a minimum, the panel will consist of two senior staff members; one with expertise in the area of the complaint who will chair the meeting and the Trust's Associate Director of Service Quality, together with one independent complaint assessor.

As a minimum the panel will:

- Review the complaint, considering whether the Trust has fully and reasonably responded and has done all it can do to resolve the issues
- Respond to any concerns that may be outstanding
- Consider if the response and action taken is customer-focused and appropriate
- Consider if the response demonstrate openness and accountability and recognises our commitment to promote equality of access to healthcare for all patient groups
- Consider if the complaint has been dealt with fairly and proportionately
- Consider if the response demonstrates that things have been put right and that the Trust has apologised
- Consider if the issue will benefit from an independent clinical review, external conciliation or mediation

If the panel is satisfied that the Trust has done all it can to resolve the complaint, the Associate Director of Service Quality will prepare a letter for the Managing Director informing the complainant of the decision of the panel.

This letter will advise that if they remain dissatisfied, they should now contact the Parliamentary and Health Service Ombudsman.

If the panel recommends further actions, the Associate Director of Service Quality will liaise with the relevant CPG(s)/directorate(s), agree timescales and track progress through to completion, using DATIX to record these. The Associate Director of Service Quality is also responsible for ensuring all supporting documentation is obtained for the complaint file.

10. Persistent and unreasonable complainants procedure

A small proportion of those who make complaints behave in a persistent and unreasonable manner. Such complainants can present particular difficulties for staff involved in the resolution of complaints and may place a significant strain on time and resources. Trust staff should respond sensitively to the needs of all complainants, but there are times when there is nothing further that can be done to assist them or to rectify a real or perceived problem.

The procedure contained in Appendix F should only be used as a final option or in extreme situations and after all reasonable measures have been taken to try to resolve the complainants concerns in accordance with this policy.

The procedure is also designed to protect and support staff who are the subject of malicious and/or persistent and unreasonable complaints and to maintain the integrity of the complaints procedure. The Trust is mindful of its duty to protect its staff and will if necessary prosecute any person harassing its staff when the procedure contained in Appendix F has been exhausted.

11. Managing complaints that cross organisational boundaries

Complainants have the right to request a combined response when they complain about multiple health and social care organisations. When the Trust receives a complaint which also reflects poor service from another health or social care organisation, the Senior Complaint Co-ordinator will:

- Arrange for the complainant to be contacted for their consent to send the complaint to the other organisation.
- If the complainant requests for separate responses to be sent from the respective organisations, to arrange for this to occur.
- Contact the other organisation(s) and decide who will provide the final response to the complainant.
- Agree timescales with the complainant and the other organisation(s).
- Cooperate with the other organisation(s) to ensure timescales are met
- Deal with the complaint in accordance with this policy

12. Parliamentary and Health Service Ombudsman

The Associate Director of Service Quality will manage all Ombudsman enquiries; ensure that the relevant CPG is informed and that any recommendations following an Ombudsman review are carried out.

13. Claims for financial redress

Financial redress will only be considered if a complaint is upheld and that the complainant has clearly suffered a financial loss as a result of a service failure when the Trust's policies or procedures have not been followed. The Trust will offer financial redress that puts the complainant back into the position they would have been in before the circumstances which necessitated the complaint.

The amount of financial redress will be agreed by the relevant CPG Head of Nursing/Corporate lead and will be paid from their budget. The amount of financial redress must be agreed during the course of the investigation and be stated clearly in the final response letter and recorded on DATIX by the Complaints Office. Financial redress paid per CPG/ Corporate Directorate will be reported quarterly to the Complaints Forum.

Where the amount of financial redress is less than £20, the Associate Director of Service Quality can decide to make a payment to ensure immediate resolution and prevent escalation of the complaint. The Associate Director of Service Quality will be responsible for drafting the response letter and ensuring that the appropriate investigating officer has sight of the complaint correspondence. The amount paid will come from the Associate Director of Service Quality's budget.

The above excludes claims for clinical negligence or harm, which must be pursued under the Trust's Claims Management Policy.

14. Possible claims for negligence

Where a complainant states in writing that legal action has been commenced, the complaint can at the same time pursue a formal complaint. However, if the Associate Director of Service Quality after consulting with the NHSLA considers that a complaint investigation may adversely affect the Trust's defence, then the complaint procedure can be discontinued. The complainant and those staff involved will be notified of this decision.

15. Serious Incidents (Serious Untoward Incident as was) Policy

The procedure for investigating a serious incident is separate from the Responding to Concerns and Complaints Policy. The Associate Director of Quality and Safety will be informed if the complaint investigation reveals the need to take action under the Serious Incidents Policy. The Associate Director of Quality and Service will also decide if a complaint should be investigated as a serious incident. In these circumstances the complainant will be notified that a serious incident investigation will be undertaken and provided with the timeframe.

If a complaint is received that includes issues being investigated as an existing serious incident and includes further concerns, the scope of the serious incident will be clarified with the Associate Director of Quality and Safety. The acknowledgement letter will set out what will be addressed by the serious incident investigation and if a concern is to be answered outside of the serious incident investigation then this will be addressed by this policy.

Where a serious incident investigation is undertaken the complainant should always be offered a meeting to discuss their care and offered a copy of the investigation report.

16. Human resource procedures

Where it emerges that investigation and / or action is necessary using Human Resources procedures, this is referred to the relevant CPG Head of Nursing / directorate lead for action in conjunction with the Human Resources Department. Details of any disciplinary investigation / action taken against current or former members of staff cannot be disclosed to complainants.

17. File maintenance and access

The complaint file is the Trust's record containing all notes and correspondence obtained in the course of the investigation held on paper and electronically. The complaint file incorporates all DATIX entries and includes any internal or external letters, memoranda, file notes and all other written correspondence and supporting documentation.

A complaint file will be stored for ten years, or in accordance with the regulations governing health records in place at the time. Any changes to the relevant statues and guidance regarding file storage will be implemented as fully and promptly as possible. A complaint file might be required by the Parliamentary and Health Service Ombudsman as part of their investigation and remains discoverable as part of a court order in the event of a claim being filed with the courts.

Complainants have the right to request a copy of their complaint file under the Data Protection Act. They also have a right to request copies of our complaints policy and anonymised reports of meetings under the Freedom of Information Act. Requests for copies of complaint files and Freedom of Information requests must be reviewed by the Senior Complaints Co-ordinator.

Copies of complaint correspondence must not be added to the patient's health records and if found by any member of staff, must immediately be forwarded to the central complaints team or Health Records Manager.

18. Training

Generic training on complaint handling is carried out during corporate induction. Staff whose role requires them to have additional training will be trained in accordance with the Trust Training Needs Analysis and Training Prospectus. Follow up of training will be carried out in line with the Trust Statutory and Mandatory Training Policy. Other training will be provided as required.

19. Monitoring mechanisms

1. The Associate Director of Service Quality will ensure all final responses, including local Member of Parliament letters received on behalf of their consistent, are signed by the appropriate staff member.

2. The PALS Manager will monitor the informal resolution process to ensure compliance with agreed timescales for resolution and will review reasons for non-compliance.

3. The Complaints Team will monitor and oversee the progress of all formal complaint investigations and LRMs, working to ensure compliance with the agreed timescales for investigation. This will be achieved through weekly performance reports, emailed to CPG/directorate leads.

4. The Complaints Forum will review all operational issues related to complaints. The PALS Manager will attend the Complaints Forum, where trends and any gaps in service identified by PALS will be discussed annually by the relevant CPG or corporate directorate. Learning and service improvements following a formal complaint investigation will be discussed at each meeting. The Associate Director of Service Quality will report on complaint KPIs annually.

5. The Clinical Risk Committee will review procedural compliance, outcomes, improvement and learning for all complaints graded as high risk and those containing Ombudsman learning recommendations.

6. The Quality and Service Committee will monitor complaints quarterly as part of the aggregated reports from risk management.

7. The Board will monitor complaints as part of the aggregated reports from risk management each quarter. Reports containing improvement and learning will be reviewed quarterly at the Governance Committee and reported up to the Trust Board.

8. The Associate Director of Service Quality will ensure learning and improvements as a result of a formal complaint investigation reflect on DATIX.

20. Standards and Key Performance Indicators

- All new Trust staff will receive training on how to handle concerns and complaints as part of Corporate Induction.
- At least 98% of new complaints and concerns will be acknowledged within three working days.
- At least 90% of complaints requiring formal resolution will be responded to within 25 working days or within a negotiated extended deadline date.
- Compliance with the identified response times will be monitored by the PALS and complaints teams by producing a monthly joint report.
- A survey will be issued to at least 25% of complainants approximately six weeks after a case is closed to review satisfaction with the complaints management and outcome to support continuous improvement of the service and to help determine if discrimination was experienced. The outcome of the survey will be reported to the Complaints Forum annually.
- The Trust Scorecard will monitor the number of complaints received and response times monthly. Quarterly governance reports to the Quality and Safety Committee, Governance Committee and through this up to the Trust Board to include learning and improvement by each CPG, and Corporate Service were appropriate.
- High risk complaints will be reported to the Clinical Risk Committee together with the associated learning and improvement by each CPG, and Corporate Service were appropriate.
- Less than 3% of complaints should result in a Parliamentary and Health Service Ombudsman review of our complaints handling.
- The Parliamentary and Health Service Ombudsman should uphold no more than 2% of all formal complaints received by the Trust.

21. Exclusions

Complaints relating to the following are not covered by this policy and must be referred to the Information Governance Manager.

- Data Protection Act
- Freedom of Information Act
- Access to Health Records Act
- Access to Medical Reports Act
- Environmental Information Regulation

22. Responsibility for Document Development

This policy has been developed in the light of currently available information, guidance and legislation and may be subject to review. The policy will be

reviewed yearly by the Governance Committee and ratified by the Trust Board.

Key stakeholders involved in the development of the strategy include the PALS and complaints teams, members of the Quality and Safety Committee, Heads of Nursing, Heads of Operations and the JNCP.

23. Equality Impact Assessment

All public bodies have a statutory duty under equality legislation to undertake equality impact assessments on all policies / guidelines and practices. The Trust's equality impact assessment tool covers the areas required by statute and also deprivation and human rights.

This policy has been equality impact assessed and the findings are included in appendix G.

24. Dissemination and Implementation

The Policy will be launched in the Trust's bi-weekly newspaper and in more detail in the quarterly Trust Safety and Quality Newsletter.

The policy will be promoted in corporate induction and any training sessions carried out.

The policy will be published on the intranet and also be presented at the Complaints Forum.

Communication with external bodies will be the responsibility the Director of Corporate affairs and Governance who may delegate this to the Associate Director of Service Quality. This policy will be shared with Imperial College London and our host PCT / commissioning groups.

25. Implementation of the policy

Complaints leads will be asked to implement the policy in their local areas

26. Document Control including Archiving Arrangements

When the new policy is published and loaded on to the intranet, it will replace the previous version, which will be automatically archived within the intranet (not visible, but accessible by the communications team on request).

26.1 Archiving arrangements

To ensure all NHSLA-related policies are appropriately reviewed, the Standards Manager will be responsible for follow-up and contacting the author of the policy.

27. Register/Library of Procedural Documents

A register/library of procedural documents and the library of Clinical Guidelines will be maintained on the intranet. Ownership of the original procedure document (together with supporting documents such as the Dissemination Plan) will remain with the author(s).

28. References

- DH 2008 **REFORM OF HEALTH AND SOCIAL CARE COMPLAINTS: proposed changes to the legislative framework**
- DH 2009 The NHS Constitution
- DH 2009 **A Guide to Better Customer Care**
- Parliamentary and Health Service Ombudsman 2008 **Improving public service: a matter of principle.** HC9, London: The Stationery office.

29. Useful Links

Department of Health homepage:
www.dh.gov.uk

Parliamentary and Health Service Ombudsman Homepage:
www.ombudsman.org.uk/

Local Government Ombudsman Homepage:
http://www.lgo.org.uk/

Independent Complaints Advocacy Service Homepage:
http://www.icasresources.com/

Independent Regulator of NHS Trusts Homepage:
http://www.monitor-nhsft.gov.uk/index.php

Information for Local Government from Central Government:
http://www.info4local.gov.uk/

The Data Protection Act:
www.opsi.gov.uk

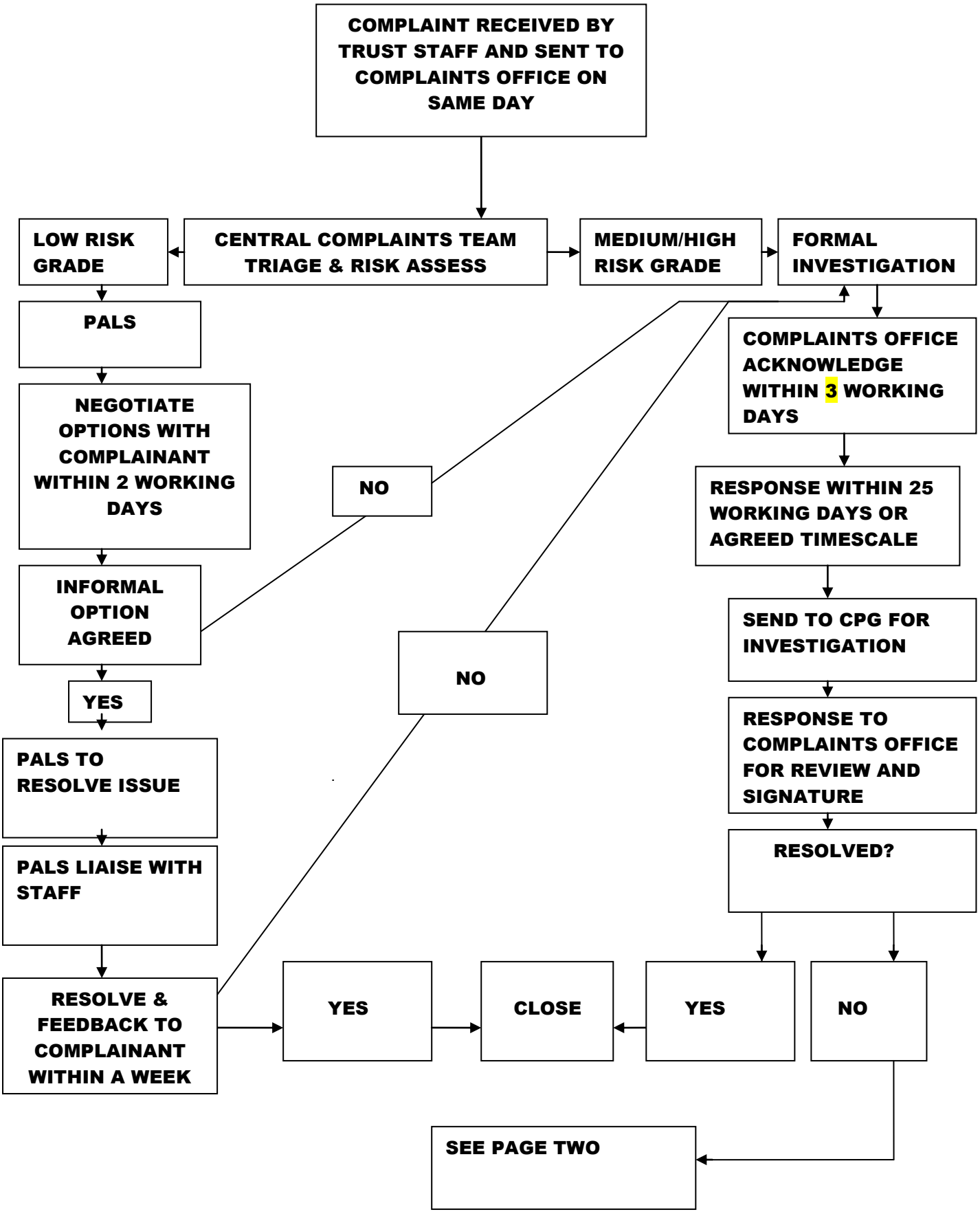
Freedom of Information Act 2000:
www.opsi.gov.uk

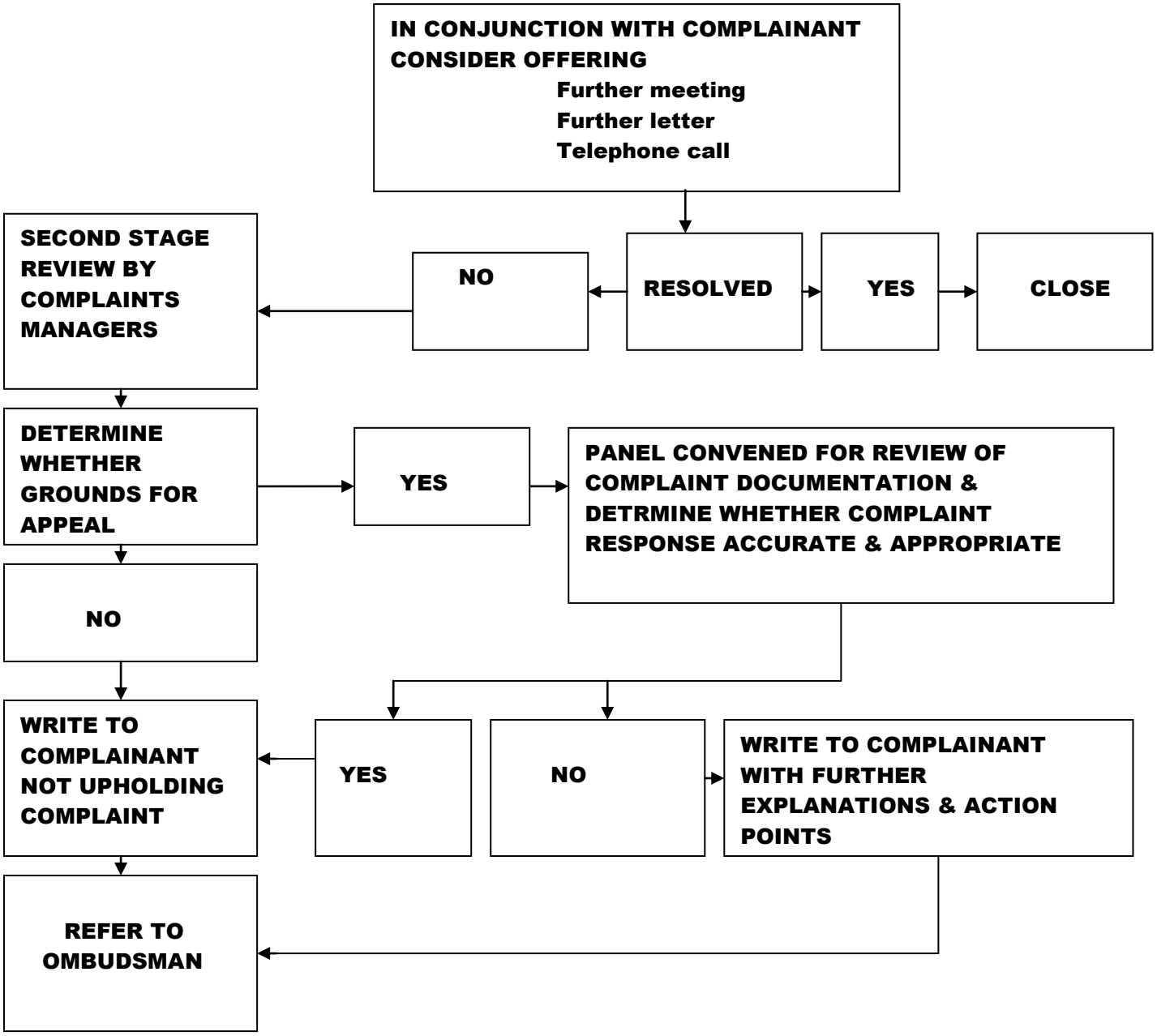
Health and Social Care Act 2008:
www.opsi.gov.uk

Health Act 2009:
www.opsi.gov.uk

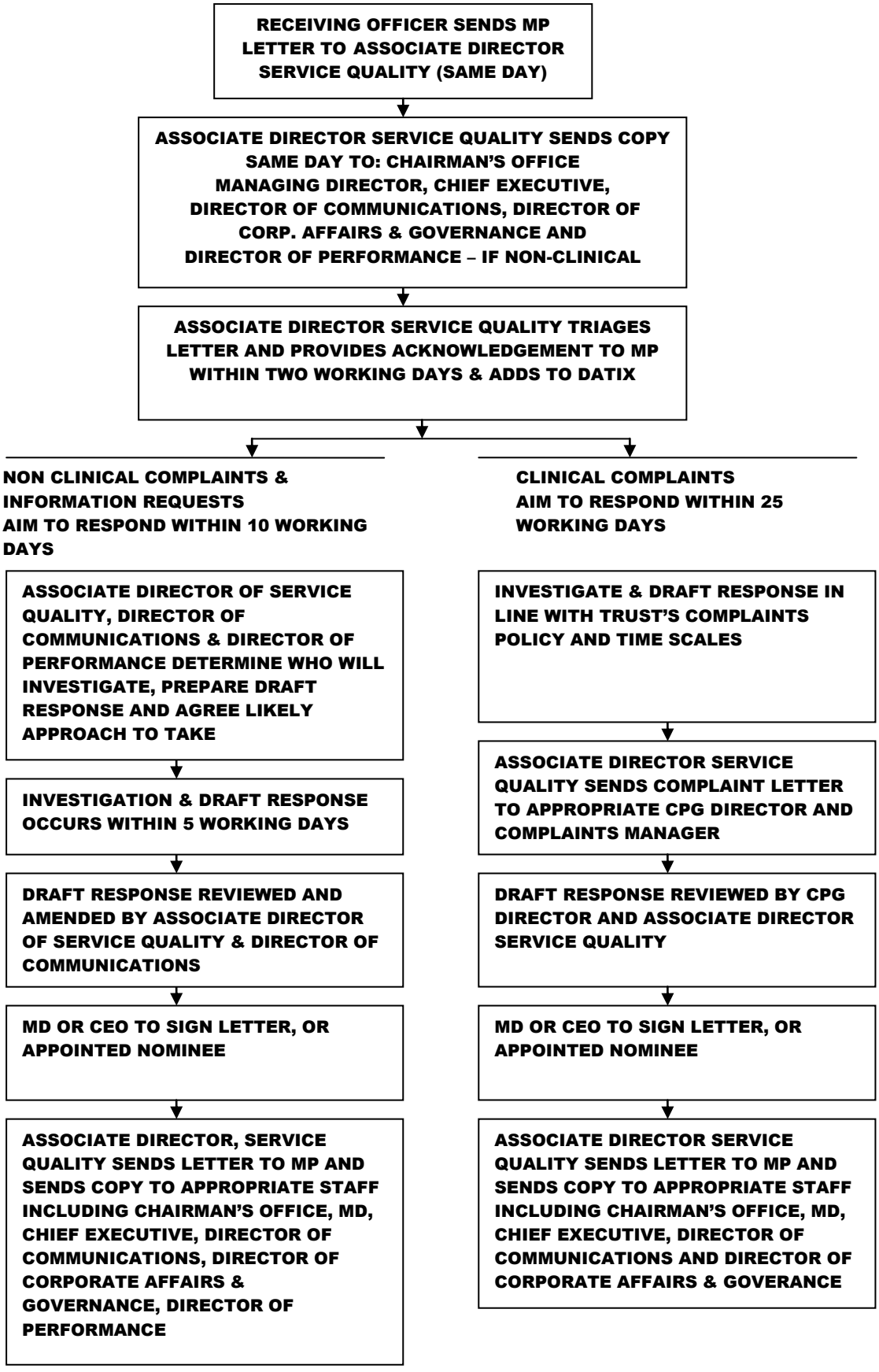
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009:
www.opsi.gov.uk

Appendix A – Complaint Pathway




IN CONJUNCTION WITH COMPLAINANT CONSIDER OFFERING
Further meeting
Further letter
Telephone call
RESOLVED
YES
CLOSE
NO
SECOND STAGE REVIEW BY COMPLAINTS MANAGERS
DETERMINE WHETHER GROUNDS FOR APPEAL
YES
PANEL CONVENED FOR REVIEW OF COMPLAINT DOCUMENTATION & DETRMINE WHETHER COMPLAINT RESPONSE ACCURATE & APPROPRIATE
NO
WRITE TO COMPLAINANT NOT UPHOLDING COMPLAINT
YES
NO
WRITE TO COMPLAINANT WITH FURTHER EXPLANATIONS & ACTION POINTS
REFER TO OMBUDSMAN

Appendix B – MP Complaint Pathway


RECEIVING OFFICER SENDS MP LETTER TO ASSOCIATE DIRECTOR SERVICE QUALITY (SAME DAY)
ASSOCIATE DIRECTOR SERVICE QUALITY SENDS COPY SAME DAY TO: CHAIRMAN'S OFFICE MANAGING DIRECTOR, CHIEF EXECUTIVE, DIRECTOR OF COMMUNICATIONS, DIRECTOR OF CORP. AFFAIRS & GOVERNANCE AND DIRECTOR OF PERFORMANCE – IF NON-CLINICAL
ASSOCIATE DIRECTOR SERVICE QUALITY TRIAGES LETTER AND PROVIDES ACKNOWLEDGEMENT TO MP WITHIN TWO WORKING DAYS & ADDS TO DATIX
NON CLINICAL COMPLAINTS & INFORMATION REQUESTS AIM TO RESPOND WITHIN 10 WORKING DAYS
ASSOCIATE DIRECTOR OF SERVICE QUALITY, DIRECTOR OF COMMUNICATIONS & DIRECTOR OF PERFORMANCE DETERMINE WHO WILL INVESTIGATE, PREPARE DRAFT RESPONSE AND AGREE LIKELY APPROACH TO TAKE
INVESTIGATION & DRAFT RESPONSE OCCURS WITHIN 5 WORKING DAYS
DRAFT RESPONSE REVIEWED AND AMENDED BY ASSOCIATE DIRECTOR OF SERVICE QUALITY & DIRECTOR OF COMMUNICATIONS
MD OR CEO TO SIGN LETTER, OR APPOINTED NOMINEE
ASSOCIATE DIRECTOR, SERVICE QUALITY SENDS LETTER TO MP AND SENDS COPY TO APPROPRIATE STAFF INCLUDING CHAIRMAN'S OFFICE, MD, CHIEF EXECUTIVE, DIRECTOR OF COMMUNICATIONS, DIRECTOR OF CORPORATE AFFAIRS & GOVERNANCE, DIRECTOR OF PERFORMANCE
CLINICAL COMPLAINTS AIM TO RESPOND WITHIN 25 WORKING DAYS
INVESTIGATE & DRAFT RESPONSE IN LINE WITH TRUST'S COMPLAINTS POLICY AND TIME SCALES
ASSOCIATE DIRECTOR SERVICE QUALITY SENDS COMPLAINT LETTER TO APPROPRIATE CPG DIRECTOR AND COMPLAINTS MANAGER
DRAFT RESPONSE REVIEWED BY CPG DIRECTOR AND ASSOCIATE DIRECTOR SERVICE QUALITY
MD OR CEO TO SIGN LETTER, OR APPOINTED NOMINEE
ASSOCIATE DIRECTOR SERVICE QUALITY SENDS LETTER TO MP AND SENDS COPY TO APPROPRIATE STAFF INCLUDING CHAIRMAN'S OFFICE, MD, CHIEF EXECUTIVE, DIRECTOR OF COMMUNICATIONS AND DIRECTOR OF CORPORATE AFFAIRS & GOVERANCE

Appendix C – Template for formal acknowledgement letter

Direct line: 020 3312 XXXX
Text Relay: 18001 020 3312 1311
Fax: 020 3312 1548
Email: complaints@imperial.nhs.uk
Our ref: «COM_ID» / «COM_NAME» / ACK /

«LCOM_DACK__COMP»

Private and confidential
«CON_TITLE__COMP» «CON_FORENAMES__COMP»
«CON_SURNAME__COMP»
«CON_ADDRESS__COMP»
«CON_POSTCODE__COMP»

Dear «CON_TITLE__COMP» «CON_SURNAME__COMP»

I am writing further to your letter dated XX, which was received in this office on «COM_DRECEIVED». I am very sorry that you have had cause to complain. I have started an investigation into the issues you have raised.

In order to ensure that I respond fully to your complaint, I will outline my understanding of the issues you raise. Please bear in mind that this is just a brief summary of the issues. Our investigation will examine all of your concerns in detail. I would be grateful if you could get in touch with me soon if you **do not** agree with my understanding or have further concerns that you wish to be investigated. As I understand it, you wish to complain that:

- «COM_DETAIL»

The investigating officer leading the enquiry into your concerns will try to contact you within the next few days, to discuss our investigation. They will agree a timescale for the Trust to respond to you and give you their contact details. If you have any questions in the meantime, please contact the Complaints Office on the number above.

Please find enclosed a leaflet from POhWER ICAS (Independent Complaints Advocacy Service), who provide independent support and advice for complainants. We have also enclosed an equality monitoring form and pre-paid return envelope for this. This information will help us to ensure that we treat all complainants fairly and also to provide any adjustments you may need to access our service.

Yours sincerely

Patient Complaints Co-ordinator
Imperial College NHS Healthcare Trust

Enc: ICAS leaflet,

Appendix D – Template for formal complaint response letter

Direct line: 020 3312 XXXX
Text Relay: 18001 020 3312 1311
Fax: 020 3312 1548
Email: complaints@imperial.nhs.uk
Our ref: «COM_ID» / «COM_NAME» / RES

DATE

Private and confidential
«CON_TITLE__COMP» «CON_FORENAMES__COMP»
«CON_SURNAME__COMP»
«CON_ADDRESS__COMP»
«CON_POSTCODE__COMP»

Dear «CON_TITLE__COMP» «CON_SURNAME__COMP»

I am writing further to the letter from XX, Complaints Co-ordinator, dated «LCOM_DACK__COMP» regarding XX. I am replying to you on behalf of the Managing Director, who has responsibility for complaint management in the Trust. I am very sorry that you have had cause to complain. A thorough investigation into your concerns has now been completed, so that I may reply to you.

Summary of your complaint

«COM_DETAIL»

Complaint investigated by

State who was in charge of the investigation of each part of the complaint and what their title or position is. This section should be completed by CPG staff (with the name and phone number added to the end of the letter). Any person named as the subject of a complaint **cannot** be the investigator of it. For example:

XX, Complaints Manager for XX Clinical Programme Group has led the investigation into your complaint. XX, JOB TITLE, has supplied information about the concerns you have raised.

Investigation findings

This is where to write the detailed response, addressing each point of complaint. Use the same headings as in the 'Summary of your complaint' section above. Ensure you re-read the whole complaint letter, as it may contain issues that need to be responded to that are not listed in the summary.

Outcome of our investigation

Outline the outcomes here. They should be specific to the complaint and not service improvements (place these below). Note any problems that have been identified. If any actions have been taken that are not service improvements, note them here. This can be done in bullet points or prose, as appropriate.

Improvements to service following your complaint

Please include details of improvements made to services here. This section should be completed for all responses, but is **mandatory** for all medium and high-risk complaints. Trust-wide schemes that are already underway **are not** acceptable (however if a particular member of staff is sent on I Care training that **can** be included. The fact that we have the I Care scheme is not sufficient. The same is true for ICHIS – if a specific problem has been resolved, it can be included. The fact we have ICHIS cannot).

Suggestions for improvements to services:

- Improving patient information literature.
- Amending clinic / admission letters.
- Arranging additional training.
- Raising issues in the relevant clinical governance meeting.
- Reviewing / updating procedures / policies / guidelines.
- Improving patient participation in service development.
- Reviewing shift patterns and workflows to increase efficiency and responsiveness.
- Repairing / upgrading equipment.
- Undertaking additional patient surveys.
- Action to improve the clinic / ward environment.
- Reviewing systems to improve communication between teams and with patients/carers.
- Improving arrangements for covering staff when they are on leave.

I hope that I have been able to respond to your concerns in a helpful and constructive way. Please accept my sincere apologies on behalf of the Trust. If you need further assistance, please contact XX on XX. Alternatively, please write back to me explaining your outstanding concerns, or email complaints@imperial.nhs.uk.

Yours sincerely

XX
Imperial College Healthcare NHS Trust

Enc: ‘Following our investigation’ leaflet.

Appendix E Equality Impact Assessment

1 Equality Impact Screening

1.1 Title of Policy/Procedure/Function/Service Risk Management Strategy	
1.2 Directorate/Department Governance	
1.3 Name of Person Responsible for This Equality Impact Assessment Anne Mottram	
1.4 Date of Completion	22 / 04 / 2009
1.5 Aims and purpose of Police/Procedure/Function/Service To provide the strategic direction for risk management	
1.6 Examination of Available Evidence – Tick evidence used:	
Census Data for UK	☐
Census Data for London	☐
Census Data for Local Authority Area	☐
Trust Workforce Data	☐
National Patients Survey	☒
Trust Patients Survey	☒
Trust Staff Survey	☒
Other Internal Research/Survey/Audit (list below) National Staff Survey	☐
Other External Research/Survey/Audit (list below) Michael, J (2008) 'Healthcare for All': Report of the Independent Inquiry into access to healthcare for people with a learning disability Parliamentary and Health Service Ombudsman (2009) Six Lives: the provision of public services to people with learning disabilities. London: The Stationery Office	☒

1.7 What is the summary of the available evidence?

The Micheal Report, 2008 (Healthcare for All) and the Health Service Ombudsman's report Six Lives: the provision of public services to people with learning disabilities, highlighted significant risks to patient safety and equality for people with learning disabilities. Both reports highlighted a lack of awareness of the reasonable adjustments needed for patients with learning disabilities as well as NHS organisation's duty to promote equality of access for this group.

The CQC & NHS London have subsequently published key performance indicators relating to all aspects of the treatment and support of patients with learning disabilities and their carers.

The ombudsman's report Six Lives was particularly critical of the way in which the NHS had delt with complaints relating to patients with learning disabilities and concluded that in some of the cases they reviewed they found "maladministration and service failure for disability related reasons. We also found in some cases that the public bodies concerned had failed to live up to human rights principles, especially those of dignity and equality".

1.8 Does the evidence indicate that there is (or is likely to be) any significant impact on anyone or any group in relation to the following Equality Strands? Select from drop-down list.

	Yes/No/ Not Enough Data	Impact is Justified
Ethnicity/Race	YES there is significant impact	Justified
Disability	YES there is significant impact	Not justified
Gender/Sex	NO there is no significant impact	Justified
Religion/Belief	NO there is no significant impact	Justified
Sexual Orientation	NO there is no significant impact	Justified
Age	YES there is significant impact	Justified
Human Rights	NO there is no significant impact	Justified
Deprivation	YES there is significant impact	Justified

1.9 If further evidence is required to complete this report, take steps to obtain it before proceeding with the assessment. If the review of evidence indicates that there is a **significant unjustified** impact, a Full Equality Impact Assessment must be carried out.

1.10 No further action required. Skip to section 5 below. ☐

1.11 Full Equality Impact Assessment required. Go to section 2 below. ☒

2 Full Equality Impact Assessment

2.1 Describe how the policy/procedure/function/service has a significant impact on people because of their ethnicity, race, colour, nationality or national origin
2.2 Describe how the policy/procedure/function/service has a significant impact on disabled people
People with a range of disabilities; including those with learning disabilities, sensory impairments or mental health problems (including dementia & confusion) are at considerable risk of exclusion from the concerns and complaints procedure. This may be as a result of impairments in communication resulting in barriers to raising concerns or complaints. There may also be organisational barriers, for example poor availability of information in alternative formats, including easy read for people with learning disabilities. In order to overcome barriers public bodies are required to adopt the social model of disability, with a focus on providing reasonably adjusted healthcare and support and to remove the barriers faced by disabled people. Under current definitions as set out by the Disability Discrimination Act (2005) amendment, approximately a fifth of the UK population may be defined as having a disability. Given the diverse nature of disability and its impact an approach which focuses on providing a tailored and personalised support to all patients (including patients with disabilities) is likely to best provide a high quality service to all patients. This said, patients with disabilities and learning disabilities are likely to have specific access needs; which will require clinical and support staff to have a dialogue with these patients (or carers) in order healthcare which is safe and reasonably adjusted. Patients with disabilities and in particular learning disabilities will likely require adjustments to allow them to participate in the complaints process on an equal and fair basis. This includes encouraging complainants to disclose disability, to discuss and agree any reasonable adjustments needed and to monitor/contrast the outcomes of complaints raised by patients with disabilities and learning disabilities. The Trust is required to monitor access to the complaints procedure by patients with learning disabilities in carrying out its disability equality duty (Disability Discrimination Act, 2005) and to report this information to NHS London on an annual basis as part of its Assessment and Performance Framework (learning

disabilities)
2.3 Describe how the policy/procedure/function/service has a significant impact on people because of their gender, sex (including gender reassignment) or because they are married or are civil partners
2.4 Describe how the policy/procedure/function/service has a significant impact on people because of their religion or belief (including other philosophies, or those with no religious belief)
2.5 Describe how the policy/procedure/function/service has a significant impact on people because of their sexual orientation
2.6 Describe how the policy/procedure/function/service has a significant impact on people because of their age (consider older people, as well as younger people)
2.7 Describe how the policy/procedure/function/service has a significant impact on people because of factors linked with deprivation, such as health, housing, education, employment etc.
2.8 Describe how the policy/procedure/function/service has a significant impact on people because of factors linked to the Human Rights Act
2.9 Describe how the policy/procedure/function/service will promote equality of opportunity between different groups; including taking account of disabled people's disabilities, even where that involves treating disabled people more favourably than other persons.
The policy, procedures and associated training needs to demonstrate that the unique needs of people with disabilities or from black and ethnic minority groups are taken into account and actions are undertaken to allow complainants to raise concerns or complaints on an equal basis *The policy will need to demonstrate how legislation relating to equality and human rights is taken into account when dealing with concerns and in the investigation process with regards to individuals complaints. i.e. did the complainant face discrimination; were they treated fairly, is there evidence that*

reasonable adjustments were agreed by clinical staff, did clinical staff involve carers (where appropriate) when supporting patients who lack capacity? . *Does the training of complaints investigators include:* *Human Rights Act principles* *Race Equality Act & principles* *Age discrimination principles* *Disability Discrimination Act (1995 & 2005)* *Mental Capacity Act (2005)* *Deprivation of Liberty Standards (DOLS)*
2.10 Describe how the policy/procedure/function/service will eliminate unlawful discrimination – both direct and indirect
2.11 Describe how the policy/procedure/function/service will eliminate harassment of people for any reason
2.12 Describe how the policy/procedure/function/service will promote positive attitudes towards others
2.13 Describe how the policy/procedure/function/service will encourage participation of people in public life

3 Action Plan

List the actions that are required to eliminate or reduce any negative impact resulting, or likely to result, from this analysis, such as amendments to policies, procedures, or other changes to functions or services. Include who is responsible for the action, the date for completion and which **corporate or directorate action plan** they have been included in.

Details of Action	Date	Manager	Action Plan

4 Stakeholder Involvement

Describe stakeholder involvement and consultation in the Equality Impact Assessment (e.g. staff, patients, etc.).

5 Monitoring Arrangements

Describe how the actions put in place to eliminate or reduce any unjustified negative impact will be monitored, including time frames and accountability.
Annual advice on monitoring audit from the Equality and Diversity lead.

6 Other Notes/Comments

Appendix F

Persistent and unreasonable complainants procedure

1. Introduction

Staff who work at Imperial College Healthcare NHS Trust come into contact with patients, their carers and relatives in a wide range of contexts, depending on their responsibilities and roles. The vast majority of contacts with patients is of a professional nature and can often be the most rewarding aspect of a person's day to day activities.

Unfortunately, on occasion a small minority of people contacting the Trust behave in an inappropriate and unacceptable manner, causing distress to members of staff. Some individuals can use a disproportionate amount of staff time and resources, harming their ability to provide a good service to others. When this happens, it is important for staff to recognise and manage this type of behaviour effectively; this procedure provides guidance to staff to help them to cope.

Imperial College Healthcare NHS Trust has a zero tolerance approach to verbal and physical abuse of staff. It is important that staff are aware of the support in place when they experience unacceptable and inappropriate contact by members of the public. It is also important that people who display this type of behaviour are clearly advised that it is not acceptable and that they cannot abuse, threaten or intimidate staff.

2. Definition of a persistent or unreasonable complainant

Unreasonable behaviour can present itself in a number of ways and there is no one feature that can be applies to all cases. It can be defined as to:

- Harass
- Cause distress
- Deliberately annoy, belittle or tease
- Use abusive, discriminatory or aggressive language
- Make threats
- Make knowingly false allegations
- Agitate, disturb or contact staff excessively.

The main criteria is that the presenting behaviour is persistent and unreasonable.

This type of behaviour is more likely in people who are experiencing or have experienced the following:

- **Enduring health problem**
- **Recent bereavement**
- **Poor service experience**
- **Personality disorder / severe mental health condition**
- **Behavioural, social and/or emotional problems**
- **Lack of family or other support**

Complainants may be deemed to be persistent and unreasonable where current or previous contact with them shows that they have met two or more (or are in serious breach of one) of the following criteria:

- Fails to change behaviour, despite being warned that they must do so during contact.

- Persisting in pursuing a complaint where the Trust's complaints process has been fully and properly implemented and exhausted.

- The substance of a complaint is constantly changing, new issues are persistently raised or complainants seek to prolong contact by unreasonably raising further concerns or questions. Care must be taken not to disregard genuine **new** issues that differ significantly from the original complaint. New issues that differ significantly from the complainant's original complaint should normally be addressed as a new complaint, rather than additions to the existing complaint

- Are unwilling to accept our final response as being factual and continually repeat their complaint.

- Do not identify clearly the precise issues they wish to be investigated despite reasonable efforts to help them do so by Trust/ICAS staff. Consideration should be given to providing extra support to help complainants to communicate effectively, which may include meeting with PALS, a member of staff from the central complaints team, or an ICAS advocate. Refusal to make use of such support and continuing with inappropriate contacts will be considered to be unreasonable behaviour.

- Focus on a trivial matter to an extent that is grossly out of proportion to its significance and continue to focus on this point. It is recognised that determining what is trivial is subjective and careful judgement must be used in applying this criterion.

- Have made verbal or written threats and/or used physical violence towards staff or their families or associates at any time. All such incidents should be documented and reported on DATIX, Non Clinical Incident Form and documented either in the patients' health records or a file note. Future contact (if appropriate) with the complainant will be by written correspondence.

- Have harassed staff and/or been personally abusive, including racist, ageist, xenophobic, sexist, disability-related or homophobic abuse; or been verbally aggressive towards staff dealing with their complaint. Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this, whilst challenging inappropriate and unreasonable behaviour appropriately and sensitively.

- Making repeated and unsubstantiated allegations of criminal behaviour by staff that are not reported to the appropriate authorities.

- An excessive number of contacts with the Trust placing unreasonable demands on staff – particularly when excessive numbers of staff members are contacted. Such contacts may be in person, by telephone, letter, fax, email or a combination of these. Discretion must be exercised in deciding how many contacts are required to qualify as excessive, using judgement based on the specific circumstances of each case.

- The complainant is known to have recorded meetings or conversations without the prior knowledge and consent of the other parties involved.

- Display unreasonable demands or expectations and fail to accept that these may be unreasonable once a clear explanation is provided to them as to what constitutes an unreasonable demand (e.g. insisting on responses to complaints or enquiries being provided more rapidly than is possible, reasonable or recognised practice).

3. Options for dealing with persistent and unreasonable complainants

When complainants have been identified as being persistent and unreasonable, in accordance with the above criteria, the Associate Director of Service Quality will decide what action to take. The Associate Director of Service Quality will implement such action and notify complainants promptly and in writing the reason why they have been classified as persistent and unreasonable and the action to be taken. This notification must be copied

promptly for the information of others involved in the complaint and form part of the complainants complaint file.

The Associate Director of Service Quality may decide to deal with persistent and unreasonable complainants in one of the following ways:

- No further action at this stage but information kept on file should further contact continues to be an issue.

- A warning letter to the individual from the Associate Director of Service Quality outlining that the behaviour displayed is unacceptable and in continuing to behave in this manner may result in further action being taken in relation to future contacts with the organisation. The letter will give specific details of the types of behaviour that the complainant is displaying that is unacceptable, so that they are fully aware of the nature of the concerns about them. Consideration should be given to agreeing with the complainant a code of behaviour for the parties involved if the Trust is to continue dealing with the complaint. This could include identifying a single point of contact for future interaction with the individual and/or limiting the acceptable methods of communication. Please see below. If this agreement is breached, consideration would then be given to implementing other actions as outlined below

- Decline further contact with the complainant either in person, by telephone, fax, letter or electronically. A suggested statement has been prepared for use if staff are to withdraw from a telephone conversation with a complainant.

- People who behave in a violent, threatening, aggressive or abusive manner should be considered for appropriate handling under the Trust's 'yellow card' 'red card' processes.

- Inform complainants that in extreme circumstances, the Trust reserves the right to refer persistent and unreasonable complainants to the Trust's solicitors and/or, if appropriate, the police.

4. Single Point of Contact (SPoC)

The Single Point of Contact provides a route whereby enquiries made by individuals who have behaved in a persistent and unreasonable way can continue to contact the organisation. All future contacts are restricted in that the individual must always contact their allocated SPoC. Once it has been identified that a SPoC is the correct process to adopt, an appropriate member of staff will be identified.

The preferred route will often be by email as this provides a formal record for both the organisation and the individual. This does not restrict contact to email alone and there may be occasions when discussion over the phone is necessary. Also, if excessive numbers of emails are sent, or the content

continues to be inappropriate, further restrictions may be put in place limiting the volume and/or nature of correspondence.

When the individual does make contact, it is important that the organisation is given time to review and respond to the enquiry. Response times may be governed by national requirements, such as the complaints process or Freedom of Information request. The individual must be made aware that failure to comply with any agreed process may result in further action being taken. Once the SPoC process has been agreed, relevant staff and departments within the organisation will need to be advised of the process in place for the individual.

Once an individual has been allocated a SPoC, staff within the organisation must not engage with the service user, as this will result in an inconsistent and confusing message being given. Effective application of this process results in significant reductions in inappropriate contacts, provided the individual is always signposted to the SPoC. Signposting should be considered for a maximum period of six months and then reviewed by the Associate Director of Service Quality. If at any point the individual varies from the agreed process, a review will be undertaken which may result in withdrawal of the process and further restrictive contact measures applied.

5. Appeals against this procedure

Complainants have the right of appeal against actions decided by the Associate Director of Service Quality. Complainants should set out their views in writing to the Director of Corporate Affairs and Governance, who will review the documentation leading to the decision. This could lead to a revision or reversal of the original decision to restrict or cease further complaint correspondence with the complainant.

6. Staff guidance for handling habitual or vexatious telephone calls

The following forms of words (or close approximations) should be used by any member of the Trust staff who intends to withdraw from a telephone conversation with a complainant. Grounds for doing so could be that individual has become unreasonable, aggressive, abusive, insulting or threatening. It should not be used to avoid dealing with a complainant's legitimate questions/concerns, which can sometimes be expressed extremely strongly. Careful judgement and discretion must be used in determining whether or not a complainant's approach has become unreasonable, and advice sought when necessary.

If you feel that a person's behaviour is unacceptable and/or makes you feel anxious, harassed or distressed try using the following statement:

"I would like to help you with your query, but will be unable to if you continue to speak to me in this manner. I will try to help you but I am

now giving you a warning that I will have to end this conversation if you do not speak to me in a civil manner."

If the inappropriate behaviour continues, a second warning should be given:

"I am now giving you a final warning that unless you communicate with me appropriately, I will end this conversation."

If the inappropriate behaviour continues further after a second warning, the conversation should be ended appropriately:

"I am now ending this conversation because you are not communicating with me in an acceptable manner. I will only accept a further call from you if you behave reasonably."

The call should then be ended. It is important that staff do not speak aggressively, even when provoked and the receiver should be placed down gently.

In an extreme situation, such as where an explicit threat of violence is made, the complainant refuses to let the member of staff speak at all or if grossly offensive/discriminatory language is excessively used, the call should be ended immediately, stating:

"I cannot have a conversation with you when you are making threats/abusing me/not permitting me to speak. I am ending this conversation and ask that you put your concerns in writing to the Trust's managing director. I will not accept further telephone calls from you."

When terminating a contact, always remain polite and courteous, but assertive in your warnings to the service user. If their behaviour does not change following your warnings, be resolute to carry out your initial notice to end the phone call. Giving warnings, then tolerating further inappropriate behaviour is usually counter-productive.

7. Follow-Up Action

The person receiving the call or dealing with the complainant should record a full statement, noting the names of the parties involved, the date and time and relevant details of what was said during the call. This should then be sent to the Associate Director of Service Quality who will then monitor the situation until resolution.

8. Equality and Diversity

Imperial College Healthcare NHS Trust is committed to ensuring that, as far as it is reasonably practicable, the way we provide services to the public and

the way we treat our staff reflects their individual needs. Imperial College Healthcare NHS Trust will not discriminate against individuals or groups on the basis of their age, disability, gender, nationality, ethnicity, religion/belief or sexual orientation or other unreasonable grounds. Furthermore, we value diversity and recognise the contribution that the different backgrounds, skills, outlooks and experiences within the organisation and wider society make. The application of this procedure will be done in a way that is not discriminatory and enables complainants with particular needs to access the complaints procedures appropriately and fairly.

Behaviour that contradicts the letter or spirit of this statement or our equal opportunities and 'Zero Tolerance' policies will not be accepted. It must be recognised that the classification of a person's behaviour as 'persistent and unreasonable' will not mean that any new issues having no connection with original enquiries will not be dealt with via the appropriate internal processes of the organisation. Where the SPoC has been applied, the Associate Director of Service Quality will determine how wholly new complaints from someone who has previously been persistent and unreasonable will be handled.