TRUST PUBLIC BOARD AGENDA
10 am
28 May 2014
Oak Suite,
W12 Conference Centre, Hammersmith Hospital,
London W12 0HS

Agenda Number		Presenter	Timing	Paper Number	Page Number
1	**Administrative Matters**				
1.1	Chairman's Opening Remarks	Chairman	10.00		Oral
1.2	Apologies	Chairman			Oral
1.3	Board Member's Declarations of Interests	Chairman		1	5 - 6
1.4	Minutes of the meeting held on 26 March 2014	Chairman		2	7 - 16
1.5	Matters Arising and Action Log	Chairman		3	17- 18
2	**Operational Items**				
2.1	Patient Story	Rodney Eastwood	10.05	Oral	
2.2	Chief Executive's Report	Chief Executive	10.15	4	19 - 28
2.3	Operational Report	Various	10.25	5	29 - 38
2.4	Integrated Performance Scorecard	Chief Operating Officer	10.35	6	39 - 42
2.5	Finance Report	Chief Finance Officer	10.40	7	43 - 46
3	**Items for Decision**				
3.1	Revised Vision & Strategic Objectives	Chief Executive	10.50	8	47 - 48
3.2	Closure of the Emergency Unit at Hammersmith Hospital	Chief Operating officer	10.55	9	49 - 54
3.3	Safe Nurse/ Midwife Staffing Levels	Director of Nursing	11.10	10	55 - 64
3.4	NHS Trust Development Authority Self-Certifications • Compliance February • Board Statement February • Compliance March • Board Statement March	Chief Financial Officer	11.20	11	65 - 66
3.5	Draft Quality Accounts 2013-14	Medical Director	11.25	12	67 - 68

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4	**Items for Discussion**				
4.1	Update on clinical strategy and outline business case for clinical and estate transformation	Director of Strategy	11.30	13	69 - 74
4.2	Annual Summary of the Trust's quality impact assessment process for cost improvement programmes (2013/14)	Director of Nursing / Medical Director	11.45	14	75 - 78
4.3	Annual Report on implementing the recommendations from the Francis Inquiry (2013)	Director of Nursing	11.50	15	79 - 84
4.4	2013 National Inpatient Survey Results	Director of Nursing	11.55	16	85 - 88
4.5	AHSC Update Review 2013 - 14	Chief Executive and Principal of the Faculty of Medicine of Imperial College	12.00	17	89 - 90
4.6	Final report of the Foundation Trust Consultation	Chief Financial Officer	12.05	18	91- 94
4.7	Complaint report	Director of Governance and Assurance	12.10	19	95 - 100
5	**Board Committee Items**				
5.1	Quality Committee To note the report of the meeting of 13 May 2014 To receive the minutes of the meeting of 6 March 2014	Prof Sir Anthony Newman Taylor	12.15	20 21	101 – 102 103 - 110
5.2	Audit, Risk & Governance Committee To note the report of the meeting of 22 April 2014 To receive the minutes of the meeting of 12 March 2014	Sir Gerald Acher	12.20	 22 23	 111 – 112 113 - 122
5.3	Finance & Investment Committee To note the oral report of the meeting of 22 May 2014 To receive the minutes of the 20 March 2014	Sarika Patel	12.25	 Oral 24	 123 - 128
5.4	Foundation Trust Programme Board To note the report of the meeting of 29 April 2014 To receive the minutes of the meeting of 18 March 2014	Dr Rodney Eastwood	12.30	 25 26	 129 – 130 131 - 142

Agenda Number		Presenter	Timing	Paper Number	Page Number
6	**Items for Information**				
7	**Any Other Business**				
8	**Questions from the Public relating to Agenda items**				
9	**Date of Next Meeting**				
	30 July 2014 at W12 Conference Centre, Hammersmith Hospital, London W12 0HS				
10	**Exclusion of the Press and the Public**				
	That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960				

Imperial College Healthcare NHS
NHS Trust

Board Members' Register of Interests – May 2014 **Appendix A**

Sir Richard Sykes Chairman
- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Chairman, Careers Research Advisory Centre since 2008
- Non-Executive Chairman of NetScientific
- Chairman of Royal Institution of Great Britain
- Chancellor Brunel University

Sir Thomas Legg Senior Independent Director
- Imperial College Healthcare Trust Charity Trustee

Sir Gerald Acher Non-Executive Director
- Deputy Chairman of Camelot Group PLC
- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Chairman Littlefox Communications Ltd
- Trustee of KPMG Foundation
- President of Young Epilepsy

Dr Rodney Eastwood Non-Executive Director
- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy [Secondary school]
- Consultant, Mazars
- Trustee of the London School of ESCP Europe (a pan-European Business School)
- Member of the Editorial Advisory Board of HE publication
- Member of the Board of Trustees of the RAF Museum

Jeremy M Isaacs Non-Executive Director
- JRJ Group Limited – Director
- JRJ Jersey Limited - Director
- JRJ Investments Limited – Director
- JRJ Team General Partner Limited - Director
- Food Freshness Technology Holdings Ltd – Director
- Kytos Limited - Director
- Support Trustee Ltd – Director
- Marex Spectron Group Limited – Director/NED Chairman
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust

Professor Sir Anthony Newman-Taylor Non-Executive Director

- Chairman, Colt Foundation
- Trustee, Rayne Foundation
- Chairman, independent Medical Expert Group, Armed Forces Compensation Scheme, MoD
- Member, Bevan Commission, Advisory Group to Minister of Health, Wales
- Rector's Envoy for Health, Imperial College
- Head of Research and Development, National Heart and Lung institute (NHLI)
- Member Advisory Board, Royal British Legion Centre for Blast Injury Studies (CBIS), Imperial College

Sarika Patel Non-Executive Director

- Board – Centrepoint
- Board – Royal Institution of Great Britain
- Partner – Zeus Capital
- Board – London General Surgery
- Board – 2020 Imaging Ltd

Dr Andreas Raffel Designate Non-Executive Director

- Executive Vice Chairman at Rothschild
- Member of council of Cranfield University
- Trustee of the charity Beyond Food Foundation
- Member of the International Advisory Board of Cranfield School of Management

Dr Tracey Batten Chief Executive

- Nil

Bill Shields Chief Financial Officer

- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Board member, NHS Shared Business Services

Steve McManus Chief Operating Officer

- Chair – National Neurosciences Managers Forum
- Chair of Governors – Tackley Primary School

Professor Janice Sigsworth Director of Nursing

- Honorary professional appointments at King's College London, Bucks New University and Middlesex University
- Trustee of the Foundation of Nursing Studies

Dr Chris Harrison Acting Medical Director

- Non-Executive Director, CoFilmic Limited
- Director, RSChime Limited
- Vice Chair, London Clinical Senate Council

Michelle Dixon Director of Communications

- Trustee of Asylum Aid

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

10.00am – 12.30pm
Wednesday 26 March 2014
New Boardroom, Charing Cross Hospital,
Fulham Palace Road, London, W6 8RF

Present:	
Sir Richard Sykes	Chairman
Sir Thomas Legg	Deputy Chairman and Senior Independent Director
Dr Rodney Eastwood	Non-Executive Director
Jeremy Isaacs	Non-Executive Director
Prof Sir Anthony Newman Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Andreas Raffel	Designate Non-Executive Director
Bill Shields	Chief Executive
Dr Chris Harrison	Medical Director
Steve McManus	Chief Operating Officer
Marcus Thorman	Chief Financial Officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Michelle Dixon	Director of Communications
Ian Garlington	Director of Strategy
Jayne Mee	Director of People and Organisation Development
Cheryl Plumridge	Director of Governance and Assurance
Helen Potton	Interim Corporate Governance Manager (Minutes)
Kevin Jarrold	Chief Information Officer
Julie Halliday	NHS Trust Development Authority
Mark Brice	NHS Trust Development Authority

1	**General Business**
1.1	**Chairman's Opening Remarks** The Chairman welcomed Board members, staff and members of the public to the meeting. He also welcomed Michelle Dixon the Trust's new Director of Communications.
1.2	**Apologies for Absence** Apologies had been received from Sir Gerald Acher, Non-Executive Director, Prof Nick Cheshire, Chief Executive, Prof Alison Holmes, Director of Infection Prevention & Control and Prof Dermot Kelleher, Principal of the Faculty of Medicine of Imperial College
1.3	**Board Members' Declarations of Interest and Conflicts of Interest** There were no conflicts of interests declared at the meeting.

1.4	**Minutes of the Meeting held on 29 January 2014** The minutes of the meeting held on 29 January 2014 were agreed as a true record.
1.5	**Matters Arising and Action Log** The Board noted the updates to the action log. Cheryl Plumridge advised that in respect of item 5.2 from the 27 November 2013 meeting, plans were in place to recruit 3,500 members by the end of July working with an external experienced membership recruitment company.
1.6.1	**Chairman's Report** Sir Richard Sykes advised the Board that since the January meeting a new Chief Executive had been appointed, Tracey Batten, who would start on 7 April 2014. She was currently the Chief Executive of St Vincent's Health, the largest charitable hospital group in Australia employing 16,000 staff with a budget of £1bn. A qualified doctor with a Masters in Health Administration and who would be able to lead the Trust with both excellent clinical and managerial skills.
1.6.2	He commended the work that Bill Shields and Prof Nick Cheshire had done as joint Chief Executives in the interim period. They had done a tremendous job in the role resulting in great progress for the Trust at an important time. He also commended the work of Marcus Thorman and Chris Harrison who had stepped into the roles of Chief Financial Officer and Medical Director and noted that this would be their last Board meeting as they would be returning to their substantive posts.
1.7	**Chief Executive's Report** The Board noted the Chief Executive's report which was presented by Bill Shields. In particular he highlighted:
1.7.1	**Update on FT Programme Plan** Progress was good and the Trust was currently awaiting confirmation of the Chief Inspector of Hospital's visit in Quarter two. He noted that the Board would be receiving external reports on progress later in the private part of the meeting.
1.7.2.1	**People and Organisational Development** NHS Change Day had been a success with staff including Directors making pledges to make a difference to the work they did. He recognised this as a very valuable way of empowering the Trust's people to be a part of the change they wanted at Imperial and linked in well with the Trust's values.
1.7.2.2	The fifth new Leadership Programme was due to commence in April which had proved to be a success for both clinical and non clinical staff.
1.7.3	**Performance** Performance remained strong with its referral to treatment time remaining strong and noted that the executive team had had a number of discussions to continue this performance which fed into the operating excellence programme.
1.7.4	**Finance** The Trust continued to deliver the forecast outturn.
1.7.5	**Research** The Trust had experienced a very successful away day with colleagues from the Academic Health Science Centre and the Academic Health Science Network, demonstrating good partnership working.
1.7.5.1	**Shaping a Healthier Future (SaHF)** Dr Rodney Eastwood asked what effect the proposals to bring Central Middlesex Hospital (CMH) back into financial balance would have on the Trust. Bill Shields advised that the original proposal under SaHF would have resulted in 18,000 day cases transferring to CMH but that currently the proposal was for only 2,500 orthopaedic day cases. The Trust was working with its clinicians to understand what this would mean and when it would be likely to happen. He proposed that a Business Case would be taken to a Board Seminar for further discussion

	Action: Chief Executive
1.7.5.2	Sir Richard Sykes asked about the proposals for the Royal National Orthopaedic Hospital and Bill Shields confirmed that they had made the decision to expand the Stanmore site.
2	**Quality and Safety**
2.1	**Director of Nursing's Report** Prof Janice Sigsworth presented her report, and in particular noted:
2.1.1.1	**Safe Nurse Staffing** The Safe Nursing and Midwifery Programme compared actual against planned staffing requirements and would be published on the Trust's website and reported to the Trust Board twice a year starting in May 2014. Prior to the Board receiving the report it would be discussed by the Quality Committee at their May meeting.
2.1.1.2	The report would contain information on around 60 inpatient clinical areas set against key quality indicators, the friends and family test, the safety thermometer and details of bank and agency staff. Currently further guidance was awaited to clarify in detail what was required but it was envisaged that information would be brought identifying ward, division and trust wide information with exception reporting of any areas of concern. Preparations were going well and she believed that the Trust would be in a reasonable position.
2.1.1.3	Dr Rodney Eastwood commented that on the nurse staffing level boards it would be helpful to have some narrative to understand what the figures referred to. Prof Janice Sigsworth advised that the boards had been developed prior to the national guidance and that the Trust had been a part of the national discussion. The boards had been subject to some piloting and similar feedback had been provided together with a request for details of the nurse in charge. Feedback from staff had been positive but as yet no feedback had been taken from patients and families.
2.1.1.4	Jeremy Isaacs suggested that the boards were very low tech and questioned whether something better could be developed. Prof Janice Sigsworth confirmed that discussions had taken place in respect of an interactive screen which would have all the information in one place and could be updated simply.
2.1.1.5	Sarika Patel asked if the Trust had had to recruit more staff to comply with the requirements and if so whether any analysis had been undertaken on the financial consequences. Prof Janice Sigsworth confirmed that the current establishment had been broadly in line with what had been required although recruitment of a small number of nurses may be required. Feedback from other Trusts had been that they had had a shortfall of 100/200 nurses.
2.1.2	**Cancer Patient Experience** This had been discussed in detail at the Quality Committee in March and progress noted. The National Inpatient Survey would be published on 8 April 2014 and had been undertaken at a time of great change for the Trust when it was moving to four divisions. Results were currently embargoed and she would provide a short briefing for the Board the day before but was able to confirm that the Trust's position was slightly up which she considered to be quite an achievement in view of the changes. **Action: Director of Nursing**
2.1.3.1	**Patient Story** Prof Janice Sigsworth noted that the Board had received six patient stories so far and she would be working with Cheryl Plumridge to link this with the work on complaints and also what other Trusts were doing to ensure that the Board received significant benefit from the stories. She would also be talking to Monitor for suggestions of best practice and would develop this area for future Board meetings.
2.1.3.2	The patient story before the Board related to a 70 year old patient who had developed a pressure ulcer following the use of splints to prevent contractures of

	his legs. The story demonstrated the speed with which pressure ulcers could develop but also how, with the correct treatment, could be quickly remedied. It also highlighted that although the correct advice relating to the splints had been given it had not been correctly followed as staff had not had much opportunity to practice with the specialised equipment so additional guidance had been put in place together with the use of tissue viability nurses for specific advice and guidance. In addition where a pressure ulcer had developed details of all nurses involved in the care of the patient was being used for revalidation purposes similar to the process already in place in respect of MRSA. Staff were aware that not doing something would be treated seriously which was in line with the principles of their own accountability, duty of candour and wilful neglect.
2.1.3.3	Sir Richard Sykes asked how often pressure ulcers became infected and Prof Janice Sigsworth explained that there were four grades with four being the worst and indicating the depth of damage. There was a risk of infection once the wound became open.
2.1.3.4	Jeremy Issacs asked about how learning from incidents was shared and Prof Janice Sigsworth explained that it was discussed at the Friday morning meetings and at the Friday afternoon meetings which involved all ward sisters and above.
2.1.3.5	Sarika Patel asked if the pressure ulcer had delayed discharge and whether there had been any feedback from the patient. Prof Janice Sigsworth confirmed that there had not been a delay but she had seen cases where it had; insofar as feedback, the patient's family had been engaged.
2.1.3.6	The Board discussed the issues around discharge and being able to find suitable places which meet a patient's needs. Steve McManus advised the Board that a central team had been set up to support complex needs cases as these cases could be extremely time consuming. He noted that for a family, where a family member was taken to after hospital, was not only an emotional decision but could be a financial one as well. Prof Sir Anthony Newman Taylor noted that this was an important issue and it was essential to begin the discussion with third parties soon after admission as it could extend a hospital stay by up to two weeks. Prof Janice Sigsworth suggested that once sufficiently recovered an acute hospital was not the best environment for a vulnerable person due to disrupted sleep patterns and increased the risk of infection. Steve McManus advised that some of the support put in place for the winter planning would be utilised to take complex discharge forward and a summary report would be presented to the Quality Committee. **Action: Chief Operating Officer**
2.2	**Medical Director's Report** Dr Chris Harrison presented his report noting that both the Quality and Audit, Risk & Governance Committees had considered much of the information currently before the Board but highlighted in particular:
2.2.1.1	**Incident Review Panel** The panel meets weekly and reviews all moderate and above incidents giving the Medical Director oversight of issues as they arise. Whilst it was working effectively further work was required to be able to demonstrate a real difference. Since its instigation the number of incidents had increased and Sir Richard Sykes asked if near misses were also considered. Dr Chris Harrison noted that this was beginning to happen and that there was evidence of events where something had gone wrong but had not caused untoward harm and that this had been helpful from a learning and future prevention perspective bringing the right culture to the Trust. He noted in particular that in maternity there had always been a high level of reporting near misses and using it positively from its learning value rather than a more punitive approach. Prof Sir Anthony Newman Taylor suggested that prescribing errors were also near misses with Dr Chris Harrison noting that they did not usually present real harm.

2.2.1.2	The Board discussed the recent Serious Incident (SI) that had taken place and their notification of it and Dr Chris Harrison confirmed that the Non Executive Directors were advised following discussion at the Friday morning meeting. He confirmed that it was a statutory requirement to have a responsible officer for misconduct and disciplinary issues and this was Associate Medical Director, David Mitchell.
2.2.2	**Medical Education** This had been discussed in detail at the AHSC away day with a wide ranging programme under development. The Trust had an obligation to make formal returns for both undergraduate education and postgraduate education and action plans were now in place to deal with serious and worrying issues which were currently being reviewed.
2.3.1	**Quality Committee** Prof Sir Anthony Newman Taylor presented the report of the Quality Committee held on 6 March 2014 noting that the Committee had been in place for approximately 9 months and the membership had been expanded to include the Director of People and Organisation Development, and Dr Nick Sevdalis to represent the research perspective.
2.3.2	He described the structure of the meetings which started with the top risks from the Divisions with particular regard to clinical risk to enable the Committee properly to understand the current issues that were being faced. The Committee then took a variety of reports in respect of the six Berwick principles.
2.3.3	In particular the Committee had discussed: • Understanding the issues of MRSA and what was being done to prevent them particularly in relation to intravenous lines; • Serious Incidents / Never Events and the links to complaints, legal cases and coroners: • Cancer waits and had received a presentation on the work undertaken to improve cancer pathways with clear benefit of patient experience and the very impressive reduction from 700 to 60 cancer waits; • The impact on quality from staffing issues in particular in relation to obstetrics and the labour wards; • Work being undertaken to improve patient experience including the development of rapid access clinics and the increase from 82% to 95% of patients recommending the Trust to family and friends; • The quality impact on Cost Improvement Plans (CIPs) noting that to date no Divisional Director had indicated that a CIP would have a detrimental impact on quality.
2.4.1	**Infection Prevention and Control Report** Dr Chris Harrison presented the Infection Prevention and Control report on behalf of Alison Holmes noting that there were three main elements to note: • There had been one MRSA attributable case since the last report; • The Trust remained below the threshold for C-*difficile;* • The guidance for managing patients with drug resistant organisms.
2.4.2	Sir Richard Sykes noted that the Trust did receive significant numbers of overseas patients who were more likely to present with multi drug resistant organisms which resulted in this being an area for concern for the Trust.
2.4.3	Sir Richard Sykes noted that currently there was no reporting on fungal infections and he suggested that the Board should have sight of these. Dr Chris Harrison agreed. **Action: Director of Infection Prevention and Control**
2.5.1	**Quality Accounts** Cheryl Plumridge presented the report on the Quality Accounts Indicators for 2014/15 which had been agreed by the Management Board and would form the

	basis of next year's Quality Account. She noted that those indicators highlighted in red were new to the Trust and where there was either a gap or an "x" this indicated that the Trust was awaiting the national targets.
2.5.2	She noted that the draft Quality Account for the current year would be presented to the Quality Committee and the Trust Board in May at which time delegated authority for sign off would be requested to enable them to be completed in accordance with the requirements from NHS England.
2.6	**Safeguarding of Children and Young People Annual Declaration 2013/14** Janice Sigsworth presented the Safeguarding of Children and Young People Annual Declaration as stipulated by David Nicholson's letter dated 16 July 2009. The Trust Board **approved** the Declaration
3	**Performance**
3.1	**Integrated performance Report and Scorecard - Month 11** Steve McManus presented the report noting that the data was mostly from February except for Cancer which was January. He highlighted in particular: • The Trust had consistently delivered the three aggregate RTT standards since November 2013; • For winter planning the Trust had moved from a three to a two through the improvements that had been made and the growing level of confidence that the NTDA had in the Trust and he would circulate the full report to the Board; **Action: Chief Operating Officer** • There had been an increased number of data feeds into the scorecard and it would be fully populated by the May report; • The current cancer backlog had reduced to 53 and he was confident that the reduction would continue; • The Trust had externally been reported as underperforming in the 62 day screening but the reporting was inaccurate and the Trust had only became aware of any issues once the Open Exeter submission had closed. This would however be amended on the next run; • The 18 weeks target had been an area of concern. Despite delivering the three RTT standards the Trust had seen a growing backlog and steps had been taken to deal with this and currently the backlog had stabilised as a result of this work; • There had been a significant improvement in data quality.
3.2	**Dementia Audit** The Board was asked to note the report as part of the CQUIN requirement.
3.3A.1	**Finance Report – Month 11** Marcus Thorman presented the report noting that the Trust was 5 days away from year end. The cash and capital targets would be met as would the planned surplus of £15.1M. Cost Improvement Plans (CIPs) had been broadly delivered and Divisional Directors were aware that they would have to deliver them recurrently. Going forward this should be easier to achieve as they would have developed the CIPs and therefore have ownership of them. In the previous year, due to the reorganisation, CIPs had been developed by different parties which had seen some difficulties particularly regarding ownership and agreement over ability to deliver. The Trust was currently behind target on capital expenditure partly due to the endoscopy unit but this target should also be met.
3.3A.2	Sir Richard Sykes asked if payment for the previous year's over performance had been agreed and Marcus Thorman explained that approximately one third of the Trust's income came from local Clinical Commissioning Groups (CCGs), terms of which had been agreed, with another third coming from specialist services from NHS England. Although agreement with them had yet to be made it was almost complete and should not be an issue.

3.3A.3	Sir Richard Sykes asked why there was a significant write off for estates in 2014/15 after the significant write off in the current accounts. Marcus Thorman advised the Board that the new valuer had undertaken a more detailed assessment. In the coming year there was likely to be changes to land value and the planning for Shaping a Healthier Future (SaHF) needed to be planned for following advice received from the Trust Development Authority (TDA)
3.3A.4	Andreas Raffel suggested that the issue around Project Diamond remained unclear and Bill Shields noted that it was a potentially significant risk of £17.7M and that the Department of Health needed to move from its current position. It had always been clear that the monies would be recurring until the more complex workload was reflected in the tariff. He was a member of the Project Diamond strategy group which was moving the issue forward: it would have a significant impact upon teaching hospitals in London.
3.3B.1	**Finance & Investment Committee** Sarika Patel provided a verbal update on the Finance & Investment Committee held on 20 March 2014 and highlighted in particular that the Committee had discussed: • The Trust currently overspends on nursing staff by £838K; • What would happen over the next two years with regards to CIPs noting that there was currently a £13.8M gap in CIPs which was being covered by revaluation of assets and private patients; • The Treasury Management Policy and where the Trust could invest; • That there would be adequate resources available once the Trust had more control over its funds; • The financial gaps relating to SaHF and the requirement to look carefully at each site individually; • Downside mitigation, the base case and the Long Term Financial Model which had included providing feedback on the process for identifying financial risks which was considered too detailed and complex; • The optimistic forecasts for private patient work and had concluded that they were achievable although there were issues around capacity which needed to be addressed.
3.3B.2	Andreas Raffel suggested that the Trust would need to have a proper structure in place for the private patients work as it could no longer be managed on a part time basis. Bill Shields advised that this was something that he was intending to pick up with the new Chief Executive.
3.4.1	**Annual and Medium Term Financial Plan 2014/15 to 2015/16** Marcus Thorman presented the report which summarised the plan to be submitted to the TDA on 4 April 2014. The plan had been discussed in detail at the Finance & Investment Committee meeting the previous week and changes made as a result.
3.4.2	There had been two developments in the Long Term Financial Model (LTFM) in respect of SaHF and NWL Pathology. The modelling updates had all been driven by the LTFM and updated every two months as per the guidance. The plan would need to be updated to reflect the recent discussions with Commissioners
3.4.3	He noted the volume and inflation assumptions which had not taken into account the pay awards which had been less than anticipated and which would add to the Trust's contingency.
3.4.4	He advised that the detailed metrics had yet to be agreed with the five inner and 3 outer CCGs and Bill Shields confirmed that the final contract meeting would include himself, Prof Nick Cheshire, Steve McManus, Nicola Grinstead and appropriate Divisional Directors. Bill Shields also confirmed that the value of the contract was agreed based on last year's output. The CCGs were keen to see the Trust operate from a smaller footprint and the Trust needed to understand if that

	was possible and seek clinical buy in to it. Sir Richard Sykes noted that both parties would have to accept some risk as the NHS in London was moving into unknown territory.
3.4.5	There had been detailed input into the CIPs but it was important to ensure that they were delivered. Steve McManus advised that the Divisional Directors were clear that they own their CIPs and there were no issues that they belonged to them and that they accepted that they were accountable for them.
3.4.6	Marcus Thorman noted the Monitor Efficiency Requirement which was based on an average organisation which would need to be addressed with Monitor.
3.4.7	He noted that expenditure on the capital programme had doubled for maintenance backlog for which John Cryer had put together a full programme of works.
3.4.8	Monitor's Financial Risk Rating had been replaced with a Continuity of Services Risk Rating (CoSRR) and the Trust was currently standing at a three which was sufficient to proceed with its Foundation Trust application but it needed to move to a four in the future. The Trust Board **agreed** the key modelling assumptions used.
3.5.1	**Director of People and Organisation Development's Report** Jayne Mee presented her report and noted that vacancies had gone up to 12% but if the establishment changes were removed it would have been at 10% and going down. Currently there were 240 people in the clearing process with 100 due to start imminently.
3.5.2	Changes had been made to process to reduce the number of vacancies with a new Head of Resourcing and the appointment of three specific nurse recruiters within the department who all had a nursing background and who would develop a talent pool of nurses that that Trust could draw on when required which should see the vacancy rate drop and would ease the pressure on the clinical team removing them from some of the administration work required. Bill Shields noted that this should have an impact on bank and agency staff costs and Jeremy Isaacs suggested that it would be useful to see those figures.
3.5.3	Turnover of staff was starting to slow and an exit survey had been introduced to understand why staff were leaving. In addition a survey of those new staff in post at three months had been introduced which together with the engagement survey should produce some very powerful data.
3.5.4	There had been a slight drop in Performance and Development Reviews but she believed that this was due to staff awaiting implementation of the new process.
3.5.5	Statutory and Mandatory training had also seen a drop but this was due to training for Cerner which had taken priority.
3.5.6	The results for the second quarterly staff engagement survey had been received with response rates slightly down and the overall engagement score down from 42% to 39%. Clear action plans were in place both at divisional and corporate level which would be discussed further in the private meeting.
3.5.7	The results for the NHS Staff Survey showed a response rate of 49.9% and an engagement level of 3.77 which put the Trust above average but not in the top 20. A comparison between this and the Trust's own survey appeared to show that the Trust received better results in the national survey however, although the response rate was higher it had been completed by a much smaller number of people. She accepted that there was considerable work to be done on engagement and she believed it was better to use the Trust's survey for this purpose. From April the friends and family tests would become a mandatory question but the Trust had already been asking it.
3.5.8	Jayne Mee advised that she had developed a new staff recognition scheme called "Make a Difference" which would replace the "I recognise" and "OSC&RS" scheme. The scheme had been developed with our staff and had an opportunity for instant recognition, divisional awards and an annual awards ceremony which

	would include a Chairman's award. Jeremy Isaacs asked if she had considered getting a corporate sponsor for the awards and she advised that the Charity had indicated that it was happy to continue its sponsorship of the staff awards. Sir Thomas Legg noted that charity organisations were currently reducing the number of staff awards but recognised the importance for the Trust and its staff. Steve McManus suggested that this could form a part of team brief with people receiving their awards in the meeting. Jayne Mee expressed her thanks to Cheryl Plumridge's team for their help and support in the development of the process.
3.5.9	Jayne Mee advised that following the departure of the Clinical Director of Health and Wellbeing the occupation health (OH) team had been restructured and a new position of Associate Director of Health & Wellbeing had been identified to drive the service forward with support from an OH consultant for 5 PAs per week.
3.5.10	Chris Harrison referred to the reference to smoking in the report suggesting that this would need to come to the Board following the NICE guidance as the Trust currently had a policy but it was not well implemented. Prof Sir Anthony Newman Taylor noted that people would inevitably smoke but the Trust needed to avoid smoking at the entrance to the hospital.
3.5.11	Chris Harrison also referenced the flu vaccination and that the Trust needed to consider offering this to a number of patients who had become more vulnerable due to treatment received whilst they were in hospital
3.6	**Remuneration and Appointments Committee** Jeremy Issacs asked the committee to note the report of the Remuneration and Appointments Committee meeting held on 26 February 2014 at which the Committee had discussed the remuneration package of the new Chief Executive. The next meeting would be held in June and then December and in the meantime the Committee would continue to engage additional support regarding market values.
3.7	**Risk Report** Cheryl Plumridge presented the Risk Report which included an updated Corporate Risk Register (CRR) which included two new risks; poor patient experience reported in the 2014 national cancer survey and failure to achieve corporate objectives for medical education. She noted that six risks had been downgraded from the CRR to local level. A revised CRR, that was more strategic and all-encompassing, would be developed and presented to the Trust Board in May 2014.
3.8.1	**Foundation Trust Consultation** Marcus Thorman presented the findings of the Foundation Trust (FT) consultation which had broadly seen a positive response with significant feedback and had been a very useful exercise. The recommendations in the paper had been made as a result of the consultation and if agreed would be published as a formal response and would also inform the Trust's Constitution. The recommendations had been put together by a small working group and discussed in detail at the Foundation Trust Programme Board.
3.8.2	He noted in particular that the recommendations looked to increase the overall size of the Council of Governors from 31 to 33. This was based on the suggestion to increase the number of seats allocated to the Clinical Commissioning Groups from one to two which necessitated an increase in the patient constituency to 9 seats to ensure that the patient and public constituency remained in the majority. He also noted the recommendation to ring fence the voluntary organisation seat to an organisation representing carers following feedback that this section of the community had not been represented in the Council.
3.8.3	Rodney Eastwood stated that the consultation had been well run and the Constitution would be presented to the Trust Board in May for agreement. **Action: Director of Governance & Assurance**

	The Trust Board **approved** the recommendations as stated.
3.9	**Terms of Reference** Cheryl Plumridge presented the Terms of Reference (ToR) for the Board Committees noting that it was required to approve the ToR for the Remuneration and Appointments Committee which would complete the set. The Trust Board **approved** the Remuneration and Appointment's Terms of Reference.
3.10.1	**Non Executive Director's Indemnity** Cheryl Plumridge presented the paper which set out the advice from the Department of Health in respect of Non Executive Directors (NEDs) being given an indemnity for the work undertaken in the normal course of Board business which would enable them to be covered under the NHSLA insurance. She explained that to affect the indemnity from a process perspective the Board would need to agree an indemnity for each individual NED but that the individual NED would abstain from voting in respect of his indemnity.
3.10.2	Andreas Raffel asked if this covered the NEDs for any act and Helen Potton advised that it provided a similar protection as the Executive Directors had by way of vicarious liability as they were directly employed by the Trust and would therefore be covered under the NHSLA insurance for acts undertaken during the course of their employment. The Trust Board **approved** the Indemnity for each of the Non Executive Directors
3.11	**Audit, Risk and Governance Committee** Andreas Raffel presented the report of the Audit, Risk & Governance Committee meeting held on 12 March 2014 on behalf of Sir Gerald Acher. Steve McManus noted the detailed review of Cerner that had taken place which had included senior representatives of Cerner.
3.12.1	**NHS Trust Development Authority Self-Certifications** Marcus Thorman presented the self-certifications which included relevant updated information.
3.12.2	The Trust Board **approved** the following Self-certifications: • December Compliance • December Board Statement • January Compliance • January Board Statement
3.13.1	**Foundation Trust Programme Board** Dr Rodney Eastwood presented the report of the Foundation Trust Programme Board meeting held on 18 March 2014
3.13.2	The Trust Board **received** the minutes of the Foundation Trust Programme Board meetings held on 23 January 2014 and 18 February 2014
4	**Any other Business** There was no other business.
5	**Questions from the Public** There was no questions from members of the public.
6	**Date and time of next meeting** Wednesday 28 May 2014, 10am - 12.30pm, Clarence Wing Boardroom, St Mary's Hospital, Praed Street, London W2 1NY
7	**Exclusion of the Press and the Public** The Board resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Imperial College Healthcare NHS
NHS Trust

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
27 November 2013

Minute Number	Action	Responsible	Completion Date	May 2014 Update
5.2	**FT Membership Strategy** The plan for building up the Membership and the creation and development of the Council of Governors to be brought forward via the FT Programme Board.	Director of Governance & Assurance	**18.2.14**	**Completed**. At the March 2014 meeting the Director of Governance & Assurance advised that plans were in place to recruit 3,500 new members by the end of June working with an experienced external membership recruitment company and an Initial report on the development of the Council of Governors was presented to the Foundation Trust Programme Board in April.

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
29 January 2014

Minute Number	Action	Responsible	Completion Date	May 2014 Update
2.2.4.2	**AHSC.** An update on the discussion at their away day around the substantial role that the AHSC could play as an interface with the University would be brought back to the Board.	Principal of the Faculty of Medicine of Imperial College		**Completed.** Included in Annual AHSC Report.

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
26 March 2014

Minute Number	Action	Responsible	Completion Date	May 2014 Update
1.7.5.1	**Shaping a Healthier Future (SaHF).** A Business Case would be taken to a Board Seminar for further discussion.	Chief Executive		**Completed.** Presented to the April Trust Board Strategy Seminar.
2.1.2	**Cancer Patient Experience.** The National Inpatient Survey would be published on 8 April 2014. Results were currently	Director of Nursing		**Completed.** 2013 Inpatient Survey on Agenda.

	embargoed but a short briefing would be provided for the Board the day before.			
2.1.3.6	**Discharge.** A summary report on the support that was put in place for the winter planning complex discharge utilisation would be presented to the Quality Committee.	Chief Operating Officer		**Completed.** On Quality Committee forward plan.
2.4.3	**Infection Prevention and Control Report.** A report on fungal infections be brought before the Board.	Director of Infection Prevention and Control		**Completed.** Agenda item. Included in the Operational Report.
3.1	**Integrated performance Report.** A full report would be circulated to the Board on improvements that had been made for winter planning and the growing level of confidence that the NTDA had in the Trust.	Chief Operating Officer		**Completed.** This was included as part of the performance report in January 2014
3.7	**Risk Report.** A revised CRR, that was more strategic and all-encompassing, would be developed and presented to the Trust Board in May 2014.	Director of Governance & Assurance		**Completed**. This will be presented to the Audit, Risk & Governance Committee in June following review and discussion at ExCo. The revised CRR will be brought to the July Trust Board meeting.
3.8.3	**Foundation Trust Consultation** The Consultation would be presented to the Trust Board in May for agreement.	Director of Governance & Assurance		**Completed.** Agenda Item

Imperial College Healthcare NHS Trust

Public Board Meeting

Wednesday, 28 May 2014

Agenda Item	2.2
Title	Chief Executive's Report
Report for	Noting
Report Author	Dr Tracey Batten, Chief Executive
Responsible Executive Director	Dr Tracey Batten, Chief Executive
Freedom of Information Status	Report can be made public

Executive Summary:

This report outlines the key strategic priorities for Imperial College Healthcare NHS Trust (Trust) and provides an environmental scan of the opportunities and threats facing the Trust.

Recommendation to the Board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Key Strategic Priorities

Over the past 7 weeks, I have met with a wide range of internal and external stakeholders (Appendix I and II). During these meetings, I have taken the opportunity to seek to understand and distill the key priorities facing ICHT. These are summarised below into short, medium and long term priorities. My focus over the last two months has predominantly been on the short term priorities but will start to shift over the next few months to the medium term priorities. Feedback from Directors on these priorities will be sought at the Board meeting.

Short Term:

1. **Governance Structures & Processes**

Since commencing at the Trust, I have reviewed the executive committee structure, the processes for executive decision making and recommendation to the Board, the roles and responsibilities of the executive team and the physical location of the executive. As a result of this review, a number of changes have been implemented to streamline the governance structures and processes of the executive and to ensure clarity of roles and responsibility for clinical governance and staff health and safety.

The Management Board has been renamed the Executive Committee (ExCo) and the membership has been streamlined to the CEO direct reports and the four divisional directors. ExCo is now meeting weekly with specific themes for each meeting during the month, one focused on quality, two on strategy and one on operational performance. These meetings will be timed to precede relevant Board and Board Committee meetings in the future to ensure papers are first considered by the full executive prior to a recommendation being made to the Board.

In terms of executive roles and responsibilities, the Medical Director now has overall responsibility for Clinical Governance across the Trust with the Nursing Director taking the lead on a number of areas of clinical governance including complaints, patient experience and the Chief Inspector of Hospitals visits. The Director of Governance & Assurance no longer has responsibility for any clinical governance matters but has taken on overall responsibility for Staff Health and Safety. The Director of Human Resources & Organisational Development retains responsibility for Occupational Health.

The position of Trust Medical Director has been advertised, interviews completed and an offer made. A verbal update on the appointment will be provided at the meeting. All members of the executive team will also be relocating to The Bays in the coming months with some minor modifications to be undertaken to facilitate this colocation. This is essential to facilitate us working together as a high performing leadership team.

The format of Board reports has also been reviewed. A new CEO Report has been developed which focuses on an environmental scan of key strategic issues and the key strategic priorities for the Trust. An Operational Report has also been produced which amalgamates all the previous executive reports and focuses on the performance for the Trust over the previous period. Feedback from Directors on these reports will be sought at the meeting.

An Annual Operating Plan is also being drafted to clearly outline the key priorities and projects of each executive and how they link to achieving the strategic objectives of the Trust and ultimately the Trust's vision. This will be presented to the Board at the July Board meeting and will be aligned in future years to the budgeting and planning cycle. Quarterly updates will be provided to the Board on the implementation of the annual operating plan.

2. **Clinical Strategy/Outline Business Case (OBC) for Site Strategy/Clinical Transformation**

The Clinical Strategy and OBC were due for presentation and consideration by the Board at this May Board meeting. However, in reviewing the work that had been done to date by the Trust, it became apparent that considerable further work was required before a recommendation on a Clinical Strategy and a preferred option for redevelopment of the sites could be made. A meeting was held with the CCG Chairs and NHS England on 15 May 2014 to share our progress. At the meeting it was agreed that the Clinical Strategy and OBC would benefit from further time to enable greater engagement of staff and external stakeholders. Importantly this engagement will include Imperial College to ensure education and research is integrated into the Clinical Strategy and the resultant site strategy. This additional time will also enable further testing of the underlying model of care and financial assumptions. It was agreed that this work would be co-produced with the aim of reaching an agreed recommendation on the preferred option in the OBC. The timeframe is now to complete this work by the end of June to enable consideration through the July Finance & Investment Committee and July Board.

A core component of the Clinical Strategy requires a transformation of the model of care to better integrate care across the continuum. Significant work is being undertaken on the Implementation Plan for the Clinical Strategy to articulate the core streams of work that will need to be actioned to achieve the vision and objectives of the Clinical Strategy. This Implementation Plan will form part of the Clinical Strategy to be considered by the Board at the July Board meeting. The revised vision and objectives are included in these Board papers for discussion and consideration by the Board.

3. **Cerner Implementation/IT Strategy**

As Board directors are aware, the Cerner Patient Administration System (PAS) went live across the Trust over the Easter break. Overall, the implementation was extremely successful and demonstrated an enormous team effort by our staff. Post implementation a number of issues have been identified, the majority of which had been anticipated prior to go live. The Board has previously been notified of the printing error which saw confidential information relating to 7 patients being printed erroneously on the back of letters sent to other outpatients. This issue has been well managed and the underlying error rectified. Backlogs for data entry are also evident in the recording of activity with a concerted effort required over the next period to catch up on unrecorded activity and to get into the rhythm of entering data onto Cerner in real time. All the evidence suggests that we are in a good position compared with other trusts at this stage of a Cerner implementation although we still have a way to go before we are operating smoothly on our new system. We are continuing to engage with and listen to staff feedback through the executive divisional managers and ICT service desk so when issues are identified they may be prioritised and resolved as soon as possible.

Once the PAS is embedded across the Trust, the next step in the IT strategy is to roll out Cerner clinical documentation, medications management, ED module and theatre module. An implementation plan will be developed over the coming months.

4. **Financial Sustainability**

We are yet to sign our two key funding contracts with NWL CCGs and NHS England. A full brief was provided to the May Board Finance & Investment Committee. Whilst the NWL CCGs contract is expected to be signed within the week, there is a key outstanding issue with the NHS England contract of up to £17m related to Project Diamond funding. Negotiations continue through the Shelford Group Trust CEOs on this issue. An update will be provided at the meeting.

The Trust already has a significant Cost Improvement Programme (CIP) target for the year of £49.1m. To date, this includes unidentified savings of £10.5m. The Chief Financial Officer has now commenced regular meetings across each division and directorate to identify the strategies needed to bridge this gap, to monitor the progress on implementation of strategies and implement corrective actions as required and to build the next 2 and 5 year CIP plans which are required as part of our FT application. A quality impact assessment of each CIP plan remains integral to the evaluation of each strategy prior to implementation.

Medium Term:

1. **Chief Inspector of Hospitals Visit/Quality of Care**

The next major milestone in our progress towards Foundation Trust status is the Chief Inspector of Hospitals visit which has now been scheduled for the first week in September 2014. Janice Sigsworth will be the Executive Sponsor for the Trust for this visit and will shortly be commencing the engagement process with staff, the Board and external stakeholders to prepare for this visit. A team from the Trust will be visiting Oxford University Hospitals NHS Trust next month to meet with their team and learn from their experience given they are a similar size and complexity of health service to ourselves. A detailed data request is anticipated from the Chief Inspector in early July which will inform the focus of the inspection. A full brief in preparation for the visit will be provided to the July Quality Committee and Board meetings. In summary, the purpose of the visit is to review the Trust's services to determine if they are safe, effective, caring, responsive and well-led. This provides the Trust with an excellent opportunity to showcase demonstrable evidence of the quality of care we deliver and importantly, where we have identified opportunities for further improvement, what our plan is to address these. Our work on improving our patient experience will be central to this plan.

2. **Medical Education**

An external review of postgraduate medical education was undertaken in February 2014 commissioned by the Trust Medical Director to better understand the drivers of a number of longstanding issues including persistent poor reviews and survey results, reporting of inadequate supervision and bullying behaviour, and a perception that the Trust is not committed to improving its performance. Despite the medical education team working hard to turn around these results, it is apparent from the findings of the review that the team has

not had access to the levers nor sufficient senior support to effect the changes required. A comprehensive action plan is now in place to address the key recommendations in the report. A meeting has been held with the Directors of Postgraduate Medical Education, the Medical Director and the CEO to demonstrate the importance of the issues to the Trust. A further meeting is scheduled for July 2014 to discuss progress to date and to agree the further steps required to continue to turnaround the performance. The CEO and Medical Director have also met with Health Education North West London (HENWL) to discuss the report findings and actions underway. This matter will continue to be driven by the Trust Medical Director.

3. **Staff Experience**

Significant work is being undertaken focussed on improving staff engagement across the Trust and the experience of staff working at the Trust. The findings from the second quarterly Staff Experience Survey were presented to the May Board Quality Committee together with an update on the actions in place to improve engagement scores.

A group of staff that are participants in one of the new leadership development programmes commenced by the Director of Human Resources & Organisational Development have also approached the executive to request that they lead a review of the organisation's values. This is a really positive sign of staff engagement and goes to the core of the culture we are working to instil across the organisation. A meeting to discuss this project has been arranged in the coming weeks with a view to commencing the review in the latter half of the calendar year.

4. **Academic Health Sciences Centre (AHSC)/Biomedical Research Centre (BRC)**

As Directors are aware, the AHSC was redesignated for a further 5 years with effect from April 2014. The BRC is also coming up for redesignation in 2016. In preparation for the redesignation of the BRC a panel will be established in September 2014 to review the BRC and ensure its strategy is clearly articulated with demonstrable evidence of the achievements and outcomes. The Trust CEO and Vice President (Health) of Imperial College London are both members of the review panel. Part of the review will be to ensure that the strategies of the BRC and AHSC are aligned and integrated which to date has not been the case. This will be essential to ensure that opportunities for translational research are fully realised.

5. **Foundation Trust Status**

A number of the key priorities outlined in this report are integral to the journey and timeframe for achieving Foundation Trust status. A separate paper on the proposed timeline for Foundation Trust is included for discussion and consideration by the Board.

Long Term:

1. **World Leading Trust**

The key priority in the longer term is for the Trust to be recognised as a world leader in transforming health through innovation in research, teaching and patient care. We are well advanced in working towards this vision in a number of areas of excellence across the Trust. However, we clearly have more work to do in other areas as identified in the short

and medium term priorities outlined above. Over the coming months, it will be important to start defining the objective measures by which we plan to measure our progress towards achievement of this vision.

Other priorities:

A number of other priorities were identified as part of the stakeholder engagement process. These are all important but perhaps not as central to the achievement of the Trust's vision and objectives. I have listed them below for completeness and would appreciate any feedback from Directors:

- Hammersmith ED Closure - a detailed brief is included in these Board papers;
- NWL Pathology - final business case will come to the July 2014 Board meeting;
- Private Patient Strategy - currently under development and due for delivery in the latter half of 2014;
- Partnership with Royal Marsden Hospital - MOU signed in February 2014 and Heads of Agreement due for completion in September 2014;
- Branding - the name of the Trust and the visual identity guide will need to be developed and agreed over the next 12 months to enable rollout concurrently with the designation as a Foundation Trust;
- Fundraising – opportunities are being explored to ensure the Trust works collaboratively with the Imperial College Healthcare Charity to ensure that we maximise our fundraising opportunities;
- Achieving Operational Excellence - this work is ongoing with a recommendation due to come back to the Board in the latter half of 2014;
- Facilities Maintenance - a detailed brief was provided to the May Board Finance & Investment Committee - this is a key risk management issue for the Trust and requires ongoing active management whilst our site strategies are approved.

Key Strategic Issues

There are a number of external opportunities and threats facing the Trust over the next few years of our planning horizon. These are summarised in the points below.

1. **Whole Systems Integrated Care (WSIC)**

Traditional pathway redesign has delivered many quality improvements over the past decade. In order to make the step change to greater out of hospital models, the national focus for Health & Social Care is on the integration of pathways to transform the way we deliver care in all settings.

Co-design of these services is in production and 32 organisations across North West London, under the co-ordination of the regional WSIC team, are facilitating early adopter schemes for proof of concept and refinement before rapid expansion to wider population groups. The recipients of services will feel the difference through joined-up personalised care. Organisations such as Imperial will support front line professionals to work together in multidisciplinary teams to deliver integrated care and we will work within provider networks with shadow capitated budgets in place. The design work will support the move to seven day working patterns.

Imperial is fully engaged in the co-design, working with all the 8 CCG's with a revised team coming together to support clinical and technical engagement.

2. **Primary Care Transformation**

To support the transformation of primary care, commissioners are working with NHS England to test ways they can co-commission primary care services. In doing so this will allow NHS England and CCGs to reconsider how pooled resources are best allocated between primary care, community resources and hospital services. This will provide a vehicle to strengthen the leadership and ownership of primary care transformation and ensure plans are aligned to local strategies, together with the links between general practice and out-of-hours services, providing positive steps towards a seven day primary care system. Where required, it will enable investment in general practice services to be made in ways that do not give rise to perceived conflict of interest for GPs involved in clinical commissioning.

North West London's bid against the Prime Ministers 'Challenge Fund', a £50m fund designed to support transformation in primary care, was recently confirmed as successful with an allocation of £5m from the fund, matched by a pledge of £4m from Commissioners and £1m from the Health Education North West London (Local Education Training Board).

Imperial is supporting the implementation of these plans through the WSIC with the development of Local Hospital models and primary care hubs on our sites.

3. **Mental Health Transformation**

From Imperial's perspective, the key areas for delivering transformation that Commissioners and Mental Health trusts are focused on are the reliance on A&E as a default 'crisis' pathway and a single point of access per CCG for urgent care that operates 24 hours a day every day of the year. These touch points will support the early intervention in a range of conditions that we presently have to manage too late in the process and accentuates the poor health outcomes of these patients.

Other initiatives include the development and testing of a transformational model of care for Severe and Enduring Mental Illness management, development of integrated pathways for Learning Disability and Mental Health, Dementia pathway and models of care, Acute mental health pathway transformation and reconfiguration (community and inpatient), Residential Rehabilitation and Perinatal and Child and Adolescent Mental Health Services.

4. **Better Care Plan**

The Tri-borough Better Care Plan (BCP) sets out the vision and the practical steps being taken by the three local authorities and eight CCGs in order to:

- transform the quality of care for individuals, carers and families;
- empower and support people to maintain their independence;
- enable individuals to lead full lives as active participants in their community and
- shift resources to where they will make the biggest positive difference.

It brings together existing budgets from health and social care to encourage integrated commissioning and integrated delivery of services, consistent with Health and Wellbeing Strategies. Around £2.6m additional funding in 2014-15 will fund the programme and preparations for the Care Bill.

It builds on existing work to integrate health and social care, such as Shaping a Healthier Future, Community Budgets, Integrated Care Pilot, Whole Systems Pioneer. It includes integrated operational services such as Community Independence, Rehabilitation and Care Planning for People with Long Term Conditions, which reflect the shared agenda with hospitals around prevention of admissions and early supported discharge. It also captures plans for integrated commissioning of health and social care services, such as home care, and care home placements. National and local priorities around 7 day working, use of NHS number for information sharing and increased self-management and better patient experience are all captured within the plan and given added impetus by inclusion within the BCP framework.

Over time it may bring together a single pooled budget for health and social care services. The initial plan is for two years 2014-16. In 2014-15 the CCGs and Local Authorities expect to have around £156m in the pooled budget for tri-borough; in 2015/16 this could be £210m and represents a future funding threat for the Trust.

The Better Care Plan is overseen by the Health and Wellbeing Boards to make sure it reflects local priorities and delivers real improvements. Reports on progress against the outcomes will be publicly available. Service providers, including acute trusts, will be involved in developing and implementing the various schemes included within the BCP.

5. **Local Elections**

On the 22nd May, more than 1,800 seats in 32 boroughs in total will be contested, following the 2010 poll when Labour secured 36.4% of the vote to the Conservatives 34.5%. Across London Labour controlled 17 councils, Conservatives 11 and Liberal Democrats two. Since the last elections the Conservatives have lost control of Harrow which goes into this round with no party in overall control. Electoral commentators suggest that this time around Labour will be targeting Tory-controlled outer London boroughs such as Croydon, Barnet and Hammersmith and Fulham. A verbal update on the outcome of the local elections will be provided at the Board meeting.

6. **National Election**

It is reasonable to predict that the Government's record on the NHS will be at the heart of the national election debate in May 2015. Commentators suggest that a positive spin from the coalition is that the unprecedented slowdown in NHS funding since 2010 has not had a serious, adverse impact on patient care.

The role of competition and the private sector in health is also likely to have considerable political value, with Labour spokespersons already arguing that Part 3 of the Health and Social Care Act 2012 should be repealed to limit the role of competition regulators and reduce the threat of legal action if commissioners decide to place contracts with NHS providers instead of testing the market.

The cost and timeliness of transition from hospital based care to new models of health and

social integrated care will be fiercely debated, with key themes around the need for the NHS to be given more time, more support and more funding to deal with real pressures felt by patients in the present system.

Appendix I (Stakeholder Meetings held to date)

Board Directors
Executives
Divisional Directors
Broad range of staff – Open Forums, site visits
TDA
Monitor
CQC
NHS England including NHS CEO and Medical Director
CCG Chairs
Shelford Group CEOs
Imperial College Court
Cancer Board
HENWL
AHSC
Imperial College Health Partners
LRCN
NIHR
AHSN
TMAC
Nursing & Midwifery Professional Practice Committee
Imperial College Healthcare Charity
The Rt Hon Jeremy Hunt
Andy Slaughter MP
NWL Pathology CEO Group

Appendix II (Upcoming Stakeholder Meetings)

Local MPs
Local Councillors
Chief Inspector of Hospitals
Imperial College Charity Trustees
Local London Education Training Board
ICHT Partnership Board
ICL Medical School
Professor Alice Gast (incoming President of ICL)
Hammersmith & Fulham Scrutiny Committee
BRC
In addition, engagement with a broad range of staff will continue, including Open Forums and regular visits to each of our sites.

Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	2.3
Title	Operational Report
Report for	Monitoring/Noting
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public

Executive Summary: This is a regular report to the Board and outlines the key operational headlines that relate to the reporting month of April 2014.

Recommendation to the Board: The Board is asked to note the contents of this report.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Title : Operational Report

Purpose of the report: Regular report to the Board on Operational Performance

Introduction: This report relates to activity within M1 (April) 2014/15.

A. Shadow Monitor compliance

Foundation Trust governance risk rating (shadow): Amber
Rationale: The Trust did not achieved the RTT admitted or non-admitted performance in April

B. Operational performance

In April, the Trust continued to deliver the 4-hour waiting time standard in our A&E department. The Trust delivered a robust winter plan and achieved the standard each month in 2013/14.

Referral to Treatment performance was challenged in April and the Trust underperformed on both admitted and non-admitted RTT standards. This was primarily due to the implementation of a new system for recording patient activity during the middle of April and the familiarisation period for staff both recording and validating activity within the system. The main focus for validation was for patients still waiting for treatment and the Trust maintained performance above the required threshold for this standard. There were no patients waiting over 52 weeks and validation of our data continues throughout May to ensure that a more accurate position can be reported in Month 2. There is also a focus on reducing the volume of patients waiting over 18 weeks in a small number of specialities

In April, performance is reported for the cancer waiting times standards in March. The Trust had continued to see improvements in the standards throughout 2013/14. In March and for quarter 4 of 2013/14 overall, the Trust achieved all 8 cancer waiting times standards and are in a position where this performance can be sustained. The Trust has achieved this by working to significantly reduce the backlog of patients and improving pathways of care with earlier access to diagnostics etc. The Trust has also worked directly with hospitals that refer to us to ensure that delays are minimised.

Actions in response

- The Trust will continue to maintain a high level of scrutiny on cancer waiting times performance to ensure that the improvement is sustained;
- Extra resources have been put in place to assist the Trust administration teams with the validation that is required of our data with the implementation of the new patient administration system. This will support the delivery of an accurate RTT position in May;
- A robust RTT remedial action plan is in place that has been agreed with our commissioners that will ensure the Trusts continues to improve at speciality level, RTT performance, so that all patients can be treated within 18 weeks.

C. Infection prevention and control

Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI)
There is a national expectation of zero MRSA blood stream infections for all Trusts for 2014/15. There was one Trust attributable case in April 2014. The source of this Trust case was unknown due to multiple risk factors. Actions from these cases included educating clinical staff on the requirements for peripheral vascular access device and urethral catheter management, MRSA screening and completion of ANTT competency assessments

The Trust reported 13 cases of MRSA BSI in 2013/14. Four of these cases were reallocated to the Trust following the post infection review process (2 were pre 48 hour contaminants, one was a deep seated infection in a cardiology patient and one was an orthopaedic surgical wound). Of the remaining nine cases, five were due to invasive devices, one was a chest trauma, two were contaminants and the final case was an unknown source.

Clostridium difficile infections
The Trust reported 58 cases of Trust attributable C. difficile in 2013/14 (the Department of Health annual ceiling for the Trust is 65 cases).

In April there were 7 Trust attributable cases reported to PHE. Of these seven Trust-attributable cases one occurred in a patient aged over 65. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in five of the April cases. The two cases that were not isolated within two hours occurred due to lack of recognition of the need to isolate patients with diarrhoea. All seven cases had unavoidable exposure to antibiotics and all of these were in line with policy or approved by the infection clinical team.

Meticillin sensitive Staphylococcus aureus bloodstream infections (MSSA BSI)
There is no threshold for this indicator at present. In April 2014 six cases were reported to Public Health England (PHE), of which two were Trust attributable (i.e. post 48 hours of admission). Of these two cases, one was associated with a long term central venous catheter and one case had pneumonia as the source of infection.

Escherichia coli bloodstream infections (E. coli BSI)
There is no threshold for this indicator at present. The steep rise in E. coli BSIs nationally is a cause of significant concern. In April 2014 there were 24 cases reported to the Public Health England (PHE), of which six were Trust attributable. Of these, three were due to urinary sepsis, one due to neutropaenic sepsis and the remaining two cases had bowel perforation and a liver abscess as the source of infection.

Carbapenemase Producing Organisms
The Trust continues to implement the PHE guidance for acute Trusts on managing patients identified with these drug resistant organisms. Current areas that screen all admissions for these organisms include adult and paediatric ICUs and the paediatric BMT unit. There is a plan in place to extend this screening to the renal and private patient population.

Fungal Infection Surveillance
At the chairman's request, candida blood stream infection surveillance has now commenced with one Trust case reported for April 2014.

Actions in response

- HCAI reduction action plan continues to be monitored through the weekly HCAI taskforce to reflect learning from MRSA BSIs and C. difficile incidents;
- Carbapenamase producing organisms plan now in place addressing identification of patients and related management;
- On-going surveillance for MSSA, E. coli and fungal infections.

D. Nursing

Female Genital Mutilation

The Chief Nurse and Regional Director for London wrote to all Provider Trusts on 13th March 2014 setting out a clear process for safeguarding girls at risk of female genital mutilation (FGM). It is estimated that 66,000 women resident in England and Wales in 2001 had undergone FGM and over 23,000 under the age of 15, from African communities, were at risk of, or may have undergone FGM. A steering group has been established in London to help support the agenda of empowering frontline professions and being clear about accountabilities.

Positive and Proactive Care: reducing the need for restrictive interventions

The Department of Health has published new guidance for staff on the use of restrictive interventions for patients with difficult behaviour. The document provides guidance for adult health and social care staff to develop a culture where restrictive interventions are only ever used as a last resort. The report identifies actions that will improve people's quality of life which should then reduce the need for restrictive interventions. It sets out ways to know who is responsible for making these improvements, including effective governance, transparency and monitoring.

Care for people in the last days and hours of life

From late October 2013 to 31 January 2014, the Leadership Alliance for the Care of Dying People ('the Alliance') carried out extensive public engagement, including engagement with families and professionals, on proposed outcomes for the care of dying people, and on guiding principles for professionals. The Alliance has developed the outcomes into five priority areas which cover:

- The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

The Alliance expects to publish more detailed descriptions of the five priority areas, as

well as the supporting documents, in late spring / early summer 2014, along with the system wide response to the recommendations made by the independent panel that reviewed the Liverpool Care Pathway.

North West London Sector Research Symposium for AHPs, Nurses, Midwives and Pharmacists
The second North West London Sector Research Symposium for AHPs, Nurses, Midwives and Pharmacists will take place on 10th September 2014 supported by the Trust and Health Education North West London.

N&M cost collection tariff exercise
The Department of Health and Health Education England have mandated Trusts nationally to cost the support required to train non-medical clinical professionals. This exercise now includes nurses and midwives.

2013-2014 saw the introduction of a 'transitional tariff' for undergraduate medical and non-medical placements. The aim of the current exercise will be to replace the transitional tariff with a tariff that more truly reflects the cost of educating and training health professionals in provider organisations.

A series of costing exercises will be taking place and is being led by the corporate nursing and education team in partnership with finance and this will help to determine the level of tariff that is awarded to the trust in the future for nursing and midwifery undergraduate support.

Reorganisation of Health Education England and Local Education Training Board management arrangements
Health Education England (HEE) is planning to re-organise the management arrangements for HEE and Local Education Training Boards (LETBs). The proposals are expected to be issued imminently and will be discussed at the HEE Board meeting on 4th June 2014.

Safe staffing
Performance related to the actual nursing/midwifery staff available versus the planned staffing levels will be reported in the next Operational Report to align with the national reporting requirements and timescales which are June 2014. The information presented will be recorded in hours and split by day and night and also by registered and unregistered nursing staff.

E. Safety and Effectiveness

Safety

Hospital Mortality Rates

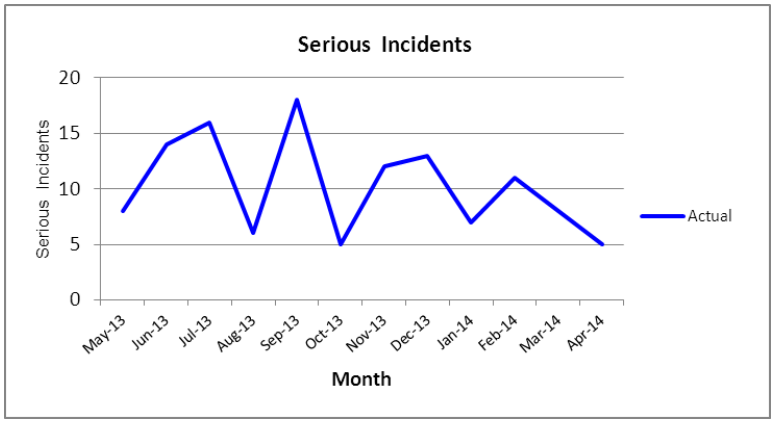
- Both the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) for the Trust remain in the top ten best performing (lowest mortality) nationally;
- For the latest data available (January 2014), the Trust monthly HSMR was 62. Our rate is lower than the the Shelford Group average of 81;
- For the latest SHMI data available (Q1, 2013/14), our SHMI rate is 74.1;

- There were no high relative risk mortality alerts or negative Dr Foster alerts in January 2013.

Incident Investigation

The weekly incident review panel continues to review all moderate and above incidents that occur within the Trust. This allows the Medical Director to have real time oversight of issues as they arise.

The graph below shows the number of SIs per month for 2013/14.



An action plan is implemented following each investigated serious incident. The actions from our SI investigations will be audited as part of the clinical audit plan for 2014/15 to ensure compliance. The following are recent examples of actions being taken to prevent issues re-occurring and improve awareness:

- Introduce regular drug calculation assessments for existing staff (already in place for new starters);
- Implement annual training and assessments for all staff administering neonatal drugs;
- Nurse in Charge and a senior Clinician to review all patients following a fall to ensure any injuries are detected and appropriate treatment is initiated;
- Review of local inductions for bank and agency staff;
- Bed rail assessment to be completed weekly for patients who are at risk of falling.

A suspected never event was reported in May 2014. No harm occurred to the patient and the incident was reported in line with national guidance. On further examination it was apparent that the incident does not meet the criteria for never events, although it remains a serious incident. The situation has been discussed at the quality committee.

Effectiveness

A review of NICE compliance, in conjunction with clinical guidelines, is currently underway. The outcome of this review will be reported to the Executive Committee and Quality Committee.

F. Finance

The income and expenditure position for month 1 2014/15 is a deficit of £1.7m against the deficit plan of £0.6m, an adverse variance of £1.1m.

Income:
The main area of underperformance on income is due to CIP schemes that were expected to deliver additional activity. Divisions will need to review these schemes to see if they are deliverable and replace if they are not realistic.

Expenditure:
Pay – there was a significant overspend on bank and agency staff, with an expenditure in month of £6.4m which is £2m more than the average spend on bank and agency in 2013/14. The main overspends were on admin staff for Cerner and nursing costs.

Non-pay – in the main non-pay was underspent in month.

CIPs – a slow start to the year has meant there was an adverse variance of £1.8m in month.

Actions in response:
- The controls on pay need to be reviewed with urgent action to address and reduce the spend to at least last year's average;
- A number of CIP income schemes have shown no impact upon the financial position and these schemes will need to be reviewed.

G. People

The Trust's operating vacancy rate, at the end of April was 13.1%; the equivalent of 1,330 WTE vacant posts. There are currently 454 candidates in our recruitment pipeline that are waiting to join which gives an adjusted un-recruited vacancy rate of 8.61%. Contingent workers are covering 122 of our vacancies and a further 311 positions are currently in the process of being advertised and interviewed. We will pro-actively review the remaining 443 vacancies, to ensure that only those posts required for current service delivery remain established, recruited to and reported on.

The Trust's recorded sickness absence for April 2014 was 3.24%; the equivalent of 290 WTE across the month. This is 9% lower than the recorded sickness levels in March 2014 (3.57%) but 2.5% higher than those recorded in April 2013 (3.16%). Across the Divisions, sickness absence ranges from 2.8 to 3.4% in April with Corporates ranging from 0.0 to 5.6%. Anxiety/Stress and Depression accounts for 19% of April's sickness with Musculoskeletal and back related illness at 18%; almost half of current long-term illness is attributable to these sickness types. Anxiety/Stress and Depression will be addressed as part of the new Health and Well Being strategy.

Since the beginning of April, over 200 Trust managers have attended the new Performance Development and Review Programme training with a further 400 booked to attend the training before the end of August. The first wave of PDRs will be completed by the end of June, by the most senior managers, and the rest of our managers will be carrying out their first PDRs between now and December. We have a target of 95%, by the end June, for all of our bands 8c to 9 to have a completed PDR. This completion rate is currently at 12.0%.

Actions in response

Vacancies

- Centralised recruitment for band s 2 – 6 nursing and midwifery vacancies;
- Bespoke Divisional strategic people planning model to support band 2-6 nursing and midwifery recruitment;
- Review of all vacant posts.

Sickness

- Weekly and monthly people planning review and support meetings with managers within Divisions with focus on management of high sickness levels and sickness absence management training;
- Divisional sickness clinics supported by Trust Occupational Health professionals.

PDR

- Ensure adequate training places are available for all Trust managers so that they can effectively participate in and deliver the new PDR programme;
- New monthly PDR reports to support delivery of the programme with compliance rates and rating spread.

H. Research and Education

Education

Education Visits – June 2014

- The Quality Team from Shared Services, on behalf of Health Education North West London, will visit the Trust on Monday 2nd June and Tuesday 3rd June 2014 to review post-graduate medical education.
- Imperial College London's Governance and Education Monitoring team will undertake a monitoring visit to the Trust on 12th June 2014 to review undergraduate medical education. This will follow up on action plans set out as a result of their previous visit in November 2013.

The Medical Director's Office is leading on the preparations for both visits in collaboration with Directors of Medical Education (DMEs), Directors of Clinical Studies (DCSs) and appropriate clinical leads to review outstanding actions in preparation for the visits.

Education Review

The review of postgraduate medical education was undertaken in February 2014 by Dr Fiona Moss, previous Director of Medical and Dental Education Commissioning for London.

Following the review, there will be a restructure of educational leadership; a workshop will be held on 4th July 2014 to engage stakeholders & plan implementation of the new arrangements. A progress report will be submitted to Executive Committee following this.

Educational SPA Review

A review of SPA allocation commenced in December 2013. A progress report will be submitted to Executive Committee in July.

Research

LCRN

- The NIHR funded NW London Clinical Research Network (NWL CRN), now

hosted by Imperial College Healthcare NHS Trust, was launched on 1st April 2014;

- The Executive Group have met twice and regular meetings with Imperial College Health Partners have been scheduled;
- The official launch will be held at BMA House on the afternoon of Tuesday June 10th;
- The Trust increased its year-on-year NIHR Portfolio activity once again in 2013/14, representing approximately 42% of the overall NWL CRN patient recruitment activity.

NIHR Imperial Biomedical Research Centre (BRC)

- BRC Themes have all recently engaged in a planning round for beyond 2014/15, and to consider priorities;
- A mid-term appraisal of BRC progress, by external reviewers, is planned for early autumn 2014 - this will inform the remaining two and a half years of the programme and plans for re-application in 2016. A panel of external reviewers been identified and will be chaired by the Dean of the Faculty of Medicine.

Divisional Research Structures

- The divisional research structures have been strengthened by the recruitment of Research Feasibility Officers who will be key to enabling the Division to establish a robust feasibility process as part of the work to ensure the Trust is able to deliver clinical research to time and target;
- The posts of Divisional Director of Research (DDoR) have been agreed. DDoRs will be full members of the AHSC Research Committee and will chair the Divisional Research Committees, wherein the budgets for the NIHR Imperial BRC and other NIHR programmes are held. Nominations for the DDoR posts have been received from each Division.

NIHR Performance Metrics for Initiating and Delivering Clinical Research

- ICHNT continues to make steady improvement in terms of the time taken to approve clinical research studies, to recruit the first patient to studies, and to deliver commercial studies to time and target;
- For the most recent quarterly period (as returned to NIHR) 42 studies met the 70-day benchmark, which translates into 47.2% of studies meeting the benchmark, when adjusted for reasons beyond the Trust's control;
- A number of iniatives are underway, both at the R&D approval/contracts stage and the study set-up stage to performance against the 70-day benchmark. A robust feasibility assessment process is being piloted in Cardiovascular.

Recommendation to the Board: The Board is asked to note the contents of this report.

Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	2.4
Title	Integrated Performance Scorecard
Report for	Monitoring
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public

Executive Summary: This is a regular report to the Board that outlines the key headline performance indicators from Monitor, CQC, and TDA frameworks as well as a number of contractual indicators as well as some that have internally generated. This report is designed to be reviewed in conjunction with the Operational Report.

Recommendation to the Board: The Board is asked to note the contents of this report

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Title : Integrated Performance Scorecard

Purpose of the report: The Board is asked to note the contents of the Integrated Performance Scorecard.

The Integrated Performance Scorecard brings together finance, people and quality metrics. The quality metrics are subdivided into the 6 quality domains as defined in the Trust Quality Strategy.

The indicators for each domain have been specifically selected and agreed by the quality domain leads as those that the Board should be sighted on.

Regulatory reforms

There are no changes to regulatory reform to report this month.

Once the methodology for the TDA governance rating is published, this will be reported in this report.

Leading/lagging indicators

Leading indicators are those where future performance may be affected e.g. patients referred via the two week wait suspected cancer route will be reported under the 62 day standard if diagnosed with cancer, or VTE risk assessment rates could have a direct impact on clinical outcomes.

Lagging indicators are those where the final outcome is reported e.g. mortality rates or 30 day readmission rates.

Source framework

The source framework is cited for each of the published indicators. This is highlighted within the scorecard e.g. Monitor, CQC, NTDA, contractual or internally generated.

Future development

In the coming months, the scorecard will be further enhanced including:

- Ensuring that all indicators have a threshold so it is clear in the summary pie charts how the indicator is performing.
- Include further comparison data, when this becomes available to allow benchmarking to be made with other London Trusts, the Shelford Group and against the national average;
- Inclusion of a definitions page which will describe the Monitor governance framework as well out outline some definitions on the indicators that have been selected and rationale for including them.
- It is proposed that the Integrated Performance Scorecard is developed into a QlikView application with an initial version to be presented to the Trust Board in September 2014. This will allow for the complex data feeds to be fully embedded into the scorecard and will allow full testing of the iPad friendly version of QlikView which is

soon to be released. QlikView will allow Trust Board members to drill down into further detail into the indicators that are presented. This could be to divisional or speciality level.

All indicators from the Monitor governance framework having a forecast Red/Green for the coming three quarters.

Recommendation to the Board: The Board is asked to note the contents of the Integrated Performance Scorecard.

Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	2.5
Title	Finance Performance Report – April 2014
Report for	Monitoring
Report Author	Marcus Thorman – Director of Operational Finance
Responsible Executive Director	Bill Shields – Chief Financial Officer
Freedom of Information Status	Report can be made public

1. **Executive Summary:** The Trust's Income & Expenditure position at the end of April was a deficit of £1.7m (after adjusting for impairment and donated assets), an adverse variance against the plan of £1.1m. The main reasons for the adverse variance are:-
   - Cost Improvements (CIPs) behind plan;
   - Expenditure on Cerner greater than expected;
   - Higher temporary staff pay costs due to the continued use of additional winter pressure beds.

2. **Recommendations to the Board:** The Board is asked to note:
   - The deficit of £1.7m, an adverse variance against plan of £1.1m;
   - Improvement in delivery of the CIPs is required in order to achieve the financial plan target.

3. **Trust strategic objectives supported by this paper:**

   To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

1. Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 30th April 2014.

1.2 The narrative report is intended to provide a more focused statement of the main drivers of the financial performance and direct the audience to the relevant pages in the finance performance report.

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 was a **deficit** of £1.7m; this was an **adverse** variance of £1.1m in month

2.2 **CCGs/NHS England Service Level Agreement (SLA) Income** - The CCGs & NHS England SLA contract income for the month was calculated using, where appropriate, the agreed contract value or plan due to the unavailability of patient level data.

2.3 **Other Income** – Non NHS Other, Research and Non Patient Care activities income categories are behind plan and will be carefully monitored over the next two months. Research income is matched to expenditure to ensure a net zero impact.

2.4 **Expenditure** - Pay expenditure shows an **adverse** variance of £3.0m in month as a result of under-achievement of CIPs and a failure to reduce bank and agency costs due to continuing use of winter beds. Non pay expenditure was showing a **favourable** variance in month of £3.7m. Other non-pay includes the contingency and funding to support service developments.

3. Monthly Performance

3.1 The Divisional & Corporate Services' financial performance has not been included this month as the Financial Risk Ratings are being reviewed with the intention of including weightings and over-riding rules to make it more targeted.

4. Cost Improvement Plan (Page 4)

4.1 The CIP plan for the year is £49.1m; actual CIP delivered in month was £1.4m against a plan of £3.3m, an **adverse** variance of £1.9m.

4.2 The forecast outturn is a shortfall of £10.5m. The Transformation Board is closely monitoring the position and significant work is taking place to ensure plans are robust in delivery of the 2014/15 target.

5. Statement of Financial Position (Balance Sheet - Page 5)

5.1 The overall movement in balances when compared to the previous month was a decrease of £1.8m and was predominately due to the depreciation charge on non-current assets.

6. Capital Expenditure (Page 6)

6.1 Expenditure in month is £1.4m, slightly behind plan. The Trust's annual Capital Resource Limit (CRL) is £30m.

7. Cash (Page 7)

7.1 The cash balance at the end of the month was £51.9m, £1m above plan. Cash is monitored on a daily basis and surplus cash is invested in the National Loan Fund scheme.

8. Monitor metrics – Financial Risk Rating (Page 8)

8.1 The overall TDA Financial Risk Rating is below an acceptable performance due to the deficit in month. Monitor's Continuity of Service Risk Rating score of 3 is acceptable as the Trust currently has sufficient cash to service debts and liabilities as they fall due.

9. Conclusions & Recommendations

The Board is asked to note:

- The deficit of £1.7m, an adverse variance against plan of £1.1m;
- Improvement in delivery of the CIPs is required in order to achieve the financial plan target.

Imperial College Healthcare NHS Trust

Public Board Meeting

Wednesday 28 May 2014

Agenda Item	3.1
Title	Revised vision and strategic objectives
Report for	Decision
Report Author	Michelle Dixon, Director of Communications
Responsible Executive Director	Michelle Dixon, Director of Communications

Executive Summary: As part of the work to develop our clinical strategy, we have been seeking to sharpen and simplify the Trust's vision and strategic objectives. The intention is to agree more accessible and impactful versions to demonstrate more clearly the strategic context for the clinical strategy, the outline business case and the related transformation programme. A refined vision and objectives will also help address one aspect of feedback from our recent Foundation Trust application consultation which indicated that many find some of our currently worded objectives difficult to understand.

Recommendation to the Board: The Board is asked to agree the revised vision and strategic objectives, enabling them to be promoted in all relevant documents and presentations, including the clinical strategy and outline business case. We will also continue to seek feedback on our vision and strategic objectives as part of our engagement work for the clinical strategy and site development.

Revised vision

To be a world leader in transforming health through innovation in research, teaching and patient care.

Revised objectives

- To achieve the best patient outcomes and experience, delivered efficiently and compassionately.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical practice.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Current vision

To improve the health and wellbeing of the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical service in order to transform the experience of our patients.

Current objectives

- To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
- To develop recognised programmes where the specialist services the Trust provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
- With our partners, ensure a high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves
- With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	3.2
Title	Closure of the Emergency Unit at Hammersmith Hospital
Report for	Decision
Report Author	Professor Tim Orchard and Claire Braithwaite
Responsible Executive Director	Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public.

Executive Summary: The Shaping a Healthier Future Programme includes the closure of the Hammersmith Emergency Unit. This will result in the redistribution of non elective activity to other hospitals inside and outside Imperial College Healthcare NHS Trust. An Implementation Group has been established to oversee this process. The ICHT Trust Board is being asked to approve the proposed reconfiguration and the proposed timescale, whilst understanding the associated risks and mitigations in place. This paper outlines the proposed process, risks and mitigations.

Recommendation to the Board:

1. To agree the programme of work to close the Emergency Unit at Hammersmith Hospital and expand and enhance the UCC, with a planned date for the transition to take effect of 10th September 2014.

2. To commence a formal consultation with the staff directly affected by the planned closure on 29th May 2014.

3. To request a further report with an update on progress and assurance for its meeting in July.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.

CLOSURE OF THE EMERGENCY UNIT AT HAMMERSMITH HOSPITAL

Purpose of the Paper:

The purpose of this paper is to update the Trust Board on progress with plans to close the Emergency Unit (EU) at Hammersmith Hospital and to seek formal approval for a planned closure date of 10th September 2014 and the start of formal staff consultation, provide further information on the enhanced urgent care centre and a summary of the communications and engagement campaign.

Introduction:

The vision for modernising and improving healthcare in North West London described in Shaping a Healthier Future (SaHF), includes closure of the emergency departments at Hammersmith (HH) and Central Middlesex (CMX) during the early phase of implementation. Following a full public consultation and a referral to the Independent Reconfiguration Panel, the Secretary of State for Health announced on 30 October that the departments would close 'as soon as practicable'.

These changes put forward by clinicians are needed to:

- Modernise and improve the delivery of health care fit for the 21st century;
- To deliver much needed care at home and in the community;
- To concentrate specialised services to provide higher quality teams.

Modernised and improved healthcare in North West London will ensure that when someone does need emergency care they are seen by a specialist more quickly and will have better access to diagnostics whatever the time of day.

Hammersmith is a general hospital and is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers. The hospital hosts the heart attack centre for North West London.

We see Hammersmith Hospital developing as a specialist hospital - providing specialist care for particular conditions - and including a 24 hour/7 day Urgent Care Centre.

Hammersmith Hospital is home to one of London's eight heart attack centres, providing specialist 24 hour/7 day emergency care and treatment for anyone suspected of having a heart attack in the west London area.

Hammersmith Hospital's current Emergency Unit combines:

- An A&E Department, open 24 hours a day, 365 days of the year, providing a coordinated service for the assessment, reception, referral and discharge of patients who have suddenly become very ill;
- An Urgent Care Centre seeing patients with minor injuries and illnesses: open Monday to Sunday: 8.00am-10.00pm.

Dependencies
It is recommended that the two emergency departments (HH and CMX) plan so that they close on the same day. This is to avoid the potential impact of one closing and those patients being diverted to the remaining one as it prepares to close. This has an impact on the preferred timing as ICHT would prefer to close at the beginning of August due to issues with medical staffing (see risks below) and NWL cannot close until mid-September, as building works will not be completed until then.

Governance Structure
The Hammersmith Hospital Emergency Unit Transition Project Delivery Board has been established with the specific remit of managing both the safe closure of the EU and the successful transition of activity from the EU to other providers, ensuring that clinical safety and quality are maintained throughout the planning and transition period.

The project delivery board includes representation from the Trust, the SaHF Programme Team, Hammersmith & Fulham Clinical Commissioning Group, London Ambulance Service and Health Education North West London.

This group reports into the following forums:

- Charing Cross and Hammersmith Non-Elective Transition (CXH NEL) Steering Group (which in turn reports into the SaHF Programme Board);
- ICHT Urgent Care Board (which in turn reports into the Tri-Borough Urgent Care Programme Board);
- ICHT Division of Medicine Committee (which in turn reports into the Imperial Trust Executive Committee);
- Hammersmith and Fulham CCG Governing Body.

Preparedness
The Hammersmith Hospital Emergency Unit Transition Project Delivery Board has established 6 workstreams which will collectively ensure that both Hammersmith Hospital and the provider organisations that will receive additional patient activity are sufficiently prepared for closure. These include:

- Clinical Pathways;
- Urgent Care Centre Reconfiguration;
- Project Management;
- Communications and Engagement;
- Workforce and Education;
- Equalities, Access and Infrastructure.

There are also readiness groups to consider preparedness for additional ED and inpatient activity at St Mary's and Charing Cross.

Hammersmith Hospital
The Hammersmith site will have a 24 hour (currently 12 hour) Urgent Care Centre (UCC) managed by Partnership for Health and staffed by a higher than currently skilled workforce of general practitioners and emergency nurse practitioners. This UCC will meet the new

London Health Programme Standards for a standalone Urgent Care Centre, and will be linked to the St Mary's Emergency Department as the "host" emergency department for referrals. The London Ambulance Service will convey patients to the UCC using a standard LAS triage tool but will not convey category A patients. The only exception will be to continue to convey suitable patients to the Heart Attack Centre at the Hammersmith (HAC).

The EU currently sees approximately 60 patients a day with an overall admission rate of 33% (13 acute medicine, 7 specialist). 25 of these patients are brought by ambulance and the majority will be taken elsewhere. Modelling suggests that this will be mainly to the emergency department at St Mary's. The UCC, which sees only walk in patients currently, refers approximately 17 of these walk in patients a day to the EU. These may be cared for in the UCC in future (by up-skilling the staff) or will be diverted to St Mary's. There are approximately 7 admissions to specialist beds a day, these will continue.

There are 104 medical beds at the Hammersmith including 26 acute beds and 78 specialist medicine beds. The majority of the beds will remain open with one acute ward converted to a medical assessment and discharge area, open 08:00 until 22:00. Admission to these beds will be via GP referral through a single point of access. This will be staffed by a senior nurse practitioner with direct input from senior medical staff. This will be used to direct all GP medical referrals to the Trust to the most appropriate place for their condition. In addition, there will be an area for patients to wait for transport and relatives having been discharged from the specialist medicine wards in order to manage the throughput of patients.

Careful monitoring of bed utilisation, transfer rates from the other sites, length of stay and patient experience will inform the final number and type of beds on site, and this may change in the light of experience after the reconfiguration.

Discussions continue within the Clinical Pathways workstream about the optimum approach to receiving patients that require specialist cardiology, haemoncology or renal services.

St Mary's Hospital
Modelling suggests that the emergency department at St. Mary's will receive an additional 25 ambulances and up to 15 UCC-referred patients a day. It is anticipated that these will convert to 13 admissions and therefore plans for additional capacity are being developed.

The current capacity at St Mary's for acute admissions is already at maximum utilisation. Work is therefore underway to identify sufficient space to establish an appropriate ward environment to accommodate these patients, as well as facilitating improvements to the existing care pathway through the expansion of the acute medical facilities on the first floor.

Charing Cross Hospital
Analysis suggests that the impact on Charing Cross Hospital in terms of additional emergency department attendances and admissions is unlikely to be significant. It will, however, be necessary to monitor bed utilisation, transfer rates from the other sites, length of stay and patient experience following the closure of the EU and to respond rapidly to any difficulties that arise as a result.

Staff Consultation
Informal discussions with directly affected staff have been on-going since the Secretary of State made his announcement about the closure of the EU. The formal consultation is planned to start on 29th May 2014, pending approval of the anticipated closure date by the Trust Board.

We will be open, fair and transparent throughout this process, and will share relevant information with people regarding the changes as it becomes available

We are not planning or expecting job losses as a result of any of the changes, particularly given the need for more staff to support the additional capacity we need for the emergency department at St Mary's Hospital.

Our aim is to retain the valuable skills and talent we have within the Trust and it is anticipated that all displaced staff will be accommodated within existing vacancies.

Communications Plan
The joint communications workstream is the group set up to bring together communications teams from the provider trusts, CCGs and the SaHF programme with lay partners to deliver a public information campaign which will inform the general public and key community groups about the closure of the emergency departments at CMH and HH and provide information on what they should do if they require unscheduled care.

To summarise, the plan is being developed to cover a range of activity including:

- Hospital and community staff engagement
- GP membership engagement
- Outdoor advertising
- Newspaper/magazine advertising
- Online activity
- Door drops to local properties
- Letter & leaflets to parents & schools
- Posters, letters & leaflets to GPs and pharmacies
- Leaflets to cab companies, hairdressers and other local businesses
- Posters and leaflets in public buildings and in hospitals
- Engagement with community and local health groups
- Updates to scrutiny bodies, Healthwatch and Health and Wellbeing Boards
- Updates to local elected representatives
- Press releases to local media

The group is also looking at the possibility of developing other materials and activities including the effectiveness of roadshow events.

Risks:

- Additional capacity at St Mary's is central to delivery – work is underway to identify sufficient capacity but this is unlikely to conclude prior to the closure of the EU. Early opening of winter "flex" beds within the Division of Medicine will mitigate this risk until we have more permanent plans in place;

- Medical staffing during transition – The junior medical staff based in the EU have rotational contracts that cease on 6th August 2014. To maintain the service into September is therefore a clinical risk in recruitment and a financial risk in the probability of a high reliance on locums. We are actively managing this risk;

- Bed utilisation at Hammersmith – anticipated and criteria driven discharge will be required to free up beds for the next day by 11:00 to maintain flow. This will require a change in practice for the specialist medical wards;

- Recruitment and retention of key staff – additional risks relate to staff leaving as the EU closes. A programme of engagement is under way with staff to ensure they have clear development plans within the Trust.

Finance issues: The financial impact of the closure is being assessed as part of the Shaping a Healthier Future implementation, and the allocation of transitional funding as part of this is being negotiated**.**

Legal and Compliance issues: None

Implications for Equality, Diversity and Human Rights: None

Engaging People: Informal meetings have been held with potentially affected staff members. The SaHF implementation has undergone widespread public consultation, and there will be a communications programme from the SaHF Implementation Board with regard to this closure. In addition, we will work closely with the Trust Communications Department to ensure appropriate engagement internally and externally**.**

Recommendation to the Board:

It is proposed that the Trust Board approve the following recommendations:

1. To agree the programme of work to close the Emergency Unit at Hammersmith Hospital and expand and enhance the UCC, with a planned date for the transition to take effect of 10th September 2014.

2. To commence a formal consultation with the staff directly affected by the planned closure on 29th May 2014.

3. To request a further report with an update on progress and assurance for its meeting in July.

Imperial College Healthcare NHS Trust

Board Public Meeting

28 May 2014

Agenda Item	3.3
Title	Safe Nurse/Midwife Staffing Levels
Report for	Decision
Report Author	Priya Rathod, Associate Director – Chief of Staff (Nursing Directorate)
Responsible Executive Director	Janice Sigsworth, Director of Nursing
Freedom of Information Status	Report can be made public

Executive Summary:

This paper was presented to the Quality Committee on 13th May 2014. The Board received a paper on safe nurse/midwife staffing at its meeting in January 2014 which provided an overview of the national guidance and next steps.

The following report is divided into two parts and provides the board with an overview of:

Part One: The Trust's progress in meeting the National Quality Board's expectations (nine out of ten expectations are applicable to the Trust).

- The Trust is currently meeting eight out of the nine expectations and will meet all expectations by June 2014. The outstanding action relates to reporting actual versus planned nursing and midwifery staffing levels.

Part Two: A summary of nursing and midwifery establishments *for* all inpatient ward areas

- Following a review of establishments by divisions across the Trust, there is a reported shortfall of 10.10 whole time equivalent (WTE) posts.

Recommendation to the Board:

- Board to sign off all inpatient NHS funded ward establishments
- Note the shortfall of 10.10 WTE to be included in 2014/15 business planning
- Note that the posts will be funded for 2014/15
- Note that the actual staff available versus planned staffing levels will be brought to the public board meeting in July.

Trust strategic objectives supported by this paper: *Retain as appropriate:*

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Safe Nurse/Midwife Staffing Levels at Imperial College Healthcare NHS Trust

1. Background

1.1 The government published its full response ('Hard Truths') to the Mid-Staffordshire NHS Foundation Trust Inquiry, in November 2013.

1.2 Further to the government's response, the National Quality Board (NQB) published a document titled *How to ensure the right people with the right skills are in the right place at the right time (2013)*. The document sets out ten expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right. Please refer to Appendix 1 for a summary of the Trust's progress in meeting the expectations.

1.3 A national reporting template to capture actual staff available on a shift-to-shift basis versus planned staffing levels is currently awaited.

1.4 NICE has published a draft 'guideline for safe nurse staffing of adult wards in acute hospitals' on 12th May 2014 and the consultation is due to end on 10th June 2014.

2. Purpose of the report

The national guidance sets out that the Trust Board be given an overview of:

- The nursing and midwifery establishments for all inpatient ward areas
- The evidence based tools used to calculate the establishment
- Confirmation of allowances for leave, sickness, etc and supervisory duties
- How gaps in staffing are currently being managed
- Plans to meet recommendations following clean sheet review (number of staff and skill mix ratio)

3. Process for setting establishments

- The Trust has a policy in place for the provision of safe nurse and midwife staffing and skill mix establishments which was ratified at the Trust's Board meeting in May 2013.
- The Trust will review the policy in line with the new guidance and following this round of clean sheet reviews.
- The Royal College of Nursing (RCN) recommendations suggest the skill mix ratio of registered nurse (RN) to unregistered nurse (healthcare assistant/HCA) should be no less than 65:35.
- The Safe Staffing Alliance suggests a nurse to patient ratio no greater than 1:8.

3.1 Clean sheet review

- The Trust has adopted the 'clean sheet review' (also known as 'establishment review') process. Divisions assess each ward on a six monthly basis using patient acuity to determine the amount of WTE's required to deliver day to day patient care. This informs the business planning cycle within the Trust.

- If there are service changes and/or a sustained change in activity, acuity or dependency, the clean sheet review may take place more frequently than twice a year and in response to these changes.
- A further 23% 'uplift' is factored in for when staff are unavailable due to annual leave, sickness, maternity leave and training.
- The nursing establishment is turned into an operational rota, which determines how many nurses and bands are working on each shift. This can vary from the agreed establishment, for example due to sickness, short notice leave, patients who require one to one care ('Specialling') and additional beds.
- All establishments post-clean sheet reviews are signed off with a signature by the divisional director of nursing and ward sister/charge nurse.
- The Director of Nursing also met with a sample of ward sisters/charge nurses across the hospital sites in May and (June 2014) to sign off their establishments. Another series of meetings will take place with ward managers following the next clean sheet review in September 2014.

4. Using evidence based tools/recognised standards

- In order to determine patient acuity, the safer nursing care tool (SNCT) is used within the Trust for inpatient ward areas and is a nationally recognised tool for setting safe nurse staffing levels.
- Staffing levels for midwifery are set using a different tool known as 'Birth rate plus'. Please refer to Appendix 2 for further detail.
- There are a variety of tools/recognised standards for specialist areas such as neonates and paediatrics.
- Professional judgement is applied in addition to evidence based tools/recognised standards.

5. Clean sheet review findings

- A clean sheet review was undertaken by Divisional Nurse Directors in:
  - October 2013 for the division of women's and children's
  - March 2014 for the divisions of medicine and surgery,
- The outputs of the review can be found in Appendix 3.
- There has been much activity through 2013/14 following the divisional restructure and re-setting of baseline establishments to meet the 2014/15 business planning round. This has resulted in a number of ward acuity, bed, service and divisional changes which divisional nurse directors have confirmed are now in the 2014/15 baseline.

5.1 Division of surgery, cancer and cardiovascular sciences

- The division has confirmed establishment requirements are being met for inpatient areas.
- The division is currently undertaking a further clean sheet review for four ward areas due to a change in acuity and the outcome will be discussed within the division.

5.2 Division of medicine

- The division has confirmed establishment requirements are being met for inpatient areas with the following exception:
- There is a shortfall of 8.10 WTE posts.
- The gap is currently being managed in a variety of ways and includes; the redeployment of staff, use of Bank and agency and utilising practice educators and senior staff when necessary.
- The approach to funding the additional posts is under discussion within the division.

5.3 Division of women's and children's

- The division has confirmed establishment requirements are being met for inpatient areas with the following exception:
- The clean sheet has identified a skill mix shortfall of 2.0 WTE HCAs (one per ward).
- The RN to HCA ratio for Samaritan ward is slightly below the recommended 65/35 ratio and this will be reviewed.

5.3.1 Paediatrics

- The division has confirmed establishment requirements are being met for inpatient areas with the following exception:
- Although the clean sheet review did not show a change in establishment for Grand Union Ward, the senior nursing team believe due to an increase in acuity and dependency additional nursing staff are required. The acuity tool will be re-run and staffing reviewed daily.

6. Supervisory allowance

- Across the Trust, ward sisters/charge nurses act in a supervisory capacity but in emergencies, if the demand for care increases or there is a shortfall in the number of staff working, they will also carry a caseload and care for patients in addition to their supervisory duties.

7. Publishing staffing information

7.1 Ward level

- The Trust displays staffing information in all its inpatient ward areas and this should include for each shift; the actual number of staff versus the planned staff, and the roles and responsibilities for each staff member.
- The Trust implemented staffing boards in February 2014.

7.2 To the public

- The Trust will publish the monthly and six monthly safe nurse and midwife staffing board reports on the Trust website as part of the board papers.
- A link will be posted on the NHS Choices webpage for each hospital site, directing the public to the Trust board papers.

8. Escalation of staffing shortfalls

- A nursing and midwifery staffing escalation process has been developed in conjunction with senior nursing and operations colleagues and will be signed off at the Executive Committee Meeting in early June 2014. The process is used when a shortfall in staffing has been identified for both in and out of hours.

9. National stock take of progress

- A series of national stock takes are in place to determine progress against meeting the commitments set out in the hard truths document.
- The Trust has completed two of these and a third stock take will take place on 28th May 2014.
- The findings from the stock takes will be published on the NHS England website in the coming months.

10. Conclusion

- Following a review of establishments by divisions across the Trust, there is a shortfall of 10.10 WTE (unfunded) nursing posts.
- The identified shortfall is not currently impacting on patient safety and a range of actions are in place to bridge the gap.
- The skill mix ratio of the registered nurse to unregistered nurse workforce for all inpatient ward areas is within the nationally recommended ratio of 65:35 with the exception of one Ward.
- The ratio of registered nurse to patient is within the RCN recommendation of 1:8, for all inpatient ward areas (day).
- The Trust needs a continued focus on filling vacancies and reducing turnover.
- The next 6-monthly clean sheet review process will take place in September 2014 and the outputs of this will be reported to the Trust Board thereafter.

11. Action required by the Board:

- Board to sign off all inpatient NHS funded ward establishments
- Note the shortfall of 10.10 WTE to be included in 2014/15 business planning
- Note that the posts will be funded for 2014/15
- Note that the actual staff available versus planned staffing levels will be brought to the public board meeting in July.

APPENDIX 1: Trust's progress in meeting the National Quality Board's expectations

Expectation (taken from the NQB document)	Trust Progress
The Board takes full responsibility for the care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and core staffing and capability.	The Board has a process in place for setting and monitoring nurse staffing levels through the Divisional establishment reviews and performance reviews. Staffing levels and patient acuity and dependency are monitored and levels are adjusted where required.
Processes are in place to enable staffing establishments to be met on a shift by shift basis.	There are a number of processes in place to monitor shift by shift staffing such as: eroster, escalation procedures, daily, weekly and monthly situation reporting within divisions.
Evidence based tools are used to inform nursing and midwifery and core staffing capacity and capability.	The Safer Nursing Care Tool is largely used to inform nursing capacity and a variety of other evidence based tools such as birth rate plus is used for midwifery.
Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feels able to raise concerns.	This can be demonstrated through; Trust policies, divisional leadership model, back to the floor Friday and the quarterly professional practice committee (attended by all band 7 and above).
A multi-professional approach is taken when setting nursing, midwifery and care establishments.	All relevant staff are involved and the Director of Nursing liaises with divisional nurse colleagues to review staffing. There is a formal establishment review every six months.
Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to the direct care duties.	All establishments have a built in uplift to cover study leave, sickness and annual leave. Further work is required to ensure that all ward sisters/charge nurses are in a supervisory role.
Boards receive monthly updates on workforce information. Staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	The Board will discuss staffing capacity and capability at its public meeting in May 2014.The Board will receive monthly updates covering the points outlined in the NQB guidance, no later than June 2014.
NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	The Trust currently displays information about staffing in all inpatient ward areas. Substantive staffing boards are currently being piloted.
Providers of NHS services take an active role in securing staff in line with their workforce requirements.	The Trust has an active recruitment programme in place and will work closely with NHS England to confirm future workforce requirements

APPENDIX 2: Overview of Acuity Tools used within the Trust for Inpatient Ward Areas

i) Safer Nursing Care Tool (2013)

- The SNCT tool comprises of two elements:
- Element 1:
  This comprises of a decision matrix based upon the classification of levels of critical care patients (Comprehensive Critical Care, DH 2000). This is used to determine the level of acuity/dependency of all patients. When this is aligned to the evidence based nurse staffing multiplier, it allows recommendations for nurse staffing required per ward based on the actual needs of those patients.

- Element 2:
  Nurse Sensitive Indicators such as infection rates, complaints, pressure ulcers and falls, are monitored to ensure that the staffing levels determined in Element 1 are enabling the delivery of patient outcomes we aim to achieve. Within the SNCT these data are converted into a rate per 1000 occupied bed days, allowing comparison across wards.

Using the two elements together offers staff a method against which to deliver evidence-based nurse staffing plans.

ii) Birth Rate Plus (1996)

- Birth rate plus is a workforce planning tool for maternity services which suggests how many midwives are required to provide safe care for women throughout the maternity journey. Birth rate plus calculates the number of midwives required by measuring the complexity of care required versus the number of births.

Imperial College Healthcare NHS
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APPENDIX 3: Summary of clean sheet review activity 2013/14 (inpatient areas)

Division	Date of clean sheet review	Tools/standards used	Establishment before review (WTE)	Establishment required after review (WTE)	Gap (+/-) between est before and after review review	Number of posts UNFUNDED in 2014/15	Staff in post (WTE)	Difference between Staff in Post and Establishment before Review	Skill mix ratio before review (%)		Skill mix ratio after review (%)	
									RN	HCA	RN	HCA
Surgery & Cancer	Mar-14	SNCT; British Association of Critical Care Nurses standards for nurse staffing in critical care	871.78	909.78	-38.00	**0**	790.69	-79.09	86	14	85	15
Medicine	Mar-14	SNCT	1051.44	1067.19	-15.75	**8.1**	904.23	-147.21	78	0	77	23
Women's and Children's		• SNCT • Royal College of Nursing standards for children and young people's services • Birth-Rate Plus • British Association of Perinatal Medicine staffing standards										
Gynaecology			41.80	43.80	-2.00	**2**	36.68	-5.12	74	26	70	30
Neonates			107.33	124.2	-16.87	**0**	94.05	-13.28				
Maternity			246.80	276.30	-29.50		232.96	-13.84				
Paediatrics	Oct-13		116.19	128.45	-12.26	**0**	100.10	-16.09				
TOTAL			**2435.34**	**2549.72**	**-114.38**	**10.1**	**2158.71**	**-274.63**				

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Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	3.4
Title	NHS Trust Development Authority Self-Certifications for February 2014 and March 2014
Report for	Trust Board
Report Author	Alex Williams, Head of Planning and Business Development
Responsible Executive Director	Bill Shields, Chief Financial Officer
Freedom of Information Status	Report can be made public

Executive Summary:

As part of the on-going oversight by the NHS Trust Development Authority (TDA) and in preparation for the Trust's application for Foundation Status, the Trust is required to submit two self-certified declarations on a monthly basis.

The Board is asked to retrospectively approve the February 2014 and March 2014 submissions.

Recommendation to the Board:

The Board is asked to note the Trust Development Agency self-certifications for February 2014 and March 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.

Introduction

As part of the on-going oversight by the NHS Trust Development Authority (TDA) and in

preparation for the Trust's application for Foundation Status, the Trust is required to submit two self-certified declarations on a monthly basis. These self–certification declarations have replaced the Single Operating Model (SOM), which the Trust completed and submitted to NHS London, up until the end of 2012/13.

The two returns being submitted monthly are:
Oversight: Monthly self-certification requirements – Board Statements;
Oversight: Monthly self-certification requirements – Compliance Monitor.

Under the new oversight model, all performance is reported one month in arrears, with the exception of cancer which is reported two months in arrears.

The February 2014 and March 2014 returns were approved by the Chief Financial Officer (CFO) prior to their submissions.

This process has been agreed with the TDA for approval of retrospective Board sign off/approval assuming Executive sign off had already been given.

There have been no changes to the compliance monitor returns since July 2013.

Please note as per previous months, Q10 (related to performance) has been updated to reflect current status on MRSA, C. difficile and Cancer, as approved by Steve McManus.

Imperial College Healthcare NHS Trust

Public Board Meeting

28 May 2014

Agenda Item	3.5
Title	Draft Quality Accounts 2013-14
Report for	Noting
Report Author	Stephanie Harrison-White/Claire Lamb
Responsible Executive Director	Chris Harrison, Interim Medical Director
Freedom of Information Status	Report can be made public

Executive Summary:

The paper presented is the Draft Quality Accounts Report 2013/14. A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

The Quality Accounts indicators form part of the Quality Accounts and have been developed following a process of engagement with stakeholders and staff. The indicators were reviewed at the Quality Committee on 6 March 2014 and signed off by Trust Board on 27 March 2014.

The DRAFT report has been presented to the Audit and Risk Committee on 22 April 2014, was agreed at the management Board on 28 April 2014 and signed off by the chief executive officer and chairman on 2 May 2014.

Some sections are in red, these are where data is being finalised for inclusion. Some sections of the report that are highlighted in yellow, these are sections that have been updated or amended since the Draft Quality Accounts document was circulated to the commissioners; Health Watch, Overview and Scrutiny Committees, NHS England and Deloitte for external review on 3 May 2014, prior to final Trust approval and publication in June 2014.

This year's Quality Accounts show that we met the following targets:

- Venous Thromboembolism (VTE) Risk assessment
- NHS Safety Thermometer (Falls & pressure Ulcers)
- Reduce c-difficile infections
- Dementia CQUIN
- Standardised Hospital-level Mortality Indicators (SHMI)
- To improve responsiveness to inpatient needs
- Friends and Family (FFT) staff and patient perspective

We need to improve on:

- Patient Reported Outcome Measures (PROMs) response rates
- Meticillin-resistant Staphylococcus aureus Blood Stream Infections (MRSA BSIs)
- Compliance with anti-infective prescribing
- Reporting patient safety incidents
- Readmissions to hospitals within 28 days

There are some areas of the **DRAFT** Quality Accounts that cannot be completed yet due to the timing of data validation. These include:

- Performance data (will require a refresh in May)
- CQUIN performance and targets

Internal audit are reviewing our dementia data as part of our internal monitoring processes and Deloitte will review the report and our *Clostridium difficile* and severe harm and death perspective data as part of the mandated external assurance checks. Their findings will be included in the final report.

Recommendation to the Board: The Board is asked to note this document in preparation for publication at the end of June 2014 and approve delegated authority to the Chief Executive and Chairman for final sign off prior to publishing.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Public Board Meeting

Wednesday 28 May 2014

Agenda Item	4.1
Title	Update on clinical strategy and outline business case for clinical and estate transformation
Report for	Discussion
Report Author	Ian Garlington, Director of Strategy
Responsible Executive Director	Ian Garlington, Director of Strategy
Freedom of Information Status	Report can be made public

Executive Summary:
An Outline Business Case (OBC) for the development of the Trust's sites was originally programmed for Board consideration in March 2014, a date coterminous with the 26 North West London (NWL) business cases that feed into the Shaping a Healthier Future (SaHF) programme. However, more work was required to complete the Trust's clinical strategy which is essential to ensuring the site developments meet future clinical need. In partnership with our local commissioners and NHS England, we are now working to complete the clinical strategy and put forward a preferred option for site development through the OBC at the July Trust board meeting.

Very good progress and staff engagement has been achieved on the clinical strategy over recent weeks, which will help to ensure that the final version and the outline business case for site development make the best recommendations for our patients and local communities.

Recommendation to the Board: The Board is asked to note the change in schedule and to expect the final clinical strategy and OBC July 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Title : Update on clinical strategy and outline business case for clinical and estate transformation

Introduction:

Following the agreement of the Joint Committee of PCTs (the eight North West London PCTs responsible prior to the transfer of powers to CCGs, NHS England and others) to implement the Decision Making Business Case (DMBC) by construction of an Implementation Business Case (to act as an Strategic Outline Case (SOC)) for the development of major changes to the health system in North West London, the Trust has been creating an OBC to identify the most advantageous option for implementing the changes. This paper is to provide context on the OBC, and to the clinical strategy that informs it, and to propose a timeline and process leading to Board consideration of an option for approval.

Recent Context

Learning the lesson from the 2006 NAO review into the failed 'Paddington Basin' development, which consumed significant cost and failed ultimately due to a lack of buy-in to the financial considerations, the Trust is committed in doing all that is possible to ensure full engagement from all stakeholders.

The OBC will consider the following options

Table 1: Options within the OBC

Option one

- Do nothing

Option two

- Build a new 'local hospital' at Charing Cross Hospital
- Small expansion at St Mary's Hospital
- Small new build at Hammersmith Hospital. No change at Queen Charlotte's and Chelsea Hospital
- Relocation of Western Eye Hospital

Option three

- Remodel and refurbish Charing Cross Hospital to provide a 'local hospital'
- Refurbishment and new build at St Mary's Hospital
- Small new build at Hammersmith Hospital. No change at Queen Charlotte's and Chelsea Hospital
- Relocation of Western Eye Hospital

Option four

- Build a new 'local hospital' at Charing Cross Hospital
- Refurbishment and new build at St Mary's Hospital
- Small new build at Hammersmith Hospital. No change at Queen Charlotte's and Chelsea Hospital
- Relocation of Western Eye Hospital

The Clinical Strategy

The clinical strategy is the key guiding strategy for the Trust. A work stream is currently underway to ensure full understanding and buy in of all the underlying assumptions that together shape the complex and comprehensive reconfiguration for clinical quality described within the OBC.

Considerable work has been undertaken over the past year to understand our clinical work and market, but we have more to do on ensuring that a clear picture of our present and future is fully understood. We are currently focusing on working with clinical leaders at all levels to plan in more detail the models of care that we will deliver over the coming years, both acutely and within integrated care.

The OBC

The OBC adheres to the Treasury 'Green Book – 5 case model' and is written by qualified Business Case practitioners, drawing on the latest advice on structure and content. During the production of the OBC we have created detailed underpinning activity, workforce and finance models (including a General Economic Model). These models are being stress tested by the coproduction process to ensure that they withstand scrutiny and business rigor and deliver clinical outcomes in line with our clinical strategy.

The appraisals feature a mix of quantitative and qualitative assessments, which when considered together lead to a view of the "preferred" option. A lot of work has been done on this to date, and this will further evolve over the coming weeks to explore:

- Whether there are additional financial benefits that can be delivered by particular options – at this stage the modelling assumes that the financial benefits of delivering clinical solutions in options 2, 3 and 4 is the same and we want to test with our clinical staff whether there is a differential, and if so to bring that into the evaluation;
- Whether there are additional non-clinical benefits from the new facilities at Charing Cross;
- Whether there are additional benefits or reduced risks from the model where the Trust and the commissioners jointly deliver the solutions;

The Options Appraised in the OBC

The preferred solution in the DMBC describes a clinical solution that all parties, the Trust included, agreed as the best response to the overcapacity of acute hospital provision in North West London. All Trusts and Commissioners agreed that changes to the shape of acute services are needed given the clinical and financial challenges that lie ahead. The Trust's concern with the solution was around the use of the hospital facilities, since the chosen solution not only failed to address the long-standing need to redevelop St Mary's, but from an estate perspective 'land locks' the site so that we would lose the ability to ever make the improvements needed. This option, called Option 2, is retained in the OBC as a benchmark for comparison with other options.

In this context the OBC sets out to find a way of making improvements to St Mary's, implementing fully the clinical solution in the DMBC and doing all this within a capital envelope that would maintain the Trust's financial surplus at a level that would be acceptable to the Trust and meets Monitor's financial thresholds as part of its Foundation Trust application.

This led to the identification of an estate solution that houses the new local hospital within the existing Charing Cross site, providing all the capacity set out by the commissioners and their advisors. By retaining the site the Trust could house non-clinical facilities displaced from St Mary's and also avoids the costs of re-providing the College. This option is named 'Option 3'.

Through-out the process the local Commissioners have expressed a strong desire for a new purpose-built local hospital at Charing Cross. A further option was worked up which provides the services required in the Local Hospital within a new purpose built hospital on the Charing Cross site. This is evaluated as Option 4.

These three options for change all assess the capacity required as a result of the activity planned through the SaHF process, including the changes in flows from Charing Cross once the status of the A&E department there alters. These three change options are then compared with a 'Do Minimum' option of no change (Option 1).

Conclusion

We are developing a comprehensive clinical vision and an implementation plan within the OBC for Board consideration.

This final stage of engagement may result in some changes to the financial, non-financial and benefit assessment. Our goal is to create a further version of the OBC with full commissioner support.

It is our strong view that this additional time is worth investing, so that we can strengthen agreement and buy-in to the solution, both externally and internally. The product of this work will be reviewed by Trust Committee structures in July and then the July Trust Board will be asked to make a decision on the options for further consideration during the Full Business Case process.

Recommendation to the Board: The Board are asked to note the change in programme and to expect the revised OBC July 2014.

Imperial College Healthcare NHS Trust

Board Public Meeting

Wednesday 28 May 2014

Agenda Item	4.2
Title	Annual summary of the Trust's quality impact assessment process for cost improvement programmes (2013/14).
Report for	Discussion
Report Author	Priya Rathod, Associate Director – Chief of Staff (Nursing Directorate)
Responsible Executive Director	Janice Sigsworth, Director of Nursing and Chris Harrison, Acting Medical Director
Freedom of Information Status	Report can be made public

Executive Summary:

This paper was presented to the Quality Committee on 13th May 2014 and to the management board on 28th April 2014.

The following report provides a summary of the Trust's quality impact assessment process for 2013/14 cost improvement programmes. It also outlines progress against 2014/15 schemes to date.

Recommendation to the Board: Note the paper for discussion.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Summary of the Trust's quality impact assessment process for cost improvement programmes for 2013/14

1. Purpose of the report

- The following report provides a summary of the Trust's quality impact assessment process for cost improvement programmes for 2013/14. It also outlines progress against 2014/15 schemes.

2. Background

- Following the lessons learnt from the Francis Inquiry (formally known as the Mid-Staffordshire NHS Foundation Trust Inquiry 2010 and 2013) and on recommendation from Monitor and NHS England, the Trust introduced a revised process for quality assuring and managing quality impact assessments (QIAs) for Cost Improvement Programmes (CIP), in August 2013.

3. Summary of the Trust CIP QIA process

- The QIAs are completed and approved within divisions/corporate areas and are entered onto a bespoke electronic system (Stratpro) which is the central portal for capturing all assessments
- The Acting Medical Director and Director of Nursing formally meet with Divisional Medical and Nurse Directors and also with corporate senior management teams.
- The purpose of the meetings is to ensure that the impact on quality (safety and effectiveness, timeliness and efficiency and patient centredness and equity) has been robustly considered for CIP schemes and that any risks identified have been mitigated.
- These meetings were initially established to take place monthly, however, as the process has developed and robust assurance given to the Acting Medical Director and Director of Nursing, it was agreed in October 2013 to change the frequency to quarterly, as this aligns with the divisional timelines for the CIP QIA process.
- The meetings also consider the impact on quality post-implementation of a scheme, taking into account key performance indicators.
- A formal letter summarizing the outputs of the meetings is sent by the Acting Medical Director to the Divisional Medical Director and corporate senior management teams.
- A summary of the CIP QIA's and outcomes are presented to the Quality Committee and Trust Board (through the Director of Nursing reports) for assurance.

- Since the introduction of the revised process, there have been a total of 24 meetings over an 8 month period with the four divisions and the corporate areas of; information, infection prevention and control and estates.

4. 2013/14 Schemes

- There were no CIP QIAs that had a risk assessment score above 9 and where risk had been identified, mitigating actions were in place.
- Through discussion with divisions/corporate areas, some schemes were identified which had either been implemented and then withdrawn or which had not been implemented at all, due to the high risk scores when carrying out the QIA and/or an adverse impact on quality recognised through close monitoring once the scheme was in place. Examples of these are outlined below.

Division/Area	Scheme	Outcome of QIA review by Medical Director and Director of Nursing
Estates	Linen level reductions (Reducing the amount of linen available on ward areas)	This scheme has not been implemented due to the adverse impact on patient dignity and on patient experience
	ISS Central HelpDesk at Night – SMH (Consolidating two roles)	This scheme has been trialled midweek but will not be introduced at weekends due to the potential advserve impact on patient safety. This has been identified from a number of DATIX submissions graded as 'low harm'.
Surgery, Cancer and Cardiovascular	Bed reductions	This scheme has not been implemented following the completion of the QIA and a high risk score.
	Clinical Pathway redesign	This scheme was initially planned to reduce the number of critical care beds in the Charing Cross ICU. Following a robust QIA, the scheme has subsequently been modified to look at having flexible level 2 and level 3 beds in one area, in order to reduce the impact on quality.
Infection Prevention and Control	Disestablishment of vacant Band 7 IPC Nurse Post	Implementing this scheme would involve an increased workload for the remaining nursing team and reduced clinical presence on the wards. After discussion, it was felt that the risk to clinical performance was too high and that this CIP project should be discontinued. It was agreed to make this post a fixed term appointment, pending further review.

- The Acting Medical Director and Director of Nursing have requested divisions and corporate areas to undertake a formal post-implementation review for 2013/14 schemes, using a range of KPIs and to present the findings at the next quarterly meetings (late June/early July).

5. 2014/15 schemes

- The last set of meetings undertaken in March 2014 focused on 2014/15 schemes and reviewing the QIAs which were available at that time.
- Since these meetings, divisions/corporate areas have identified further schemes and the QIAs for these are either currently pending approval by divisions on the Stratpro system and/or have not been viewed by the Acting Medical Director and Director of Nursing.
- To this end, further meetings will be scheduled in May and June to formally meet with divisions/corporate areas to discuss all the QIAs for 2014/15 schemes.
- Of the 2014/15 schemes and QIAs discussed in March 2014, a common theme was identified that many of the proposed schemes are income generation.
- In essence they are about increasing activity within the same capacity and resources. Although no significant risk has been identified to date, these schemes will be closely monitored by the Acting Medical Director and Director of Nursing going forward.

6. Next steps

- Meet with divisions/corporate areas to review all QIAs for 2014/15 schemes (May/June)
- Report the outcomes from these meetings to the management board and provide an assurance report to the quality committee (July)
- Report the outcomes of the post-implementation reviews for 2013/14 schemes to the management board and provide an assurance report to the quality committee (July)
- Review the Trust CIP QIA guidance (June)
- Consider how the CIP QIAs for other corporate areas are assessed (June)
- Strengthen process for linking and monitoring key QIA performance indicators for CIP schemes (July).

7. Recommendation to the Board

- Note the paper for discussion.

Imperial College Healthcare NHS Trust

Board Public Meeting

Wednesday 28 May 2014

Agenda Item	4.3
Title	Annual report on implementing the recommendations from the Francis Inquiry (2013) (formally known as the 'Mid Staffordshire NHS Foundation Trust Inquiry (2013)')
Report for	Discussion
Report Author	Priya Rathod, Associate Director – Chief of Staff (Nursing Directorate)
Responsible Executive Director	Janice Sigsworth, Director of Nursing
Freedom of Information Status	Report can be made public

Executive Summary:

This paper was presented to the Quality Committee on 13th May 2014. The management board received the paper and complete action plan at its meeting on 28th April 2014. The Trust board has received updates on progress at its meetings on; 27th November 2013, 24th July 2013 and 27th March 2013.

The following paper provides an annual update to the Board on the actions taken in response to the Francis Inquiry (formally known as the 'Mid Staffordshire NHS Foundation Trust Inquiry 2013) recommendations. This report also meets the requirement of the Trust to 'publish on a regular basis its progress on implementation, not less than once a year', as set out in the inquiry.

This report advises the Board of key actions undertaken in response to the recommendations, under the headings of the Quality Strategy goals (QG15), and of those actions requiring further work.

The Director of Nursing has been leading the Trust's review of the Francis Inquiry working with colleagues across the Trust.

Recommendation to the Board:

- To note progress against the actions and those areas which require further work
- To receive assurance about the Trust's progress with implementing the Francis Inquiry recommendations

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Annual report on implementing the recommendations from the Mid Staffordshire NHS Foundation Trust Inquiry (2013)

1. Purpose of the report

- The following paper provides an annual update to the Committee on the actions taken in response to the Francis Inquiry (formally known as the 'Mid Staffordshire NHS Foundation Trust Inquiry 2013) recommendations. This report also meets the requirement of the Trust to 'publish on a regular basis its progress on implementation, not less than once a year', as set out in the inquiry.

- This report advises the Board of key actions undertaken in response to the recommendations, under the headings of the QG15 goals, and of those actions requiring further work.

- The Director of Nursing has been leading the Trust's review of the Francis Inquiry working with colleagues across the Trust.

2. Background

- Robert Francis QC, Chairman of the Inquiry published his final report following consideration of over 250 witnesses and over one million pages of documentary evidence on 6th February 2013.
- The Inquiry made 290 recommendations designed to change culture and ensure 'patients not numbers come first' by creating a common patient centred culture across the NHS. The essential aims of what has been suggested are to:
- Foster a common culture shared by all in the service of putting the patient first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.

- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3. Previous Board response and the Trust's approach to implementing the recommendations

- Board members received a copy of the inquiry after its publication and an initial summary of the Trust's response and actions to the findings were presented at its public Board meeting on 27th March 2013.
- A further paper summarising progress against actions was presented to the Board at its meeting on 24th July 2013.
- The recommendations from the Francis Inquiry were subsequently included within an integrated quality governance work plan which incorporated actions from the clinical governance review of the Trust (undertaken by NHS London in 2012) and actions relating to self-assessments (undertaken in 2013) against Monitor's quality governance assurance framework. All of the actions were aligned to the goals outlined in the Trust's Quality Strategy (safety, effectiveness, patient centredness, equity, timeliness and efficiency) and also under the heading of 'workforce'.
- The complete integrated quality governance work plan was presented to the Management Board and Quality Committee in November 2013 and the Board received an update on progress against the Francis Inquiry actions specifically, at its meeting on 27th November 2013.
- The Quality Committee formally agreed at its meeting in November 2013 that all of the actions from the Clinical governance review had been completed.
- As the Trust is managing its foundation trust application within a defined work stream and governance framework, the actions relating to the quality governance assurance framework are now captured as part of a wider foundation trust application work plan which includes actions relating to the external reviews of the; quality governance assurance framework, board governance assurance framework and the historical due diligence assessments.
- The integrated quality governance work plan therefore now only includes actions relating to the Francis Inquiry and is now known as the 'Francis Inquiry work plan'.

4. Progress on implementing the recommendations

- Of the 50 actions, 44 have been completed and progress against these is summarised below under the headings of the QG15 goals.

4.1 Safety and effectiveness

- The Trust introduced a new organisational structure in July 2013 designed to be clinically led and to ensure that quality is at the centre of all that we do. Alongside this, the Trust's governance structure was revised to create a Quality Committee (sub-committee of the Board), chaired by a Non-Executive Director with a medical background.
- New quality boards aligned to the QG15 goals and chaired by Executive Directors have also been established and are responsible for delivering the quality strategy at an operational level.
- The Trust has implemented the national early warning score (NEWS) across all

sites to help identify deteriorating patients. The effectiveness of the NEWS tool is currently being audited.

- The Trust's incident and risk management system DATIX, has been upgraded to improve learning from incidents across the organisation.
- As part of the Trust's internal audit plan, an internal audit review of waiting list data quality was undertaken in April 2013 and in September 2013. The audit opinion was given as 'adequate assurance'.

4.2 Patient Centredness and Equity

- A revised patient centredeness strategy has been developed pulling together the strands of; patients, people and processes. A new patient centredness board has been established to oversee the delivery of the workplan and therefore of the strategy.
- The Trust has introduced 'intentional rounding' which is the timed, planned intervention of healthcare staff in order to address common elements of nursing care. This is typically by means of a regular bedside ward round that proactively seeks to identify and meet patients' fundamental care needs and psychological safety. Further work is to be carried out to ensure that intentional rounding occurs across the organisation and to this end; a Darzi Fellow will be joining the Trust later this year to focus on this area.
- Patient headboards outlining the named nurse and consultant have been implemented across the Trust in inpatient areas.
- Duty of candour: When a serious incident occurs, the patient is informed as soon as possible and formally written to. They are invited to meet with members of the medical director's office and are also offered the opportunity to receive the investigation report. The Trust's being open policy has also been reviewed to ensure it is in line with the National Patient Safety Agency guidance
- The Trust launched a 'see something say something' campaign in 2013 to encourage openness and transparency for staff when they have concerns.
- A new employee relations advisory service has also been introduced to help staff manage performance issues and offer support and guidance.
- The NHS Constitution and values have been inserted into all Job Descriptions and new contracts for staff including those from agencies managed by HR issued from 1st July 2013 onwards.
- A consultation on the draft regulations for of a 'Fit and Proper Persons Test' closes on 25th April 2014. Once the consultation findings and formal regulations are published, the Trust will respond accordingly.
- A new quarterly staff engagement survey was undertaken in October 2013 and in January 2014. Divisional/directorate level action plans have been developed to address the findings and a further survey was undertaken in April 2014. In addition, the national friends and family test for staff was implemented in April 2014 and this will be carried out every quarter.
- A range of actions has taken place within the management of complaints. These include; revised training which includes a module on the 'duty of candour' and how to recognise a complaint that may be a serious incident, a new patient information leaflet giving more detail on how to make a complaint and the introduction of new Patient Safety Managers who are the single point of contact to collate and triangulate all sources of feedback to strengthen learning.

4.3 Timeliness

- The Trust has revised its integrated performance scorecard to bring together finance, people and quality metrics. The quality metrics are subdivided into the six QG15 quality goals as defined in the Trust Quality Strategy. The eight indicators for each domain have been specifically selected and agreed by the quality domain leads as those that the Board should be sighted on.

4.4 Workforce

- The Trust is undertaking several actions to ensure safe nurse/midwife staffing following the publication of the government's response to the Francis inquiry and subsequently the expectations published by the National Quality Board and NHS England. A detailed report on this will be presented to the Trust Board at its meeting in May 2014.
- In partnership with the Shelford Nurse Directors and following successful implementation of a strengths based profile for ward sisters and charge nurses, which was effectively used during the Trust phase 2 restructure in 2013, the Trust is working with Shelford to create further profiles for a range of staff.
- A revised personal development review process was introduced in March 2014 which now includes a set of ratings so that line managers can give staff a clear picture of how they are doing and feedback on what has gone well, as well as areas they can improve upon.
- A new suite of leadership programmes were launched in 2013 aimed at developing the leadership skills of our staff.
- Mentoring for undergraduate nursing students will be introduced over the coming months,

5. Areas that require further work

The following areas require further work and were agreed at management board.

- Feedback and learning from complaints
  (Lead: Director of Governance and Assurance)

- Nurses/Midwives to be in supervisory capacity
  (Lead: Director of Nursing)

- Feedback from students and trainees
  (Lead: Director of Nursing and Acting Medical Director)

- Clinical audit - Mortality and efficacy of treatment
  (Lead: Acting Medical Director)

- Certifying death
  (Lead: Acting Medical Director)

6. Next Steps

- The actions relating to the Francis inquiry will be monitored quarterly through the management board and assurance reports presented to the quality committee (six-monthly) and Trust board (annually). The Trust will publish progress against the actions on an annual basis (as part of the public Trust board papers), as outlined in the inquiry recommendations.

7. Recommendation to the Board

- To note progress against the actions and those areas which require further work
- To receive assurance about the Trust's progress with implementing the Francis Inquiry recommendations.

Imperial College Healthcare NHS Trust

Board Public Meeting

28 May 2014

Agenda Item	4.4
Title	2013 National Inpatient Survey Results
Report for	Discussion
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing
Freedom of Information Status	Report can be made public

Executive Summary:
This report summarises the Imperial College Healthcare NHS Trust results from the 2013 national inpatient survey. Overall, there has been little change since the 2012 survey, and the trust performed "the same as" it would be expected to when compared with other organisations.

A short term action plan is in place to address the three questions where the trust performed "worse than" other trusts, but a longer term strategic approach is required to improve overall performance. This will need to integrate with other strategic work such as the achieving operational excellence programme and the clinical strategy.

Recommendation to the Board:
The board is asked to note the results of the survey and the associated actions**.**

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

2013 National Inpatient Survey Results

The 2013 inpatient survey was published by the CQC on 08 April 2014. The survey consisted of a sample of patients who had an inpatient stay at ICHT during August 2013. 235 patients responded which represents a 35% response rate (national rate = 49%).

There has been no significant change in the overall trust performance since the 2012 inpatient survey. When asked to provide an overall rating of care patients scored a mean of 8 out of 10 (nationally the lowest performing trust scored 7.1, highest performing trust 9.1). The previous year ICHT scored 7.9. ICHT performance in the inpatient survey has been and remains solid but in the middle when compared with similar organisations in London.

The scoring methodology and RAG rating is based on a statistic called the "expected range", which is uniquely calculated for each trust for each question. This is the range within which a trust would be expected to score if it performed '*about the same'* as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance. It should not therefore be viewed as a traditional RAG rating; in effect an amber rating demonstrates that the trust is performing as expected when compared with other trusts.

The survey consists of 10 sections, each made up by a number of questions. There are 60 questions in all. Table 1 shows the section scores for ICHT and four other comparable London trusts. It is notable that with two exceptions all are scoring in the "same as" category.

Table 1: comparative section scores

Survey section	GSTT	UCLH	Imperial	Royal Free	Barts Health
The emergency/A&E department	9.0	8.6	8.7	8.4	8.5
Waiting list and admissions	9.0	8.8	8.6	8.4	8.7
Waiting to get a bed on the ward	8.2	7.6	7.4	7.3	7.2
The hospital and ward	8.5	8.3	8.2	8.1	8.0
Doctors	8.7	8.9	8.3	8.5	8.3
Nurses	8.6	8.3	8.0	7.9	7.9
Care and treatment	8.0	7.6	7.6	7.4	7.4
Operations and procedures	8.2	8.3	8.1	8.0	8.1
Leaving hospital	7.5	7.5	7.1	7.3	7.0
Overall views and experiences	5.9	5.6	5.6	5.0	5.2
Mean score	**8.16**	**7.95**	**7.76**	**7.65**	**7.63**

Within the sections, ICHT scored worse than other trusts in three questions;

- Did nurses talk in front of you as if you weren't there?
- Were you told how you could expect to feel after you had [your] operation or procedure?
- Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?

A specific action plan is in place to address these particular questions in advance of the next survey period. This plan will be monitored by the Executive Committee.

There is evidence to suggest that negative responses to the question "Did nurses talk in front of you as if you weren't there?" seem to be related to the use of bedside shift handover and this is where the focus of the work will be in relation to this question.

The score for being told how they would feel after the operation has dropped significantly since last year and is in fact anomalous with the rest of the questions in this section of the survey. This is being explored in more detail.

The question related to new equipment is a new question in the survey this year and work is underway to understand why patients would answer this negatively, in order to plan the required actions for improvement.

Additional analysis on ICHT's results performed by the Picker Institute has identified some key areas for further improvement. These areas are known to correlate strongly with patients overall experience. Evidence suggests that improving in these key areas has the effect of patients feeling more positive about their overall care and hence has a positive impact on all questions in the survey. These key areas are related to being treated with dignity and respect and building greater trust and confidence in doctors and nurses.

This work requires longer term delivery and planning and a proposed work plan, which aligns with the patient centredness strategy, will be agreed and overseen by the Executive Committee. The strategy and work plan need to be seen in the context of the people and operational excellence work and will need to be reviewed in light of the Cleveland Clinic exploratory visit. There is also an innovative pilot project in partnership with Disney/McKinsey in maternity (post-natal) focused on service improvement and women's experience. This needs to be considered as a model of improvement for trust wide adoption.

Whilst there will be specific actions related to these survey results, they should be considered against that backdrop of improvements already underway to improve the patient experience, for example:

- Strengths based recruitment;
- Intentional rounding;
- Patient bed boards;
- Delivering safe nurse/midwife staffing;
- Using real-time patient feedback;
- Welcome packs;
- Poster campaign including “you said, we did” examples.

Imperial College Healthcare NHS Trust

Trust Board Public

28 May 2014

Agenda Item	4.5
Title	AHSC Annual Review 2013-14
Report for	Discussion
Report Author	Professor David Taube, AHSC Director
Responsible Executive Director	Dr Tracey Batten, Chief Executive, Imperial College Healthcare NHS Trust/ Professor Dermot Kelleher, Principal of the Faculty of Medicine of Imperial College
Freedom of Information Status	Report can be made public

Executive Summary:

2013-14 was an important year for Imperial College Academic Health Science Centre (AHSC). It saw the AHSC submit an application to the Department of Health in a competitive process to designate new AHSCs. The application was successful and the AHSC became one of six organisations designated for 5 years from the 1st April 2014. Considerable progress was made in the lead up to the designation and in the period from the confirmation of AHSC status to the end of March 2014.

This first AHSC annual review sets out the achievements of the AHSC Directorate and presents a detailed breakdown of costs for the period April 2013 to March 2014 in order to provide assurance to the founding AHSC partners, Imperial College and Imperial College Healthcare NHS Trust that the investment in the Directorate has been well managed and that it demonstrates value for money.

In addition Information is provided on the AHSC away day and the recent AHSC showcase event.

Trust strategic objectives supported by this paper:

4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Imperial College Healthcare NHS Trust

Board Public Meeting

28 May 2014

Agenda Item	4.6
Title	Final report of the foundation trust consultation
Report for	Discussion
Report Author	Mick Fisher, head of public affairs
Responsible Executive Director	Bill Shields, Chief Financial Officer
Freedom of Information Status	Report can be made public

Executive Summary:

Two final foundation trust consultation reports were published electronically and distributed widely on 23 April:

- A summary of the results of the consultation and the Trust's response;
- A full outcome report on the consultation providing more information on the process of the consultation, what people said and how the Trust responded.

Recommendation to the Board:

To note the publication and distribution of the final summary and outcome reports on the foundation trust consultation in line with the Trust Board's decisions made at its meeting on 26 March 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Final report of the foundation trust consultation

Purpose of the report

To inform the Board of the completion of the final stage of the consultation process on the application to become a foundation trust.

Introduction

We see achieving foundation trust status as a means towards bringing our Trust closer to our patients, the people who work for us, our local communities and partner organisations.

Becoming a foundation trust will demonstrate that our healthcare meets the highest standards of safety and quality and that the Trust is a well-organised and well-governed organisation.

An important feature of the Trust's application for foundation trust status is listening to the views of our patients, the people who work for us, public and partner organisations. A consultation on the proposals for becoming a foundation trust was undertaken during the period Monday 11 November 2013 until Monday 10 February 2014.

The Trust's proposals for becoming a foundation trust were set out in the consultation document 'Working in Partnership' which contained 13 specific questions.

All the feedback received from the consultation has been analysed and reviewed. The findings were considered by the Trust Board at its meeting on 26 March.

Two final foundation trust consultation reports were published electronically and distributed widely on 23 April:

- A summary of the results of the consultation and the Trust's response;
- A detailed outcome report on the consultation providing more information on the process of the consultation, what people said and how the Trust responded.

The outcome report provides a comprehensive evaluation of the public consultation programme. It describes the consultation processes used, level and quality of responses, and how responses were used to amend the final application for foundation trust status.

Both reports can be read on the Trust website: www.imperial.nhs.uk/foundation-trust/consultation

We now have three main steps to take:

- Provide feedback to those who took part in the consultation and communicate the results to all interested parties;
- Submit our application to become a foundation trust to Monitor later in 2014;
- Hold governor elections among our members and discuss with the nominated partner organisations who will appoint governors and the process for doing this.

We hope for a successful outcome to our application and look forward to becoming a foundation trust in the early part of 2015.

We are confident that the governance arrangements we will put in place will ensure that becoming a foundation trust will:

- bring us closer to our patients and local communities;
- further strengthen engagement with our people;
- provide greater freedom to innovate and develop our services.

Risk

The foundation trust application programme incorporates the management of risks featuring a risk register which is regularly reviewed and considered by the Foundation Trust Programme Board.

Finance issues

There are no financial issues associated with this report as the foundation trust consultation process has now closed and has been fully funded under the overall allocation for the application programme.

Legal and Compliance issues

We believe that the consultation process has been robust and successful, reaching all of our target audiences.

Implications for Equality, Diversity and Human Rights

This paper does not affect people due to their protected characteristics.

Engaging People

The consultation summary and outcome reports set out how have the views of patients, carers and the public have been gathered and considered.

Recommendation to the Board

To note the publication and distribution of the final summary and outcome reports on the foundation trust consultation in line with the Trust Board's decisions made at its meeting on 26 March 2014.

Imperial College Healthcare NHS Trust

Trust Board Public Meeting

28 May 2014

Agenda Item	4.7
Title	Complaint report
Report for	Discussion
Report Author	Director Governance & Assurance
Responsible Executive Director	Director Governance & Assurance
Freedom of Information Status	Report can be made public

Executive Summary: This report updates the Board on complaints received by the Trust and includes an end of year summary position together with analysis of complaints received and benchmarking with other Shelford Group Trusts. The reports includes a note of further work that is underway to improve our analysis and organisational learning from complaints, and refers to changes in governance arrangements whereby responsibility for complaint handling transfers to the Director of Nursing from 1 June 2014.

Recommendation to the Board: To note and discuss.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

1.0 Background

Regular reports on complaints have been provided to the Board in recent months: this report provides a year-end look back together with analysis on trends and comparisons with our peers. The analysis has produced data and statistics, some of which requires further work to understand and to ensure lessons are learned and changes are made to improve the patient experience in the round. With the latter particularly in mind, the move of the complaints team to the Nursing Directorate, with the Medical Director having overall accountability for quality, will further strengthen governance of this area. The closer linkage of the Patient Advice and Liaison Service (PALS) and complaints under one executive director will improve the Trust's response to patient feedback and allow for optimum use of resource. Additionally, we are pleased that Dr Rodney Eastwood has agreed to become the non executive with particular responsibility for complaints and PALS.

2.0 Numbers of formal complaints received

During 2013/14 the Trust received a total of 971 complaints, an increase of 2.7% compared to last year. A total of 884 formal complaints were formally investigated and 87 low risk grade cases were investigated by PALS.

The number of formal complaints investigated has increased in each quarter throughout 2013/14 and by 5.6% over the year. However the number of low risk grade complaints resolved by PALS has fallen by 19.4%. This demonstrates a trend of an increase in complaints overall with a tendency to more complex complaints. One reason for the increase is likely to be the current media profile of the NHS in general and, specifically, the focus on complaints following publication of the Francis report and the Ann Clwyd MP review into NHS complaint handling. Some London Trusts have seen an increase in complaints of some 30%.

Formal complaints received in the Trust range from 56 – 87 per month. The majority of complaints – both formal dealt with by the central complaints team, and informal complaints handled by PALS - are received by two divisions. Medicine now accounts for 32% of all the complaints the Trust receives, whilst Surgery & Cancer accounts for 42%.

2.1 Total number of formal complaints received by specialty

The top five specialties generating the most complaints have remained the same compared to last year. This in part reflects their increased foot flow compared to other specialties: this is particularly true for the busy Emergency Departments (A&E). Orthopaedic Surgery saw the largest increase in complaints at 59% whilst Oncology saw a reduction in complaints over the year due most probably to an extensive review of their services. The following table sets this out in more detail.

	2013/2014		2012/2013	
Speciality	Number received	Percentage of formal complaints	Number received	Percentage of formal complaints
Emergency Dept.	100	**11.31%**	76	**9.08%**
Orthopaedic Surgery	73	**8.25%**	46	**5.49%**
Obs & Maternity	69	**7.8%**	59	**7.04%**
General Surgery	51	**5.76%**	41	**4.89%**
Oncology	35	**3.95%**	37	**4.42%**

2.2 Top Themes 2013/14

The top three themes for 2013/14 were all aspects of clinical treatment (51%), appointments, delays/cancellation (outpatients) (11%) and Communication /Information to patients (10%).

Complaints received under the heading of clinical care predominantly reflect poor care received from doctors and from nursing staff (55%), and to a lesser extent misdiagnosis, ineffective or lack of treatment (28%).

Complaints received under the heading of communication/information to patients tend to focus on information not provided to the patient (33%), shared with other staff (26%) or incorrect information provided (16%).

Complaints received under the heading of appointments, and delays/cancellations predominantly reflect delays in receiving a first appointment (28%), waiting times in out patient departments (21%) and delays in follow up appointments (20%). Appointments either cancelled or made and not communicated account for 19%.

2.3 Top Three Areas for complaints

The Trust has also analysed which areas generated most complaints by ward, service area and speciality. Areas of most concern were Riverside Wing at Charing Cross (26 complaints), A&E at St Mary's (18), 5 West Ward at Charing Cross (12) and specialities with the most complaints were orthopaedic surgery (20), urology (15) and oncology (14).

We continue to analyse why these areas give rise to significantly more complaints notwithstanding the greater number of patient interactions. A number of initiatives and actions have been taken to address specific issues in complaints but we have, in addition, looked at some potentially more deep-seated causes.

In terms of surgery, a number of operating weeks have been lost due to theatre airflow issues which the Board will be aware of: this has particularly affected orthopaedic surgery. Another key reason has been the increase in referrals which has put a strain on resources, and a lack of suitable beds resulting in cancellations particularly in vascular surgery. Action has been taken to identify additional suitable beds, there are plans to tackle the backlog involving additional lists, and waiting time lists are being closely monitored from a performance and a quality perspective.

Complaints received about Riverside Wing were split fairly equally between cancelled surgery, nursing care, poor communication and attitude of nursing staff/dignity not being observed. A review was commissioned to encompass both the ward and the riverside day case unit and theatres. The review identified issues around leadership and communications and a lack of senior nurses on the ward. Action to address the findings has included a new management post for the daycare and theatres element of the unit, a new ward manager and, as a result of a review of ward establishment, the creation of additional Band 6 posts. Further work is proposed in the context of patient experience initiatives and actions already taken include staff being reminded about staggering break times and checking on patients' needs hourly and recording interactions in health records.

3.0 Comparison of Data from Shelford Group

To enable comparison with a similar London Trust, we benchmarked with UCLH. In terms of total number of formal (i.e. not including PALS) complaints received in 2013/14, the Trust received 884 compared with UCLH's 791 but in terms of overall complaints per 1,000 contacts the Trust received 0.61 compared to UCLH's 0.65. ('Contacts' compares complaints to activity i.e. total bed days plus total outpatient attendances: the 'bed days' descriptor used in the main table refers only to inpatient admission measured by bed days.) The following table shows comparison with other Shelford Group Trusts.

Trust	**Total Complaints incl PALS 12/13**	**Total Complaints incl PALS 13/14**	**Complaints per 1,000 bed days**	**Top 5 Areas for complaint by speciality**
Kings – Denmark Hill campus only	635	789 Increase of 24.2%	0.8	Emergency dept Neurosurgery Acute medicine General surgery Obstetrics
UCLH	677	791 Increase of 16.8%	Data not available	Neurosciences Emergency dept Womens health Surgery (inc T and O, head and neck, urology) Gastro
Newcastle	650	702 Increase of 8%	1.3	Medicine Surgery Womens services Neurosciences
ICHNT	945	971 Increase of 2.7%	1.1	A&E Dept Orthopaedic Surgery Obs & Maternity General Surgery Oncology

4.0 Conclusions and Way Forward

The landscape for complaint management within the NHS is rapidly changing to ensure organisational learning occurs as a consequence of a complaint. The Francis Report highlighted that “a health service that does not listen to complaints is unlikely to reflect its patients’ needs”. The Ann Clwyd MP report on NHS complaint handling also made a large number of specific recommendations. Previous Board reports have identified how we are taking forward the vast majority of these recommendations and explained why in the very few cases where we are not. We have changed the style of our letters to complainants, we are working hard to ensure we are exercising a full duty of candour, and we are in the throes of establishing an in house legal team which will enable us to get a better understanding of how we can also learn from claims and inquests and to help with organisational learning. Over the last few months we have improved our analysis of complaints and started to compare this analysis with that from serious incidents and inquests: there is more we can and will do to learn from these forms of patient feedback. We have also just begun to benchmark with other Shelford Group hospitals and to explore common metrics e.g. complaint re-open rates. We are improving our mapping of, and holding to account for, implementation of action plans arising from both incidents and complaints. And by co-locating the complaints team with PALS and the Patient Experience Team under the Director of Nursing we will bring together all forms of patient feedback to help ensure continuous improvement occurs and that lessons have been embedded.

Imperial College Healthcare NHS
NHS Trust

Report Title: Quality Committee Chairman's Report

To be presented by: Professor Sir Anthony Newman Taylor, Chairman Quality Committee

1. Introduction

The Quality Committee met on 13 May 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- The committee were updated on the Chief Executive's review of arrangements in relation to quality. Henceforward the Medical Director would be have overall accountability for quality supported by the Director of Nursing. The Director of Nursing would assume the lead on preparation for the CIH visit in September 2014. The Director of Governance & Assurance would be the Executive lead on health and safety issues.
- The Director of Nursing was also confirmed as lead for both Adult's and Children's safeguarding.
- The committee received an update on the CIP QIA Process 2013/14 and the Chief Executive endorsed the need to consider potential impacts on quality as a result of capital programme decisions.
- Key clinical risk updates were provided by Divisional Directors.
- The committee received an update from the Director of Governance & Assurance on the draft Quality Accounts 2013/14 and noted comments from stakeholders would need to be incorporated as well as internal and external audit, and several areas of outstanding data. Confirmation was received that in future responsibility for the Quality Accounts would fall to the Medical Director.
- The committee received an update on the Trust Annual Report noting that the Annual Governance Statement and information on performance data needed to be incorporated into the document prior to final approval and submission.
- The committee received an update on the development of a programme related to vascular device management CRE, and the Surgical Site committee was reviewing policy and procedure to ensure compliance with NICE guidelines.
- The committee received an update on safe nurse and midwifery staffing which confirmed the Trust was meeting workforce requirements on staffing these areas which resulted from the 2013 "Hard Truths: Putting the Patient First" report including details of various cover arrangements and future rota developments to enhance cover arrangements.
- The committee received an update on the annual audit of Supervision of Midwifery and its successful conclusion including areas for on-going development.
- The committee received an update on the first two quarters of the experience and engagement survey identifying feedback and examples of resultant actions.

- The committee received an update on the Post Francis Annual Report highlighting that the Trust remained on track to meet all recommendations with 44 of 50 actions identified already completed.
- The committee received an update related to 62 day cancer waits with the 8 national standards met in February and March 2014 and overall quarterly performance also meeting standards.

3. Key risks discussed

The following risks were discussed:

- Emergency surgery cover at Charing Cross Hospital
- Delays in patients waiting for vascular surgery
- RIS/PACS
- Estates infrastructure
- Increased demand on MRI
- Capacity issues at SMH recovery
- Delay in delivery of appointment letters
- Midwifery staffing levels
- Anaesthetic day and night cover at SMH
- Potential infection risk at PICU
- Suspected Never Event
- Cerner implementation
- Arrangements relating to the future of Hammersmith Hospital EU

4. Key decisions taken

The following key decisions were made:

- None

5. Agreed Key Actions

The committee agreed actions in relation to:

- Tracey Batten to review impact on Quality aspects of current capital programme
- Professor Tim Orchard to update at July Quality Committee on transition of services to St Mary's from Hammersmith EU
- Steve McManus to provide Winter Pressures look back paper for June Quality Committee
- Jayne Mee to report 3rd quarter staff survey to a future Quality Committee
- Steve McManus to provide an update on Critical Care staffing restructure and failure to rescue final report to the Audit, Risk and Governance Committee on 18th June

6. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE QUALITY COMMITTEE

Wednesday 6 March 2014
10:00am – 1.00pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Prof Sir Anthony Newman Taylor	Chairman
Sir Gerald Acher	Non-Executive Director (until item 3.2.7)
Dr Rodney Eastwood	Non-Executive Director
Sir Thomas Legg	Non-Executive Director
Prof Nick Cheshire	Chief Executive (for agenda items 1, 2, 3.1.1, 3.2.1,3.2.2, 3.2.5, 3.2.6)
Steve McManus	Chief Operating Officer (for agenda items 3.2.5, 3.2.6, 2, 3.1.1, 3.2.2, 3.2.3, 3.2.7, 3.3 – 6)
Prof Janice Sigsworth	Director of Nursing
Dr Julian Redhead	Divisional Director: Investigative Sciences & Clinical Support
TG Teoh	Divisional Director: Women & Children (until agenda item 3.4.1)
Prof Jamil Mayet	Divisional Director: Surgery & Cancer
Prof Tim Orchard	Divisional Director: Medicine
Cheryl Plumridge	Director of Governance and Assurance
Prof Alison Holmes	Director of Infection Prevention & Control
Jayne Mee	Director of People and Organisation Development
In Attendance:	
Shona Maxwell	Chief of Staff for the Office of the Medical Director
Nick Sevdalis	Centre for Patient Safety and Service Quality (until agenda item 3.2.7)
Julie Halliday	Head of Quality (London) TDA
Mark Brice	Portfolio Director TDA
Sathya Singh	Quality Manager TDA
Sarah Webster	Advisor KPMG
Stephanie Harrison-White	Risk Standards Manager Corporate Governance
Elisabeth Ryder	Interim Committee Clerk (Minutes)

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Prof Sir Anthony Newman Taylor welcomed all present to the meeting, including Jayne Mee, Director of People and Organisation Development who had been invited to become a full member of the Quality Committee.
1.2	**Apologies for Absence**
	Apologies had been received from Bill Shields, Chief Executive, Dr Chris Harrison, Medical Director and Helen Potton, Interim Corporate Governance Manager.

1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared at the meeting.
1.4	**Minutes of the Committee's meeting on 12 February 2014** Alison Holmes requested an amendment to the section on 3.2.3 Infection, Prevention and Control to read: "Each case was thoroughly examined *and reviewed.* ~~dealing with issues from surgical safety to leadership in accordance with new visual structures from NICE guidelines.~~ *A Surgical Safety Group has been formed to address the prevention of Surgical site infection (SSI).The group will oversee and ensure that NICE quality standard 49 on SSI is delivered and it has clinical engagement and leadership in accordance with the new divisional structures."* This amendment was agreed by the Committee and the minutes of the meeting held on 12 February 2014 were subsequently approved as a true record.
1.5	**Matters Arising and Action Log** The Committee noted the updates to actions in the log. Prof Nick Cheshire advised that under item 6.1.1 Mike Anderson had been invited to talk to the Board and the TDA Director would also be invited to talk to the Board which would link in with the Board Development Programme. Prof Tim Orchard suggested it would be helpful for Divisional Directors and key senior staff in the Divisions also to hear what they had to say. **Action: To explore whether it would be possible for the TDA Director and Mike Anderson to attend a meeting of the Management Board or the Quality Committee** - **Prof Nick Cheshire**.
1.6.1	**Chief Executive's Introduction** Prof Nick Cheshire noted his aim that all staff in the Trust to be able to recite the six dimensions of the Quality Strategy. Rodney Eastwood commented that the six dimensions needed to be accessible and suggested that an acronym might help.
1.6.2	Prof Nick Cheshire noted that more work was needed to strengthen the effectiveness of clinical audit and a £400,000 business case had been put together to do this.
2.	**CLINICAL RISK**
2.1	**Update on Key Risks from Divisional Directors** Each Divisional Director presented a report on their key risks:
2.1.1	**Surgery & Cancer**
2.1.1.1	Prof Jamil Mayet presented his Division's key risks summary. In particular he noted that there had been a successful recruitment initiative in India and new staff would be starting at the Trust within the next four weeks. Another recruitment drive in India would be repeated in the future.
2.1.1.2	He noted the increase in the backlog of patients waiting longer than 18 weeks, which was causing concern. Whilst the number of referrals had increased, the Trust's performance remained better than other major London teaching hospitals. Prof Sir Anthony Newman Taylor asked if the Trust remained confident that this would be cleared within six months' time and Steve McManus advised that the issue was being dealt with at the Timeliness Board.
2.1.1.3	Prof Jamil Mayet advised that an agreement had been reached to replace the current cardiol/ICU 1 on site/2 on call overnight junior doctor system with one cardiac registrar supplemented by anaesthetic/interventionist junior cover on site. This should work better, and recruitment and handover would take place by August. Sir Gerald Acher asked how we communicate these changes. In discussion it was agreed that communication was key to the process and Nick Cheshire noted that staff needed to be informed, supported and provided with explanations for any changes. Sir Gerald Acher suggested that it was essential for staff to know that they were being listened to.
2.1.1.4	Prof Jamil Mayet advised that a new rota to provide improved surgical cover was in place at Charing Cross and had provided improved senior cover.

2.1.1.5	Prof Jamil Mayet highlighted that the impact of the divisional restructure was being worked through and this risk would be able to come off the register.
2.1.2	**Investigative Sciences & Clinical Support**
2.1.2.1	Julian Redhead presented his Division's key risks summary. He noted that the RIS/PACS issue was being addressed. Rodney Eastwood asked why the software was not doing its job and Julian Redhead gave the committee an explanation of the history of the problem. He noted that there were ongoing discussions with the European head of GE to sort out the issue.
2.1.2.2	Julian Redhead advised the issue of chiller units for MRI scanners needed a permanent solution which was being sought.
2.1.2.3	Julian Redhead highlighted that the in-patient pharmacy Ascribe computer system worked with Windows XP which would not be supported by Microsoft after April 2014. An outline business case for setting up a new system had been presented to the Investment Committee in February and a full business case would go to them in July. Sir Gerald Acher asked why this had suddenly become a problem as the Trust should have known earlier that Windows XP would cease to be supported. Julian Redhead accepted that it should have been noted earlier and Steve McManus advised that he was supporting Julian Redhead in this issue and that Kevin Jarrold, Chief Information Officer was also involved, offering in house support whilst switching to the new system.
2.1.2.4	Sir Gerald Acher suggested that the completion dates on the register needed to be reviewed. He also expressed surprise that corrective action was being delayed by waiting for committees to meet to make a decision. He asked for this issue to come to the Audit, Risk & Governance Committee. **Action: Ascribe to be put on the Audit, Risk & Governance Committee Agenda.**
2.1.3	**Women & Children**
2.1.3.1	TG Teoh presented his Division's key risks summary. He briefed that a new consultant had been recruited for the labour ward to meet the recommended benchmark for the number of births and that this risk should come off the register after April 2014.
2.1.3.2	He advised that the midwifery ratio was 1 midwife to every 30 births although the recommendation from the Royal College of Midwives was 1 in 28. Prof Sir Anthony Newman Taylor asked what the difference was between 1 in 30 and 1 in 28 and TG Teoh explained it was a difference in the quality of care. Janice Sigsworth explained that it was the post and antenatal wards where the patient experience results were poorer than Trusts with lower ratios.
2.1.3.3	TG Teoh noted that mitigation was in place for the PICU issue and Steve McManus advised that relocation would happen in Q4 rather than Q3.
2.1.3.4	TG Teoh noted that obstetric-trained anaesthetists would be on call to provide advice to non-obstetric trained anaesthetists.
2.1.3.5	He confirmed that there were plans to travel overseas to recruit 30 specialist nurses, 10 of whom would be neonatal nurses.
2.1.4	**Medicine**
2.1.4.1	Prof Tim Orchard presented his Division's key risks summary. He highlighted that the division was inevitably concerned over interruption to services as a result of the implementation of CERNER the following month.
2.1.4.2	He noted that the renal surgeon rota had stabilised with the development of a BC for a fourth permanent post for a consultant surgeon. He also referred to ongoing estates issues with outpatient renal dialysis areas.
2.1.4.3	He advised that at the Hammersmith EU locums had been recruited as consultant cover.
2.1.4.4	He highlighted the ongoing discussion on the timetabled closure of Hammersmith EU and the need for close coordination between the closure of Hammersmith EU and Central Middlesex. Prof Sir Anthony Newman Taylor asked if there was increased capacity in NW London to deal with the closure and whether this was in place. Prof Tim Orchard said this was not yet clear but ICHT had a plan to expand the entry pathway to SMH to provide three options - urgent,

	major and minor, and that this should improve patient experience. Prof Nick Cheshire noted that it was crucial that this was the Trust's own approach. Rodney Eastwood suggested that the Trust Board should be updated on future plans in May. **Action: Update on ICHT Plans for HH EU to the Trust Board in May.**
3	**QUALITY OVERSIGHT**
3.1	**Quality**
3.1.1	**Quality Accounts** Stephanie Harrison-White presented the Quality Accounts. She noted that the accounts were structured around three domains: patient safety, clinical effectiveness and patient experience but that in the future they would be aligned with the quality strategy. After some discussion it was decided that the indicators would be agreed at the Management Board. Sir Anthony Newman Taylor asked when the accounts would be published and Stephanie Harrison-White advised that this would be in June 2014.
3.2	**Safety**
3.2.1	**Safety and Effectiveness Board Update** Shona Maxwell, on behalf of Chris Harrison, updated the Committee on the Safety and Effectiveness Board. She said it was key to develop the safety and effectiveness improvement programme including linking clinical audits with SIs and key risks. The Board would be looking at data in weekend outcomes compared to outcomes during the week and a review would come back to the Quality Committee probably in May.
3.2.2	**Safeguarding Adults Progress Report** Prof Janice Sigsworth updated the Committee on the Safeguarding Adults Progress Report. She noted that the Executive Director Lead for Adult Safeguarding had transferred to the Director of Nursing in January 2014. There were a range of training initiatives available and a training strategy was due in April 2014 to streamline the process and build compliance rates. Current reporting systems and processes were under review and would be designed to demonstrate adequate assurance. She advised that at the present time record keeping for staff training was not satisfactory and that safeguarding for adults and children would be included into the performance scorecard indicators.
3.2.3	**HCAI with details of MRSA cases** Before Prof Alison Holmes presented her report she informed the committee of a letter she had received from Public Health England (PHE) which advised the Trust of a new infection risk from a multidrug–resistant infection. The Trust was already aware of this major risk from highly resistant gram negative organisms and actions were already in place to minimise this growing major threat and the IPC department were working closely with PHE. She noted that it was important for the Quality Committee to be aware of this risk and she would bring a report back to a future committee meeting. **Action: Alison Holmes to report on the new infection risk**
3.2.3.1	Prof Alison Holmes presented the HCAI report with details of MRSA Blood Stream Infection (BSI) cases. She noted that the Trust dealt with between 2,000 and 3,000 blood screens per month. Of the ten Trust attributable cases this year, four cases had been allocated to the Trust, five related to indwelling devices in complex patients and one was a blood culture contaminant. She noted that each case had been thoroughly investigated and reviewed by senior management and actions mapped to the action plan as useful learning points. Rodney Eastwood asked if all junior doctors were being fully appraised and Prof Alison Holmes confirmed this was the case.
3.2.3.2	Sir Anthony Newman Taylor noted that compared to the rest of the Shelford Group the Trust had a high rate for MRSA blood borne infections and asked about observation of indwelling devices. Prof Alison Holmes explained the Trust had a line safety group with senior anaesthetists and appropriate divisional leads. There was a review of devices at the bedside during every shift and that it was a multi-disciplinary issue. Rodney Eastwood asked if junior doctors received their ICHT emails with information on IPC and Prof Tim Orchard noted that

	communication with junior doctors was a major issue. Jayne Mee noted that their reading Trust emails was an issue and that they were in the process of providing junior doctors with NHS.net email accounts. Prof Tim Orchard suggested that consultants should take responsibility for communicating with their junior doctors and Jamil Mayet highlighted that this was being addressed in vascular and that constant reinforcement was a challenge. More resources might be required. **Action: Alison Holmes to consider providing a business case to the Management Board.**
3.2.4	**TDA Review of the Trust's MRSA BSI Prevention Activity** Prof Alison Holmes presented the TDA review of the Trust's MRSA BSI Prevention Activity. The Trust had been working with the TDA's Infection control lead to review the Trust wide practice of infection prevention with a particular focus on MRSA BSIs. The report was an informal review of procedures on the wards following site visits with the IPC department. At SMH the TDA had been impressed with the knowledge shown by the senior clinicians but noted that there were issues regarding cleaning and isolation space. They commented favourably on the IPC information on noticeboards and the action plan on work to be done.
3.2.5.1	**Patient Safety – SI Report** Shona Maxwell, on behalf of Chris Harrison, updated the Committee on the Patient Safety – SI Report. The report provided a breakdown of the serious incidents reported by the Trust during the 2013/14 financial year. It outlined the top three trends of reported incidents, an update on reported Never Events and a more in-depth look at the incidents reported by Maternity Services. It was noted that there had been in increase in reporting over the last year since the introduction of the weekly review panel.
3.2.5.2	The Medicine Division was the highest reporter of SI's and the SMH site reported the most. Sir Anthony Newman Taylor asked what proportion of patients at the Trust attended the Medicine division. Prof Tim Orchard noted that half of all patients were categorised as under the Medicine Division so the number of incidents proportionately was about right. Rodney Eastwood suggested that a report showing trends over time was needed within the different groups which Prof Sir Anthony Newman Taylor suggested would help to put the information into context. Shona Maxwell noted that in the top categories of SI investigations there was no difference between maternity services at Queen Charlotte and St Mary's and that approximately 74% of incidents reported were mandatory report categories. Prof Sir Anthony Newman Taylor expressed his surprise at the number (96) of shoulder dystocia and it was explained that any possible risk that the shoulders could not be delivered spontaneously had to be reported. It was also observed that 96 was a small proportion of 9,000 deliveries annually.
3.2.5.3	Shona Maxwell reported that a new upgraded Datix reporting system would go live in April which would further better enable incident reporting and help with feedback and analysis.
3.2.5.4	Sir Gerald Acher asked if incidents were listed on noticeboards and Prof Janice Sigsworth noted that in most clinical areas this was done, for example, days since the last MRSA case, ulcers and falls.
3.2.6	**Dr Foster Mortality Report** Prof Nick Cheshire updated the Committee on the Dr Foster Mortality Report. The Trust's monthly HSMR performance for November 2013 showed a decrease in the reported ratio between August to November 2013 to 57. The Trust had maintained a significantly low mortality risk for each month in the last seven months of data and the monthly HSMR had seen four months of successive falls. November showed the lowest ratio for the last year of data. This was a good level and showed confidence in safety. He suggested that the report needed to look at trends over the year and Sir Gerald Acher asked if there was a performance dashboard published on our website. Steve McManus noted that the dashboard was a published document and was accessible but could be made more easily available and more readily understandable. Sir Gerald Acher noted that it was important to be transparent, and that the Trust should make available good news stories.

3.2.7	**Quarterly whistleblowing report:**
3.2.7.1	**CQC** Stephanie Harrison-White presented the externally reported (CQC) whistleblowing report to the committee. Since April 2013, the Trust had received two externally reported whistleblowing reports via the Care Quality Commission. The two incidents related to issues on the renal dialysis unit and staffing at the day surgery on Victor Bonney ward. Thorough investigations had been undertaken and action plans developed with the findings shared with the CQC who had been satisfied with the Trust's response. Prof Sir Anthony Newman Taylor asked if staff were now confident on the Victor Bonney ward. Stephanie Harrison-White noted that Jacqueline Dunkley Bent, Director of Midwifery & Divisional Director of Nursing, had worked hard at improving the issues on the ward and things had now moved forward. Prof Janice Sigsworth said that she received a report on the staffing levels on the ward which was very busy and TG Teoh advised that he was aware of the issue.
3.2.7.2	**Internal** Jayne Mee presented the internally reported whistle blowing report to the committee. The report provided details of whistleblowing activity since April 2013 and outlined when the incident was reported, the action taken and the outcome achieved. Additionally, the Trust had reviewed its whistleblowing policy in the last six months to encourage staff to raise any concerns rather than just issues that may be claimed as whistleblowing. The Trust had produced a "if you see something, say something" campaign which was on-going and had been publicised via posters and communication through the Source. As an observation, staff appeared to be raising concerns which were of a grievance nature more often and these had been dealt with speedily through the People & OD Department.
3.2.7.3	Jayne Mee noted that cases had largely been anonymous so in practice, feedback was hard to provide although there was a trend towards non anonymous cases. Main themes were staff working under pressure, and not getting on with line managers. The counselling and mediation service was encouraging people to raise issues and opportunities to raise issues were supplemented by walkarounds, email and webcam chats. Additionally Jayne Mee had pledged as part of NHS Pledge Day to attend different areas of the Trust each month to enable staff to discuss any concerns, issues or ideas with her.
3.3	**Patient Centredness**
3.3.1	**Patient Centredness Board Update** Prof Janice Sigsworth updated the committee on the Patient Centredness Board advising that there had not been a meeting since the last Quality Committee meeting. The Board would be focusing on implementing the patient centredness strategy including PEX results, FFT, PALS/complaints, as well as workforce areas. Janice Sigsworth also said it would be helpful if Divisional areas could ensure attendance at these meetings on a consistent and regular basis.
3.4	**Efficiency & Timeliness**
3.4.1.1	**62 day Cancer Waits** Steve McManus presented the 62 day cancer wait report. He noted that the aim was to review every patient who had breached their treatment target date to ascertain whether any harm had occurred as a result of the delay, to review reasons for the delay and to confirm that they were part of an ongoing action plan. Learning points were being collated that could also contribute to future pathway improvements. He noted that there would be a review of performance at the Audit, Risk & Governance meeting on 12 March 2014.
3.4.1.2	There was a Trust wide focus on sustaining the 62 day standard with areas being targeted for improvement to address organisational delays and improve patient experience. The backlog had reduced dramatically from last April from around 700 to just 60 (and not all of whom will have a confirmed diagnosis). When the backlog diminishes, the Trust was confident of delivering 62 days in future. The Trust was achieving the reduction by carrying out key diagnostic tests much earlier in the redesigned pathways. Prof Sir Anthony Newman Taylor noted that the Trust's position had improved significantly. Steve McManus noted, however, that

	there would always be some backlog due to other organisations making late transfers.
3.4.1.3	Prof Janice Sigsworth reported on the last 100 day event which had been an inspiring event. The process showcased redesigned pathways which were having a positive improvement in patient expereince. The next event was on 27 June and all NEDs were invited which would be an excellent opportunity for them to see the commitment, compassion and dedication of staff.
3.4.2	**Update on Winter Pressures** Steve McManus gave an update to the committee on Winter Pressures to provide assurance on the operational management of winter pressures and maintenance of the appropriate ED performance standard. Review was undertaken weekly, daily and on occasion hourly to enable early identification of potential issues. The focus and plan was now on how to de-escalate specific winter schemes after Easter. In 2012/13 Q1 performance had been less good and Steve McManus said work was being done to pre-empt a repeat performance. A review would come back to the Quality Committee in June. **Action: A review of Winter pressures organisational learning and early preparations for Q3/4 in 2014/15 to be reported to the Quality Committee in June**
3.4.3	**Timeliness Board Update** Steve McManus updated the committee on the Timeliness Board. The Board would be looking at timeliness of care as well as surgery cancellations, outpatient cancellations, and patients' ability to communicate with the Trust including telephone answering times. There would be a deep dive on elective surgery cancellations which remained high.
3.4.3.1	Rodney Eastwood asked if there was any patient groups represented on the boards. Janice Sigsworth said patient representatives tended to be specific to clinical areas and thought would be given in future to using the FT members to help with more general engagement.
3.5	**Effectiveness (monitoring and improving clinical performance)**
	There were no agenda items to report.
3.6	**Equity**
	There were no agenda items to report.
4	**ANY OTHER BUSINESS** Sir Anthony Newman Taylor asked the divisions if there was any risk associated with CIPs and it was agreed that a summary would be brought to the committee in May or June, when this year's CIP's had been agreed, highlighting any potential CIPs that had been rejected on quality grounds. **Action: Divisional directors to provide details of risks associated with CIPs in May or June**
5	**ITEMS FOR FUTURE MEETINGS & COMMITTEE WORK PLAN**
5.1	There were no additional items noted.
6	**DATE OF NEXT MEETING**
6.1	Wednesday 13 May 2014 10.00am - 1.00pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

Report Title: Audit, Risk & Governance Committee 22 April 2014

Chairman's Report

To be presented by: Sir Gerald Acher, Chairman Audit, Risk & Governance Committee

1. Introduction

The Audit, Risk & Governance Committee met on 22 April 2014 and the main issues discussed at the meeting are set out below. The Trust Board is asked to note that this meeting's focus was on reviewing documents that would be required as part of the Annual Accounts sign off and was not a full meeting of the committee.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- The committee was updated on the most recent version of the Annual Governance Statement (AGS) and recognised Dr Tracey Batten being identified as the Accountable Officer which role she assumed on her first day.
- The committee received an update on the production of this year's Quality Accounts and were reminded that they were based on last year's priority indicators. The committee also received an update on priority indicators for this year.
- The Quality Accounts final sign-off deadline was end of May 2014.
- The committee received an update on the Trusts Annual Accounts and was informed that all required financial targets had been met as part of the Foundation Trust application process.
- The Committee received an update on the implementation of the Cerner patient record system and was informed that the project remained on track including the successful linking to 32 Trust legacy systems.

3. Key risks discussed

The following risks were discussed: None

4. Key decisions taken

The following key decisions were made: None

5. Agreed Key Actions

The committee agreed actions in relation to:

- The AGS to reflect committee member's feedback and comments.
- The production and communication of thank you messages to staff regarding support during Cerner implementation.

6. Future Business

None highlighted at meeting.

7. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE

Wednesday 12 March 2014
9.30am – 12.30pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sir Gerald Acher (Chairman)	Non-Executive Director
Sir Thomas Legg	Non-Executive Director (until item 2.4)
Prof Sir Anthony Newman Taylor	Non-Executive Director
Andreas Raffel	Designate Non-Executive Director
Sarika Patel	Non-Executive Director
In Attendance:	
Bill Shields	Chief Executive
John Cryer	Director of Estates & Facilities
Prof Chris Harrison	Medical Director
Kevin Jarrold	Chief Information Officer (until item 2.2.1)
Steve McManus	Chief Operating Officer
Cheryl Plumridge	Director of Governance & Assurance
Helen Potton	Interim Corporate Governance Manager
Prof Janice Sigsworth	Director of Nursing
Marcus Thorman	Chief Financial Officer
Heather Bygrave	Deloitte
Julian Hunt	Deloitte (until item 2.2)
Paul Grady	Head of Internal, TIAA
Philip Lazenby	Associate Director, TIAA
Andrew Townsend	TIAA Chief Executive
Philip Acott	TIAA (until item 2.2)
Arti Patil	Senior Counter Fraud Specialist
Arthur Vaughan	KPMG
Sue Grange	Associate Director, Organisational Development (until item 2.3.1)
Mark Brice	Trust Development Authority
Vicky Scott	Trust Development Authority
Mark Fletcher???	Grant Thornton
Emil Peters	Managing Director of Cerner UK. (until item 2.1)
Scott Bailey	Cerner (until item 2.1)
Trupti Sheth	Senior Lead Pharmacist Computers Projects & Business Support (until item 2.2.1)
Sue Newton	Executive Lead Pharmacist, Hammersmith Site Pharmacy (until item 2.2.1)
Elisabeth Ryder	Interim Committee Clerk (minutes)

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Sir Gerald Acher welcomed all present to the meeting.
1.2	**Apologies for Absence**
	Apologies were received from Prof Nick Cheshire.
1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared at the meeting.
1.4	**Minutes of the Committee's meeting on 11 December 2013** The minutes of the meeting held on 11December 2013 were approved as a true record.
1.5.1	**Matters Arising and Action Log** The committee noted the updates in the action log. Marcus Thorman advised that under item 3.1 as part of the World Class Supply Chain the Trust would have a better control on consulting spend through procurement as part of the overall project. Bill Shields stated that there had been discussion at Management Board and that they would take as much out of the Consultancy spend as possible and Sir Gerald Acher commented that he did not want to see contract tender waivers on large management consultancy contracts but did want to see tight control of management consultancy spend and did not want to see compromises on clinical capability due to disproportionate spend on management consultancies.
1.5.2	Sir Gerald Acher advised that under item 5.2 on Emergency Preparedness he had spent a day with Steve McManus' team and he was very impressed with what he had seen.
2.	**GOVERNANCE & RISK BUSINESS**
2.1	**Cerner Update** Kevin Jarrold distributed an updated version of the slides. Sir Gerald Acher highlighted the importance of the implementation of Cerner, the impact on patient safety and that it could set back the Trust obtaining Foundation Trust status if it failed. He noted that in July there had been some concerns which had resulted in the implementation being delayed. As a result of this Emil Peters, Managing Director of Cerner UK had taken over the Trust's implementation and there had been considerable work done in setting the standard.
2.1.1	Kevin Jarrold updated the committee on the latest position of the Cerner implementation which continued to make good progress and was on track to go live on 22 April 2014. The Trust had progressed successfully through various Gateways and a Cutover Risk Mitigation Plan had been developed as a proactive approach to the management of risks. The Trust was now entering a phase of intense activity as the final countdown had began. Steve McManus noted that there had been very positive progress on providing assurance in respect of potential technical risks, post go live. When the system was stabilised and the Trust was receiving the benefits a report would be provided to a future meeting on post go live implementation. **Action: Report on post go live Cerner implementation to come to a future meeting.**
2.1.2	Kevin Jarrold advised that there were two criteria rated red on the key performance indicators in respect of training and reporting and that plans were in place to mitigate these. 90% of staff were booked for training with 40% already trained. If staff failed to attend they received a personal email from Steve McManus Julian Hunt advised the Committee that his work had identified that good processes were in place and that the implementation was on track. Emil Peters suggested that the testing process was vigorous and very comprehensive with a thorough reporting system. Bill Shields noted that there was more work to be done to validate

	waiting lists data as the current system had many duplicates. More resources would be deployed and Management Board was focussed on this issue.
2.1.3	Kevin Jarrold explained that the Trust was receiving less external support than was expected resulting in an additional cost to the Trust. Bill Shields advised that the Trust needed to raise this with the Department of Health (DH). **Action: Bill Shields to report back after his discussion with DH.**
2.1.4	Kevin Jarrold explained that the Cutover Risk Mitigation Plan included a floorwalker strategy which included 45 floorwalkers with previous experience of Cerner implementations being available to help and support staff. Julian Hunt commented on the detailed work that had been undertaken on the pathways and risks being resolved enabling a state of organisational readiness. Philip Acott commented on the good work that was being undertaken and Emil Peters highlighted the good level of communication between Cerner and the Trust .
2.1.5	Sarika Patel asked what the plan was if things went wrong and Steve McManus explained that the emergency planning, command and control way of working would be deployed. He was Gold and would be on site over the Easter weekend. Silver was Nicola Grinstead for the organisation and Kevin Jarrold for technical support over the weekend with both Prof Janice Sigsworth and Prof Chris Harrison being available for clinical/nursing support The critical team would be very visible all weekend.
2.1.6	Prof Sir Anthony Newman Taylor noted the level of assurance that the work provided and asked what was the way forward and how would Cerner interface with the other systems that the Trust used. Kevin Jarrold explained that there were 30 systems across the Trust that needed to interface with the new system making it a complex and real challenge. All 30 suppliers would be involved over the weekend and formed part of a very detailed implementation plan. Sir Thomas Legg asked whether the work being undertaken in respect of data completeness would have an impact on the way of working and the time required and Kevin Jarrold advised that there had been much preparation as some processes would take longer and as a result additional resource would initially be provided. The main issue was that Cerner was a real time system which meant that records needed to be updated in real time as opposed to currently records could be updated a day or two later the effect of this was that additional time would be required to update on a real time basis. Patient safety was absolutely critical and Sir Gerald Acher asked who was the owner of the risk and Steve McManus advised that this responsibility was ultimately his but that Prof Janice Sigsworth and Chris Harrison would be involved from a clinical/nursing perspective and that every senior nurse was aware of the clinical safety detail in the plan. Sir Gerald Acher suggested that it was very important for senior people to be seen around the Trust on Cerner go live weekend.
2.1.7	Prof Janice Sigsworth noted that she had already been significantly involved with the implementation and that at every Management Board and Executive team meeting the issues had been discussed. She would also be in the Trust on Easter Monday and reminded the Committee that there had been a similar deployment in the past. Chris Harrison stressed the level of discussion that had taken place on a regular basis at Management Board which had included Divisional Directors. Steve McManus advised that there would be a bed census on the Monday afternoon which would result in every ward being physically signed off as ready to go live.
2.1.8	Emil Peters' advised that as part of the implementation plan Cerner would provide 30 days of intensive support which would be reviewed on a week by week basis and that more support would be provided if required.
2.1.9	**XP Pharmacy issue** Kevin Jarrold advised the committee that the Trust was in the process of a programme of upgrading PCs which ran on the XP operating system to Windows 7 in anticipation of XP no longer being supported by Microsoft from 31 March 2014. There was a number of areas where the Trust had not been able to replace the PCs because the applications that ran on them would not operate with Windows 7 and pharmacy was one of those areas. The risk was

	that if Microsoft no longer supported XP they would not be undertaking patches for viruses that had been identified which would increase the risk of a virus attack to the Trust. He noted that this was an issue for the whole of the NHS and that in recognition of the problem, NHS England had been in dialogue with Microsoft to negotiate with them to extend their support that although no deal had yet been done. However, he believed that the Trust was in a better position than many other Trusts with the plans that they had in place.
2.1.10	Trupti Sheth advised that Pharmacy currently used two systems but that only one of them used XP. An outline business case to move to a single pharmacy system had been approved and was about to go out to tender with a view to a full business case going to the Investment Committee on 14 July 2014. She advised that it would take approximately six months to implement the new system and that the Trust would therefore be running at risk for approximately one year.
2.1.11	Sir Gerald Acher asked how the Trust would support pharmacy to mitigate this risk if a national deal was not achieved. Kevin Jarrold advised that there would be an increase in the level of checks to the relevant PCs. Andreas Raffel asked if all PCs had their own anti-virus package and Kevin advised the committee that they did. Sir Gerald Acher asked if this could impact upon patient safety and it was noted that there could be if the system failed. However, Steve McManus noted that there were already in place robust business continuity plan in case of a system failure which would take effect if the system failed and which should be reviewed and tested to ensure that they were sufficient. Andreas Raffel noted that ultimately the Trust would be going to one system in pharmacy and Sir Gerald Acher highlighted that it had to be the correct system for the pharmacy and the Trust as delays in pharmacy were often highlighted to the Board. However, it was noted that pharmacy turnaround was at a level of 90/91% within 2 hours and 80% within an hour. **Action: An update to brought back to a future meeting**
2.2.1	**Staff Survey Update** Sue Grange, on behalf of Jayne Mee, updated the committee on the staff surveys. There had been two surveys, a local engagement survey and NHS national survey. For the second local survey, 2,000 staff had been invited to take part via email with all members of staff being asked to take part once a year. The results had been similar to the first survey. The first survey indicated that 42% of our people were satisfied with the second showing that 39% were satisfied and Sir Gerald Acher commented that this was not a good result. This had been discussed at Management Board with Divisional Directors and action plans were being put in place to achieve a better result. Andreas Raffel asked how the results were fed back into the organisation and Sue Grange explained that Senior leaders were able to produce their own report with data being available at ward level in some areas. Communication was also enabled through the Source and during staff meetings. Sir Gerald Acher highlighted that this was a critical area and further investigation was required and corrective action taken if needed. Prof Sir Anthony Newman Taylor noted that the participation level of 27% and 26% was not unusual for a new survey within an organisation but commented that the Trust was unaware of what 75% of its people thought of it.
2.2.2	Sue Grange said that the national survey, which had sampled 800 staff, had a higher response rate of 49%. Overall the engagement score was 3.77 which was up from 3.74 for the previous year. Against other Trusts the Trust was above average for the second year running but it was not in the top 20% unlike other teaching hospitals in the London area and fellow members of the Shelford group.
2.2.3	Andreas Raffel asked why the survey was email based and Sarika Patel noted that some staff did not have access to PCs to respond to the surveys. Sir Gerald Acher suggested that there were a number of issues as to why staff had not completed and asked for further work to be undertaken in an attempt to get a better level of engagement by utilising other methods. **Action: The committee in June to receive a further report on the engagement survey and the action plan to address shortcomings.**

2.3.1	**Corporate Risk Register** Cheryl Plumridge presented the Corporate Risk Register (CRR) which had been discussed in detail at the Trust Board in January and the Trust Board Seminar in February. Following those discussions a number of changes had been requested and a review of the CRR would take place over the next few weeks. It was noted that Cerner would be reviewed after implementation at Easter, neurosurgical risk was being mitigated and improvement on poor cancer patient experience was being fast tracked and would be reviewed by the Quality Committee and Prof Sir Anthony Newman Taylor would give a report to the next meeting. **Action: Prof Sir Anthony Newman Taylor would update from the Quality Committee on cancer patient experience**
2.3.2	Sir Gerald Acher noted that risks regarding estates maintenance had been discussed in detail at Trust Board level so there was no requirement for a deep dive into this issue at the moment.
2.3.3	It was noted that Shaping a Healthier Future and Finance were very specific and potentially bigger risks and a way of better articulating them was being considered.
2.3.4	John Cryer explained that as regards the red risk around the chiller units and the MRI scanners at SMH, work to improve the chillers was ongoing and that the chillers were in a sealed room so the risk did not change depending on the time of year.
2.3.5	Sir Gerald Acher suggested that all the risk registers should be aligned on the same basis and the consistency of risk registers should be monitored. Cheryl Plumridge explained that she was recruiting a member of staff specifically to work on risk and Helen Potton noted that the upgraded Datix system for the risk module, in early summer, would ensure the required level of consistency.
2.3.6	Bill Shields suggested that the CRR should have broad themes with sub headings. Sarika Patel queried whether staff engagement should be on the CRR and Sir Gerald Acher stated that he would like to see workforce issues included on the Corporate Risk Register. Mark Brice responded to a question from Sir Gerald Acher by saying that the risk register needed to be aligned with the Trust's objectives.
2.4.1	**Safeguarding Adults Progress Report** Prof Janice Sigsworth updated the committee on the safeguarding adults progress report. The Executive Director Lead for Adult Safeguarding had transferred to the Director of Nursing in January 2014. It was noted that the key areas of strength were: active engagement of clinical staff, good safeguarding adult alert reporting, active participation with Tri-borough arrangements and an active Trust Adult Safeguarding Board. It was highlighted that key areas of development included a review of policies, the launch of the training strategy – linking the Mental Health Act/Mental Capacity Act training/dementia training and the development and strengthening of reporting, and analysis of safeguarding incidents. It was noted that the report would be presented to the North West London commissioners CQG (Clinical Quality Group) on 13 March 2014. Thereafter a quarterly update would be provided to the commissioners and this would form the basis of a bi-annual assurance update to the Quality Committee. It was recommended that an internal audit on adult safeguarding should take place towards the end of the year.
2.4.2	Prof Janice Sigsworth noted the new updated Datix system would improve tracking but Sir Gerald Acher suggested that 457 incidents was a large number. Prof Janice Sigsworth advised the committee that they were not all safeguarding issues and that it was important to ensure that every incident was put into the correct category in the Datix system. **Action: A short report to come back to the June meeting.**
2.5.1	**Medical Education** Chris Harrison updated the committee on the changes in medical education. He highlighted the developments in arrangements within the Trust since the transfer to the Medical Director's office in late 2013 and advised that plans were in place for further improvements. Specific action to address immediate problems had been taken and action plans would be discussed at Management Board. The report was in the preliminary stage as issues would need further

	consideration by the Management Board prior to more extensive reporting to the Trust Board and its sub committees.
2.5.2	He noted that the Trust was losing good students and medics and the issue of education needed to be addressed quickly. The report highlighted areas for improvements including concerns about bullying and harassment. Sarika Patel asked if steps had been taken to recruit to the vacant position of Director of Education. Chris Harrison explained that the review had suggested implementing a different model of shared leadership between the Directors of Medical Education and the Directors of Clinical Studies working closely together without a single Director of Education and that there would be a launch event in April which would include strong timelines. Andreas Raffel asked if cases of bullying were recorded on individuals' personal files. It was agreed this would be discussed with Jayne Mee. **Action: Action taken following cases of bullying to be explained by Jayne Mee**
2.5.3	Prof Sir Anthony Newman Taylor suggested that consultant staff did not see education as part of their job and Bill Shields commented that this had been discussed at Management Board and the consultant joint executive group. Prof Sir Anthony Newman Taylor noted that this was a long standing risk and Chris Harrison agreed to review whether it should be included on the CRR. There was no quick fix and the issue would be addressed initially with new consultants and then with existing consultants. **Action: Chris Harrison to draft a corporate risk for the register based on failure to achieve corporate objectives for medical education**
2.6.1	**Elective Access Assurance Report** Steve McManus presented the Elective Access Assurance Report. He noted that in January 2012 the Trust Board took the rare step of approving a reporting break for data relating to the 18 week referral to treatment (RTT) time target and waiting times for cancer including two week waits and diagnostics. Following the reporting break, external reviews were commissioned resulting in a series of recommendations to improve the accuracy of reporting, including rebuilding the reporting systems used to capture patient pathways. Following positive assurance from the NHS Intensive Support Team (IST), reporting for cancer including two week waits and diagnostics, recommenced in June 2012, and for the 18 week referral to treatment (RTT) time target, in July 2012. Since reporting had resumed, the Trust had met the six week diagnostic test in each month, with steadily improved performance against the eight national cancer targets, from achieving just three of the eight targets in June 2012, to achieving seven in September 2013. The Trust had also improved RTT performance from July to November 2012 when all three standards, admitted performance, non-admitted performance and incomplete pathways had been achieved at aggregate Trust level. Since November these standards had been achieved by an increasing number of specialties as well as at aggregate level and by September, all but three specialties had been achieving these standards and work was continuing to ensure all standards were consistently met.
2.6.2	The Trust recognised that there were outstanding issues which needed to be further resolved. It was important, however, to note that the Trust had put in place internal standards in line with recommendations that the IST had made as part of their review. The Trust had developed a level of scrutiny and validation whilst testing industry best practice. A further cultural change, with the implementation of the new patient administration system in April 2014, would assist the Trust in achieving correct data entry at the point of input when the patient attends the Trust. In October the Interim Chief Executives commissioned a review which had been circulated with the papers.
2.6.3	It was noted that details in the review had been discussed at Management Board and with colleagues at Deloitte and internal audit. Sir Gerald Acher asked for an understanding of the failings to be brought back to a future meeting noting that there had been an improvement in audit mechanisms and data quality. Congratulations were expressed to Steve McManus and Kathryn Hughes who had produced the report. **Action: An understanding of the failings to be brought to a future meeting**

2.7.1	**Cancer Performance Update report on 62 day waiting** Steve McManus presented the update on the cancer performance 62 day waiting. He highlighted that the 62 day performance was improving although Q4 remained at amber but the backlog had reduced to less than 60. The Trust was on course to deliver in Q1 and sustain performance thereafter.
2.7.2	The current performance in the cancer standards was 7 out of 8 for January and 7 out of 8 in Q3. Performance in Q4 was marginal because of the backlog legacy. Sir Gerald Acher noted that the Trust was in a much better position than this time last year. Dr Katie Urch had undertaken an audit which had looked at the impact of delays and whether any physical harm had occurred as a result of the delay and the audit had showed that no physical harm had occurred.
2.7.3	Sarika Patel queried how harm was measured and Steve McManus advised that it related to whether there had been changes to the treatment plans. Bill Shields asked how close the Trust was to achieving its target and Steve McManus explained that there would always be a backlog as patients occasionally delayed treatment and other organisations made late transfers but that the backlog would not be Trust related. He noted that there were 46 patients for the quarter beyond the 62 day wait as some patients delayed having treatment from December until January. In total there were 56-60 patients beyond the 62 days. Bill Shields asked if the position would be achievable in April and Steve McManus noted that the exit from March into April would be positive, it was January and February that were the risk. He highlighted the significant improvement in the diagnostic pathways and patient experience. Sir Gerald Acher remarked that it was good to see the improvements and Prof Sir Anthony Newman Taylor suggested that it had been a remarkable achievement.
2.8	**Update to the Scheme of Delegation** Marcus Thorman provided an update to the scheme of delegation by noting that this would come to the June Audit, Risk & Governance Committee meeting when appropriate controls would be in place. **Action: Update to the Scheme of Delegation to go to the June meeting**
2.9.1	**Patient Transport Update** John Cryer updated the committee on patient transport. He noted that the performance of DHL continued to recover although winter pressures had added some challenges which they had responded to. Overall, complaints and incidents remained low and a satisfaction questionnaire was being piloted to extend feedback beyond the current scope, which related only to the waiting lounges. Cost recovery was a topic being pursued through the CCG contract negotiations and controls on demand had been clinically reviewed to ensure that the correct mobility was being assigned. However, more detailed analysis was being undertaken to understand why there was a trend of deteriorating mobility. The report provided an update on measures taken since the previous meeting to further improve the service to patients and controls on demand and cost. The issues raised at the last AR&GC related to DHL's performance against contractual requirements and patients' mobility being correctly assessed for transport eligibility and the Trust was fully recovering costs from CCGs for renal patients.
2.9.2	John Cryer noted that patient transport continued to improve and that there was a high level of confidence that data was accurate and was being correctly reported and charged. There had been more focus on efforts to improve the patient experience and examine areas for further improvement or efficiency. The service continued to be monitored closely.
2.9.3	Sir Gerald Acher noted that this issue was now proceeding in the right direction and the close work with DHL was working well resulting in a positive turnaround. John Cryer noted that there had been no incidents regarding safeguarding.
2.9.4	John Cryer noted that were issues around discharge and the timing of booking of transport and that there was now a member of DHL staff in the discharge room to address this. It was noted that it was important to book the correct transport for each patient and to ensure the correct questions were being asked to enable this to be done.

2.10	**Integrated Performance Scorecard** Steve McManus updated the committee on the Integrated Performance Scorecard. The Scorecard was presented to the Trust Board in January who were happy with the format and style. The Committee was advised that the Trust was monitoring the relevant indicators and that Patient Centredness had a robust process for signing off. Work was currently being undertaken to make an electronic interactive version of the scorecard. This would provide monthly reporting on quality, finance and performing and Sir Gerald Acher suggested that this would provide a proper process and review.
2.11	**Draft Annual Governance Statement** The Interim Corporate Governance Manager presented the draft Annual Governance Statement which provided assurance that the Chief Executive, as the Accountable Officer of the Trust, had embedded systems and processes to identify, manage and control all aspects of risk. Members of the Committee were asked to comment outside of the meeting on the current draft which would be brought back to the April meeting as part of the Annual Accounts. **Action: Comments on the draft AGS to be sent to Helen Potton**
3	**EXTERNAL AUDIT BUSINESS**
3.1.1	**External Audit Progress Report** Heather Bygrave presented the External Audit Update. The plan set out a summary of the work performed during their interim audit visit which focussed on the significant audit risks and the Value for Money risk assessment. The report included the Trust's income and CIP as at 31 December 2013 noting the significant risk from NHS revenue. Some control testing had been carried out and further procedures would be required at year-end but currently there were no issues noted to date. She commented that a significant net impairment of £114.8m had been recognised by the Trust following a new valuation system. The impairment was due to the level of detail applied to building usage estimates, rather than a change in accounting policy. There were no issues around Value for Money but they would be keeping a watching brief on this until sign off in June. There would also be a watching brief on new risks. Sir Gerald Acher stated that he would not expect to have any surprises in the report at the next Audit meeting on 22 April with the accounts to be signed off in draft form on 23 April 2014.
3.1.2	Prof Sir Anthony Newman Taylor noted that under the risk assessment findings the Trust was performing in line with the plan and the key challenges identified by Monitor for large acute trusts**.**
	INTERNAL AUDIT MATTERS
4.1.1	**Internal Audit Progress Report** Paul Grady presented the Internal audit progress report and in particular noted that the report summarised internal audit activity for the period to 3 March 2014. Since the last meeting audit activity had been delivered in accordance with the original plan adjusted according to Trust preferences. Consequently, year to date activity against the 2013/14 plan had been thirteen additional audits where fieldwork had been completed and a draft report issued, discussion with management regarding timing of audits and consequent Audit Committee reporting, planning and preparation for individual audits and starting of fieldwork on IT. The audit plan for the year had now been largely completed, apart from governance related audits, where there had been a number of areas where the Trust had requested work not to be undertaken as originally planned, given the current separate governance work being undertaken as part of the FT process. He noted that there was limited assurance in some finance areas which were compliance issues and would be reviewed in six months' time. John Cryer noted that the estates and facilities issues had been due to an IT system failure which was not backed up.
4.1.2	Paul Grady noted that there had been some data linkage and there were some improvements but that these were not as effective as they should be. The plan going forward was to align the audit with the CRR. Steve McManus noted that a timetable would go to the Management Board. Sir Gerald Acher asked that Cheryl Plumridge and other key executives should be involved in developing the audit plan.

	Action: The audit plan for next year to on the agenda of the June meeting.
4.2.1	**Counter Fraud Progress Report** Arti Patel presented the counter fraud progress report and in particular advised that since the last Audit Committee they had undertaken initial investigations into a sick leave fraud claim.
4.2.2	Four counter fraud and bribery sessions had been conducted since the last Audit Committee. The National Fraud Initiative review had identified 393 data matches. 384 matches had been closed with three investigations arising to date (PAA 5756 - subject arrested and deported, PAA 5851 – subject dismissed and PAA 6047 subject removed from the Trust Bank and refused further shifts). The Arrest Protocol had been revised and was with management for comment prior to it being issued. Six investigations were currently open and five investigations had been closed with two subjects dismissed. With regard to duplicate invoices, there had been no further instances of the company concerned submitting duplicate invoices. Arti Patel would be meeting with the Chief Financial Officer to agree next year's plan.
5	**FINANCIAL & OTHER BUSINESS**
5.1	**Tender Waivers Report** Marcus Thorman presented the Tender Waivers report which set out the number and value of waivers for Quarter 3 of the financial year 2013/2014. During that period there had been a total of 87 waivers requested, with 75 being approved to a value of £2,473,787,72. It was noted that a new linear accelerator had been purchased and would be operational by the Autumn. The report was approved.
5.2	**Losses and Special Payments Register** Marcus Thorman presented the losses and special payments register. There had been a large amount of overseas visitors this month. Sir Gerald Acher noted that there were further areas where tightening up of policies on reclaiming costs from non entitled overseas visitors were required. Marcus Thorman explained that this was an NHS-wide issue.
5.3	**Six Month Review of Terms of Reference** Cheryl Plumridge presented the AR&GC Terms of Reference for the 6 monthly requirement for review. Sir Gerald Acher suggested that the Audit Risk & Governance Committee was working well with the other committees and the Board and no changes were made to the Terms of Reference. It was noted that a new HfMA Audit Committee handbook was being published and a copy would be provided to Cheryl Plumridge.
6	**DATE OF NEXT MEETING**
6.1	Tuesday 22 April 2014, 2.00pm – 3.00pm Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS Trust

Minutes of the Finance and Investment Committee
Thursday, 20 March 2014
Clarence Wing Boardroom, St Mary's Hospital, Praed St, Paddington, London

Present:	
Sarika Patel	Non-Executive Director (Chair)
Dr Andreas Raffel	Non-Executive Director Designate
Bill Shields	Chief Executive
Marcus Thorman	Chief Financial Officer
Steve McManus	Chief Operating Officer (part of the meeting)
John Cryer	Director of Estates and Facilities
Janice Sigsworth	Director of Nursing
In attendance:	
Neil Callow	Deputy Director of Finance (Business Partnering)
Jonathan Evans	Deputy Director of Finance (Financial Planning)
Deirdra Orteu	Senior Planning Manager (on behalf of Ian Garlington)
Naomi Brooks	Service Manager to the Office of the Chief Executive (Minutes)

1.	**Preliminaries**
	Apologies for Absence Apologies were received from: Ian Garlington, Director of Strategy Jeremy Isaacs, Non-Executive Director
1.2	**Declarations of interest** None
1.3	**Minutes of the Meeting held on 23 January 2014** The minutes of the meeting held on 23 January 2014 were agreed as a true record.
1.4	**Action Log** Sarika Patel requested Estates backlog maintenance with costs be added to the agenda for the next meeting.
2.	**Main Items**
2.1	**Finance Report – Month 11** Marcus Thorman delivered the month 11 update and confirmed that, since the last update, the Trust was reporting a £12.3m surplus at the end of February, after adjusting for impairments and donated assets, an adverse variance against the plan is £1.2m. This is based on a deficit in month of £2.8m, which was an adverse variance of £0.4m. Marcus confirmed CIPs are behind plan by £3.3m but this had been offset by over-performance income, on CCG contracts. Marcus advised he was confident the Trust will still deliver the planned surplus of £15.1m, after adjusting for impairments and donated assets.

	Expenditure Marcus advised that expenditure was above plan, due to bank and agency staffing costs. For non-pay the main overspend was on drugs and clinical supplies, the former related to the sale of drugs to Lloyds Pharmacy and the latter the sale of devices to Medtronic. SP questioned the reason for significant increase in bank and agency spend and requested for an analyses of this to come back. It was also agreed that the controls on this items need to be reviewed. Divisional Performance Marcus confirmed the Divisions have achieved their targets, against the revised forecasts, with a few deviations. Cost Improvement Programme (CIP) Marcus confirmed that the Trust is delivering the target against the revised plan. Marcus advised there is a deficit of £3.3m, against the original plan. Sarika Patel asked, if it was achievable for the Trust to go from £41.8m to £46m in month 12. Marcus confirmed it would be achieved. Balance Sheet Marcus advised the Trust's cash balance has improved in month due to the local CCGs settling the majority of the contractual over-performance for the year. The only major items outstanding were NHSE over-performance, which as previously reported were being cleared each month. Capital Expenditure Marcus advised capital expenditure is currently £18.2m year to date. Approximately £8m behind plan, which is due to delays in the endoscopy project in QEQM. Marcus confirmed the Trust would achieve the CRL target. Sarika suggested this would be useful to factor into the cash flow plan. Andreas Raffel asked is the capex on cash or accrual. Marcus confirmed it is on an accruals basis. Cash Bill Shields advised the forecast outturn will achieve the EFL. Marcus advised, this is being monitored daily and the EFL would be delivered as part of the year-end process. Andreas Raffel asked is revenue from other NHS organisations lower than expected. Marcus confirmed this is the split between NHSE and CCGs. The rules in regards to who is the Commissioner are still moving hence the variation to plan. Marcus confirmed there would be another rules change in 2015. Andreas asked why the forecast outturn in clinical supplies was so high. Neil Callow advised the sale of stock to Medtronic was the issue, and this is included within the income position. Sarika asked why there was a significant overspend in bank and agency spend. Marcus advised there were a number of contributing factors, which include February half term and an understatement from January. There had also been an increase in nursing pay rates to reduce the Trust's vacancy rate from 11% down to 5%. Bill advised he has requested this to be looked into, via the Management Board and has asked for clear guidelines and

	controls to be implemented, around booking bank and agency staff. Sarika commented that it is not acceptable to have a £1m overspend in 1 month. Action management Board Andreas asked there had been a lot of press coverage recently, about lower paid nurses being employed over specialist nurses. Does this happen at this Trust. Janice Sigsworth confirmed that the Nursing directorate had been restructured with high-level senior nurses being put back into clinical settings. Janice confirmed the Trust has not suffered in the way the press are reporting.
2.2	**Financial Plan 2014/15** Jon Evans presented the Financial Plan 2014/15. Jon advised the paper summarises the draft Annual and Medium Term Financial Plan (MTFP) which was submitted to the TDA on 6th March 2014. The document focuses on the forecast financial position, over the next two years from 2014/15 to 2015/16, including the key assumptions that impact upon the projected performance. <u>Income and Activity assumptions</u> Jon confirmed the impact on growth is as follows: 2% demographic 0.7% activity -3% for demand management <u>Inflation</u> Jon advised Private Patients has increased its delivery by 2.7% The income guarantee for 14/15 is modelled on 13/14 outturn. <u>Expenditure</u> Jon confirmed the pay award is less than 1.5%. Jon advised there would be a pensions impact for 14/15 and 15/16. Jon advised CNST has increased by £2.9m. <u>Balance sheet</u> Jon advised there were no significant changes to the balance sheet. <u>CAPEX</u> Jon confirmed it is a £30m programme for the next two years. The only way to increase the source of funds for the capital programme is through an increased surplus or via selling property. Marcus Thorman advised the Trust is considering the sale of Ravenscourt Park Flats, which could add £2.5m to the capital programme. The plan for Shaping a Healthier Future was discussed as part of the capital programme. Marcus advised it could cost approximately £20-30m in fees to develop the SMH site on a net £450m build programme. Sarika Patel advised further discussion is required at Trust Board with options analyses to agree the preferred option.

	Action: The April Board seminar to consider the SaHF capital options
2.3	**Financial Risks** Jon Evans presented a proposal process for identifying financial risks as part of creating the downside modelling for the Foundation Trust process. Jon advised this will also help with the Trust's governance. Andreas Raffel commented that, the process is fundamentally right, but may be a little too detailed. Bill Shields commented that this is a good piece of work, which will enable the Trust to mitigate the risk. Marcus Thorman advised this is a 1st draft that can be refined. Marcus confirmed that once the process has been simplified it will be circulated to Executive Director colleagues for completion on their risks.
2.4	**Cost Improvement Programme (CIP)** Neil Callow presented the CIP for 2014/15. Neil advised the plan is £14.0m behind what is required. Andreas Raffel asked where has the £4.0m for length of stay come from. Neil confirmed, it is based on what the Divisions currently have in plan. Bill Shields confirmed that length of stay needs to be delivered and monitored closely, as not delivering the target will be a significant risk to the Trust. Bill suggested there may be a requirement for a programme management function that would be responsible, for ensuring the target is delivered and adhered too. Sarika Patel requested names be added to the plan to show, who is not delivering their divisional CIP target. The committee discussed and decided the CEO office should effectively monitor the CIP target through the Transformation Board and hold Divisions and Departments to account, that are not delivering their CIP target. **Action:** CIP targets to be monitored through Transformation Board chaired by the CEO and a report brought back to FIC on delivery. (Bill Shields) Bill Shields advised this issue needs to be resolved at this committee, or the Trust Board. All Departments and Divisions need to understand the CIP is final. What is in the plan and agreed, needs to be delivered. Sarika Patel suggested there should be a separate meeting to discuss CIP delivery. Suggestions made by Grant Thornton on CIP reporting should be incorporated as appropriate. **Action:** A meeting to be organised to discuss CIP delivery. (Marcus Thorman). Future reporting to reflect above discussion.
2.5	**Private Patients** Tg Teoh and Phil Church provided an update on the Private Patients service. Tg Teoh confirmed that, turnover has increased. The service has also had a brand identity refresh. Tg Teoh confirmed since joining the Trust, the service has gone from decline to growth. Andreas Raffel asked is there a workforce issue at CXH. Tg Teoh explained the nurses at CXH, are no longer taking on additional shifts, of bank and agency work, due to the pay rates. The Committee discussed and agreed, there should be no differing rates of pay across the Trust sites. Neil Callow advised the Private Patients service has seen an increase in growth of 13% on last year, with a predicted growth to 35% the following year. Neil Callow advised the service is also negotiating a 6% price increase on treatment charges.

	Phil Church confirmed he is working closely with clinicians to address the service shortfall. Phil Church also raised concerns around theatre work, as there was no dedicated space for private patient theatre work. Sarika Patel requested Steve McManus look into this issue and provide a solution at the next meeting. **Action:** Steve McManus to identify a solution, for mixed theatre lists and provide an update at the next committee meeting. (Steve McManus) Tg Teoh advised it may be beneficial to appoint a Managing Director to support the service. As well as a small working group to shape the service, that would include a NED, a stakeholder and an investor. Andreas Raffel commented, that he is not sure having a NED on the group would offer significant benefit. The committee discussed and agreed a committee working group should be set up with NED support as needed, to drive forward the service. This group must also have clear ToR. **Action:** A committee working group to be set up with NED support, to drive forward the service. This group must also have clear ToR. (TgTeoh) Sarika Patel suggested Private Patients also need a policy in place on payments, overseas payments, counter fraud and money laundering. **Action:** A policy be implemented that addresses payments, overseas payments, counter fraud and money laundering. (Tg Teoh)
2.6	**Service Line Reporting and PLICS** Deferred to the next meeting
2.7	**Treasury Management Policy** The committee requested the table in section 6.5 be amended, to reflect the cut-off period for investments. Marcus Thorman requested all comments relating to the Policy, be directed through him. The committee approved the first draft of this Policy. There was an action here to ensure that the policy was time bound and investment cyclyes could only be short term as the current policy allowed investments g over £5m without a time bound period which is contrary to Trust financial guidelines.
2.8	**SaHF Presentation update** Deirdra Orteu attended to provide an update on SaHF. Deirdra confirmed the OBC will be 85% complete by the end of March. The OBC will then be discussed at Trust Board in May. Deirdra confirmed SMH will become the emergency acute hospital, CXH the local hospital and Hammersmith will become the Acute Specialist Hospital. John Cryer then presented the latest capital figures. The gross capital costs are as follows: • SMH - £466m with £184m of land sales • CXH - £160m with £82m of land sales • HH - £23m • Imperial College re-provision of £50m The total net capital taking into account corporate offices is therefore currently £448m. Bill Shields advised this needs to be looked into further. Specifically:

	• Office space at SMH • New build versus modifying current building at CXH • More flexibility on building specialities • Revenue consequences from CCGs The costings for the above are above the SaHF limit and have an impact upon revenue affordability. Marcus Thorman confirmed, the business case will need to be signed off by the end of June. Steve McManus suggested the 10th floor at SMH currently used for research and academics could be turned back into clinical space. Sarika Patel requested that all available space, be reviewed, to ensure optimal use. **Action:** John Cryer to review all available space to ensure maximum utilisation. (John Cryer) Action - Full options analyses, including economic case for each option, to be presented to Board.
3.	**Governance Items -** These items were sent out to the committee members to read and raise any queries or questions of which there were none.
3.1	**Work plan Review** The committee requested this to be updated, prior to the next meeting.
3.2	**Summary of Investment Committee** No queries or questions were raised for this item.
3.3	**Trust Loans and advances of pay Policy** The committee approved the Policy.
4.	**Finance Items –** These items are sent out to the committee members to read and raise any queries or questions of which there were none.
4.1	**Capital Report: Month 11** No queries or questions were raised for this item.
4.2	**Cash Flow Report: Month 11** No queries or questions were raised for this item.
5.	**Any other Business** Nothing raised.
6.	**Date of next meeting:** 22nd May 2014, 16:00 – 18:00

Imperial College Healthcare NHS
NHS Trust

Report Title: Foundation Trust Programme Board - Committee Chairman's Report

To be presented by: Rodney Eastwood, Chairman Foundation Trust Programme Board Committee

1. Introduction

The Foundation Trust Programme Board met on 29th April 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

FT timeline and quality/governance scores: The Programme Board was informed that in order to proceed to the TDA readiness review, an independently assessed quality score of less than 4 needed to be attained. It was agreed that Grant Thornton would be invited back to assess our quality, most likely in July. The sole 'red flag' in the governance report - engagement with future members and governors - is being addressed by the governance team and a paper will be produced in due course.

Integrated Business Plan and Long Term Financial Model:
A discussion was had around the IBP and LTFM and the need to submit "interim" versions of these to the TDA by their June 20 deadline. However, given the ongoing uncertainties surrounding the Shaping a Healthier Future business case, it was suggested that further discussions are needed with the TDA to ensure their understanding that the IBP that is submitted to TDA in June will continue to be updated after this date.

Quality Governance Framework (QGF) Rescore Update:
Chris Harrison presented the paper outlining the internal rescoring exercise that was held w/c 28 April reviewing progress against the QGF and stressed that this needs to be the Boards' self-assessment.

Key Issues Surrounding Governor Recruitment and Engagement
Helen Potton gave an overview of her paper and informed the Programme Board that membership recruitment has now started using the external membership recruitment company MES. The Programme Board noted that a proportion of those recruited will be followed up to check on the quality of the process followed by the recruiters.

A discussion followed about how the role of Governors can be developed at ICHT.

Draft Constitution
Helen Potton provided an overview of the draft constitution that has been provided to the FTPB, with changes tracked to highlight difference from the model constitution provided by

Monitor, for further consideration.

A detailed discussion around aspects of the constitution then took place.

3. Key risks discussed

The following risks were discussed:

Risk ID2:

Marcus Thorman highlighted that in relation to the development of CIPs, progress has made but the Trust is not yet ready for the HDD Stage 2 review.

Risk ID6:

Dr Tracey Batten asked whether the Trust Commissioners are aware of the FT application and are supportive

Marcus Thorman confirmed that this was the case and that support had been expressed during the FT Consultation process.

4. Key decisions taken

The following key decisions were made:

None

5. Agreed Key Actions

The Programme Board agreed actions in relation to:

QGF: All Directors to review the QGF action plan for those areas upon which they have been identified as leads to ensure progress towards QGF score of 3.5

6. Future Business

The Programme Board will focus on the following areas in the next three months:

- IBP submission
- CIH visit preparations

7. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board
Tuesday 18th March 2014.
15:00 – 17.00
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Cheryl Plumridge (CP), Marcus Thorman (MT), Chris Harrison (CH), Sir Anthony Newman Taylor (ANT), Janice Sigsworth (JS)

IN ATTENDANCE: Mick Fisher (MF), Alex Williams (AW), Helen Potton (HP), Vicky Scott (VS) Mark Brent (MB), Richard Cook (RC), Michelle Dixon (MD)

1. **Apologies:** Nick Cheshire (NC), Bill Shields (BS), Steve Mc Manus (SM), Jayne Mee (JM), Sir Tom Legg (TL).

2. Minutes of last meeting

The minutes were accepted as a correct reflection of the meeting held on 18th February 2014.

3. Matters Arising

The Action Log was reviewed;

Action 20: The composition of the Council of Governors - invitation to NHS England still outstanding.

- **ANT** has spoken with AMRC and is waiting for a response and a nomination. Agreed to wait a further 2-3 weeks.

Action 26: Further work needs to be done to deliver five year CIP plan

- **RE** queried whether this matter could now be closed. **MT** requested that it remain on the action log until the LTFM is signed off – this is expected to take place in May.

Action 49: The question of whether the Trust will need to obtain permission to use Imperial College name…. SG to review Joint Working Agreement with the College.

- **ANT** confirmed he is still waiting for a written response confirming consent from Imperial College that the name can be used by ICHT after FT authorisation.

Action 50: SG to arrange a meeting with Trust lawyers RE and TL to review detail of draft constitution.

- **HP** confirmed that a paper will return to the next meeting of the FTPB outlining proposed changes to the Constitution on the basis of the consultation outcome.

Action 55: MF and the Office of Chief Executive to engage with Local Authorities on representation

- Consultation update is an agenda item for this month's meeting. Action point can now be closed.

Action 67: MB to confirm NEDs involvement with CIH visit

- **VS** suggested this action can now be closed. There is a letter from the TDA updating on the timing of the CIH visit for discussion at today's meeting.

Action 71: MB to confirm timeline of when Monitor will visit the Trust after CIH visit

- Remains open

Action 74 and 76: MF to set up working group to analyse and prepare responses to main themes of consultation response and MF to ensure consistency across all the documents.

- Consultation responses are an agenda item at today's meeting. Close action.

Action 78: More information is needed on Pathology….John Wood to update the Board on the NWL Pathology Path.

- Pathology update is being provided to Trust Board on March 26th – it was agreed this can be removed from the Action Log

Action 80: The IBP document needs a golden thread and that it all needs to hang together.

- **MB** confirmed that the review and refresh of IBP is on-going with TDA receiving drafts from IG – remains open

Action 81: Voluntary organisation representation on Council of Governors

- Noted that this was for discussion on the agenda for today's meeting

Action 82: CP to commission a rolling brief on the NWL Pathology programme

- Noted that this is being taken to Trust Board on 26th March. Agreed this action point needs amendment to reflect that a rolling brief will not be possible.

Action 83: Amend Risk Register to show that CIH visit a key risk

- Noted this action complete and can be closed.

Action 84: CP to rewrite risk 15

- Noted this action now complete and can be closed.

4. Foundation Trust Programme Plan Update

MT gave an overview of the FT Programme.

- **Stage 1 of FRP** (Financial Reporting Procedures) finished on site yesterday.

Draft report will be issued by KPMG on Friday March 21st for review for factual accuracy before report submitted to Trust Board on March 28th – this will be presented at the private section of the Board meeting.

The report – together with the Grant Thornton work will also go to Trust Development Agency (TDA) and Monitor.

Informal feedback suggests that the review has not identified anything that ICHT was not aware of beforehand and that there are no "red flag" issues.

MT outlined that the next stage of the process will be Historic Due Diligence (HDD) and a review of the Long Term Financial Model (LTFM) – this would comprise approximately 85% of the review. To date KPMG have had a cursory glance and appear happy with what they have seen.

The next stage will also include triangulation with Commissioners – including NHS England.

CP reported that KPMG have been doing a lot of follow up work with her Department that has proved to be resource intensive focussing questions upon the constitution and governance issues, the recruitment process for NEDs and the Chair as well as seeking information about claims liability and clinical negligence.

MT advised that this is the sort of information they will require, as they need to understand issues of financial risk that the Trust may face. We need to be confident in the data we are providing.

CP confirmed that she is confident about the data she is providing although with regards to some of the claims information this is "finger in the air" as claims may currently be letters of disclosure – the NHSLA give their worst case estimate in these instances.

MT stated that he would expect KPMG to focus on this information. He added that the NHSLA is changing its processes and moving towards a model that may result in increased premiums.

MB said that a consistent message is important and that the Trust should be joined up in its risk numbers.

- **Grant Thornton update**

MT advised that a report will be taken to March Trust Board.
Comparing the Trust Self-Assessment against the Board Governance Assurance Framework (BGAF) and the score allocated by Grant Thornton (GT) in broad terms, the Trust has assessed itself accurately.

In 1 area GT has increased the score from that identified by the Trust in its self-assessment
In 3 areas the scores were reduced
In all other areas, GT had assessed the score at the same level as the Trust.

GT highlighted one “red flag” – future engagement with FT Governors.

The Trust has not sufficiently demonstrated that it has considered;

- The roles and responsibilities of the Council of Governors
- How to engage with the Council once established
- Election process for the Council

All other areas were assessed as green or amber green. An amber green assessment highlights that the area has not yet been embedded.

GT have fed back that following meetings with Ward Managers they have been impressed by the Managers’ ability to convey their understanding of QG15. GT’s comments were generally positive – they were impressed with the focus upon quality.

JS said that GT had done a deep dive into staff engagement and experience and that there were some interesting comments that we should review.

In the GT review of QGF in which the Trust had scored itself 5 they had scored 5.5 – again the key factor affecting the assessed score was the degree of “embededness”. The Trust needs time to be able to demonstrate this.
There were no recommendations arising out of the review.

MT summarised by saying that if we are able to demonstrate embededness we can assume that in 3 months time we will have improved the QGF score to a 4 – and that there is potential to improve upon other areas as well.

The Board will be discussing Quality Governance Framework (QGF) at its March meeting. There is the potential for Monitor to run its QGF review in June, which may allow sufficient time for embedding.

MB observed that the report is positive and shouldn’t adversely affect the timeframe of the application process.

It was noted that whilst the election of Governors is outlined in the Constitution, the composition of the Council is for discussion later in the meeting.

RE noted that whilst the mechanisms exist for the appointment of Governors we need further understanding of how we involve, engage and train them.

Action:
AW *to produce a draft report outlining the key issues surrounding Governor recruitment and engagement.*

RE asked MB for an update on the TDA interviews.

MB replied that voting Directors have been interviewed and that feedback would be given on Thursday March 20th to Sir Richard. The meetings had gone well and demonstrated that the Board was “joined up” and no red flags had been highlighted.

The TDA had also observed the Quality Committee and Audit & Risk Committee and will be reporting back on these as well. Nothing seen was likely to adversely affect the authorisation trajectory.

5. Response from TDA in regards to delayed Chief Inspector of Hospitals (CIH) Visit and

6. Proposed FT Authorisation date (items combined)

FTPB noted that the CIH visit has been delayed into the second quarter of 2014/15.

MB outlined how quality issues can cause delays in the assessment process, particularly where the Monitor view varies to that of the external assessor.

RE asked if the Monitor QGF assessment could be brought forward.

MB replied that there could be benefits to the organisation in bringing Monitor in to undertake their assessment early although the Trust needs this to occur after it has had the chance to embed processes in those areas previously discussed.

JS said that the timing of the Monitor visit had been discussed at Trust Board and asked what score was needed – does the score need to be 3.5?

MB responded the score doesn't need to be 3.5 but that the Trust needs to have all of its governance processes embedded before the CIH visit.

JS queried what would happen if the Trust did not score 3.5 with Monitor.

MB said that he would seek clarification on whether Monitor would visit again prior to the Board to Board if the Trust had scored above 3.5 on their visit.

A general discussion followed about the application timeframe.

MT outlined that if Monitor undertakes its QGF assessment in June and the CIH visit is scheduled for July, the back end of the application timetable could be reduced by a month. The Trust would then have time to address any issues identified prior to the Monitor follow up visit that would take place in October/November.

JS queried whether there would be any advantage to shaving a month off the timeframe.
VS said that the advantage was that the Trust would have a period in which to put right any issues identified, whereas if the review is left until November and issues were identified at that point, this could put pressure on the application timetable.

CH said that we should have a fixed timetable to work to.

RE stated that he wants to ensure that the Trust gets to Monitor before the General Election, expressing concerns that if there is change of Government in 2015 and ICHT has

not achieved authorisation, the whole FT policy could change. RE stated that his view is that the Trust should get to the Monitor Board by February/March 2015.

MT agreed the need for a fixed timetable, suggesting that we tell Monitor in June that the Trust has assessed itself as 4.5 and leave the decision whether to visit at that time to them.

JS asked if clarity could be sought from Monitor .

MB said that Monitor will want to highlight anything likely to impact upon FT authorisation.

MT said that the Executive team would be discussing the timetable and that this would be agreed at March Trust Board.

CP asked whether there had been any movement in the CIH visit itself.

RE said that the Trust would be informed 6 weeks before the start of Q2 about the timing of the visit and so we should know in May. The date will be sometime between July and October.

CH said that there has been a suggestion that the CIH may have spare slots in Q1

MT replied that the Trust should prepare for a CIH visit in June but that he expected it to be in July.

VS clarified that the visit itself lasts 2-3 days on site with a report 6 weeks later. Barts Health NHS Trust had 80 inspectors.

CP highlighted the volume of information required before the visit itself and that this will be a huge requirement with over 500 separate pieces.

JS queried whether we should make contact with Kathy McClean .

MB confirmed that he had spoken with Kathy and would be seeking to arrange a slot at the next Board Development session on 10th April.

ACTION:
***MT** will be meeting with VS and MB to discuss the authorisation timeline and will report back to FTPB next month.*

7. Frequency of Meetings

RE questioned whether the FTPB needs to meet monthly. It needs to meet in April and in May to discuss matters of the constitution but may not need to meet in June.

MT suggested that after reviewing the authorisation timetable it would be helpful if FTPB meeting schedule could be overlaid so that it would be clearer to identify which meetings may or may not be needed.

ANT suggested that the dates should be kept in the diary; it is easier to cancel than to reinstate a meeting.

MT agreed. We need to establish a "gateway" approach to meetings so that it is clear what needs signing off at particular meetings.

RE suggested for example that we will need to agree whether to rescore the QGF before the Monitor visit.

RE queried whether we still aim to have the IBP taken to Trust Board in May.

MT replied that the LTFM and IBP must be locked down in May – although this will be subject to the finalisation and agreement of the SaHF business case which was expected at March Trust Board and is now delayed.

The SaHF business case impacts upon the LTFM and IBP and could affect the critical path of the FT application.

Action: *Updated timetable for FT application to be produced overlaid with meeting dates to enable gateway meetings to be identified*

8. TDA Planning Returns for information

AW updated the Board on the TDA planning rounds. The final round is due April 4th.

JS recommended that Board members review the submission as it is very informative regarding quality and performance.

JS suggested that the returns should be reported to the FTPB and that this should become a regular agenda item.

Action: *AW agreed to email TDA return round with the minutes of the meeting. TDA returns to become regular agenda item.*

9. Consultation Update

MF gave an overview of the Consultation Report previously circulated amongst the FTPB. The working group has met to consider the results of the consultation and recommend the Trust response. The paper circulated gave, for each consultation question, a suggested response to the feedback and recommendations for consideration by the FTPB to enable formal recommendations to be made to Trust Board.

RE noted that comments received were broadly as expected and that many of the critical comments related to the Shaping a Healthier Future (SaHF) programme and not the FT application or proposals.

MF stated that the Trust is obliged to produce a public facing document that responds to the issues raised during the consultation and that this could be an opportunity to present back to the public the Trust Board decisions regarding SaHF.
The consultation timetable had been for a public response to be produced in April and that this would be taken to April Trust Board for consideration.

MB said that the consultation outcome must be reflected in the IBP

Action: *RC to ensure that the FT Consultation process and outcomes arising from it are reflected within the IBP*

RE stated that the consultation response will affect the constitution and that this will be taken to Trust Board in May.

MD suggested that there were two broad issues that had been responded to; Governance issues associated with the FT Process and the general direction of travel for the Trust. The consultation response document can be used as another engagement tool.

ANT said there had been some concerns regarding the LT finances, income generation and CIPs. He added that the impact of financial changes can be difficult to predict and queried whether we have any idea of whether the commissioners have the finances and ability to deliver the service changes outlined in SaHF. It is difficult to understand the timings.

MT replied that “out of hospital” plans appear to be the least developed and that the Better Care Fund will see a transfer of funds from Health into Social Care. This year sees many providers in deficit and commissioners generating a £700m overall surplus.

ANT asked for the TDA perspective.

MB responded that there is a joined up strategy for North West London (NWL). It will be critical for the Trust to develop its sensitivity analysis and downside modelling and reflect this in the LTFM. We need to give stakeholders confidence that we consider ourselves “in” the SaHF programme. MB suggested that it might be worth testing the level of risk Monitor is keen for the Trust to take on.

The FTPB went on to consider the consultation report and recommendations;

Q1 – Vision & Strategy: Response & Recommendation agreed

Q2 – Minimum Age for Membership: Response & Recommendation agreed

Q3 – Public Constituency Make up : Response & Recommendation agreed

Q4 – Public & Patient Constituency: Response & Recommendation agreed

Q5 – Patient Constituency shouldn’t include Carers: Response & Recommendation agreed

Q6 – Staff Membership automatic: Response & Recommendation agreed

Q7 – Only directly employed staff eligible: Response & Recommendation agreed

Q8 – Staff Constituency subdivisions: Response & Recommendation agreed

Q9 – Levels of Membership Engagement - Response & Recommendation agreed

Q10 – Size and Composition of Council of Governors

The recommendation that the Council of Governors should be increased from 31 to 33 seats was agreed and that this is to be achieved by increasing the patient constituency by 1 and CCG representation by 1. (Reccs 10.9.3/4/5) The FTPB noted that 33 Governors remains "within the range" of that which is considered to be a "normal" number of council members.

Recommendation 10.9.6 – that the 8 NWL CCGS nominate the 2 representatives themselves – Agreed

Recommendation 10.9.7 – that the LA seats be allocated to Hammersmith & Fulham and Westminster City Council and that the process for filling them is their responsibility - Agreed

Recommendations10.9.9 – that the voluntary sector seat be ring fenced for an organisation representing carers in Greater London – Agreed.

JS suggested that Healthwatch be approached and asked to nominate a carer charity

MF said that some other organisations had actually suggested Healthwatch as the nominated organisation.

HP suggested approaching Carers UK to ask them to nominate a suitable carers representative.

RE asked if HP could approach other Foundation Trusts to gauge their experience of using Carers UK.

MT queried whether we were restricting the definition of carers to Greater London?

HP responded that the Patient constituency is wider than Greater London and so perhaps the carers' nominated representative should be drawn from a national body.

Action: *HP to contact other Foundation Trusts to establish how they have used Carers UK to nominate a carers representative organisation.*

Q11 – Minimum age for Governors to be 16: Response & Recommendation agreed

Q12 – Proposed arrangements for elections - Response & Recommendation agreed

Q 13 – Proposed plan for Board of Directors - Response & Recommendation agreed.

It was noted that the arrangements for numbers of Directors may change with new CEO. Discussion clarified that there has to be one additional NED than voting executive directors (including Chairman)

Currently ICHT has 5 voting Execs and 6 voting NEDs and 1 Chairman. As an FT a further voting exec can be added to the Board as defined in the constitution. MT described how the wording in the constitution could make the arrangements broader – i.e. provide for *up to* 6 Execs and 6 Non-Exec plus chairman as long as the number of NEDs plus the Chairman always exceeds the number of execs

Actions: ***MF*** *to write a paper for the Board detailing the recommendations of the FTPB arising out of the Consultation.*
MF *will also produce a public facing document in April summarising the consultation and outcomes. A formal consultation report will also need to be included within the IBP and available for TDA and Monitor.*
MF *noted that specific reports will also be required for individual Councils that responded to the consultation.*

JS asked if consultation feedback would also be provided to staff

MF replied that the same distribution methods would be used to inform staff of the result of consultation as those used to engage with them during the process itself.

10. AOB

10.1. Risk Register review

Risk 2: Risk needs updating to reflect that Financial Risk ratings have now been replaced by CoS Rating (Continuity of Services rating) and that ICHT must achieve 3 or 4 or 3*

Risk 6: Wording needs to show that Commissioner support will need demonstrating by way of a formal letter. The level of risk has been reduced as result of consultation exercise. The HDD exercise will triangulate with Commissioners. Risk to be updated

Risk 10: FTPB members queried whether the Consequence of the risk (Board lacking capacity and capability to deliver) should be reduced – it was agreed that the consequence of this should remain at 5 which results in an overall risk score of 5.

Risk 14: Risk retained – although wording to be updated to reflect imminent arrival of new CEO

Risk 15: (Failing to achieve good or outstanding at CIH visit) Discussion resulted in agreement that the likelihood of a poor outcome should be reduced to a 2 reflecting the preparatory work that is underway but the consequences should have remained at 5 – delivering an overall residual risk score of 10.

Risk 16: (Deferral of FT application) potential for delay of QGF and impact upon authorisation timeline needs reflecting on the risk register.

Risk 17: (Delay to FT application due to CIH visit later) agreed to retain the risk but update wording to reflect discussions held at FTPB today.

Actions: *Risks to be updated to reflect discussions at FTPB.*

10.2. Purdah

RE questioned whether the potential impact of Purdah should also be flagged as a risk, in that the Trust is seeking FT authorisation in advance of the next General Election. The risk should be described as that of a new government being elected and a subsequent change in healthcare policy.

Others reflected that the risk could be associated with change in commissioning processes.

Action: AW to *add to Risk Register Change in Government Policy*

10.3. FT Budget

CP asked whether the FT project budget or potential overspend against it should also be highlighted as a risk.

MT responded that the FT project budget has been set for 2 years and that he can bring details to the next meeting.

CP highlighted that her department is currently incurring costs and needs to consider the process for recovering these.

Action: *MT to bring FT project budget details to April FTPB*

10.4. Membership Recruitment

CP updated that she has met with the Membership recruitment company – they have undertaken to recruit 2000 new members in April/May and a further 1500 in June. Recruitment takes place face to face and at all main hospital sites with Mystery Shoppers checking on the process. Recruitment will be reflective of the population served by the Trust, i.e. gender, age and ethnicity.

10.5. Critical Path

Discussions took place on whether the BGAF should be added to the Risk Register. CP advised that it shouldn't be added at this stage.

Key elements of the timeline were identified by MT as being

- SaHF Business Case
- Integrated Business Plan

- CiH Visit
- TDA assessment
- Monitor and QGF

MB stressed that Commissioner support will be crucial to the application and the Trust needs to focus upon this relationship.

10.6. Accountability Framework

MB advised that the Accountability Framework is being refreshed currently and will be issued at the end of the month. If needs be the requirements of the revised Accountability Framework will be retro-fitted by the TDA to the ICHT application.

11. Date of Next Meeting

29th April 2014
14:00 – 16:00 Clarence Wing Boardroom

Focus will be upon Constitution and Governors.

Imperial College Healthcare NHS
NHS Trust

Public Trust Board Meeting on 28 May 2014
Supporting Documents

Trust Board Performance Report
Report Period Month 1
(to end April 2014)

Trust Board Wednesday 28th May 2014

innovation respect care achievement pride

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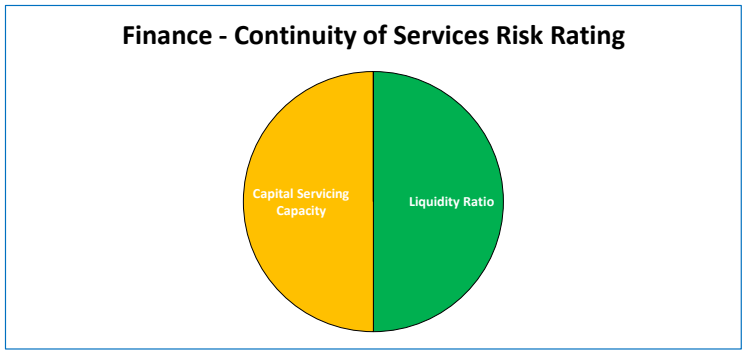
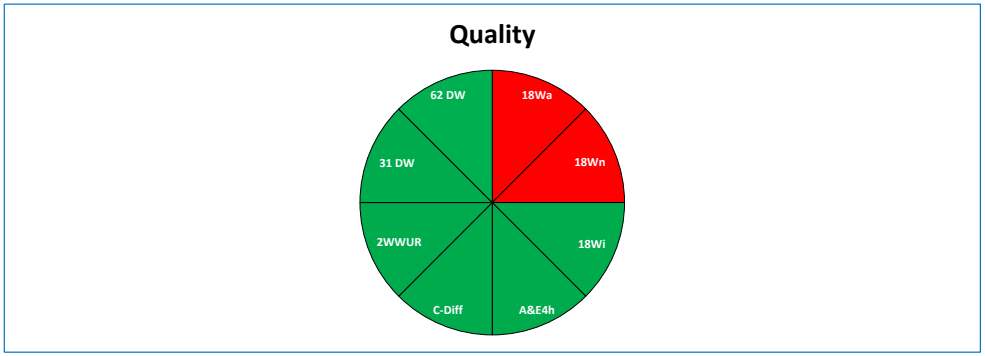


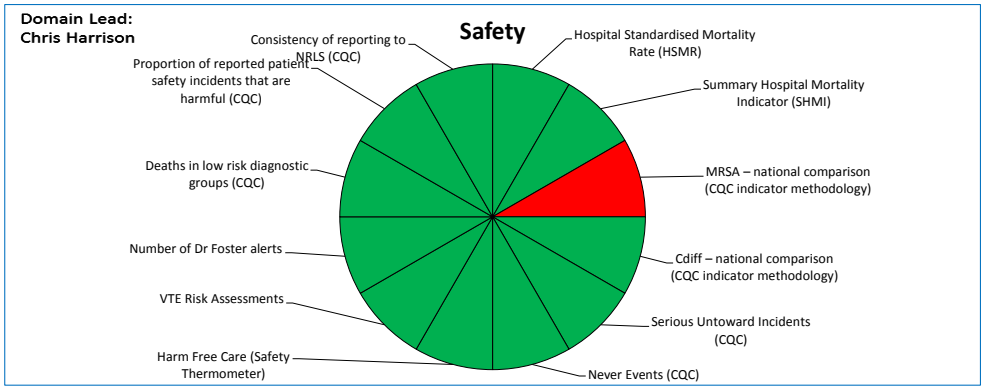


2014/2015			Performance to date 14/15		Forecast		
Area	Indicator	Threshold	Q4 2013/2014	Q1	Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15
Finance	Capital Servicing Capacity		4	2			
	Liquidity Ratio		2	3			
	Continuity of Services Risk Rating		3	3			
Access	18 weeks referral to treatment - admitted	90%	90.77%	88.28%			
	18 weeks referral to treatment - non admitted	95%	95.28%	94.44%			
	18 weeks referral to treatment - incomplete pathway	92%	94.58%	92.90%			
	2 week wait from referral to date first seen all urgent referrals	93%	95.80%				
	2 week wait from referral to date first seen breast cancer	93%	94.70%				
	31 days standard from diagnosis to first treatment	96%	97.50%				
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%				
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	99.10%				
	31 days standard to subsequent Cancer Treatment - Surgery	94%	95.30%				
	62 day wait for first treatment from NHS Screening Services referral	90%	92.10%				
	62 day wait for first treatment from urgent GP referral	85%	85.80%				
	A&E maximum waiting times 4 hours	95%	95.97%	95.40%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	11	7			
	Governance Risk Rating		1	2			

Other triggers of governance concern not addressed in Integrated Performance Scorecard

CQC judgements - warning notice issued, civil and/or criminal action initiated	None	None			
Third party reports from e.g. from GMC, the Ombudsman, medical Royal Colleges etc - judgement based on severity and frequency of reports	None	None			

Domain Lead: Chris Harrison



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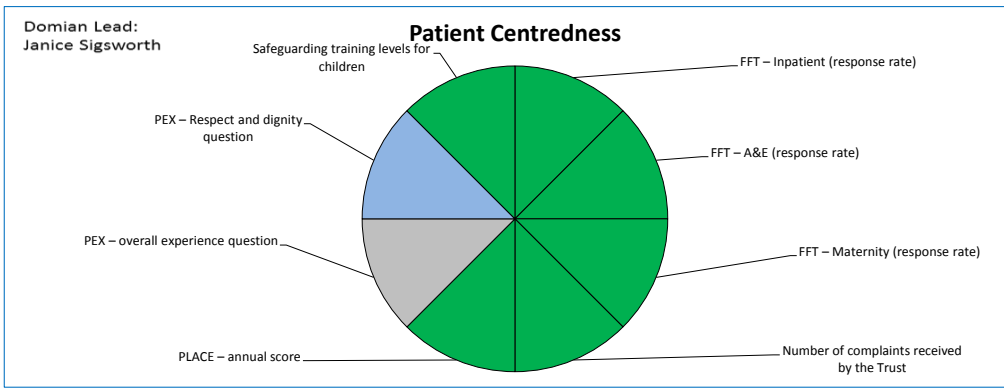
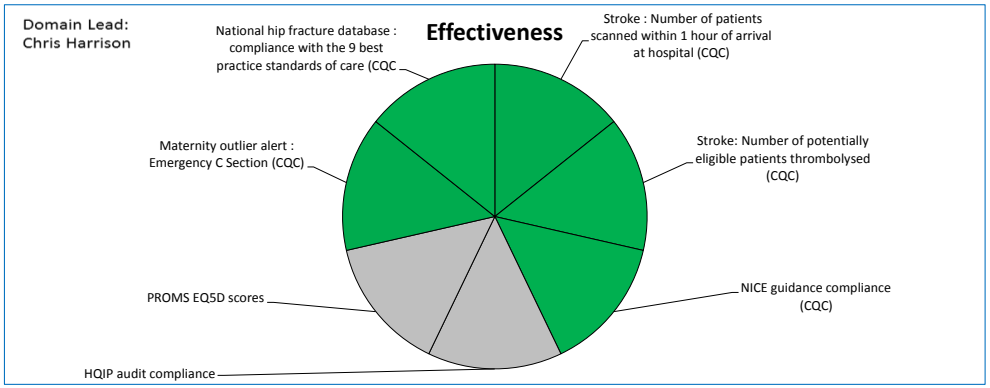
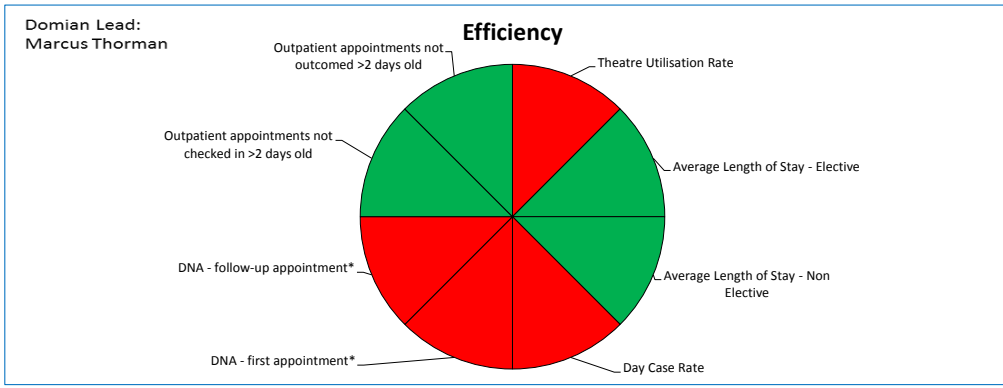


Domain Lead: Chris Harrison



Domian Lead: Marcus Thorman



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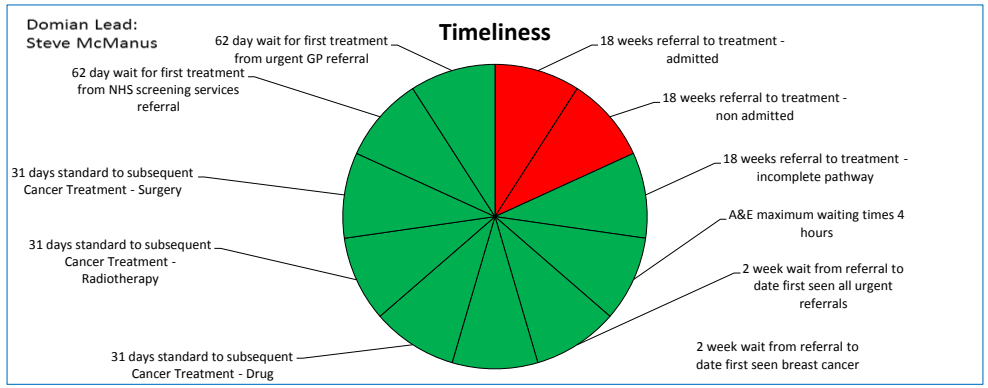
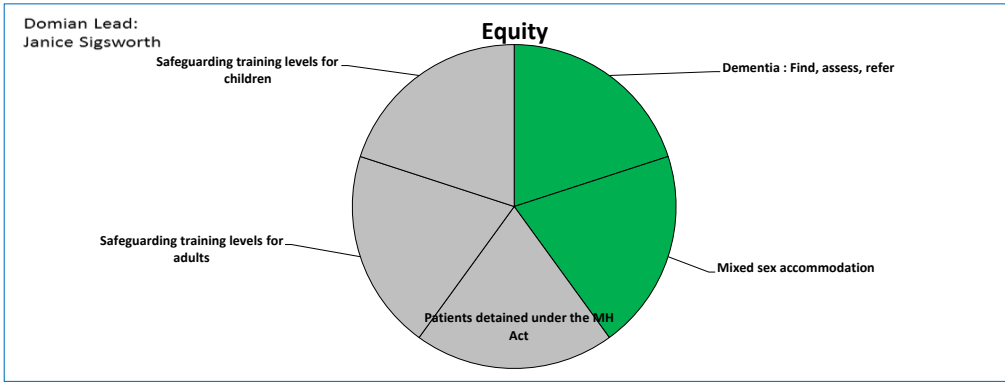
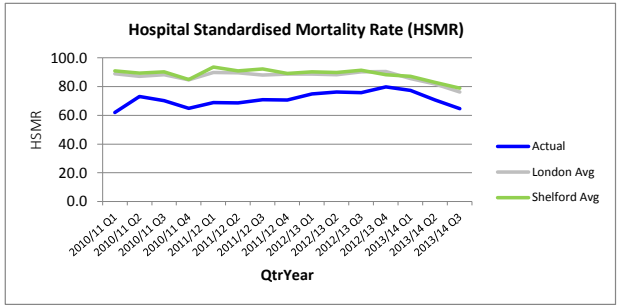


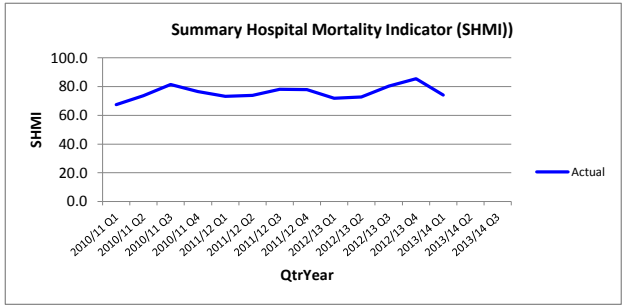
Domian Lead: Janice Sigsworth

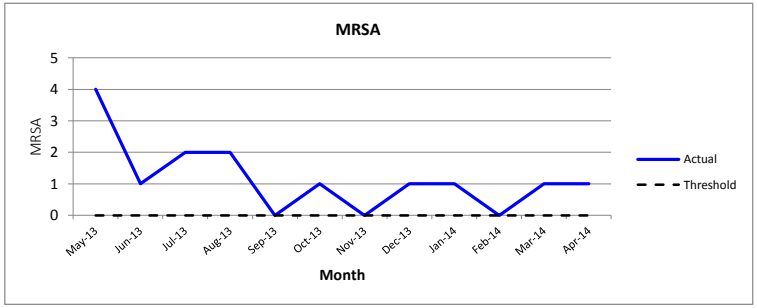


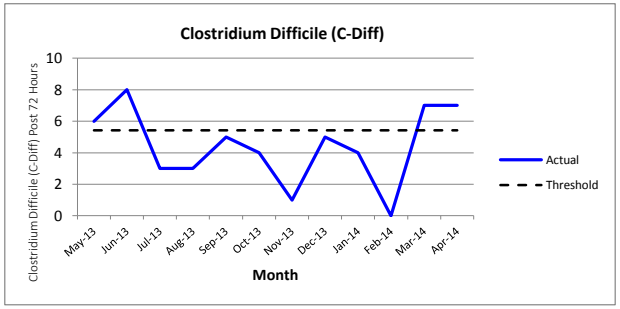
CQC/Threshold met
CQC/Threshold NOT met
To be developed (NO Data - NO Threshold)
Have Data - NO Threshold

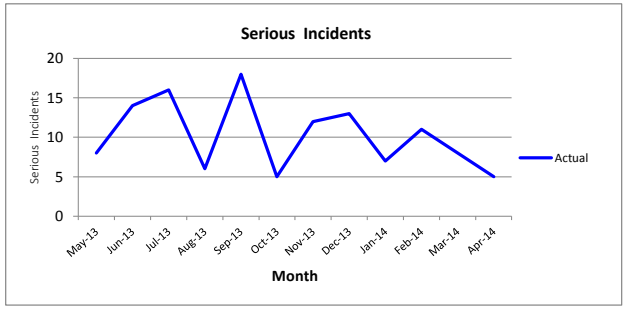
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Mortality Indicators																
Hospital Standardised Mortality Rate (HSMR)	HSMR	-	Qtr	n/a	n/a	71.9	64.7									CQC
Summary Hospital Mortality Indicator (SHMI)	SHMI	-	Qtr	n/a	n/a	74.9	n/a									CQC
Infection Control																
MRSA	MRSA	-	Mth	0	0	5	1									TDA, CQC
MRSA (latest CQC report)	MRSA (CQC)	-	Qtr	0	Not avail.	Not avail.	-									TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	C-Diff	-	Mth	65 p/a	12	26	7									Mon, TDA, CQC
Clostridium Difficile (latest CQC report)	C-Diff(CQC)	-	Qtr	0	Not avail.	Not avail.	-									Mon, TDA, CQC
Incidents																
Serious Incidents	SUI	-	Mth	*tbc*	11	33	5									TDA, CQC
Never Events	Nev	-	Mth	0	0	1	0									TDA, CQC

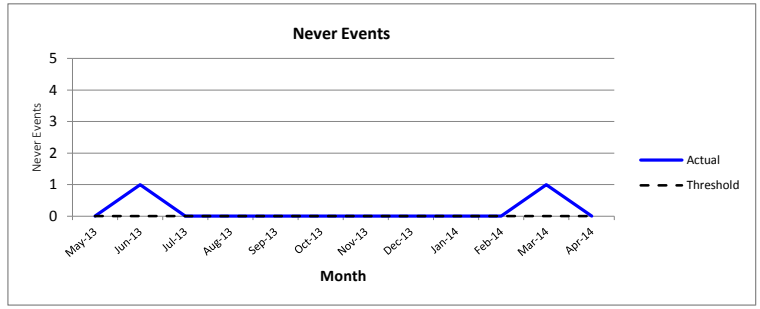






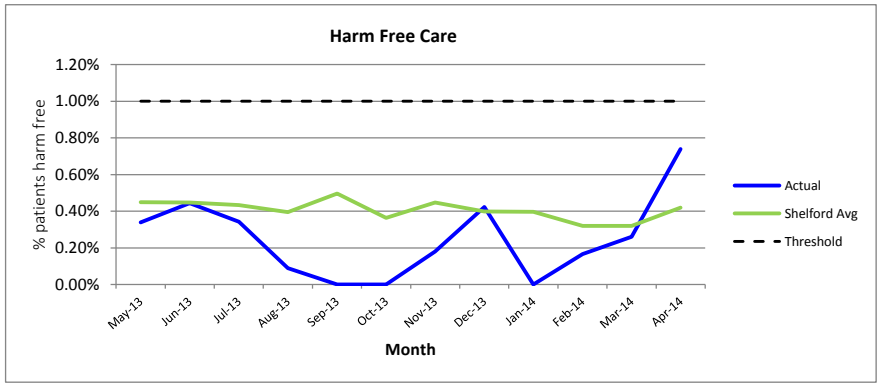


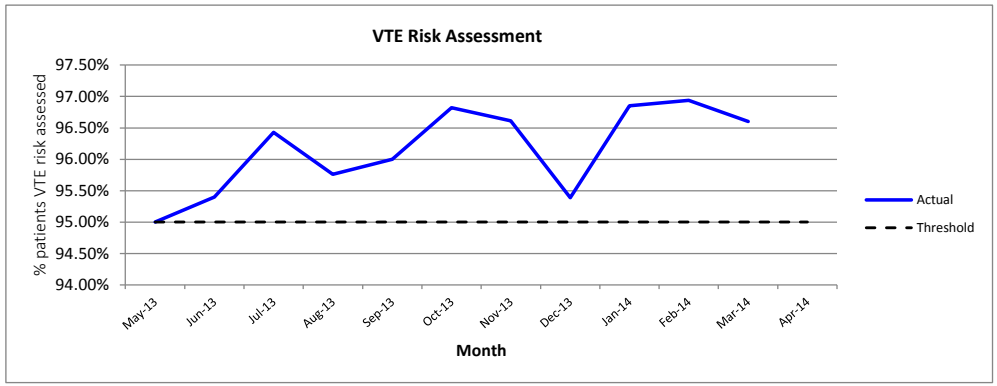


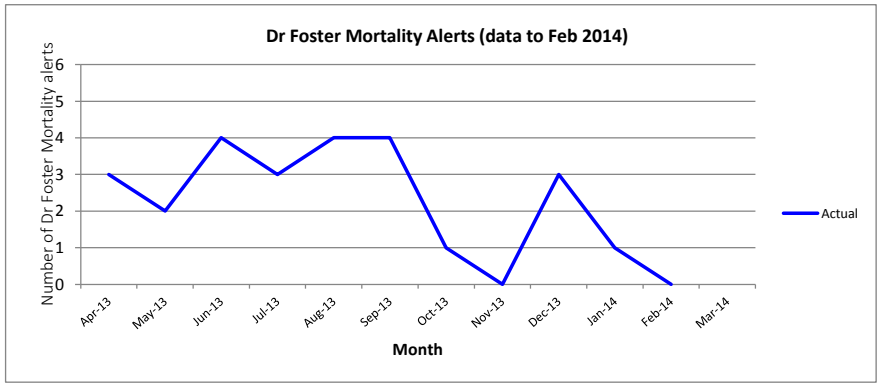


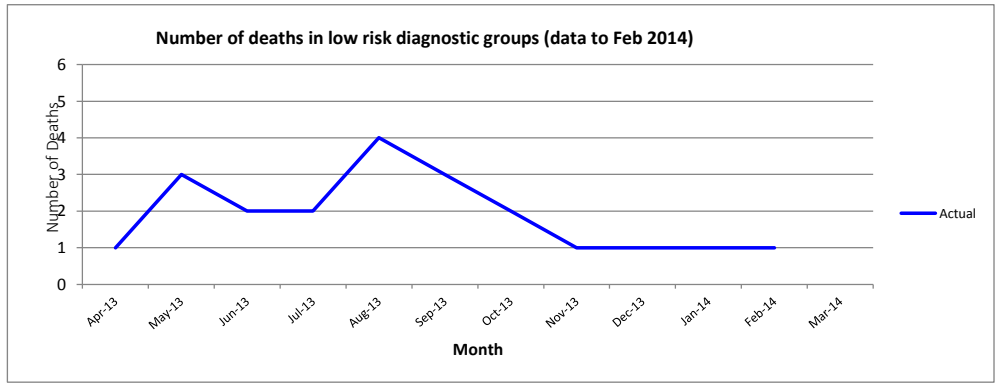
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Safety Thermometer																
Harm Free Care (Safety Thermometer)	HF	-	Mth	90%	95.1%	95.2%	95.62%									TDA, CQC
VTE																
VTE Risk Assessments*	VTE	✓	Mth	95%	95.0%	95.1%	96.80%									CQC, Contractual
Dr Foster Alerts																
Number of Dr Foster mortality alerts	DrF	-	Mth	*tbc*	3	9	Not Available									CQC
Deaths in low risk diagnostic groups																
Number of deaths in low risk diagnostic groups	DrFLR	-	Mth	n/a	1	6	1									CQC

Indicators to developed
Proportion of reported harmful incidents
Consistency of reporting to NRLS



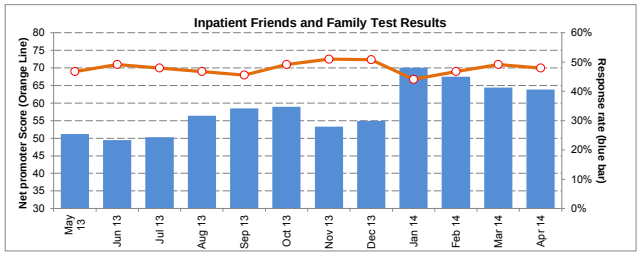


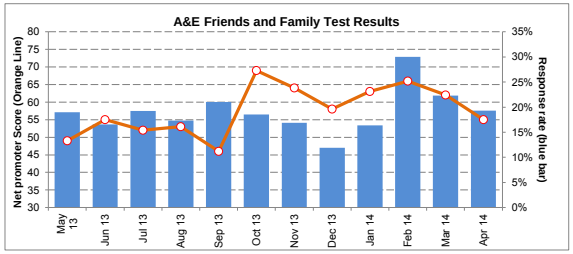


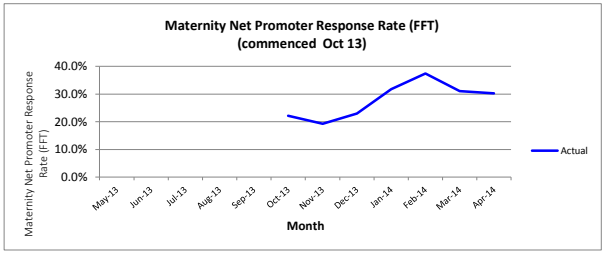


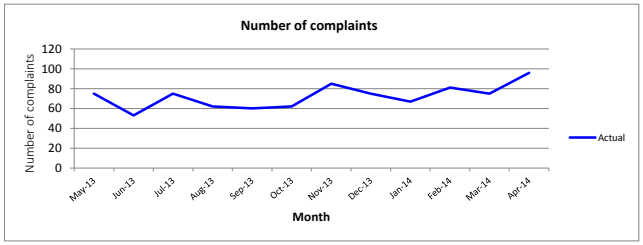
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15	Source Framework
Friends & Family Test																
Inpatients Net Promoter Score (FFT)	InNet	✓	Mth	*tbc*	70	70	70									Contractual
Inpatients Net Promoter Response Rate	InNet	✓	Mth	25%	26.42%	25.09%	40.58%									
A&E Net Promoter Score (FFT)	A&ENet	✓	Mth	*tbc*	43	49	55									Contractual
A&E Net Promoter Response Rate	A&ENet	✓	Mth	15%	18.30%	17.93%	19.30%									
Maternity Net Promoter Score (FFT)	MatNet	✓	Mth	*tbc*	Not avail.	Not avail.	63									Contractual
Maternity Net Promoter Score Response Rate	MatNet	✓	Mth	15%	Not avail.	Not avail.	30.30%									Contractual
Complaints & Compliments																
Number of complaints received	ComRE	-	Mth	100	64	192	96									CQC
Environment																
PLACE - Cleanliness	Pla	-	Annual	*95%*	99.03%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Food	Plb	-	Annual	*84%*	80.91%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Privacy, Dignity & Well being	Plc	-	Annual	*82%*	88.60%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Facilities	Pld	-	Annual	*83%*	89.22%	Aug-13	Survey due Aug 14									*tbc*
Patient Experience																
(LQ36) Have you been treated with dignity and respect by staff on this ward?	PEXa	-	Mth	*tbc*	98.01%	97.63%	96.6%									CQC
Safeguarding																
Safeguarding Adults : Referrals per month	Sga	-	Mth	*tbc*	41	107	11									CQC

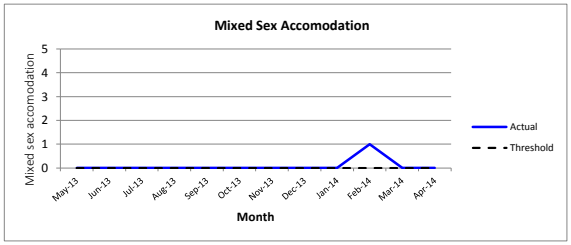
Indicators to developed
Patient Exp. - Overall experience
Patient Exp. - Cancer

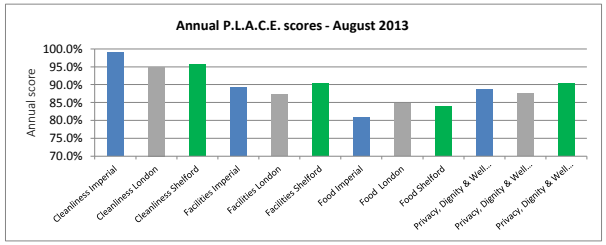


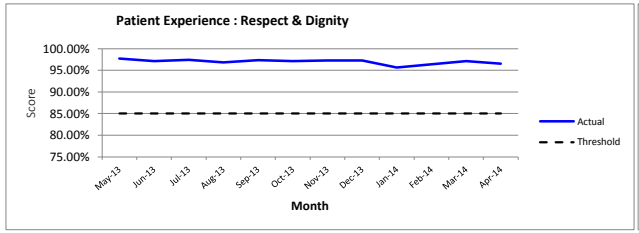


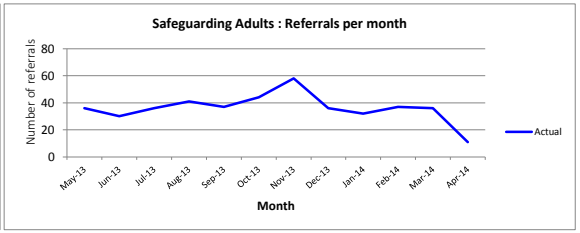












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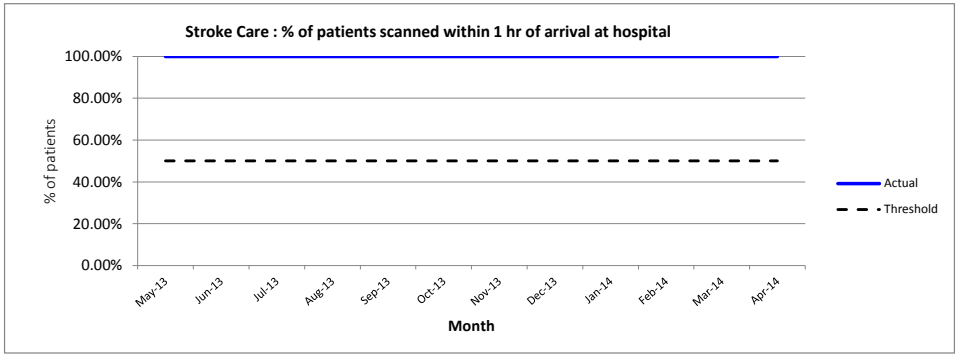
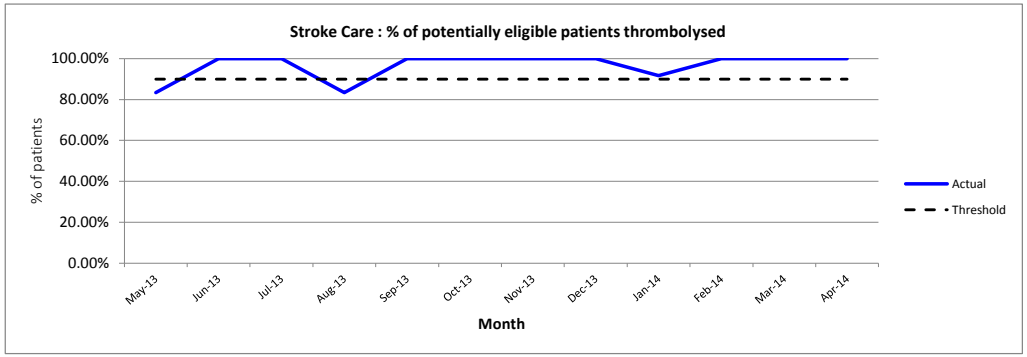
Maternity Outlier Alerts																
Stroke Care : % of patients scanned within 1 hr of arrival at hospital	Str1	-	Mth	50%	100.0%	100.0%	100.00%									CQC
Stroke Care : % of potentially eligible patients thrombolysed	Str2	-	Mth	90%	95.0%	92.3%	100.00%									CQC

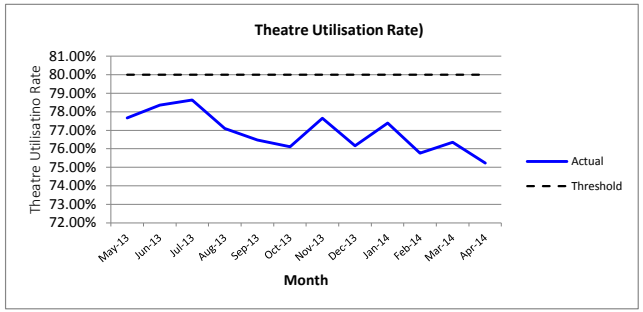
Indicators to developed
Nice Guidance Compliance
HQIP Audit Compliance
PROMS ESQD Scores
Maternity outlier alert : Emergency C section
National Hip Fracture Database : Compliance With 9 Best Practice Standards

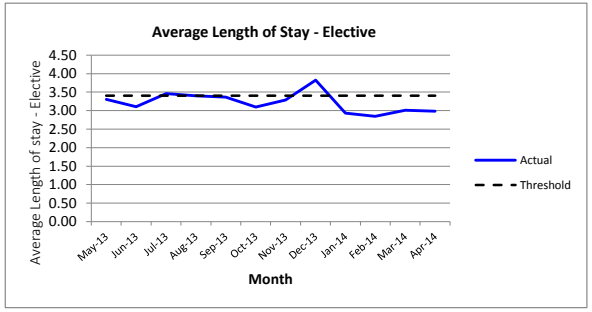


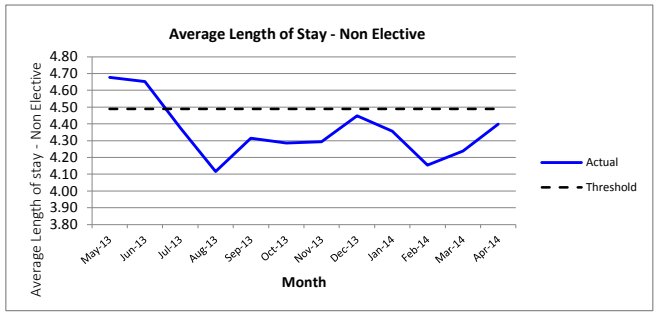


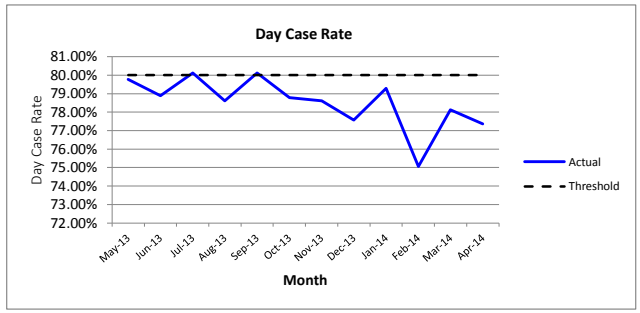
Indicator	Abrv.	Leading	Frequenc	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Productivity																
Theatre Utilisation Rate	ThUR	✓	Mth	81.00%	77.20%	77.74%	75.22%									CQC
Average Length of Stay - Elective	LOSe	✓	Mth	3.40	3.29	3.23	2.98									CQC
Average Length of Stay - Non Elective	LOSne	✓	Mth	4.49	5.00	4.78	4.40									CQC
Day Case Rate	DCR	✓	Mth	80.00%	81.06%	79.90%	77.36%									CQC
DNA - first appointment	DNA1	✓	Mth	12.31%	13.69%	13.82%	15.70%									Internal
DNA - follow-up appointment	DNA2	✓	Mth	11.33%	12.68%	12.80%	15.07%									Internal
Hospital Appointment Cancellations (hospital instigated)	HAC	✓	Mth	*tbc*	1.66%	1.88%	1.76%									Internal
Data Quality																
Outpatient appointments not checked in >2 days old	DQ6	✓	Mth	1%	3.59%	3.67%	Not available									Internal
Outpatient appointments not outcomed >2 days old	DQ7	✓	Mth	1%	6.71%	5.75%	Not available									Internal

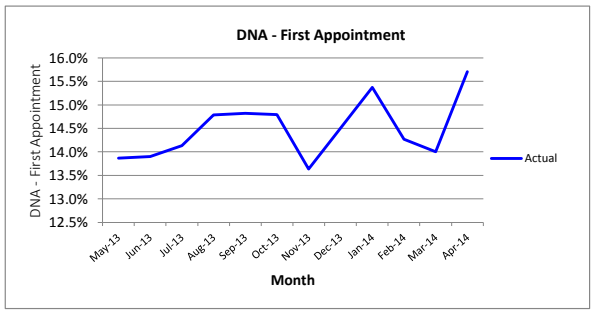
Indicators to developed
*BADS Day Case Rate - Paediatric**

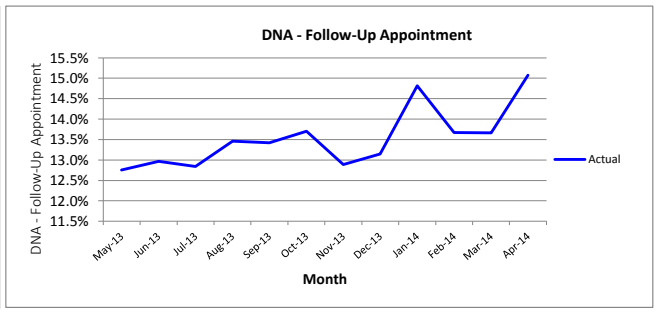


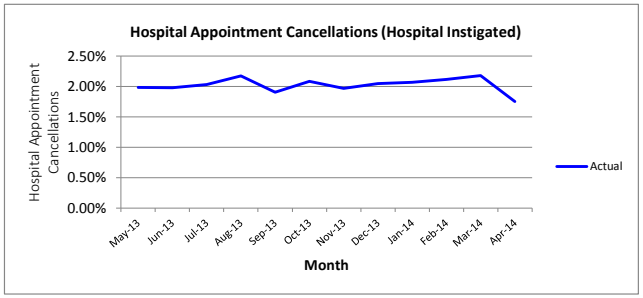


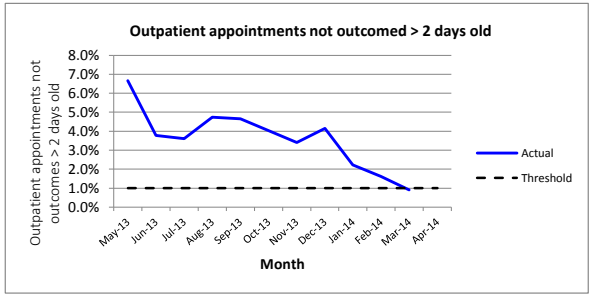


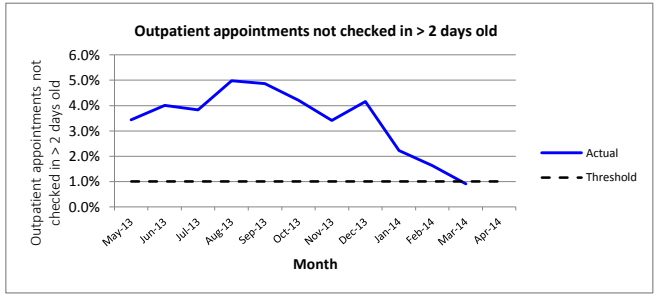




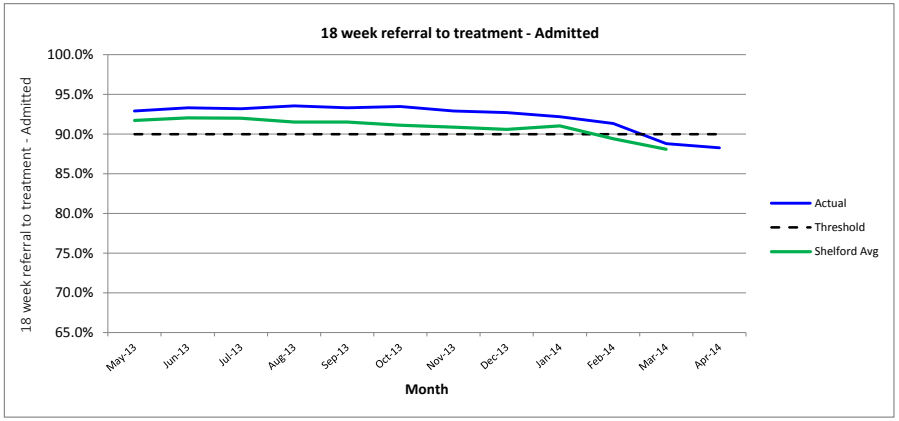


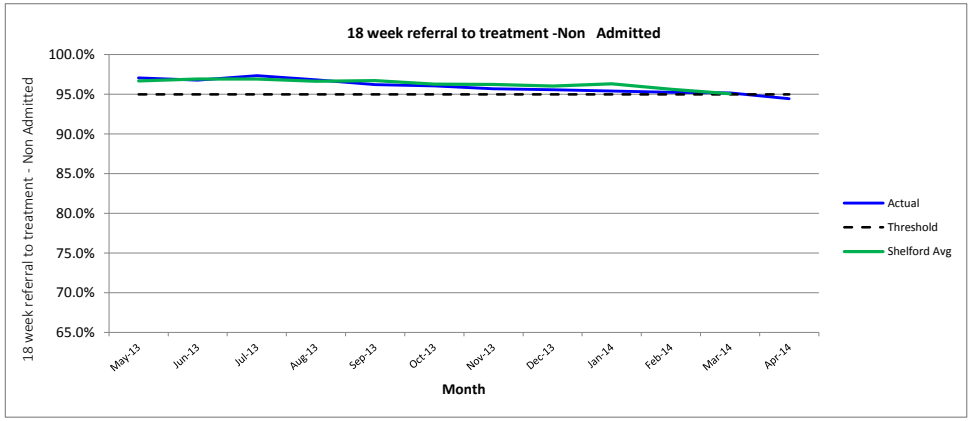


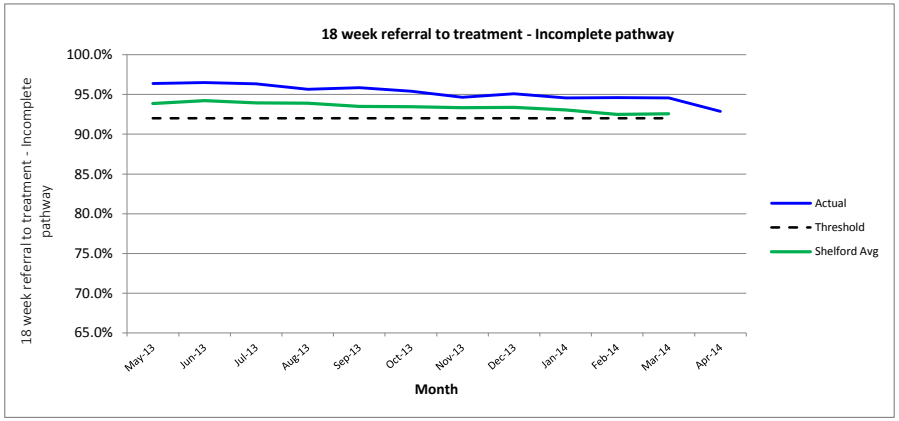


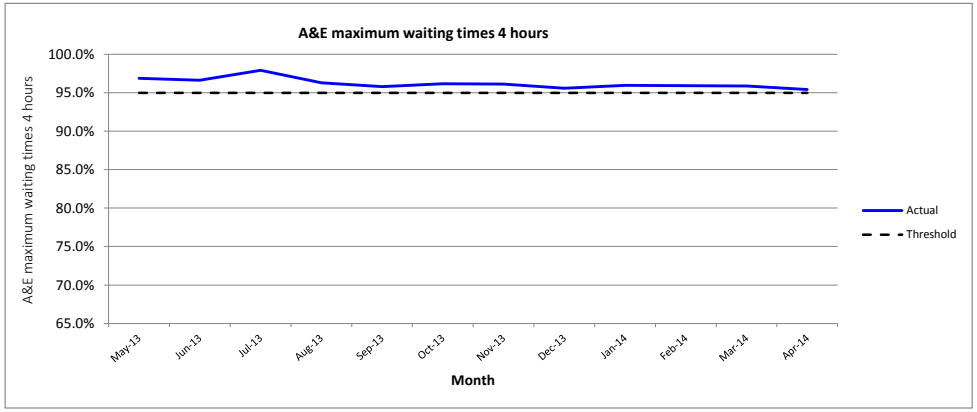


Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Elective Access																
18 weeks referral to treatment - admitted	18Wa	-	Mth	90%	91.3%	92.5%	88.3%									Mon, TDA, CQC
18 weeks referral to treatment - non admitted	18Wn	-	Mth	95%	96.7%	96.8%	94.4%									Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	18Wi	-	Mth	92%	95.0%	96.0%	92.9%									Mon, TDA, CQC
A&E Quality																
A&E maximum waiting times 4 hours	A&E4h	✓	Mth	95%	95.2%	96.2%	95.4%									Mon, TDA, CQC

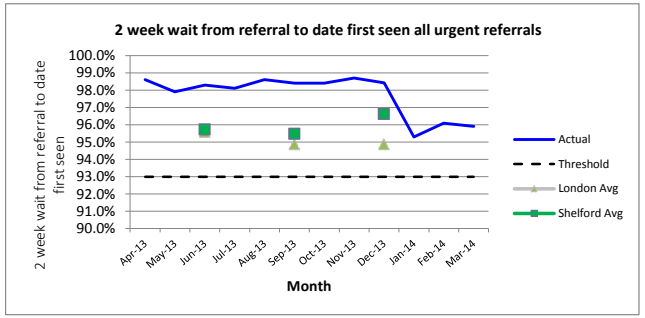


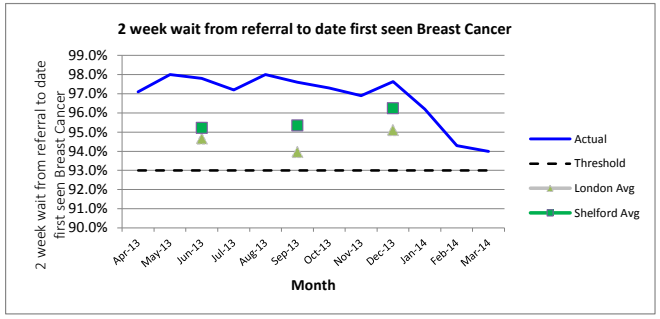


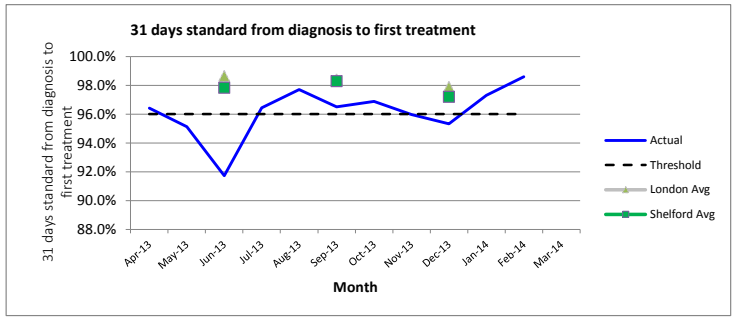


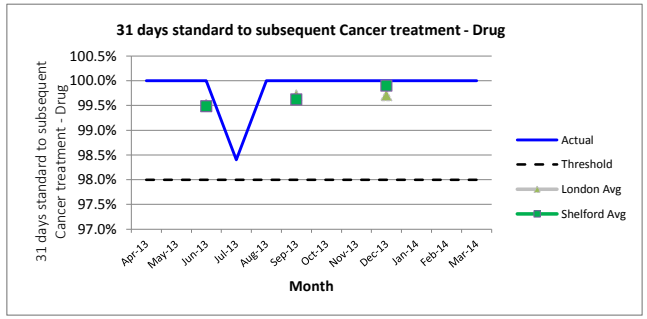


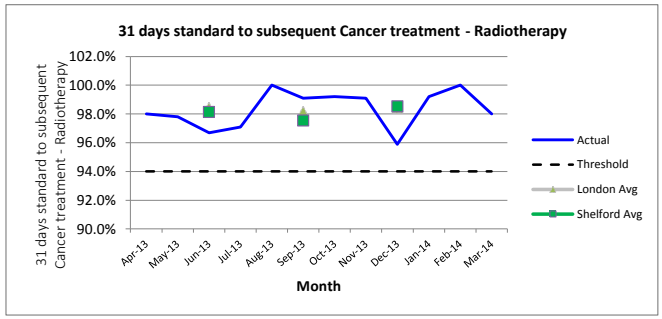
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1-13	Q2-13	Q3-13	Q4-14	YTD	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Source Framework
Cancer Access Waiting Times																
2 week wait from referral to date first seen all urgent referrals	2WW	✓	Qtr	93%	98.6%	98.3%	95.9%	98.3%	98.4%	98.5%	95.8%	97.7%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	2WW	✓	Qtr	93%	97.1%	97.6%	94.0%	97.6%	97.6%	97.3%	94.7%	96.8%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	31DW	-	Qtr	96%	96.4%	94.4%	100.0%	94.4%	96.9%	96.1%	98.0%	96.3%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	31DT	-	Qtr	98%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	99.9%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	31DT	-	Qtr	94%	98.0%	97.5%	98.0%	97.5%	98.7%	98.1%	99.1%	98.3%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	31DT	-	Qtr	94%	94.2%	96.1%	94.7%	96.1%	95.5%	95.4%	95.3%	95.6%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	62DW	-	Qtr	90%	79.3%	91.3%	94.3%	91.3%	95.6%	92.2%	92.1%	92.8%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	62DW	-	Qtr	85%	75.0%	74.3%	89.3%	74.3%	74.0%	80.1%	85.8%	78.5%				Mon, TDA, CQC

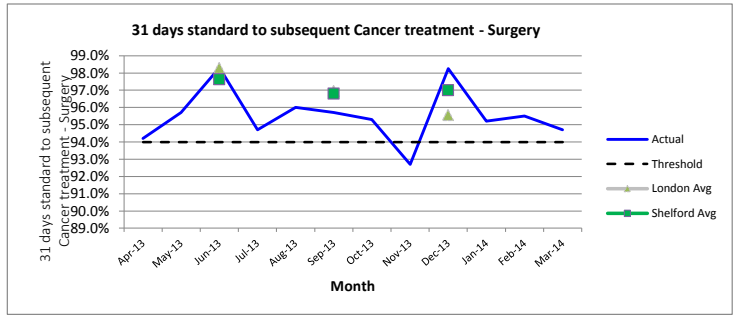


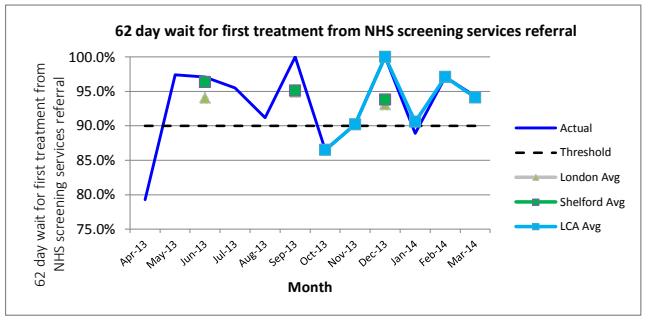


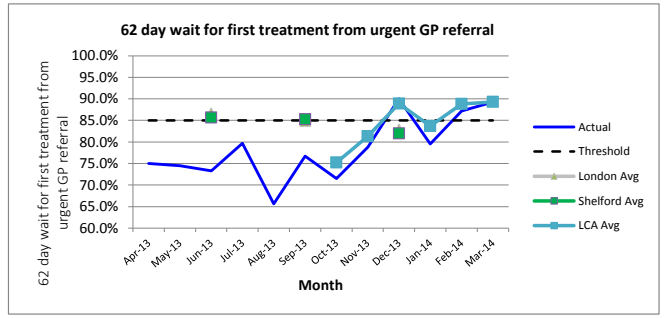






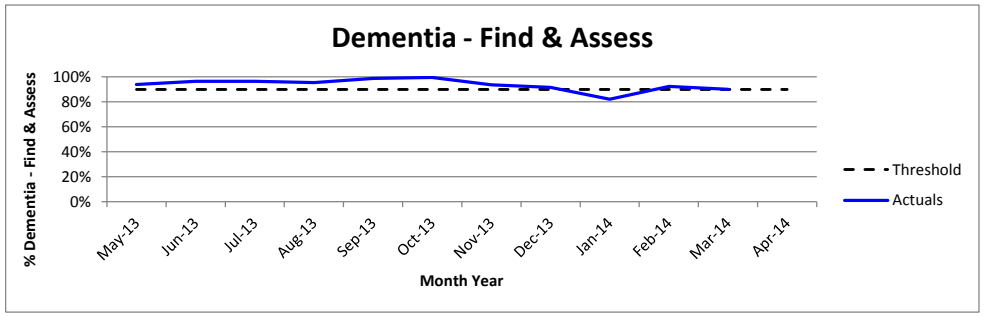


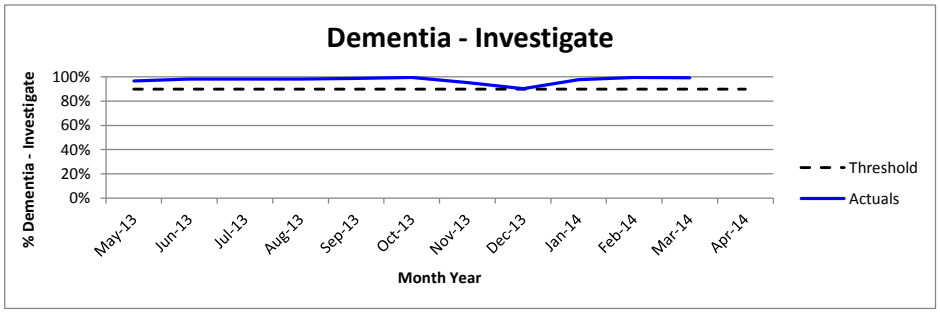


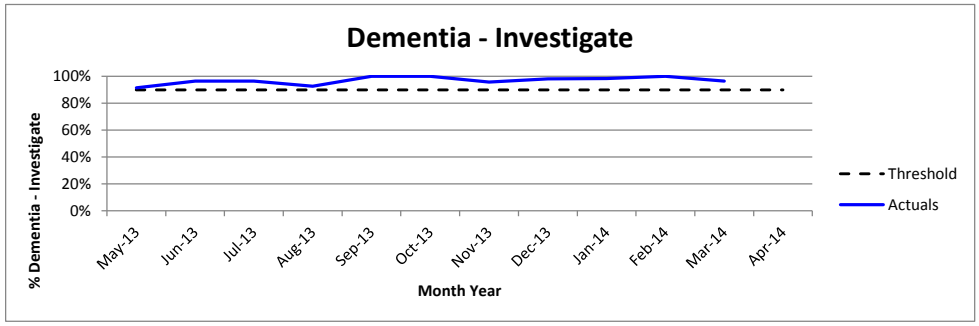


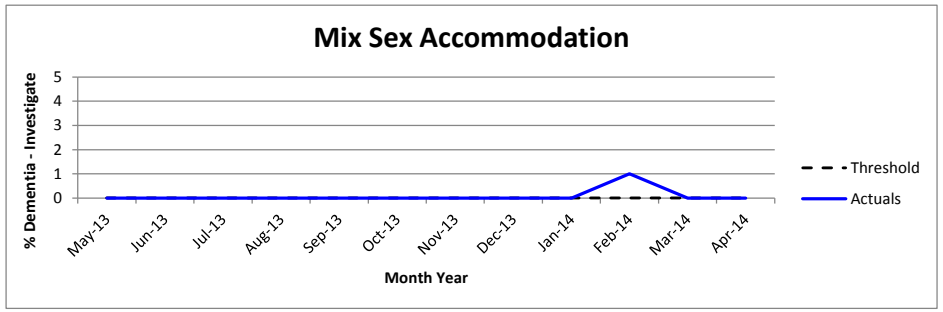
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
CQUIN - Dementia																
CQUIN - Dementia - Find & Assess*	DFE	-	Mth	90%	93%	94%	Not avail									Contractual
CQUIN - Dementia - Investigate	DI	-	Mth	90%	96%	97%	Not avail									Contractual
CQUIN - Dementia - Refer	DR	-	Mth	90%	95%	94%	Not avail									Contractual
Accomodation																
Mixed Sex Accommodation	EMSA	-	Mth	0	0	0	0									TDA

Indicators to developed
*Patients detained under the MH Act **
*Safeguarding training levels for adults **
*Safeguarding training levels for children **

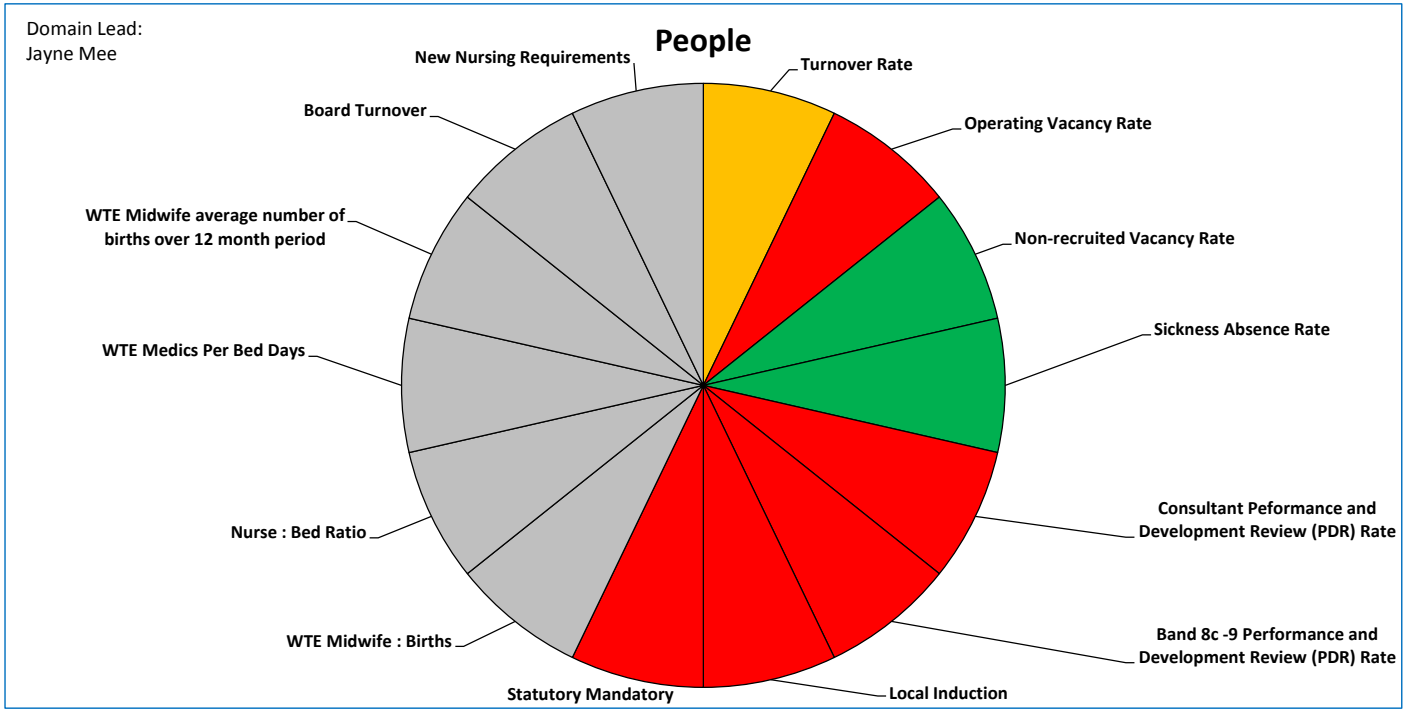








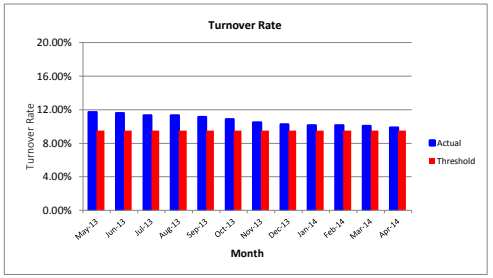
Domain Lead:
Jayne Mee

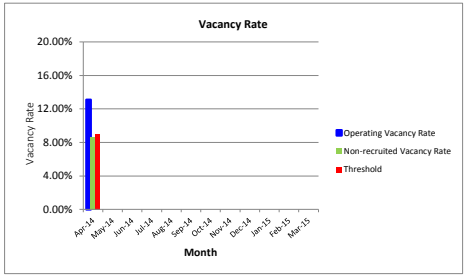


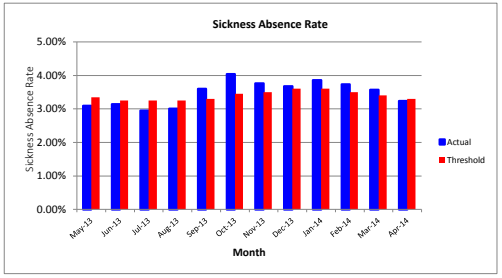
*Clarity as to how these indicators are measured and which domain they are included in is being proposed and will be refreshed in the next integrated performance scorecard.

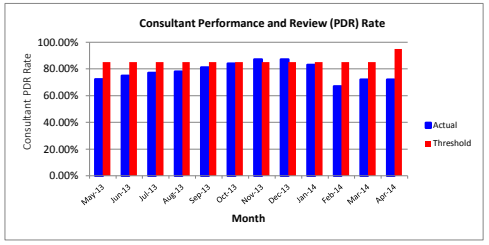
Indicator	Abrv.	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Turnover & Vacancy Rate																
Turnover Rate	TR	✓	Mth	<9.50%	11.54%	11.61%	9.86%					10.07%				TDA
Operating Vacancy Rate	OVR	✓	Mth	<9.00%	Not available	Not available	13.10%									CQC
Non-recruited Vacancy Rate	NrVR	✓	Mth	<9.00%	Not available	Not available	8.61%									CQC
Sickness Absence Rate	SA	✓	Mth	<3.4%	3.16%	3.13%	3.24%					3.45%				CQC
Appraisal Rates																
Consultant Peformance and Development Review (PDR) Rate	CA	✓	Mth	>95.00%	65.14%	70.84%	72.00%									Define
Band 8c -9 Performance and Development Review (PDR) Rate	B89	✓	Mth	>95.00%	Not available	Not available	12.00%									Define
Training Compliance																
Local Induction	LI	✓	Mth	>95.00%	71.56%	74.04%	75.84%									Define
Statutory Mandatory	SM	✓	Mth	>95.00%	72.41%	71.82%	69.52%									Define
Bank and Agency Spend																
Bank Spend (%)	BS	✓	Mth	<7.00%	Not available	Not available	5.88%					10.45%				Define
Agency Spend (%)	AS	✓	Mth	<7.00%	Not available	Not available	8.12%					10.45%				Define
Corporate Welcome																
Corporate Welcome Attendance	CWA	✓	Mth	>100.00%	Not available	Not available	75.51%									Define

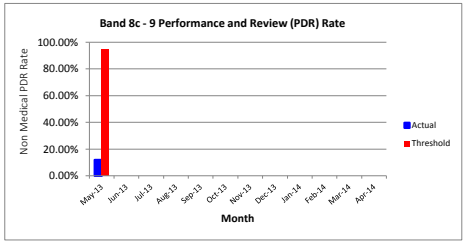
Indicators to be developed
WTE Midwife : Births
Nurse : Bed Ratio
WTE Medics Per Bed Days
WTE Midwife average number of births over 12 month period
Board Turnover
New Nursing Requirements

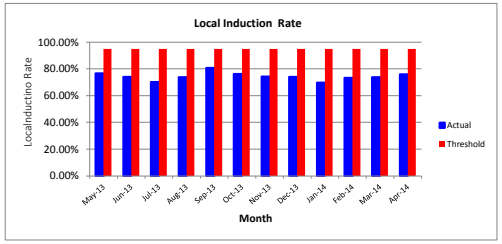


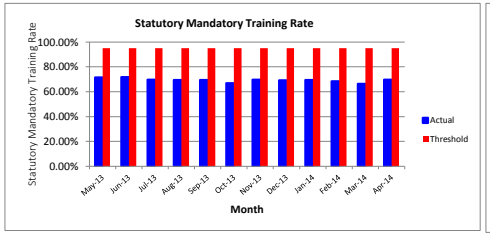


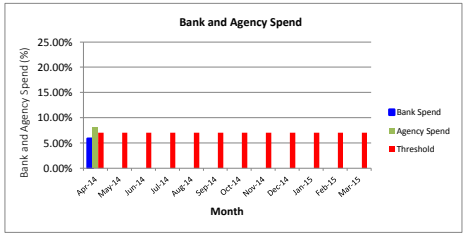


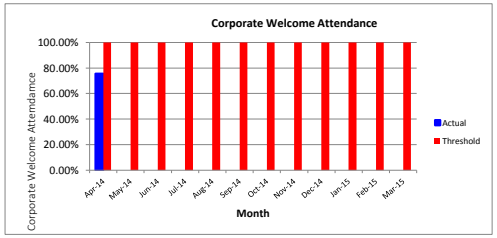


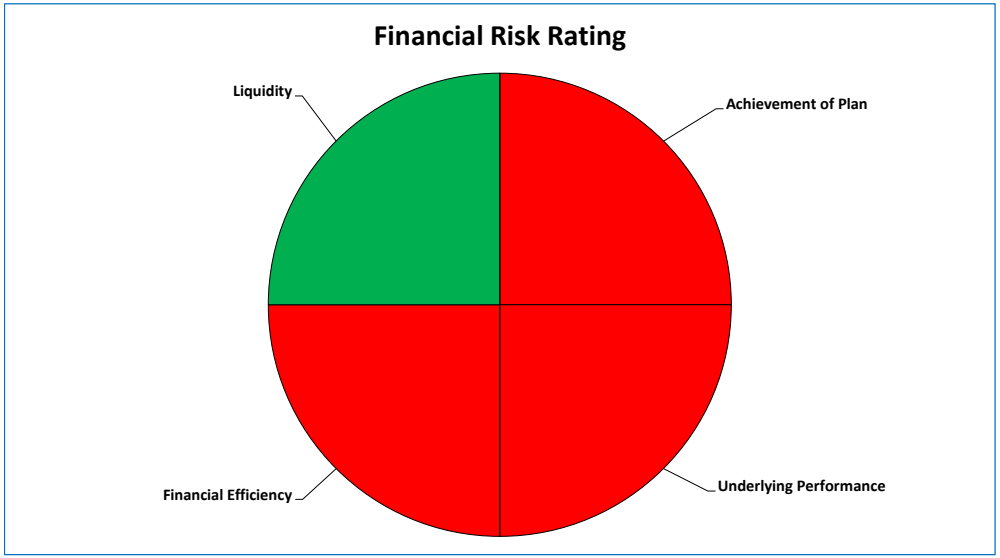


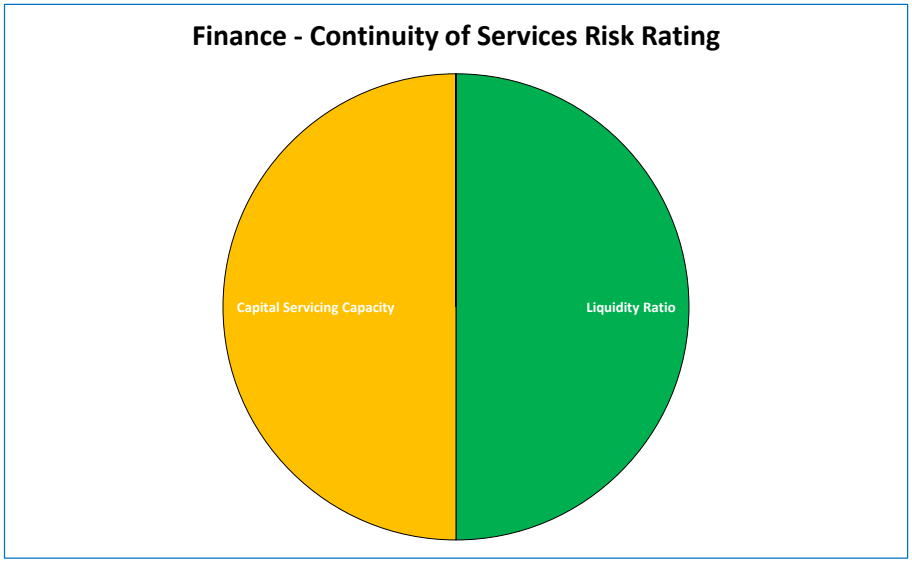




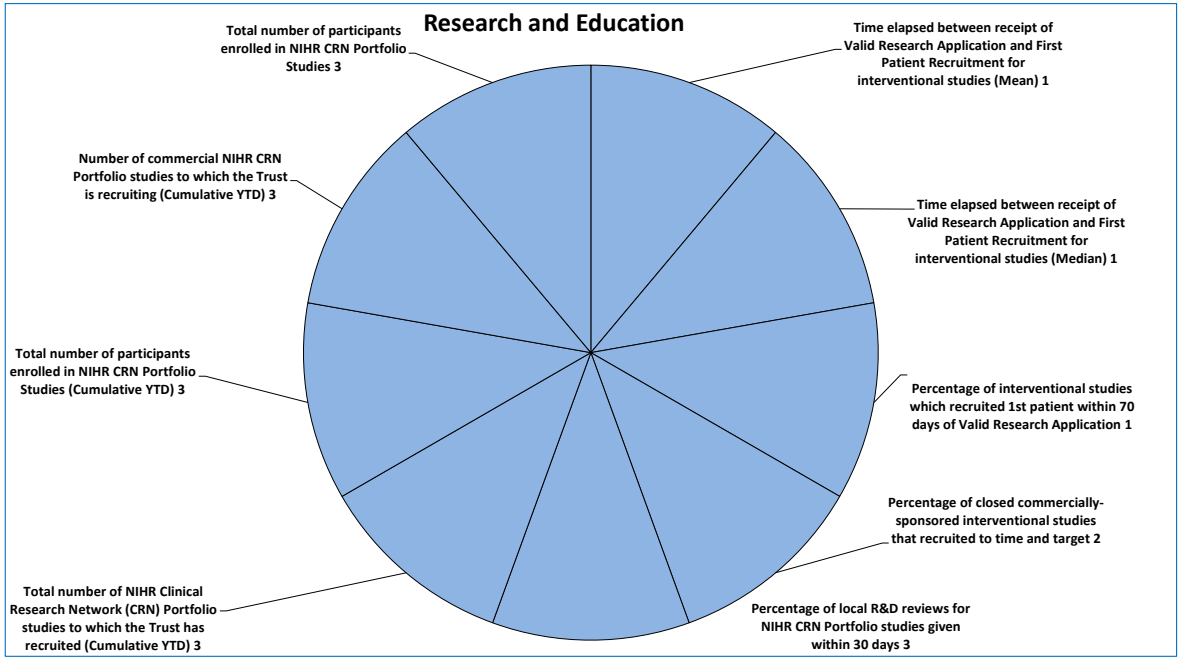





Financial Risk Rating
Liquidity
Achievement of Plan
Financial Efficiency
Underlying Performance


Finance - Continuity of Services Risk Rating
Capital Servicing Capacity
Liquidity Ratio

Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2013/14 Apr	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Financial Risk Rating															
Achievement of Plan	AP		Mth	10%	Not available	5	2								
Underlying Performance	UP		Mth	25%	Not available	3	2								
Financial Efficiency	FE		Mth	40%	Not available	2	2								
Liquidity	LI		Mth	25%	Not available	4	4								
Overall Financial Risk Rating							2								
Continuity of Service Risk Rating															
Liquidity Ratio	LR		Mth	50%	Not available	4	3								
Capital Servicing Capacity	CS		Mth	50%	Not available	4	2								
Overall Continuity of Service Risk Rating							3								

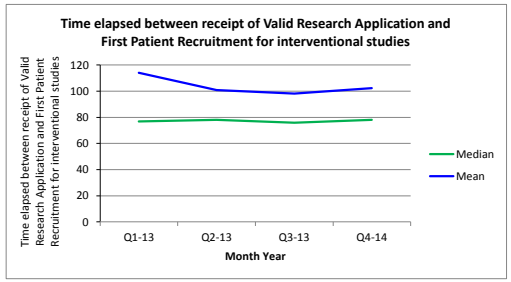

Research and Education
Total number of participants enrolled in NIHR CRN Portfolio Studies 3
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Mean) 1
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Median) 1
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 1
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 2
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 3
Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days 3

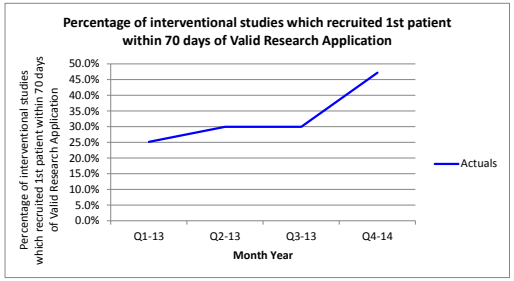
Indicator	Abrv.	Frequency	Threshold	Performance in 2012/2013 Q4	Performance Current Q1-13	Q2-13	Q3-13	Q4-14	YTD	Forecast 2014/15 Q1	2014/15 Q2	2014/15 Q3	Source Framework
Research & Development													
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Mean)** [1]		Qtr	*tbc*	118	114	101	98	102	416				Define
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Median)** [1]		Qtr	*tbc*	84	77	78	76	78	309				Define
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application [2]		Qtr	*tbc*	23.0%	25.2%	30.0%	30.0%	47.2%	33.1%				Define
Percentage of closed commercially-sponsored interventional studies that recruited to time and target [2]		Qtr	*tbc*	N/A	N/A	N/A	N/A	N/A	N/A				Define
Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days [3]		Qtr	*tbc*	18.00%	58.00%	78.29%	74.17%	52.07%	65.63%				Define
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) [3]		Qtr	*tbc*	302	182	241	291	332	1046				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) [3]		Qtr	*tbc*	10503	2857	6215	9211	12292	30575				Define
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) [3]		Qtr	*tbc*	43	18	35	51	63	167				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies [3]		Qtr	*tbc*	378	101	380	554	764	1799				Define

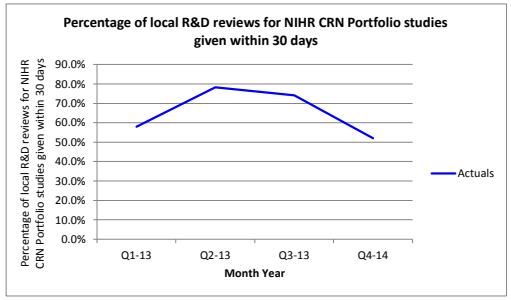
[1] Data source: IC BRC quarterly returns to NIHR CCF.

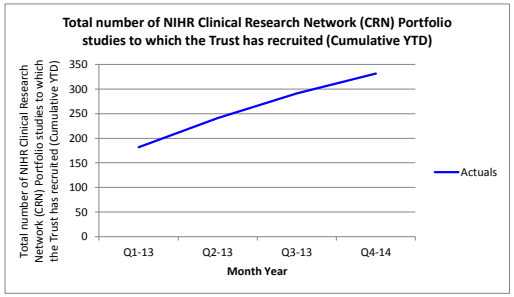
[2] Data source: monthly performance reports from NWL CLRN; data include all study suspensions.

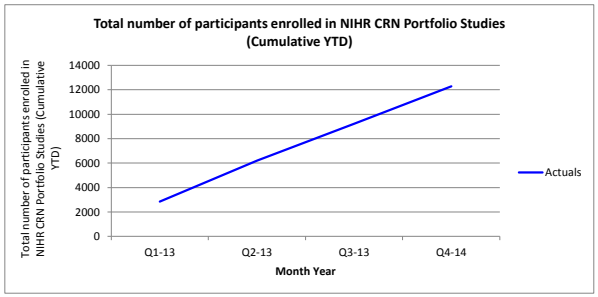
[3] Data source: CLRN Recruitment Summary – Individual CLRNs reports from NIHR portal for 15 March 2014. Period analysed = Q1 (April to June); Q2 (April to September); Q3 (April to December) in each FY. COSMOS study not included in recruitment totals.

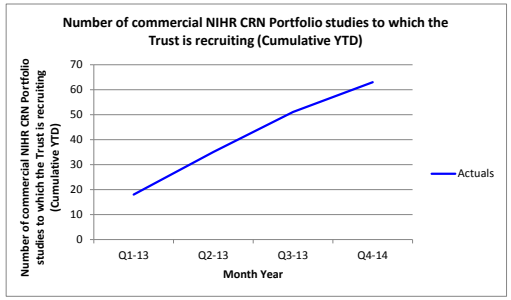


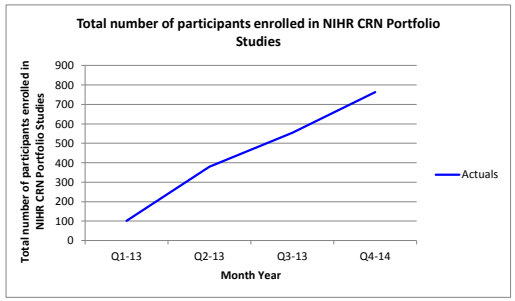












Contents

Finance Performance Report for the month ending 30th April 2014

Building world class finance

innovation respect care achievement pride

PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income									
Clinical	63,368	62,757	(611)	63,368	62,757	(611)	783,853	783,853	0
Research & Development & Education	10,096	9,351	(745)	10,096	9,351	(745)	121,199	121,199	0
Other	6,967	6,202	(764)	6,967	6,202	(764)	83,632	83,632	0
TOTAL INCOME	**80,430**	**78,310**	**(2,120)**	**80,430**	**78,310**	**(2,120)**	**988,684**	**988,684**	**0**
Expenditure									
Pay - In post	(39,562)	(39,332)	230	(39,562)	(39,332)	230	(480,756)	(480,756)	0
Pay - Bank	(1,169)	(2,736)	(1,567)	(1,169)	(2,736)	(1,567)	(14,019)	(14,019)	0
Pay - Agency	(2,067)	(3,691)	(1,624)	(2,067)	(3,691)	(1,624)	(22,119)	(22,119)	0
Drugs & Clinical Supplies	(17,841)	(18,329)	(487)	(17,841)	(18,329)	(487)	(215,952)	(215,952)	0
General Supplies	(3,530)	(3,094)	436	(3,530)	(3,094)	436	(42,178)	(42,178)	0
Other	(12,934)	(8,837)	4,097	(12,934)	(8,837)	4,097	(154,533)	(154,533)	0
TOTAL EXPENDITURE	**(77,105)**	**(76,020)**	**1,085**	**(77,105)**	**(76,020)**	**1,085**	**(929,556)**	**(929,556)**	**0**
Earnings Before Interest, Tax, Depreciation & Amortisation	**3,325**	**2,290**	**(1,035)**	**3,325**	**2,290**	**(1,035)**	**59,127**	**59,127**	**0**
Financing Costs	(4,030)	(4,060)	(30)	(4,030)	(4,060)	(30)	(203,807)	(203,807)	0
SURPLUS / (DEFICIT) including Impairment	**(705)**	**(1,770)**	**(1,065)**	**(705)**	**(1,770)**	**(1,065)**	**(144,680)**	**(144,680)**	**0**
Impairment of Assets & Donated Asset treatment	110	105	(5)	110	105	(5)	155,867	155,867	0
SURPLUS / (DEFICIT)	**(594)**	**(1,665)**	**(1,071)**	**(594)**	**(1,665)**	**(1,071)**	**11,187**	**11,187**	**0**

Statement of Comprehensive Income (SOCI)	**Risk:**	**R**

Variance: Favourable / (Adverse)

PAGE 2 - INCOME

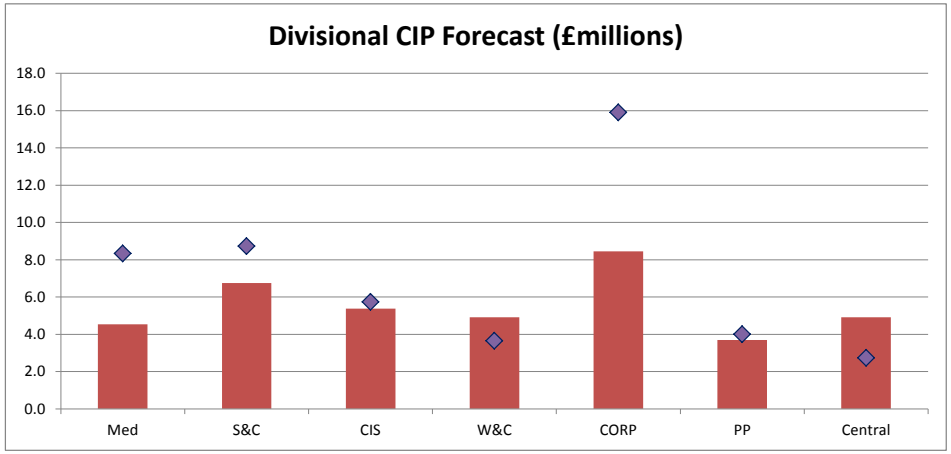
	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income from Clinical Activities									
Clinical Commissioning Groups	33,769	32,948	(821)	33,769	32,948	(821)	418,450	418,450	0
NHS England	23,778	24,207	429	23,778	24,207	429	294,645	294,645	0
Other NHS Organisations	462	1,009	547	462	1,009	547	5,721	5,721	0
Sub-Total NHS Income	**58,008**	**58,164**	**155**	**58,008**	**58,164**	**155**	**718,816**	**718,816**	**0**
Local Authority	832	814	(19)	832	814	(19)	10,316	10,316	0
Private Patients	3,234	3,264	30	3,234	3,264	30	38,824	38,824	0
Overseas Patients	183	117	(66)	183	117	(66)	2,200	2,200	0
NHS Injury Cost Scheme	130	156	26	130	156	26	1,557	1,557	0
Non NHS Other	980	243	(737)	980	243	(737)	12,140	12,140	0
Total - Income from Clinical Activities	**63,368**	**62,757**	**(611)**	**63,368**	**62,757**	**(611)**	**783,853**	**783,853**	**0**
Other Operating Income									
Education, Research & Development	10,096	9,351	(745)	10,096	9,351	(745)	121,199	121,199	0
Non patient care activities	3,017	2,397	(620)	3,017	2,397	(620)	36,221	36,221	0
Income Generation	355	296	(59)	355	296	(59)	4,264	4,264	0
Other Income	3,594	3,509	(85)	3,594	3,509	(85)	43,147	43,147	0
Total - Other Operating Income	**17,062**	**15,553**	**(1,509)**	**17,062**	**15,553**	**(1,509)**	**204,831**	**204,831**	**0**
TOTAL INCOME	**80,430**	**78,310**	**(2,120)**	**80,430**	**78,310**	**(2,120)**	**988,684**	**988,684**	**0**

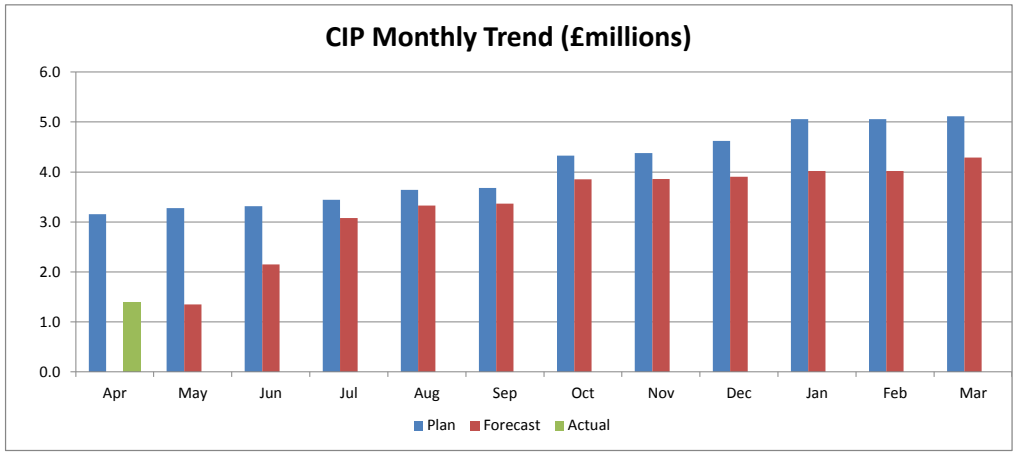
Statement of Comprehensive Income (SOCI)	**Risk:**	**R**

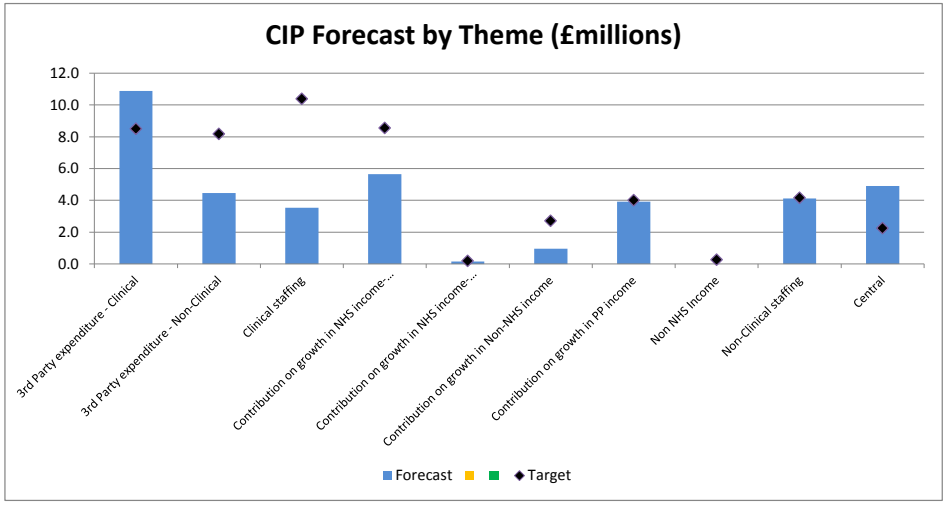
Variance: Favourable / (Adverse)

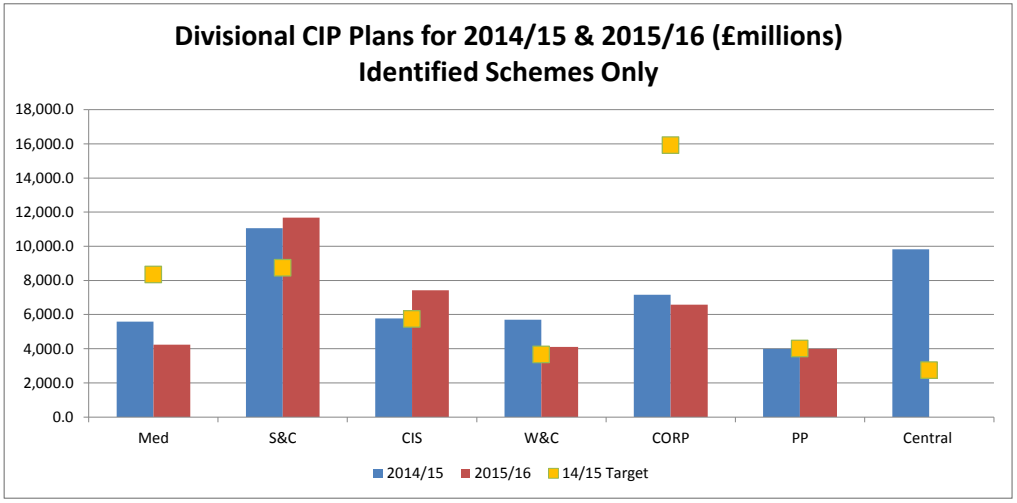
PAGE 3 - EXPENDITURE

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,118)	(12,767)	(650)	(12,118)	(12,767)	(650)	(148,806)	(148,806)	0
Nursing & Midwifery	(12,399)	(12,294)	105	(12,399)	(12,294)	105	(151,492)	(151,492)	0
Scientific, Therapeutic & Technical staff	(5,662)	(5,506)	156	(5,662)	(5,506)	156	(68,549)	(68,549)	0
Healthcare assistants and other support staff	(2,418)	(2,335)	83	(2,418)	(2,335)	83	(28,981)	(28,981)	0
Directors and Senior Managers	(2,759)	(2,411)	347	(2,759)	(2,411)	347	(33,375)	(33,375)	0
Administration and Estates	(4,208)	(4,018)	190	(4,208)	(4,018)	190	(49,553)	(49,553)	0
Sub-total - Pay In post	**(39,562)**	**(39,332)**	**230**	**(39,562)**	**(39,332)**	**230**	**(480,756)**	**(480,756)**	**0**
Pay - Bank/Agency									
Medical Staff	(523)	(1,249)	(726)	(523)	(1,249)	(726)	(6,160)	(6,160)	0
Nursing & Midwifery	(889)	(2,336)	(1,447)	(889)	(2,336)	(1,447)	(10,433)	(10,433)	0
Scientific, Therapeutic & Technical staff	(487)	(358)	130	(487)	(358)	130	(5,787)	(5,787)	0
Healthcare assistants and other support staff	(165)	(533)	(368)	(165)	(533)	(368)	(1,875)	(1,875)	0
Directors and Senior Managers	(53)	(121)	(68)	(53)	(121)	(68)	(508)	(508)	0
Administration and Estates	(1,120)	(1,832)	(712)	(1,120)	(1,832)	(712)	(11,376)	(11,376)	0
Sub-total - Pay Bang/Agency	**(3,236)**	**(6,428)**	**(3,191)**	**(3,236)**	**(6,428)**	**(3,191)**	**(36,138)**	**(36,138)**	**0**
Non Pay									
Drugs	(8,925)	(8,432)	493	(8,925)	(8,432)	493	(109,419)	(109,419)	0
Supplies and Services - Clinical	(8,917)	(9,897)	(980)	(8,917)	(9,897)	(980)	(106,533)	(106,533)	0
Supplies and Services - General	(3,530)	(3,094)	436	(3,530)	(3,094)	436	(42,178)	(42,178)	0
Consultancy Services	(1,304)	(1,095)	209	(1,304)	(1,095)	209	(15,585)	(15,585)	0
Establishment	(639)	(622)	17	(639)	(622)	17	(7,639)	(7,639)	0
Transport	(961)	(905)	56	(961)	(905)	56	(11,483)	(11,483)	0
Premises	(3,071)	(3,111)	(40)	(3,071)	(3,111)	(40)	(36,687)	(36,687)	0
Other Non Pay	(6,959)	(3,103)	3,855	(6,959)	(3,103)	3,855	(83,138)	(83,138)	0
Sub-total - Non Pay	**(34,306)**	**(30,260)**	**4,046**	**(34,306)**	**(30,260)**	**4,046**	**(412,662)**	**(412,662)**	**0**
TOTAL EXPENDITURE	**(77,105)**	**(76,020)**	**1,085**	**(77,105)**	**(76,020)**	**1,085**	**(929,556)**	**(929,556)**	**0**
Financing Costs									
Interest Receivable	20	18	(2)	20	18	(2)	244	244	0
Receipt of Grants for Capital Acquisitions	0	0	0	0	0	0	0	0	0
Interest Payable	0	(68)	(68)	0	(68)	(68)	(810)	(810)	0
Other Gains & Losses	0	0	0	0	0	0	0	0	0
Impairment on Assets	0	0	0	0	0	0	(154,538)	(154,538)	0
Depreciation	(2,875)	(2,836)	39	(2,875)	(2,836)	39	(34,599)	(34,599)	0
Public Dividend Capital	(1,175)	(1,175)	(0)	(1,175)	(1,175)	(0)	(14,104)	(14,104)	0
TOTAL - FINANCING COSTS	**(4,030)**	**(4,060)**	**(30)**	**(4,030)**	**(4,060)**	**(30)**	**(203,807)**	**(203,807)**	**0**









Key Issues:
£1.4m savings delivered against a £3.3m plan (deficit £1.9m)
£38.6m of savings forecast against a £49.1m plan (deficit of £10.5m)
Action is required to bring CIP delivery and forecast in line with plan
New system 'StratPro' for Quality & Efficiency Programme is now being used for quality, operational and financial monitoring of schemes and delivery
91% of the CIP requirement for 2015/16 has been identified in StratPro
78% of the CIP requirement for 2016/17 has been identified in StratPro

Cost Improvement Programme (CIP) **Risk:** R

PAGE 5 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Plan as at April £000s	Previous Month Balance £000s	Current Month Balance £000s	In Year Movement £000s	Plan as at April £000s	Monthly Movement £000s
Non Current Assets	Property, Plant & Equipment	595,639	594,335	595,639	594,284	(1,355)	(51)	(1,355)
	Intangible Assets	1,413	1,461	1,413	1,379	(34)	(82)	(34)
Current Assets	Inventories (Stock)	14,214	15,006	14,214	14,119	(95)	(887)	(95)
	Trade & Other Receivables (Debtors)	96,256	83,816	96,256	101,934	5,678	18,118	5,678
	Cash	50,449	50,914	50,449	51,917	1,468	1,003	1,468
Current Liabilities	Trade & Other Payables (Creditors)	(128,280)	(125,747)	(128,280)	(135,660)	(7,380)	(9,913)	(7,380)
	Borrowings	(2,701)	(2,701)	(2,701)	(2,701)	0	0	0
	Provisions	(25,091)	(16,150)	(25,091)	(25,144)	(53)	(8,994)	(53)
Non Current Liabilities	Borrowings	(20,709)	(20,709)	(20,709)	(20,709)	0	0	0
	Provisions	(17,149)	(17,149)	(17,149)	(17,149)	0	0	0
	TOTAL ASSETS EMPLOYED	**564,041**	**563,076**	**564,041**	**562,270**	**(1,771)**	**(806)**	**(1,771)**

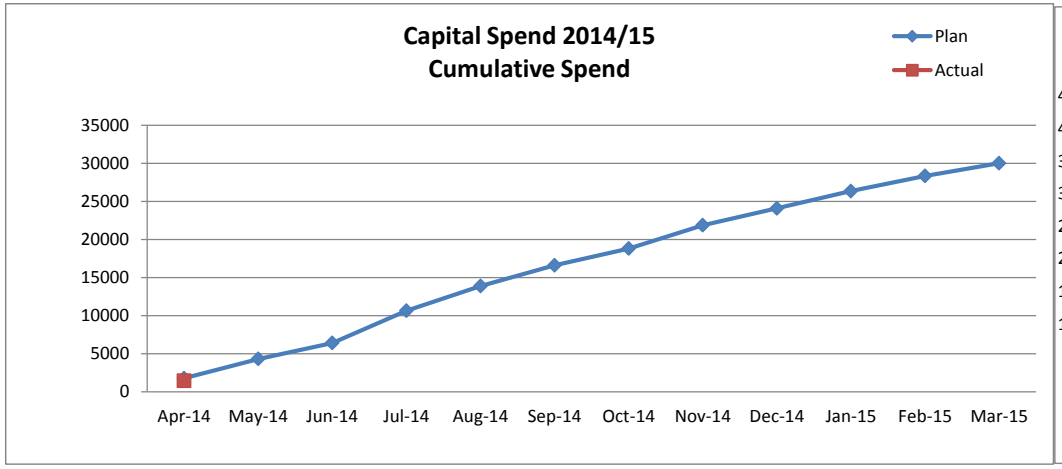
Ratio/Indicators	**Risk Rating**		
	Current Month	**Previous Month**	**Change in month**
Debtor Days	39	33	(6)
Trade Payable Days	54	48	(6)
Cash Liquidity Days	26	26	(0)

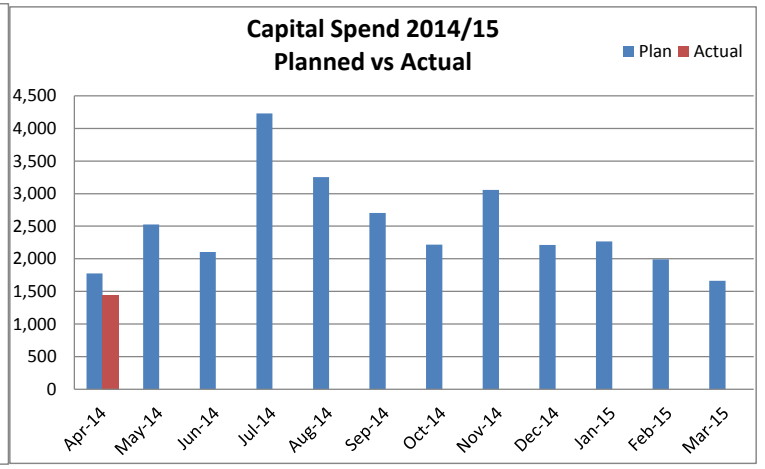
Statement of Financial Position (SOFP) **Risk: G**

Variance: Favourable / (Adverse)

PAGE 6 - CAPITAL EXPENDITURE

By Scheme	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Endoscopy provision QEQM level 2 (SMH)	330	161	169	330	161	169	330	330	0
Site Redevelopment	130	108	22	130	108	22	2,192	3,200	(1,008)
Capital Maintenance (Backlog & Statutory) - CXH	0	55	(55)	0	55	(55)	2,520	3,160	(640)
Capital Maintenance (Backlog & Statutory) - HH	150	12	138	150	12	138	2,020	2,540	(520)
Capital Maintenance (Backlog & Statutory) - SMH	0	126	(126)	0	126	(126)	2,090	1,950	140
Imaging Review	0	(2)	2	0	(2)	2	2,650	2,500	150
Medical Equipment purchases	0	256	(256)	0	256	(256)	2,420	4,600	(2,180)
Theatre Refurbishment Programme	0	0	0	0	0	0	1,000	560	440
ICT investment programme	1,143	495	648	1,143	495	648	7,226	5,000	2,226
Minor Works (below £50k)	0	152	(152)	0	152	(152)	500	500	0
Improving the cancer inpatients experience (6 North and 6 South)	0	0	0	0	0	0	700	751	(51)
Private Patient Facility improvements	0	11	(11)	0	11	(11)	250	0	250
Waste compound relocation (HH)	0	0	0	0	0	0	500	0	500
Development of Business Cases/Feasibility Studies	0	16	(16)	0	16	(16)	220	250	(30)
PICU St Mary's	0	3	(3)	0	3	(3)	2,583	1,480	1,103
Private Patients Refurbishment	0	0	0	0	0	0	878	0	878
Other site developments	0	50	(50)	0	50	(50)	0	0	0
Imaging Improvements (HH) - providing expanded Imaging in A-Block	24	3	21	24	3	21	1,921	3,179	(1,258)
Total Capital Expenditure	**1,777**	**1,446**	**331**	**1,777**	**1,446**	**331**	**30,000**	**30,000**	**0**
Donations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Total Charge against Capital Resource Limit	**1,777**	**1,446**	**331**	**1,777**	**1,446**	**331**	**30,000**	**30,000**	**0**
Capital Resource Limit							**(30,000)**	**(30,000)**	**0**
Over/(Under)spend against CRL							**0**	**0**	**0**

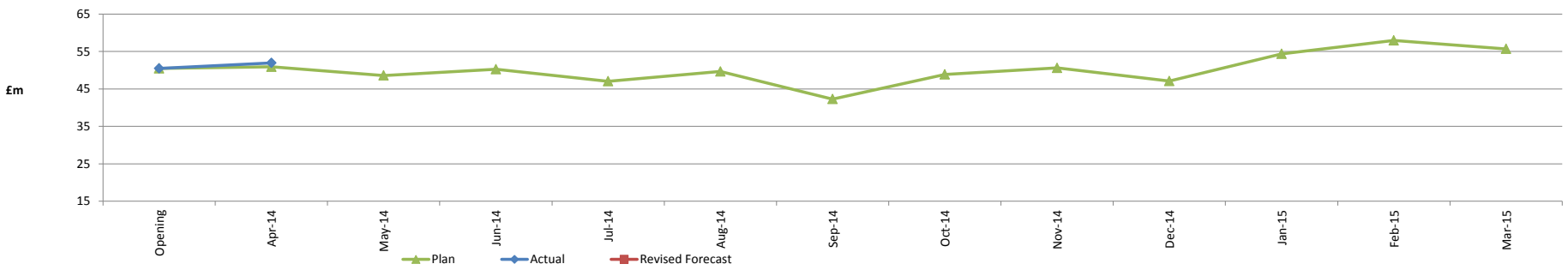




Statement of Financial Position (SOFP) **Risk: G**

Variance: Favourable / (Adverse) **Month 1, April 2014**

PAGE 7 - CASH



	Opening	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Plan	50,449	50,914	48,591	50,245	47,044	49,636	42,286	48,863	50,577	47,091	54,358	57,958	55,701
Actual	50,449	51,917											
Revised Forecast													

Aged Debtor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	Over 90 Days	Grand Total	Previous Month Total
NHS	22,524	9,011	5,557	10,720	47,813	59,344
Non-NHS	4,303	4,094	3,434	10,039	21,870	28,156
Total	**26,827**	**13,105**	**8,991**	**20,760**	**69,683**	**87,500**
% of Total Debt	**38.5%**	**18.8%**	**12.9%**	**29.8%**	**100.0%**	

Aged Creditor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	Over 90 Days	Grand Total	Previous Month Total
NHS	1,941	985	338	1,392	4,655	**10,973**
Non NHS	15,501	3,864	824	4,988	25,177	**40,203**
Total	**17,442**	**4,848**	**1,162**	**6,380**	**29,832**	**51,176**
% of Total Creditors	**58.5%**	**16.3%**	**3.9%**	**21.4%**	**100.0%**	

Statement of Financial Position (SOFP) **Risk:** G

Page 8 - FINANCIAL RISK RATINGS (FRR)

Financial Risk Rating

Metric	Weighting	Metric Description	April
Achievement of Plan	10%	Actual YTD EBITDA dividend by Plan YTD EBITDA	2
Underlying Performance	25%	Actual YTD EBITDA divided by Actual YTD operating income (excluding finance costs)	2
Financial Efficiency	40%	- YTD Actual Net Surplus/Deficit divided by average Net current Asset for the month - YTD Actual Net Surplus/Deficit divided by Actual YTD operating income	2
Liquidity	25%	Net current Assets for the month less inventory divided by YTD operating expenditure, and expressed in days	4
Overall Financial Risk Rating			2

Continuity of Service Risk Rating

Metric	Weighting	Metric Description	April
Liquidity Ratio	50%	Liquidity ratio (days)	3
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	2
Overall Continuity of Service Risk Rating			**3**

* The liquidity ratio for FRR is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

Financial Risk Ratings	**Risk:**	**A**

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: February 2014 Submitted 28/03/2013.

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. Condition G5 - Having regard to monitor guidance.
3. Condition G7 – Registration with the Care Quality Commission.
4. Condition G8 – Patient eligibility and selection criteria.
5. Condition P1 – Recording of information.
6. Condition P2 – Provision of information.
7. Condition P3 – Assurance report on submissions to Monitor.
8. Condition P4 – Compliance with the National Tariff.
9. Condition P5 – Constructive engagement concerning local tariff modifications.
10. Condition C1 – The right of patients to make choices.
11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence
COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICT Response: Yes** **Comment: None**	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICT Response: Yes** **Comment: None**	Marcus Thorman. Director of Finance.
Q3. Condition G7 Registration with the Care Quality Commission. **ICT Response: Yes** **Comment: None**	Cheryl Plumridge Director of Governance.
Q4. Condition G8 Patient eligibility and selection criteria. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q6. Condition P2 Provision of information. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q7. Condition P3 Assurance report on submissions to Monitor. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q8. Condition P4 Compliance with the National Tariff. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q10. Condition C1 The right of patients to make choices. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.

Q12. Condition IC1 Provision of integrated care. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: February 2014, Submitted 28/03/2014.

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.
In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (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.* **ICT Response: Yes** **Comment: None**	Chris Harrison, Medical Director.
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance & Assurance.
Q3. *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.* **ICT Response: Yes** **Comment: None**	Chris Harrison, Medical director.
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICT Response: Yes** **Comment:** The Trust remains a going concern as defined by the most up to date accounting standards.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework 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.* **ICT Response: Yes** **Comment:** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation.	Cheryl Plumridge, Director of Governance and Assurance.
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.* **ICT Response: Yes** **Comment:** The Annual Governance Statement identifies significant issues for the coming year.	Cheryl Plumridge, Director of Governance and Assurance.
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.

Q9. *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)* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **ICT Response: Yes** **Comment:** **MRSA BSI** In February no cases of MRSA BSI occurred, however one of the cases that was in arbitration from January 2014 has now been allocated to the Trust. The total number of 'cases' reported against the Trust is eleven year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced this year. **C.diff** The Trust is now within trajectory for *C.difficile*. For 2013/14, the annual ceiling for the Trust is 65 cases of *C.difficile* infection. In February there were no Trust attributable cases.Year to date 51 Trust attributable cases have been reported to the PHE, the Trust remains on trajectory for year end. **Cancer** Any pathway that breaches this standard is personally reviewed by the Chief of Service to ensure that there was no harm to any patient due to any delays. The Trust has a robust process in place to track urgent suspected cancer referrals. Referrals are received to a central team and are immediately entered onto the tracking system, as are diagnosed patients not referred via the urgent two week referral route, to ensure that patients are seen within the two week, 31 day and 62 day standards. We now have a level of confidence regarding an underlying positive trend regarding the 62 day standard as we see our historic backlog reducing.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICT Response: Yes** **Comment:** The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
Q12. *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.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q13. *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.* **ICT Response: Yes** **Comment:** A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICT Response: Yes** **Comment:** A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan. A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.	Jayne Mee, Director of People and Organisational Development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: March 2014 Submitted 30/04/2014

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. Condition G5 - Having regard to monitor guidance.
3. Condition G7 – Registration with the Care Quality Commission.
4. Condition G8 – Patient eligibility and selection criteria.
5. Condition P1 – Recording of information.
6. Condition P2 – Provision of information.
7. Condition P3 – Assurance report on submissions to Monitor.
8. Condition P4 – Compliance with the National Tariff.
9. Condition P5 – Constructive engagement concerning local tariff modifications.
10. Condition C1 – The right of patients to make choices.
11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence
COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICT Response: Yes** **Comment: None**	Jayne Mee, Director of People and Organisational Development.
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Q10. *In 2013/14 the annual ceiling for the Trust was 65 cases of C.difficile infection. In March there were 7 Trust attributable cases. During the year, there were a total of 58 Trust attributable cases reported to PHE.* *The total number of MRSA 'cases' reported against the Trust in 2013/14 was thirteen, four of these represent cases re-allocated to the Trust through the review process introduced in April 2013.* *In February 2014 the Open Exeter published data indicated that the Trust passed all 8 Cancer Waiting Times standards. Most significantly this included the 62-day 1st treatment (after GP referral) standard, which the Trust achieved for the first time in 11 months.* *In March 2014, the Trust met two out of the three RTT aggregate standards. Out of 3,218 patients treated in March on an admitted pathway, 88.8% were treated in 18 weeks against a 90% threshold. The Trust has been working to clear a build-up of patients waiting more than 18 weeks for treatment and for the first time in March for eight months saw a reduction in the backlog so this caused a higher number than usual of patients to be treated over 18 weeks. The backlog had built up due to a number of issues including reduction in theatre capacity (both unscheduled and scheduled downtime), a focus on cancer backlog reduction having an impact on non-urgent elective work and theatre staffing issues at Charing Cross and the Trust has recently received a high volume of referrals already late in their pathway from community triage clinics. There was also a high number of cancellations of inpatient procedures within the month of March due to pressures on bed and theatres. Trust has implemented a backlog reduction plan which is focussing on increasing the run rate to continue to reduce the backlog to enable the Trust to achieve all three standards at aggregate and at speciality level.*	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICT Response: Yes** **Comment:** The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
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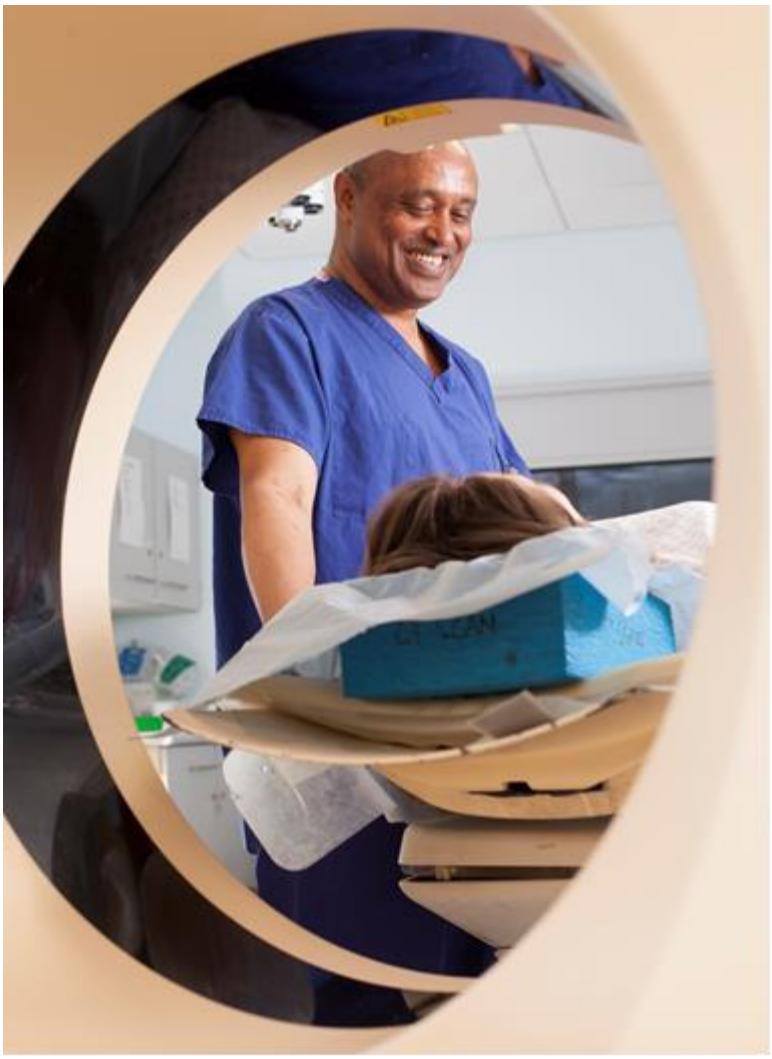
Draft Quality Accounts

2013-2014



If you need the document in a different format

This document is available in large print, audio, Braille and other languages on request. Please contact the communications team on 020 8383 3860 or email: quality.accounts@imperial.nhs.uk**.**

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Este documento encontra-se também disponÍvel noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Dokument ten jest na życzenie udostępiany także w innych wersjach językowych, w dużym druku lub w formacie audio.

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Sipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madhe dhe në formë dëgjimore.

Contents

Part one: Statement on quality from the chief executive

Providing safe, high quality and patient centred care and treatment for all of our patients is our priority at Imperial College Healthcare NHS Trust and this responsibility sits with every staff member no matter where they are in the organisation.

Our focus and commitment to quality is enshrined in our Quality Strategy 2013-15 where we outline ambitious quality goals which the Trust aims to achieve by 2015. The Trust wide strategy ensures quality is at the forefront of everything we do.

We have reviewed how our organisation is structured and how we report on all of the six domains of quality – safety, effectiveness, patient centredness, equity, timeliness and efficiency.

Our commitment to quality was recognised by a number of significant achievements in 2013-14 including:

- being named in the top four hospital trusts in England for Summary Hospital-Level Mortality Indicator (SHMI) ratios and categorised as 'lower than expected' when compared with other trusts
- meeting all essential standards of quality and safety as assessed by the Care Quality Commission during unannounced and a themed dementia inspection on three of our five sites
- achieving an 'above average' engagement score, compared to other acute trusts around the country, of 3.74 for our people in the annual NHS staff survey.

It is important that our Quality Accounts are accurate and accessible. I can confirm that to the best of my knowledge the information included in this document has been subjected to all the appropriate scrutiny and validation checks to ensure the data is accurate.

I hope that this document is user-friendly and informative and I would like to thank everyone who contributed in its development, including members of the public, our people, Healthwatch, shadow members, local authorities and commissioner colleagues.

We have many challenges ahead including ensuring that every one of our patients has a first-rate experience whenever they use our services. I am sure that together with our partners we can meet these challenges and build Imperial College Healthcare NHS Trust into a truly integrated health provider worthy of foundation trust status.

If you would like to be involved in developing our Quality Accounts for 2014-15 please get in touch with the Trust by emailing: quality@imperial.nhs.uk

Trust board endorsement

I confirm that this Quality Account has been discussed at, and endorsed by the Trust Board. ***The final report is to be reviewed by the Trust Board in May. The Draft report has been reviewed by the Audit and Risk Committee, Management Board, the chief executive officer and chairman.***

Chief executive's signature

I declare that to the best of my knowledge the information contained in the Draft Quality Account is accurate.

Yours sincerely

Dr Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust

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A guide to the report's structure

The following report outlines targets the Trust board[1] have agreed for the coming year, 2014-15. It also summarises the Trust's performance and improvements against the quality priorities and objectives we set ourselves for 2013-14.

We have reported against the priorities, including explanations of where we have not met our targets and how we are addressing those issues.

We have worked with stakeholders and staff to establish our priorities for the year ahead and have detailed our new priorities under the headings: patient safety; clinical effectiveness; and patient experience. We have explained how we decided upon our priorities and how we will achieve and measure performance against them. We have included additional measures relevant to our Quality Improvement Goals as outlined in the Quality Strategy.

Finally, we have provided other information to review that is relevant to the overall quality performance of the Trust. We have published statements from Healthwatch, overview and scrutiny committees, Health and Wellbeing Boards, commissioners and external auditors, which were submitted in response to these Quality Accounts.

[1] The Trust board agreed targets for 2014-15 at its public meeting on 27 March 2014.

About the Trust

Imperial College Healthcare NHS Trust was formed in 2007 and is one of the largest trusts in the country. The Trust is comprised of Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye hospitals and seven renal satellite units offering haemodialysis throughout North-West London.

The Trust delivers world-leading clinical, acute hospital and integrated care services, treating patients at every stage of their lives – with over 55 specialist services for both children and adults.

As one of the largest Trusts in the country, in 2013-14 we had:

- 1,223,380 million patient contacts
- 192,168 inpatient cases
- 1,031,212 outpatient contacts
- an average of 85,934 outpatient appointments a month.

Our vision for the future and how we will achieve it

The Trust's vision statement places improving patient experience as the ultimate goal.

'To improve the health and wellbeing of all the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical services in order to transform the experience of patients.' **Quality Strategy 2013-15**

In delivering this vision we will always put our patients first – making high quality, safe and compassionate care our top priority.

Four strategic objectives are helping us to achieve our vision. These are:

1. to develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
2. to develop recognised programmes where the specialist services the Trust provides are among the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners
3. with our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities that the Trust serves
4. with our partners in the Academic Health Science Centre and leveraging the wider catchment population afforded by the Academic Health Science Network, innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Academic Health Science Centre

Together with Imperial College London, the Trust formed the UK's first academic health science centre (AHSC) in 2009. Imperial College London has a campus on each of our main sites and is closely integrated with all of our clinical specialties.

Imperial College Healthcare is one of eleven National Institute for Health Research (NIHR) Biomedical Research Centres. This designation is given to the most outstanding NHS and university research partnerships in the country; leaders in scientific translation and early adopters of new insight technologies, techniques and treatments for improving health.

The AHSC's work in delivering excellence in healthcare, research and education has been recognised through the confirmation of its AHSC status for a further five years from 1 April 2014.

The clinical sciences centre of the Medical Research Council (MRC) is based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

Our hospitals

There are five hospitals in the Trust. These are:

Charing Cross Hospital, Hammersmith

- Charing Cross is a general hospital, providing a range of adult clinical services. It hosts one of eight hyper acute stroke units in London and is a key site for teaching medical students from Imperial College London.

Hammersmith Hospital, Acton

- Hammersmith is a general hospital and home to the heart attack centre for North West London. It is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers.

Queen Charlotte's & Chelsea Hospital, Acton

- Queen Charlotte's & Chelsea Hospital provide maternity and women's and children's services. The hospital has extensive high-risk services and cares for women with complicated pregnancies. It also has a midwife-led birth centre for women with routine pregnancies who would like a natural childbirth experience.

St Mary's Hospital, Paddington

- St Mary's is a general acute hospital that diagnoses and treats a range of adult and paediatric conditions. The hospital also provides maternity services and hosts one of four major trauma centres.

Western Eye Hospital, Marylebone

- Western Eye is dedicated to ophthalmology. It offers the only 24-hour emergency eye care service in west London.

In addition to the main hospital sites, we have seven renal satellite units offering haemodialysis throughout North-West London. These are located at:

- Ealing
- Watford
- Brent
- Northwick Park
- West Middlesex
- Hayes
- St Charles & Hammersmith

The way we provide services

During 2013-14, our clinical services were initially organised into six clinical programme groups (CPGs), with each containing a range of specialist services. In August 2013, we restructured our organisation into four divisions – medicine, surgery and cancer services, women's and children's and investigative sciences and clinical support (appendix two). Each division has its own management board responsible for the service, led by a medical and nursing director. More information about our divisions is available on our website: www.imperial.nhs.uk/aboutus

In 2013-14 the majority of our services were commissioned on behalf of our local population by Ealing Clinical Commissioning Group (CCG), Hammersmith and Fulham CCG, Kensington and Chelsea CCG, and Westminster CCG. We also provide highly specialist care that is not available in all acute hospitals, and these services are commissioned to provide patient care in other parts of London and in some cases nationally.

Quality Strategy

In November 2013, the Trust launched a three-year Quality Strategy, which outlines the quality goals the Trust aims to achieve by 2015. It explains the approach to driving improvements including governance processes and how these are set by the vision of safe, high-quality, patient-centred services for patients. You can view a copy of the Quality Strategy on our website: http://source/prdcont/groups/intranet/@corporate/@communications/documents/websiteasset/id_042162.pdf

> 'Delivering our Quality Strategy is a shared responsibility in which every member of the Imperial team has a vital role to play.' **Quality Strategy 2013-15**

The Trust's approach to improving quality is based on Professor Donald Berwick's six principles for improvement. Professor Berwick was commissioned to review the changes needed in the NHS following the Mid-Staffordshire Inquiry.

The six principles are:

1. safety: our patients will be as safe in our hospitals as they are in their own homes
2. effectiveness: our people will minimise the use of ineffective care and maximise the use of evidence based care
3. patient centredness: our people will respect the individual patient and their choices, culture and specific needs

4. timeliness: we will strive to continually reduce waiting times and delays for patients and our people
5. efficiency: we will strive to continually reduce waste and thereby cost of care; (this included supplies, equipment, space, capital, ideas and human spirit)
6. equity: we will seek to ensure that everyone we care for has the same high quality outcome, regardless of status.

Going forward, these Quality Accounts will be used to report against progress of the Quality Strategy, in addition to reporting against the Quality Accounts priorities. The goals and the priorities may differ slightly as the strategy is a three year plan and the Quality Accounts are reviewed each year through a process of engagement with our stakeholders and staff.

What are Quality Accounts and why are they important?

Quality Accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide. The Trust is committed to continuously improve the quality of the services we provide to patients and the Quality Accounts are a report of:

- our priorities for 2014-15
- how well we performed against the targets we were set by the Department of Health
- our local clinical commissioning groups (CCG's) and those we set ourselves
- how well we performed against similar healthcare providers (where possible)
- where we need to focus to improve the quality of the services we provide.

How we monitor and report on quality

The Quality Accounts delivery group aims to meet quarterly throughout the year to monitor progress on the indicators. A scorecard is produced so our divisions can monitor their performance and establish which indicators require further work. In 2013-14 the scorecard was reviewed by the quality committee and reported to the Trust board.

Assurance and compliance

The Trust board is accountable for the systems of assurance, internal control and risk management and regularly monitors and reviews these at both Trust board level and via its committees. The chief executive is ultimately responsible for ensuring the Trust delivers a high quality service for all patients and for the delivery of and compliance with assurance, quality and performance targets.

This responsibility is delegated to the medical director, director of nursing and director of governance and assurance for quality and governance, to the chief operating officer for operational performance and performance targets, and to the chief financial officer for financial targets.

Board engagement

The Trust board is actively engaged in reviewing the quality of our services. The chief executive and chairman take part in regular ward visits to meet staff and talk with patients. In addition, monthly leadership walk rounds assess the quality of our services and provide internal assurance that we are compliant with the essential standards of care. Throughout the year, teams consisting of executive directors, senior nurses, infection prevention and control, estates and facilities, maintenance, corporate services and operational managers visit all our sites to assess the environment and speak with staff and patients. Local and site action plans are developed and monitored as needed. Key themes and risks were reported through the

quality and safety committee to the Trust board. In 2014, the key themes will now be reported through the quality committee each quarter.

Our 'back to the floor Friday' initiative provides senior nurses, including the director of nursing, with protected time to work clinically and lead local audits. This has been an invaluable tool in driving the quality of care through senior nurse role modelling. The director of nursing has introduced 'back to the night' walk rounds. These are led by senior nurses including the director of nursing, to focus on 'out of hours' care ensuring that we provide a safe, high quality service at all times.

Trust board reports

The Trust board gains assurance on quality through a number of reports including:

- the monthly key performance indicators (dashboard) report
- quarterly quality and safety reports such as the quality account indicators and regulatory assurance including compliance with external regulators
- patient experience/patient feedback
- board visits to wards
- patient complaints.

Quality actions for 2014-15

- A safety and quality improvement network will be set up across the Trust and its learning priorities set to drive the quality goals.
- The use of global comparator networks will be introduced in all appropriate areas.
- Updated incident and effectiveness systems will be fully rolled out across the Trust.
- Targets for improvement in QG15 (Quality Goals 2015) will be set to directorate level and variation tracked from ward to board.
- The meeting structures for quality will be embedded and their effectiveness reviewed on an annual basis.

Part two: Our priorities for quality improvement in 2014-15

We want to demonstrate our commitment to quality and to show where we intend to focus our efforts next year. We have agreed with our stakeholders to 'roll-over' some of last year's priorities as many of our priorities are significant areas of work that are continuous and require time to implement successfully.

We have agreed/selected areas under the three quality themes as defined in the Quality Accounts framework. These are:

1. patient safety: having the right systems and staff in place to minimise the risk of harm to our patients and, if things go wrong, to be open and learn from our mistakes
2. clinical effectiveness: providing the highest quality care, with world class outcomes, whilst being efficient and cost effective
3. patient experience: meeting our patients' emotional as well as physical needs.

In addition to the areas we have chosen this year, there are those that our stakeholders have told us are important. Where appropriate, we have aligned our priorities with our 2014-15 Commissioning for Quality and Innovation (CQUIN) targets – a range of locally and national quality priorities chosen by our commissioners and the Department of Health.

How we decide on our priorities

Our priorities are developed in consultation with members of the public, our patients, shadow foundation trust members, HealthWatch, local authority overview and scrutiny committees, commissioners and clinical and management staff across each of the Trust's service delivery areas.

Based on feedback received during this engagement process, the Trust board have considered the proposals and agreed the priorities for 2014-15, which are set out in the section below.

We have made every attempt to write our Quality Accounts in a way that is accessible to patients, the public and our staff. If you are interested in being involved in the development of our Quality Accounts in the future please contact the Quality Accounts team by email: quality@imperial.nhs.uk

In addition to these priorities, we will report our performance against the Quality Strategy goals.

Summary of Priorities for 2014-15

The tables below summarise our priorities and objectives for 2014-15, reflecting our Quality Strategy goals. Please refer to the glossary for an explanation of all clinical terms.

Priorities for 2014-15

Patient safety

Quality Strategy goal: safety

Safety in clinical practice is our most significant goal; all patients will be as safe in our hospitals as they are in their own homes and outcomes will be as good as anywhere in the world. Our patient safety measures below reflect two of the key outcomes for this goal, as identified below.

Our quality priority	What will success look like
To achieve year on year reductions in infection prevention and control. We have chosen this priority to support our Quality Strategy goal. .**C.difficile* is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will achieve the *Clostridium difficile* (*C.difficile*) Department of Health (DH) target of less than **65** cases in the Trust during 2014-15. We will aim to achieve the MRSA blood stream infections (BSI's) national directive to have a **zero** tolerance for all healthcare associated MRSA Blood Stream infections (BSI's) across the NHS. We will be **90 per cent** compliant with the Trust anti-infective prescribing as measured by: • a reason for starting the antibiotic clearly documented within the patients' medical notes/drug chart • a stop/review date on the drug chart to optimise duration of therapy • antibiotics are prescribed in line with the Trust antibiotic policy or approved by specialists from within our infection teams.
To increase incident reporting rates and reduce their reported harm to meet NRLS peer target. We have chosen this priority to support our Quality Strategy goal. *Patient Safety incident reporting are a mandated indicator in the DH reporting arrangement for the Quality Accounts.	We will **meet** the NRLS (National Reporting and Learning System) **peer target** for patient safety reporting rates per 100 admissions. To be **below the peer target** for incidents graded as extreme (death). To be **below the peer target** for incidents graded as major (severe). To have a **zero** tolerance for 'never events'.

To continuously improve Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital-level Mortality Indicators (SHMI) ratios and reduce variation across the week days. We have chosen this priority to support our Quality Strategy goal. *SHMI are a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will be **better than the national average** for mortality rates as measured by SHMI and HSMR.
To ensure high performance against the NHS Safety Thermometer. We will deliver 95 per cent harm free care to our patients by reducing the number of falls, pressure ulcers and catheter related infections, as evidenced by the NHS Safety Thermometer. This allows frontline teams to measure how safe their services are and to deliver improvements locally.	Falls to **remain below the national average** for falls with harm. Pressure ulcers to reduce the total number of all grades pressure ulcers. The current **CQUIN target is awaiting confirmation.** Venous thromboembolism to **reduce avoidable harm** of patients acquiring a VTE through risk assessment and appropriate treatment. We are awaiting confirmation of this target. Urinary catheter related infections to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts.
We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed.	We will achieve our CQUIN target of **90 per cent** compliance with the three key measures: Element A: **F**ind; identify patients aged 75 and over and ask case-finding question Element B: **A**ssess and **I**nvestigate; Element C: **R**efer; ask GP to refer on for specialist memory service assessment.

Clinical effectiveness

Quality Strategy goal: effectiveness
Our objective is that systems must match care to science, avoiding overuse of ineffective care and underuse of effective care. The Quality Accounts has two mandated indicators that measure clinical effectiveness indicators that we have included in this section.

Our quality priority	What will success look like
To reduce the number of emergency readmissions to hospital within 28 days of discharge. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To reduce the number of readmissions to hospital within 28 days of discharge for patients under the age of 14 years. To reduce the number of readmissions to hospital within 28 days of discharge for patients 15 years and over. **To be below the national average** for this indicator for both categories.
Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and provide valuable information on the outcome of the surgery for our patients. To ensure the data is reflective of our patient groups, we need to increase our participation rates. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To **increase our participation rates to above 80 per cent** for all PROMs (groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery).

Patient experience

Quality Strategy goal: patient centredness
Our goal is that our people will respect the individual patient and their choices, culture and specific needs. For the Trust, a key component of this goal is to improve the reported experience of our patients when compared nationally.

Our quality priority	What will success look like
We aim to provide the highest quality of healthcare. We will ask patients in adult inpatient and A&E departments the Friends and Family Test (FFT): 'How likely are you to recommend our ward/A&E department to friends/family if they	We will meet our CQUIN targets of: **Inpatient** Quarter 1= 25 per cent response rate Quarter 4 = 30 per cent response rate with month 12 (March 2015) having a 40 per cent response rate

needed similar treatment or care?' We have chosen this priority to support one of our Quality Strategy goals. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	**A&E** Quarter 1= 15 per cent response rate Quarter 4 = 20 per cent response rate. In addition to monitoring our response rates, we will include feedback on our scores over the year.
We aim to provide the highest quality of healthcare. We will ask patients in our outpatients departments (OPD): 'How likely are you to recommend our OPD to friends/family if they needed similar treatment or care?' We have chosen this priority to support one of our Quality Strategy goals.	We will **complete** the implementation of the FFT question for all outpatient areas by **October 2014**.
To improve the reported experiences of our patients including responsiveness to the personal needs of our patients. We have chosen this priority to support one of our Quality Strategy goals. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To **improve on our 2013 scores** in the National Patient Survey and National Cancer Survey. To **improve on last year's score** in relation to responsiveness to patient needs.
We recognise that by listening to our people (staff) and by improving our staff experience, we will make a positive difference to our patients' experience. We have chosen this priority to support one of our Quality Strategy goals. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will **remain above average of 60 per cent** of staff who would recommend the Trust to friends/family needing care as measured through the annual National Staff survey and we will implement the staff FFT test in line with national guidance by June 2014.
We will nurse our patients in single sex accommodation as defined by the DH and our Trust policy.	We will have a **zero tolerance** of breaches of mixed sex accommodation as defined by the Trust policy.

Progress against these priorities will be monitored through the Quality Accounts delivery group. In line with the recent organisational changes the Trust is currently reviewing the reporting arrangements of this group.

2.1 Statement of assurance from the board

This section contains statutory statements concerning the quality of services provided by Imperial College Healthcare NHS Trust. These are common to all trust Quality Accounts and can be used to compare us with other organisations.

2.2 A review of our services

During the reporting period 2013-14 Imperial College Healthcare NHS Trust provided and/or sub-contracted 75 NHS services.

The Trust has reviewed all the data available to them on the quality of care in all of these NHS services through its performance management framework and its assurance processes.

The income generated by the NHS services reviewed in 2013-14 represents 76 per cent of the total income generated from the provision of NHS services by the Trust for 2013-14.

2.3 Participation in clinical audits and National Confidential Enquiries

Clinical Audit drives improvement through a cycle of service review against recognised standards, implementing change as required and re-review. The Trust uses audit to benchmark our care against local and national guidelines so we can put resource into any areas requiring improvement, part of our commitment to ensure best treatment and care for our patients.

National Confidential Enquiries investigate an area of healthcare and recommend ways to improve it.

During 2013/14, the NHS services that the Trust provides were covered by 40 national clinical audits and four national confidential enquiries.

During that period the Trust participated in 100 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries that we were eligible to participate in.

The following table covers:

- The **active** national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible for and participated in during 2013/14.
- **Where data collection was completed during 2013/14**, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100 / 742
Adult Cardiac Surgery	Yes	Yes	100 / 749
Adult Critical Care (ICNARC CMP)	Yes	Yes	100 / 565
Adult Diabetes National Audit	Yes	Yes	100 / 6815
Blood Transfusion Management of Patients in Neuro Critical Care Units (NHSBT)	Yes	Yes	100 / 8
Blood Transfusion Patient Information and Consent (NHSBT)	Yes	Yes	37.5 / 24
Blood Transfusion Use of Anti-D (NHSBT)	Yes	Yes	100 / 51
Bowel Cancer (NBOCAP)	Yes	Yes	Data collection ongoing, closes 1st October 2014
Cardiac Arrest (NCAA)	Yes	Yes	100 / 373 (2012/13 last data-complete year available)
Cardiac Arrhythmia (Heart Rhythm Management)	Yes	Yes	100 / 1277
COPD	Yes	Yes	Data collection ongoing, closes 31st May 2014
Congenital Heart Disease (Paediatric Cardiac Surgery) (CHD)	Yes	Yes	100 / 54 (2012/13 data, which has a submission deadline of 12th April 2014)
Coronary Angioplasty (aka Cardiac Interventions)	Yes	Yes	98.8 / 1361 (January 2013 to December 2013)
Diabetes Inpatient Audit (NADIA)	Yes	Yes	100 / 193
Elective Surgery (PROMS)	Yes	Yes	100/675 (January 2013 to December 2013)
Emergency Use of Oxygen	Yes	Yes	100 / 173
Epilepsy 12	Yes	Yes	Data collection ongoing, closes 23rd May 2014
Falls and Fragility Fractures (FFFAP – incorporating National Hip Fracture Database)	Yes	Yes	100/310
Head and Neck Oncology (DAHNO)	Yes	Yes	100 / 180
Heart Failure (HF)	Yes	Yes	83.6 / 584
Inflammatory Bowel Disease	Yes	Yes	100 / 54

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
(IBD)			
Lung Cancer (NLCA)	Yes	Yes	100 / 240 (January 2013 to December 2013)
Moderate or Severe Asthma in Children	Yes	Yes	SMH – 100 / 50 CXH – N/A
National Audit of Seizure Management (NASH)	Yes	Yes	100 / 30
National Emergency Laparotomy (NELA)	Yes	Yes	100 / 29
National Joint Registry (NJR)	Yes	Yes	100/552 (January 2013 to December 2013)
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100 / 94
National Pulmonary Hypertension Audit	Yes	Yes	100 / 1006
National Vascular Registry (NVR)	Yes	Yes	100 / 231
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	SMH – 100 / 299 QCCH – 100 / 467 (January 2013 to December 2013)
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100 / 126
Paediatric Asthma	Yes	Yes	100 / 22
Paediatric Bronchiectasis	Yes	Yes	NO ELIGIBLE CASES
Paediatric Intensive Care (PICANet)	Yes	Yes	100 / 339 (January 2013 to December 2013)
Paracetemol Overdose in Emergency Departments	Yes	Yes	SMH – 100 / 50 CXH – 100 / 50
Renal Replacement Therapy (Renal Registry)	Yes	Yes	Prevalent: 100 / 3219 Incident: 100 / 343
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Data collection ongoing,
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100 / 1818
Severe sepsis and septic shock	Yes	Yes	SMH – 100 / 50 CXH – 100 / 50
Trauma Audit & Research Network (TARN)	Yes	Yes	100 / 1027
CONFIDENTIAL ENQUIRY – Child Health (CHR-UK)	Yes	Yes	NO ELIGIBLE CASES
CONFIDENTIAL ENQUIRY – Maternal, Infant and Newborn Programme (MBRRACE-UK)	Yes	Yes	100 / 102 (January 2013 to December 2013)

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
CONFIDENTIAL ENQUIRY – NCEPOD Lower Limb Amputation	Yes	Yes	93 / 14 for Clinical care 93 / 14 for case notes 100 / 3 for Organisational forms
CONFIDENTIAL ENQUIRY – NCEPOD Tracheostomy	Yes	Yes	75 / 56 for Insertion 93 / 56 for Critical Care 79 / 56 for Ward Care 100 / 6 for case notes 100 / 3 for Organisational forms

The reports of **39** national clinical audits were recorded as being reviewed by the provider in 2013/14. The Trust continues to follow up the reports from all relevant national audits to identify how we make improvements. The reports were as follows:

National clinical audit
National Paediatrics Diabetes Audit (NPDA)
Adult Asthma BTS
NCEPOD Alcohol Related Liver Disease
NCEPOD Sub-Arachnoid Haemorrhage
Adult Community Acquired Pneumonia BTS
Paediatric Asthma BTS
Paediatric Pneumonia BTS
Child Health Reviews UK (Child Health Programme)
National Lung Cancer Audit
Potential Donor Audit (NHS Blood and Transplant)
Chronic Pain (National Pain Audit)
Pulmonary Hypertension Audit
Blood Transfusion (Blood Sampling & Labelling) NHSBT
Head and Neck Oncology (DAHNO)
Hip Fracture Database
National Joint Registry (NJR)
UK IBD Audit - 4th Round
National Diabetes Audit Adult Patients (NHS Information Centre)
Sentinel Stroke National Audit Programme (SSNAP)
Renal Colic
Fracture Neck of Femur
Emergency Use of Oxygen
National Diabetes Inpatient Audit
Fever in Children
Non-invasive Ventilation in Adults
Chronic Heart Failure Audit
Cardiac Arrhythmia - Heart Rhythm Management (HR-UK)
Acute MI & other ACS - Cardiac Ambulance Services (MINAP)

National clinical audit
PICANet
National Neonatal Audit Programme - NNAP
Coronary Angioplasty Adult Cardiac Interventions Audit
NVD for AAA procedures
Carotid Interventions Audit - Endarterectomy (UKCEA)
Renal Transplantation - NHSBT UK Transplant Registry
Renal Replacement Therapy - Renal Registry
National Audit of Dementia
Bowel Cancer (NBOCAP)
National Audit of Seizure Management (NASH)
Heavy Menstrual Bleeding

Many of these audits demonstrated effective care, with no actions being required. The Trust intends to take the actions listed to improve the quality of healthcare provided.

National Clinical Audit	Description of actions
Adult Asthma BTS	Ensure CXH and SMH Emergency Departments are giving systemic steroids if appropriate within 1 hour
	Ensure post-bronchodilator PEFR is recorded in CXH and HH Emergency Departments
	Ensure smoking status is documented (HH)
	Ensure documentation of arrangement of follow up in Respiratory OPC at SMH
NCEPOD Alcohol Related Liver Disease	All relevant recommendations of the published NCEPOD report have been implemented.
NCEPOD Sub-Arachnoid Haemorrhage	All relevant recommendations of the published NCEPOD report have been implemented.
Paediatric Asthma BTS	Carry out an audit of all wheezy children presenting to A&E, including those who are not admitted,
	Create a modified discharge checklist to be used for patients discharged from the ward and from A&E including mandatory device technique assessment and clear advice for follow up.
	To present current audit at general paediatrics audit meeting and use this as a forum to discuss overuse of chest x-rays and antibiotic prescribing.
	To put together a case for an asthma nurse once the A&E asthma audit is complete.
	Perform an audit 6 months after the introduction of improved discharge planning arrangements to assess whether this has led to a change in practice.
	Review A&E symphony notes of patients with non-documented observations and clarify the situation - arrange to meet with A&E consultants to discuss if appropriate.
Pulmonary Hypertension Audit	Local audit of first line treatment of pulmonary hypertension with sildenafil
Blood Transfusion	Collector must label by the patient side taking patient

National Clinical Audit	Description of actions
(Blood Sampling & Labelling) NHSBT	information from the wristband.
	Competency assessment of correct sample collection procedure for all staff members who collect samples.
Hip Fracture Database	Circulation of robust weekly performance data to all key stakeholders in the pathway.
	Quarterly presentation at Clinical Governance Meetings to raise awareness of position to department.
	Escalation process to theatre teams if they require additional emergency capacity.
	To hold meeting at SMH site with attendance of key stakeholders to review and agree any remedial actions.
NVD for AAA procedures	Coding issues need to be closely examined and a structure is now in place to ensure correct procedure recording and coding.
Renal Replacement Therapy - Renal Registry	Explore funding/business case options for a dedicated Renal Unit Data Manager
National Audit of Dementia	Trust Policy for Dementia
	Care pathway for dementia to include acute admission and end of life care - currently in progress
	Protocol for the management of behavioural and psychological symptoms of dementia
	Development of a comprehensive dementia awareness training programme for all health and allied health professionals employed by the Trust

The reports of **72** completed local clinical audits were reviewed by the provider in 2013/14 (out of **284** local clinical audits registered in 2013/14 or carried over from 2012/13) and the Trust records all recommendations which it intends to implement to improve the quality of healthcare provided. By the end of 2013/14, **40** of the **72** completed local clinical audits had recommendations which had been recorded as being implemented, with a total of **68** implemented recommendations. It should be noted that much of the planned implementation of recommendations for local clinical audits completed in 2013/14 will be on-going into 2014/15.

Local Clinical Audit	Implemented actions
Reviewing the accuracy of assembling discharge medications and patient information given on discharge at ward level 2012/13	Education and training for nursing staff specifically related to labelling requirements, and the importance of communicating changes to medicines on discharge
Cone biopsies showing CIN1 or less after High	Should discuss these patients at MDT if in Reproductive age group

Local Clinical Audit	Implemented actions
Grade cervical punch biopsy 2012/13	
Review of the pre-assessment patient pathway within the Imperial Surgical Innovation Centre 2012/13	patient pathway to be reviewed to make the process clearer for both staff and patients supported by a patient informaton leaflet
	patients to be discussed at the MDT prior to being added to the waiting list for surgery
Written discharge communication from Acute Stroke Inpatient Service	Ensure consistent agreement with and implementation of Stroke Discharge Summary Template, to be used in conjunction with EDC software
	Re-audit following implementation of discharge summary template across ICHT Stroke service
	Feedback of findings of full audit cycle and recommendations to senior clinicians
	Training of staff involved in discharge summary writing and reviewing
	Review of recording of key items in medical notes (e.g. NIHSS on discharge, cognitive and psychological assessments)
Trust Consent Form Audit 2012/13 - Re-audit	Encouragement of thorough completion of Form 4
	The importance of thorough documentation of the consent process, using the appropriate consent form, needs reinforcing through education.
	Raise awareness of the findings of the Consent Audit
Vitamin D supplementation in babies and mothers in Prolonged Neonatal Jaundice Clinic	Compulsory follow up of vitamin D supplementation in deficient babies by current doctors/nurses
	Specific medications and their dose on the discharge letter to parents and GP
Acute oncology service activity	development of a spinal MDT to track AOS patients
Management of pleural effusions	A Pi bundle should be created and placed on the source, to ensure guidelines are followed – including identifying who, where, when and how chest drains should be put in.
	A chest drain “bundle” should be created and placed on the source, to ensure guidelines are followed – including identifying who, where, when and how chest drains should be put in.
Safety and monitoring around blood transfusion	Improved documentation of end time of transfusion
EDC to GP Audit	Disseminate results to CQUIN GP information in real time group, and relevant groups who can work on improving the system

Local Clinical Audit	Implemented actions
	Review systems and processes for distributing EDCs - ongoing
	Raise GP awareness of how they can access EDCs - ongoing
	Share results with ICP
Recurrence following piecemeal resection of large polyps (re-audit)	Satisfactory results, recommend continue current practice
Withdrawal time for negative colonoscopies for colonsocopists	Colonoscopists should aim for withdrawal time of 10 minutes
Colonoscopy completion, photographic evidence, adenoma/cancer detection, polyp retrieval	Cover for vacant lists to be offered to Colonoscopist C in first instance.
	Colonoscopist C's list to be filled with patients prior to filling list of other screening colonoscopist.
Management of jaundice on Neonatal Unit & Postnatal Ward (2013/14)	Education of staff re updated local guideline
Data accuracy on BCSS (re-audit)	Improve communication practice between screening practitioners and consultants
HASU to SU transfer of patients	Develop transfer proforma for movement of stroke patients from HASU to SU (Grafton Ward)
	Distribute proforma to local HASUs
Dementia assessment in patients admitted under Acute Medicine at CXH (re-audit)	Teaching for junior doctors rotating through Acute Medicine (3-4 monthly basis) - ongoing
Nurse led Nipple Areola micropigmentation service - Audit	service to be expanded over the next 6 months to allow for 3-4 patients per clinic as appose to 2 patients
Swab counting techniques in the operating theatre (Reaudit)	To ask the senior surgeons to remind their colleagues (especially new junior colleagues) about pause for the gauze.
Colonoscopy Complications	SSP's to ensure that adverse events on BCSS have a corresponding entry on AVI log
Bowel Preparation Recorded for Each Colonoscopi Procedure	Satisfactory results. Recommend continue current practice.
Prescription of Long Term Anti TNF Medication in Gastroenterology and Dermatology	Satisfactory results, recommend continue current practice
Repatriation Documentation from HASU	Agreed criteria for stability of transfer of patient with MEWS incorporated into criteria and documented prior to transfer

Local Clinical Audit	Implemented actions
to SMH SU	
	Feedback to HASUs on advanced planning of patient transfer to SU to ensure in hours transfer
Prescribing in Hammersmith EU	Prescribing doctors to be taught about the Trust prescription guidelines and importance of accurate written communication
Anti-DsDNA antibodies in patients with SLE 2013/14	To stop measuring anti-ds-DNA antibodies by Luminex (Retrospective Study)
Trust Documentation Audit 2013/14 - Re-audit	Findings to be shared within the relevant Divisions via the Divisional Governance Leads, who will present to their Divisions and develop and deliver their own local actions.
Trust Consent Form Audit 2013/14 - Re-audit	Share report with Tissue Guardian, Patient Information Leads and Medical Education Leads
	Raise report at Guidelines & Clinical Effectiveness Monitoring Group
Clinical indications for CTPA requests	Improved training for EU doctors
	New request system
Longitudinal audit of turnaround times for core Chemical Pathology / Haematology tests from A&E	Satisfactory results - continue current practice
Urea and Electrolytes That Require a Change in Preparation	Satisfactory results. Recommend continue current practice.
8 Day Re-admission (April 2012 - March 2013)	Satisfactory results, recommend continue current practice
30 Day Mortality	Satisfactory results, recommend continue current practice
Gastric Ulcer Endoscopy Follow-up	Follow up OGDs must be recorded accurately on Scorpio
	Endoscopists to be reminded of the endoscopic criteria for gastric ulcers and their responsibility for ensuring OGD follow up within 12 weeks where appropriate
	OGD to be offered to patients identified as having no follow up performed
Random Colonic Biopsies in Patients with Persistent Diarrhoea Attending for Colonoscopy	Endoscopists to ensure they taken random biopsies from patients with unexplained persistent diarrhoea and that they accurately detail the clinical indications in the endoscopy report and indications box.
	Endoscopists to ensure they record when they take biopsies in the 'findings' section of the colonoscopy report so it can be audited.
OGD Completion Rates	Disseminate audit results to all endoscopy users
Assessment of Out of Hospital Falls in the Elderly During Medical	Teaching to acute medical team of use of falls bundle and referral to falls clinic

Local Clinical Audit	Implemented actions
Admissions	
	Discussion with ED clinical leads and orthogeriatrics to extend scope of bundle to other clinical areas
	Design of new falls bundle
	Falls screening questions added to acute medical clerking proforma
	Teaching new acute medical team for ongoing use of falls bundle
Comfort Score (re-audit)	Satisfactory results, recommend continue with current practice.
Referral to orthoptic services from SMH stroke unit	Document where patients are not appropriate for referral.
	Refer pts who have diplopia, hemianopia or other visual issues as long as they can sit in a chair and can communicate and follow commands
	Perform full visual assessment inc visual fields, eye movement and acuity for all new patients on admission and 2 weeks later
Colonoscopy completion rate	Colonoscopist's lists to be filled with patients prior to filling lists of other operators
	Cover for vacant lists to be allocated to colonoscopist who did not perform the required number of procedures
	Lead colonoscopist to discuss low ADR with operator to determine reasons for fall in ADR. This will be monitored in next audit in 6 months time
Withdrawal Time for Colonoscopies	Colonoscopists to aim for withdrawal time of 10 minutes as may increase ADR

2.4 Participation in clinical research

We are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into diagnostic methods and treatments across a broad spectrum of specialities, and for some of the most complex illnesses, with benefits for patients everywhere. Our clinical staff keep abreast of the latest possible treatments – active participation in research leads to more successful patient outcomes.

The Trust has continued to make significant scientific advances in 2013-14 and to attract further new investment to support clinical research and development (R&D). The Trust's research strategy is integrated with that of Imperial College London – together we constitute the Imperial academic health science centre (AHSC), a designation we successfully renewed in 2013 for a further five years (one of only six AHSCs in the country).

We are also part of Imperial College Health Partners (ICHP), a network which brings together academic and health science communities across North West London (NWL). As the designated academic health science network for NWL, ICHP aims to deliver demonstrable

improvements in health and wealth for the region and beyond, through collaboration and innovation.

During 2013-14, a total of 306 new studies were approved within the Trust, of which 76 were sponsored by commercial organisations. The number of patients receiving NHS services provided or sub-contracted by the Trust in 2013-14 that were recruited during that period to participate in research approved by a research ethics committee was 19,179 – representing more than 600 active research projects.

The National Institute for Health Research (NIHR)
Within the specific context of the NIHR Portfolio, more than 12,000 patients were recruited into 329 portfolio studies in 2013-14, an increase of over 12 per cent from 2012-13. This included 500 patients within 62 studies sponsored by commercial clinical R&D organisations (a 50 per cent increase from 2012-13).

The Trust hosts the largest of the 11 NIHR Biomedical Research Centres (BRCs) in the country. BRCs are awarded to the most outstanding NHS and university research partnerships – leaders in scientific translation and in the early adoption of new insights in technologies, techniques and treatments for improving health. In 2013-14, the NIHR Imperial BRC continued to develop a wide range of novel devices, diagnostics, and new therapeutic advances across 15 research themes. Its portfolio of projects was underpinned by state-of-the-art facilities for gene sequencing, imaging, metabolic analysis, and biobanking. In the last year our BRC supported clinical academics published over 450 peer-reviewed articles.

The Trust is playing an active role with other major NIHR BRCs in establishing the NIHR BioResource – a national database of consented and genotyped healthy volunteers. It will provide the basis for testing the next generation of personalised medicines.

The Imperial BRC is also involved in a collaborative initiative to explore the possibility of integrating and sharing electronic patient data, together with genotypic and phenotypic information derived from clinical studies, in order to demonstrate benefits for particular patient populations. The NIHR Health Informatics Collaborative (NHIC) joins Imperial with the BRCs at Cambridge, Oxford, UCLH and Guys & St Thomas' hospitals to link the collection of routine clinical data for research, in the five fields of cardiology, transplantation, cancer, liver disease and critical care.

The NIHR complimented the Imperial BRC on the patient and public involvement and engagement activities which took place within its research themes in 2012-13. Together with other research organisations, it intends to build on this success by developing an integrated approach to patient and public involvement across NIHR programmes in NWL.

In September 2013, the Trust was selected to host the NIHR Clinical Research Network for NWL (NWL CRN) – one of only 15 in the country. The Trust will receive around £80 million to run the NWL CRN for five years. With other NHS providers in the region, the network will increase opportunities for patients to participate in clinical research, ensure studies are carried out efficiently, and support the Government's Strategy for UK Life Sciences by improving the environment for commercial contract clinical research in the NHS.

The Trust continued to attract further R&D investment from the NIHR in the form of a Diagnostic Evidence Collaborative (DEC) – one of only four in the country – which aims to catalyse the generation of evidence of clinical utility and cost-effectiveness of diagnostic medical devices. The Imperial DEC will focus on evaluating new point-of-care diagnostics which will bring diagnosis out of the laboratory and to the bedside.

The Imperial AHSC was also awarded four new NIHR Health Protection Research Units (HPRUs) – centres of excellence for studying particular priority areas in public health. The Imperial HPRUs will focus on respiratory infections, antimicrobial resistance, modelling outbreaks of infectious disease, and the health impact of environmental hazards (with King's College London). This is a considerable achievement, given that only 13 HPRUs were awarded nationally, and reflects the strong research base in infectious diseases across the Imperial AHSC.

2.5 Our CQUIN performance

CQUIN framework & data quality (goals agreed with commissioners)

Commissioners hold the NHS budget for their area and decide how to spend it on hospital and other health services. A proportion of the Trust's income in 2013-14 was conditional on achieving quality improvement and innovation goals agreed between Imperial College Healthcare NHS Trust and any person or body they into a contract or agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN).

TO BE UPDATED FOR THIS YEAR
In 2013-14, 2.5 per cent of our clinical income depended on achieving these goals. This equated to £xx of our income and we secured xx percent of this.

Further details of the agreed goals for 2013-14 can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131988 and details of last year's CQUINs can be found in the Trust board performance reports as part of the Trust board papers on our website.

2.6 Care Quality Commission (CQC) registration status

The Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions' at all of our sites.

The Care Quality Commission has not taken enforcement action against Imperial College Healthcare NHS Trust during 2013-14.

We are subject to periodic reviews by the Care Quality Commission and three sites have been inspected between April 2013 and March 2014. These were:

- St Mary's Hospital
- Western Eye Hospital
- Charing Cross Hospital.

The Trust was found to be fully compliant with the Essential Standards of Quality & Safety that were assessed. The reports of these inspections are available on the CQC website at www.cqc.org.uk/directory/ryj

2.7 Our data quality

The Trust continues to improve its data quality and has a robust governance structure for monitoring and improvement. Data quality indicators are reported to the Trust Board and Management Board and are also included within the Trust's monthly divisional performance scorecards to ensure data quality governance is aligned with the Trust's performance management framework.

An operational data quality group, which has representation from all service areas, looks in detail at a number of data quality indicators and monitors improvement. There are 44 priority data quality indicators in use across the Trust, which are available via a data quality dashboard tool.

Access to the dashboard is via the Trust's intranet site and is promoted regularly to staff through internal communications and training sessions.

NHS number and general medical practice code validity

The Trust submitted records during 2013-14 to the Secondary Users Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data to month eleven of 2013-14 (latest available) which included the patient's valid NHS number was:

- 97.3 per cent for admitted patient care
- 98.7 per cent for outpatient care
- 87.3 per cent for accident and emergency care.

The percentage of records in the published data to month 11 which included the patient's valid general medical practice code was:

- 100 per cent for admitted patient care
- 100 per cent for outpatient care
- 99.9 per cent for accident and emergency care.

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

- Continue to implement the Trust's NHS number strategy, including implementation of a new patient administration system with a real-time connection to the national patient demographic service, which can be used to search for patients' details.
- Assess the benefit of patient self check-in kiosks in outpatient areas, where patients have the opportunity to validate their demographic information.
- Continue to include data quality indicators in the Trust and divisional performance scorecards for review and performance management.

2.8 Review of data on quality of care

The Trust's performance against national priorities for 2013-14 is shown in appendix three. We have met our threshold targets for this year to date. In 2013-14, the Trust has

consistently delivered on the 18 week referral to treatment (RTT) standards and the six week diagnostic standard. This meant that over 90 per cent of patients having inpatient treatment, over 95 per cent of patients having an outpatient treated waited less than 18 weeks and over 92 per cent of patients waiting for treatment were under 18 weeks.

The Trust has achieved this by following best practice guidance on the management of 18 week pathways. This includes treating the longest waiting patients first, whilst prioritising urgent patients, such as those with cancer.

An online staff training programme on the RTT standards and rules has been developed and will be rolled out over 2014-15. This will be targeted at all new starters to the Trust and for those staff who need refresher training.

Internal and external audits on the quality of RTT data concluded that there was no evidence for concern and adequate data assurance was given. RTT will continue to be part of the annual audit cycle to ensure that the quality of our reported data remains high priority.

In 2013-14 the Trust also continued to meet the six week diagnostic test standard and has delivered this standard each month since June 2012.

The focus on cancer performance and the patients experience remains high on our agenda and the Trust has made great improvements in 2013-14. These include:

- establishing a cancer steering board in 2013 led by the chief operating officer and the deputy medical director, Dr Chris Harrison. Dr Harrison was previously medical director at The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe
- the cancer steering Board further strengthens the focus on the initiatives of the multi-disciplinary team (MDT). The MDT sits at the centre of improving cancer performance delivering success through improved team work
- with the guidance of Macmillan cancer support, launching a north west London initiative to link with partner trusts improving patients experience throughout London
- holding a continuing series of workshops held every 100 days bringing all staff working on cancer care together to share best practise and update on progress.

2.9 Information governance toolkit scoring

Good information governance means keeping the information we hold about our patients and staff safe.

The information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to Connecting for Health in order to assess compliance.

The Trust's information governance assessment report overall score for 2013-14 was 72 per cent and was graded 'satisfactory'.

This is comparable to last year although we have seen an improvement in performance training due to the development, implementation and delivery of new in-house on-line training that achieved a compliance rate of 98 per cent against the target of 95 per cent.

2.10 Clinical coding quality

The Trust was subject to the Payment by Results audit by the Audit Commission during 2013-14 and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were: (**Note: the final audit report is expected to be ready in late May 2014**, **however, an interim error report has been made available and the results are):**

Two areas were looked at in the 2013-14 clinical coding audit and 100 finished consultant episodes were audited in each area:

HRG Sub chapter SA (Haematological Procedures & Disorders), Short Stay Admissions in Gastroenterology and Cardiology.

Diagnoses and procedures coded correctly:

Primary diagnoses = 95%
Secondary diagnoses = 83%
HRG error rate = 10.3% (spell based)

Primary procedures = 90%
Secondary procedures = 75%

Attainment level two (with three being the highest) was reached for clinical coding quality under the national information governance assessment report in 2013-14.

Diagnoses and procedures coded correctly:

Primary diagnoses = 87%
Secondary diagnoses = 91%
HRG error rate = 14.5% (spell based)

Primary procedures = 90%
Secondary procedures = 90%

Part three: Progress against priorities for 2013-14

Of the fifteen targets we set ourselves in last year's Quality Accounts, we have fully achieved seven, partially achieved four, did not achieve one and did not report against one. A summary of our performance against the quality account priorities is in the tables below. Details of our progress against each of the priorities are discussed after the table.

Data is generally produced quarterly, presented as Q1, Q2, Q3 and Q4, and this will be represented in the smaller tables under each priority. We have added a RAG (red-amber-green) rating to the data to highlight if we have met our target or not; therefore the final column will be coloured. Where possible we have included national comparative data. The data is presented using different measurements; these are identified for each individual indicator.

Summary of Progress against Quality Account indicators for 2013-14 (details follow the table)

Patient safety			
Our quality indicator	**What success looks like**	**How did we do?**	**Page reference**
Reducing avoidable harm by ensuring patients are assessed for a risk of Venous Thromboembolism (VTE).	95 per cent of all inpatients having been assessed for a VTE within 24 hours of admission in accordance with the CQUIN target.	**We achieved this target throughout the year.**	**To be added when final**
To ensure high performance against the NHS Safety Thermometer.	Falls – to reduce low and minor harms falls (per 1,000 bed days) by 10 per cent. Pressure ulcers – to reduce the total number of grade 1 and 2 pressure ulcers (per 1,000 bed days) by a further 10 per cent Urinary catheter related infections – to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts.	**We met all of these targets throughout this year.**	**To be added when final**
To reduce healthcare associated infections.	*C. difficile* to achieve the DH target of less than 65 cases in the Trust during 2013-14. MRSA BSI's to meet the national directive to have a zero tolerance for all healthcare associated MRSA BSI's.	**We met the target over the year for *C.difficile*, with a total of 58 cases during the year.** **We have not met this target with 13 MRSA BSI's reported this year.**	**To be added when final**
To increase compliance with anti-infective prescribing.	To be 90 per cent compliant with the Trust anti-infective prescribing policy.	**We have not met this target this year with 83 per cent compliance, although we continue to make improvements.**	**To be added when final**
To create a culture of	To be 10 per cent above the	**We did not meet**	**To be**

openness and learning through patient safety incident reporting.	national average for reporting patient safety incidents. To be 10 per cent below the national average for reporting patient safety incidents resulting in severe harm or death.	**this target, reporting rate was under the national average** **We partly met this target; met severe harm reporting but not death reporting**	**added when final**
To increase awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened and have access to specialist assessments as needed.	To be 90 per cent compliant with the CQUIN target.	**We met this target.**	**To be added when final**

Clinical effectiveness

Our quality indicator	What success looks like	How did we do?	Page reference
Standardised Hospital-level Mortality Indicators (SHMI).	To be in the top ten trusts in the country for below the national average for SHMI rates.	**We achieved this target.**	**To be added when final**
Readmissions to hospitals within 28 days.	To remain below the national average for emergency readmissions to hospital within 28 days of discharge.	**We did not meet this target of 6.53 per cent**	**To be added when final**
Patient Reported Outcome Measures.	To be above the 80 per cent participation rates for all PROMs (groin hernia surgery; varicose vein surgery; hip replacement surgery and knee replacement surgery).	**We did not meet this target.**	**To be added when final**

Patient experience

Our quality indicator	What success looks like	How did we do?	Page reference
Waiting times in outpatients department (OPD).	To reduce the number of patients waiting over 30 minutes as measured in the annual OPD Patient Survey.	We were unable to measure this indicator as there was not an annual	**To be added when final**

		OPD Patient survey.	
To improve responsiveness to inpatient needs.	To improve on last year's score and to be one of the best performing trusts.	**We have met this target.**	**To be added when final**
To have caring and compassionate staff.	To improve on last year's score.	**We have part met this target.**	**To be added when final**
Friends and Family Test – staff perspective.	To remain above average for staff who would recommend the Trust to friends or family needing care.	**We met this target.**	**To be added when final**
Friends and Family test – patient perspective.	To achieve the DH target of 15 per cent response rate.	**We met this target.**	**To be added when final**

3.1 Progress against each of the 2013-14 priorities

Priority 1: patient safety priorities

To be compliant with the venous thromboembolism (VTE) CQUIN

Venous thromboembolism – VTE or blood clots is a major cause of death in the UK. Some blood clots can be prevented by early assessment and intervention.

Over the past year, the Trust has worked hard to continue to improve our VTE assessment so that 95 percent of patients are now assessed for their risk of thrombosis (clotting) and bleeding on admission. The Trust considers that this data is as described for the following reasons: we have met our target of >95 per cent of all inpatients having been assessed for a VTE within 24 hours of admission and that patients receive the appropriate treatment as indicated by this assessment.

VTE results

Indicator CQUIN 1	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**
Inpatients assessed for VTE **2013-14**	95.13%	96%	96.27%	96.05%	>95%	95%
Inpatients assessed for VTE **2012-13**	91.10%	91.11%	91.13%	91.83%	>90%	90%

The number in the brackets in the table below, is the target agreed for that quarter.

Indicator CQUIN 2	**Q1**	**Q2**	**Q3**	**Q4**
Patients identified with a hospital acquired VTE (HAT) have a formal root cause analysis **2013-14**	87.50% (50%)	90.48% (60%)	88.57% (70%)	84.12% (80%)

Action
The Trust has taken the following actions action to continue to improve this percentage and so the quality of its services:

- developing a weekly report to the divisional teams of the number of VTE assessments completed ward by ward. Wards that have not been meeting the targets have been reviewed and supported to improve
- as from the second part of last year, all patients identified as having a hospital acquired VTE (HAT) are subjected to a formal root cause analysis (RCA) with the responsible clinician. This means a thorough investigation is undertaken and any learning identified and shared. The outcome of the RCA is reviewed by the VTE lead
- the VTE task force meeting bimonthly and continuing to raise awareness through internal advertising campaign on all sites. The new trust VTE guidelines (directly linked to the NICE guidance) were launched in June 2013.

VTE has also been collected as part of the NHS Safety Thermometer for 2013-14 and this monthly spot audit has repeatedly demonstrated high levels of harm-free care. This means that patients in our organisation are less likely to develop a VTE.

VTE risk assessment compliance will not be a CQUIN scheme in 2013-14. However, performance against the 95 per cent threshold will continue to be monitored through the contract as it remains a high priority for the Trust to continue to deliver.

To ensure high performance against the Safety Thermometer: reducing harm from pressure ulcers, falls and catheter related urinary infections.

What is the NHS Safety Thermometer? The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. In this report, the Safety Thermometer records pressure ulcers, falls and catheters with urinary tract infections. We have measured our venous thromboembolisms (VTEs); using the CQUIN data.

The Trust has had between 95 per cent to 97 per cent harm free care during April 2013 and March 2014. This compares with the national average of between 92-94 per cent during the same period. We have performed better than the majority of our peer comparators over the same time period. This means that patients in our hospital are less likely to experience harm when compared with other trusts.

Falls

What are slips, trips and falls? Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. A significant number of falls result in severe or moderate injury. Patients of all ages fall. Certain risk factors are more common in younger people (including trip hazards, faints, fits, acute illness, recovery from anaesthetic) but falls are most likely to occur in older patients, and they are much more likely to experience serious injury (NPSA 2007). The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, cardiac, neurological or muscular-skeletal conditions, side effects from medication, or problems with balance, strength or mobility. Problems like poor eyesight or poor memory can create a greater risk of fall when someone is out of their normal environment on a hospital ward.

The Trust reports falls as patient safety incidents via our datix reporting system. We consider that this data is as described for the following reasons: we have continued to remain below the national average rate of reported falls, that being 5.6 per 1,000 bed days. We have also met our target of having fewer than 33 per cent of cases per year where falls have resulted in low/minor harm.

Falls results 2013-14

Indicator	Q1	Q2	Q3	Q4	Target
Remain below the national average of total reported falls	3.61	3.70	3.70	**3.53**	Below 5.6 per 1000 bed days
To reduce the percentage of patient falls that result in low/minor harm (%)	27.5%	33.3%	30.5%	**28.3%**	<33 %

We also collect data using the NHS Safety Thermometer National tool. The Safety Thermometer Tool measures falls in a different way from patient safety reporting. Each month, on one day we measure how many patients had a fall in the 72 hour period before the time of audit. This type of measurement is referred to as point prevalence as it refers to how many people or patients have fallen at this time of measurement. It is therefore a snap shot of time whereas the patient safety reporting measures all falls over a period of time, in this case a year.

The Safety Thermometer results confirm that patients in our Trust are less likely to come to harm through falls than in other NHS trusts.

Action

We have taken the following actions to continue to improve this score and so the quality of our services by:

- using nursing forums to promote best practice in falls treatment and management
- monitoring falls by the number, type, severity of harm and location in order to learn from them and share this information with clinical teams

- reviewing our compliance with our falls care plan through our 'back to floor Friday' audit schedule. Falls are also monitored alongside other key performance indicators at divisional performance reviews
- our falls nurse specialist conducts a falls clinic and reviews patients who fall
- our falls specialist consultant works alongside the falls nurse specialist to review those high risk patients.

Pressure ulcers

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Pressure ulcers are graded from 1-4 to indicate their severity, with 1 indicating less damage and 4 indicating severe damage.

The Trust reports pressure ulcers as patient safety incidents via our datix reporting system. We consider that this data is as described for the following reasons: we have met our target for this year to have less than 1.23–1.89 pressure ulcers graded as 1 or 2 per 1,000 bed days.

Pressure ulcer results 2013-14

Indicator	Q1	Q2	Q3	Q4	Total	Target
To reduce the number of pressure ulcers graded 1 or 2 per 1000 bed days,	2	1.33	0.86	0.98	**1.29**	<1.23-1.89 per 1000 bed days

We also collect data using the NHS Safety Thermometer National tool. The Safety Thermometer Tool measures pressure ulcers in a different way from patient safety reporting. We record pressure ulcers as a 'snap shot' of time as explained in the falls section above. The Safety Thermometer results show that we are performing better than most other NHS trusts and therefore our patients are less likely to develop a pressure ulcer whilst in our care.

Action

We have taken the following actions to continue to improve this rate, and so the quality of our services:

The Trust established a pressure ulcer prevention and reduction working group, chaired by the deputy director of nursing. This group will oversee the pressure ulcer work, underpinning Trust wide improvements with key principles and objectives, and setting targets for the on-going prevention and reduction of all pressure ulcers. The working group is:

- developing a Trust wide pressure ulcer reduction and prevention strategy
- launching a new pressure ulcer policy in 2014 to deliver the pressure ulcer reduction strategy and outline clear management strategies for the investigation, reporting and management of pressure ulcers
- developing new ways of working to improve practice including a focussed approach to pressure area management in critical areas led by senior nurses

- undertaking a thorough investigation of all pressure ulcers using a pressure ulcer toolkit
- sharing learning between the divisions to support improvement in clinical practice.

In addition, the tissue viability nurses are conducting quality rounds to support staff at ward level.

Urinary catheter related infections

A urinary tract infection is an infection that can happen anywhere along the urinary tract. People are at increased risk of urinary tract infections if they are diabetic; older; have a urinary catheter (a tube inserted into the urinary tract to drain the bladder); have kidney stones; are immobile or have had surgery.

The Trust considers that the data is as described for the following reasons; we did not set a target for this indicator other than to report the data, we have done this through the Safety Thermometer tool.

Action
The Trust will continue to submit NHS Safety Thermometer data related to urinary catheters and urinary tract infections over the next year and to compare ourselves against peer NHS organisations.

To reduce the risk of healthcare associated infections

- ***Clostridium difficile** (*C.difficile*)**

Clostridium difficile (*C.difficile*) is an anaerobic (an organism living in the absence of air) bacterium that can live in the gut of healthy people, where it does not cause any problems. However, some antibiotics can interfere with the balance of bacteria in the gut which may allow *C.difficile* to multiply and produce toxins that damage the gut. The bacteria can be spread on the hands of healthcare staff and others who come into contact with patients who have the infection or with environmental surfaces contaminated with the spores.

- ***C.difficile* results (Trust data)**

Year	Indicator	Q1	Q2	Q3	Q4	Total	Number set by DH
2012-13	To reduce the number of C.*difficile* cases as set by the Department of Health (DH)	23	20	23	20	**86**	110 cases per year
2013-14		26	11	10	11	**58**	65 cases per year

The number of cases of *C.difficile*, as a rate of patients admitted to our hospitals per 100,000 bed days, is 15 cases per 100,000 bed days (using 2012-13 bed days data, supplied by Public Health England).

ADD PARAGRAPH RE DATA COLLECTION METHODOLOGY

Over the past year, the Care Quality Commission (CQC) has reviewed our infection control practices in one of their planned inspections. They found the wards they inspected to be clean and that the Trust had the right systems in place to prevent and control the risk of infection.

The CQC inspection team found many examples of good practice in the care they observed our teams providing and did not require us to carry out any additional actions.

Action
We have taken the following actions to continue to reduce this rate and so the quality of its services:

- Implemented the guidance from Public Health England that requires the isolation of patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea.
- Reviewed and updated our policies and procedures to reflect the above.
- We closely monitor the time to isolation as a quality metric.
- Conduct detailed clinical reviews of each case of *C. difficile.*
- Monthly MDT review of all *C. difficile* cases is undertaken in which risk factors for each case are collated and learning shared with primary care colleagues. Our consultant pharmacist has highlighted these issues to GP's (via the GP bulletin newsletter) to help raise awareness and look to mitigate these.

- ***Meticillin resistant Staphylococcus aureus (MRSA) Blood Stream Infections (BSI)***

Meticillin resistant *Staphylococcus aureus* (MRSA) is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure.

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

- We had continued to reduce the total number of MRSA BSI cases per year. In 2011-12 there were thirteen cases of MRSA BSI's attributable to the Trust, with a further reduction noted in 2012-13 to eight.
- In 2013, a new system was introduced as to how we measure MRSA BSI's. We believe this has made a difference to our numbers and note that six of the cases reported below are actually attributable to the Trust.

MRSA BSI results

Indicator	Year	Q1	Q2	Q3	Q4	Total	Number set by DH
To reduce the number of MRSA cases as set by the Department of Health (DH)	2011-12					**13**	
	2012-13	1	1	2	3	**8**	9
	2013-14	5	4	2	2	**13**	**0**

Action
We have taken the following actions to continue to reduce this rate and so improve the quality of our services:

- We are working with peer hospitals, the Clinical Commissioning Group, Trust Development Authority and Public Health England to ensure all appropriate processes are in place and a robust MRSA action plan has been developed to ensure these key elements are delivered.
- We have reviewed the MRSA policy including increased MRSA screening reflecting themes identified from in depth reviews of each case of MRSA blood stream infection.
- We discuss and review all cases of MRSA BSI with the individual consultant at the weekly medical directors meeting with actions agreed and implemented.
- We have reviewed and re-launched our Trust wide vascular access committee to reflect the changes in clinical structures across the Trust, this group consists of senior clinicians and managers who are key to supporting the clinical divisions to deliver our on-going quality improvement programme.
- Since the aseptic non-touch technique (ANTT) programme commenced in 2012, 9,645 staff have now been competency assessed.
- We have increased our vascular access team.
- We have reviewed all our isolation facilities and have highlighted the limited availability of these on the Trust risk register.
- We commissioned an international expert to undertake a review of vascular access practice and quality improvement programmes with a view to providing recommendations on how to further improve our outcomes. The independent expert endorsed our competency assessment framework, and gave further recommendations for the planning and implementation of the reassessment process. They highlighted the need to increase multi-professional involvement in the planning and delivery of a comprehensive BSI prevention programme and also provided their expert opinion on surveillance and analysis of the overall burden of MRSA across our health economy.

To ensure compliance with the Trust policy for anti-infectives

Anti-infectives include anti-bacterials, antifungals and antiviral. These agents are often referred to collectively as antibiotics. They are extremely important and potentially life-saving therapies. However, if they are used inappropriately and excessively, drug resistant organisms can emerge, and patients are at an increased risk of developing a more resistant strain of an infection or *C.difficile.*

The Trust considers that the data is as described for the following reasons: we looked at three parts of anti-infectives prescribing, including:

- having a reason for starting the antibiotic clearly documented within their medical notes/drug chart
- a stop/review date on the drug chart to optimise the duration of therapy
- Are anti-infectives prescribed in line with the Trust's antibiotic policy or approved by a Trust infection specialist.

These three parts were chosen as they are considered to be the most important aspects of using anti-infective medications. The inappropriate use of such medications can increase the risk of infection or reduce their effectiveness in treating an infection. Our own target is 90 per

cent compliance in all three areas. We found that we did not meet our target for all three areas.

Results

We conducted two Trust-wide audits in 2013-14 and have reported them as audit 1 and audit 2 (see overleaf). The Trust made significant progress with 93 per cent of our prescriptions having a documented reason for starting anti-infective medications; and 90 per cent for prescribing in line with the Trust antibiotic policy or having prescriptions reviewed by an infection specialist. However, we need to continue to improve on the documentation of start-stop dates as we achieved 66 per cent against this measure.

Average compliance with anti-infective policy results 2013-14

Indicator	Audit 1	Audit 2	Target
To ensure we are compliant with the anti-infective policy	**83%**	**83%**	90% compliant with policy

Action

We have has taken the following actions to improve our practices in prescribing anti-infectives:

- Increased our monitoring of compliance from twice a year to quarterly to facilitate greater feedback and engagement within the organisation. This will take effect from April 2014.
- Launched a revised adult antibiotic policy and a new adult surgical prophylaxis policy.
- Reviewed various anti-infective policies within the organisation.
- Continued to promote the Department of Health 'Start Smart Then Focus' initiative which aims to encourage regular review of patients who are taking antibiotics.
- Updated our Trust antibiotic application for smart phones to facilitate access to our policies and started work on a paediatric version.

Our anti-infective prescribing is monitored and reviewed at regular intervals by the Trust infection prevention and control committee, antibiotic review group and pharmacy department. These groups engage with clinical and managerial teams to promote best practice.

In 2013, the Department of Health launched its five year antibiotic resistance strategy. This focuses on raising the awareness of antibiotic resistance, improving both staff and patient's knowledge of antibiotics and ensuring antibiotics are used correctly. The Trust will be working on implementing this throughout 2014.

We are committed to making improvements in this important area and will continue to monitor our indicators as part of the 2014-15 Quality Accounts in our priority to reduce healthcare acquired infections.

Reporting of patient safety incidents

The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning.

To avoid duplication of reporting, all incidents (including near misses) are reported to the NRLS who then report incidents resulting in moderate harm, severe harm or death to the Care Quality Commission (CQC). There is a mandatory requirement for trusts to report incidents resulting in severe harm or death to the NRLS and CQC. The majority of NHS trusts report patient safety incidents through NRLS.

There isn't a nationally established and regulated approach to the reporting and categorising of patient safety incidents and as such, clinical judgement is often relied upon. This may differ between professionals and between organisations. In addition, the classification of an incident may change as a result of lengthy investigations. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable

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

- We have not met our targets to be 10 per cent above the national average for patient reporting safety incidents or to be 10 per cent below the national average for reporting patient safety incidents resulting in death (graded extreme).
- We have met out target to be below the national average for reporting patient safety incidents graded severe.

Results

An important measure of an organisation's safety culture is its willingness to report adverse events, learn from them and deliver improved care. A high reporting rate of patient safety incidents is viewed as an organisation having a positive reporting culture, as staff feel supported to report. Our reporting rates have increased over the past year when compared with 2012-13 (6.5 per cent last year); however nationally patient safety reporting rates have also increased. The 'major' (severe) and 'extreme' (death) incidents are reported as a percentage of the overall incidents reported.

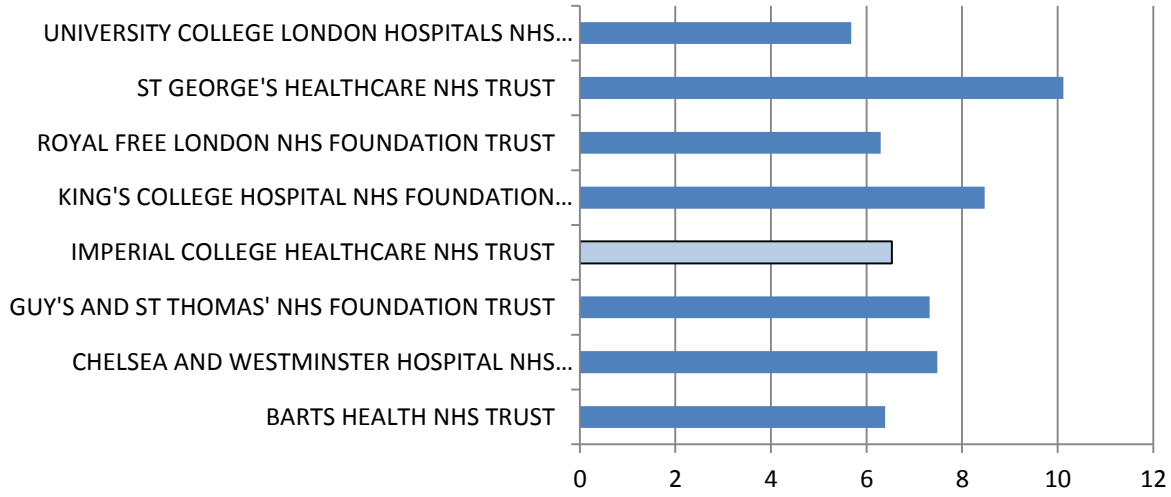
During the data period April 2013-March 2014, a total of 12,742 patient safety incidents were reported. (data extracted from online incident reporting system on 14th April 2014. The online incident reporting system is a live database and the data is subject to change)

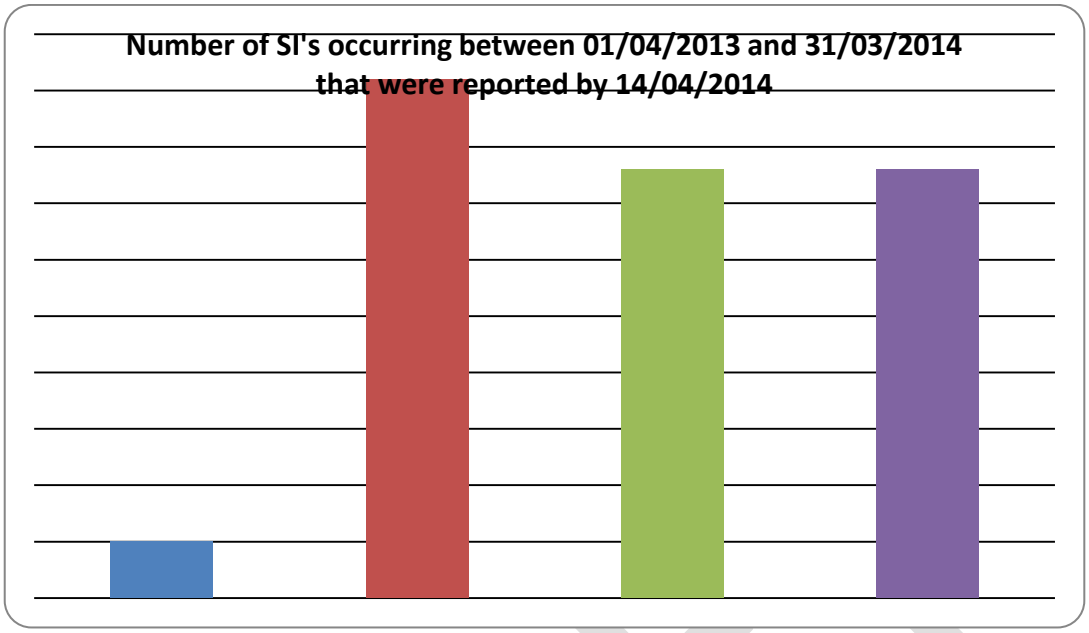
Indicator	Q1	Q2	Q3	Q4	Average	Target
To remain above average for patient safety reporting rates per 100 admissions in 2013-14	6.90	6.5	6.5	6.9	**6.6**	**>8.03 per 100 admissions**
To remain below the peer average for incidents graded as extreme (death) in 2013-14	15 (0.5%)	7 (0.2%)	9 (0.2%)	4 (0.1%)	**35 (0.3%)**	<0.1 % of average patient safety incidents reported for the Trust graded as extreme (death)
To remain below the peer average for incidents graded as major (severe)	3 (0.1%)	7 (0.2%)	3 (0.1%)	7 (0.2%)	**20 (0.2%)**	< 0.2% of average patient safety incidents reported for the Trust graded as major (severe)

Serious incident data is not available nationally so benchmarking is not possible. Using National Reporting and Learning System (NRLS) to benchmark performance of incidents reported (per 100 bed days) places the Trust as either within or better than the peer group.

Each incident which is declared a serious incident is investigated using root cause analysis (RCA) methodology, a report is written which is presented to a panel chaired by the medical director, where an action plan is agreed and implemented. The aim of the investigation is to improve care delivered to our patients and to prevent a recurrence of the incident or similar situation. The table overleaf shows the overall reporting rate of all patient safety incidents by the Trust compared to London Teaching Hospitals.

London Teaching Hospitals Rate of Incidents occuring per 100 Admissions





The table above shows that:

- the investigative sciences and clinical support division are the lowest reporters of serious incidents
- the medicine division are the highest reporting.

In addition to this, the Trust site with the most reported SIs over the past year was St Mary's Hospital. To put this into context, the medicine division accounts for the largest activity in the Trust and St Mary's site has the majority of the acute services with the major trauma centre being located there.

The most reported five themes from serious incidents in 2013-14 are:

- pressure ulcers (Grade 3 and above)
- maternity services
- delayed diagnosis
- unexpected death
- sub-optimal care of the deteriorating patient.

Action

During 2013-14 the Trust has taken the following actions to improve patient safety reporting and the quality of services:

- Introducing a weekly incident panel, led by the medical director where all incidents that result in moderate or above harm are reviewed with the divisional director and their top team.
- Launching a new Quality Strategy for the financial years 2013-15, based on Berwick's six goals for improvement.

- Introducing division based quality and safety teams to provide thorough and regular review of incident themes, trends and implementation of action plans ensuring local learning.
- Upgrading the Datix Incident Reporting system to provide improved systems and processes for the monitoring, reporting and learning from adverse events.
- Linking of incident trends and themes to service improvement and junior doctors training.
- Implementing a rolling programme of training for all clinical staff. The new system is easier to use and allows feedback of actions to the person who reported the incident.
- Developing new patient safety registrar roles within the divisions.
- Establishing new divisional quality boards to ensure that learning from incidents is shared within and across the divisions.
- Sharing learning from all serious incidents with staff through the Trust intranet site.

In relation to the most reported themes arising from patient safety incidents, the Trust has taken the following actions:

- The escalation process for emergency theatre access has been modified, with escalation now direct to the consultant.
- The step-down process for major trauma ward has been revised.
- A new process implemented for tracking direct access referrals to diagnostic services in primary care has been implemented.
- Outreach support is available on all sites and is supported out of hours by the site team.
- Introduced the National Early Warning System (NEWS) across the organisation, to assist our people in the early recognition and escalation of a deteriorating patient.
- Launched the SBAR across the organisation (Situation-Background-Assessment-Recommendation) to support our people in escalating concerns in a clear and concise manner.
- All staff who use the NEWS chart have been trained on how to use the chart.
- Additional ward based training and support has been provided by the outreach team.
- Auditing compliance with the use of the NEWS chart, ensuring that patients have been escalated appropriately.
- Purchased new equipment to enable simultaneous monitoring of the fetal and maternal heart rate.
- Recruited into consultant posts (maternity) to ensure we have 98 hour consultant presence on the labour ward.
- Enhanced midwifery training focusing on CTG (continuous cardiotocography) assessments and drug calculations.
- Business plans are in place to increase our midwife: woman ratio from 1:33 to 1:28 in accordance with national guidelines.

"The NEWS chart and the SBAR tool have been well received by staff. People tell us they like it and that it gives them confidence to escalate their concern, they find it empowering."

Julie Oxton, critical care consultant nurse

Patient safety registrars

We have appointed seven registrars to act as patient safety representatives across the Trust. These roles give the post holders an opportunity to work with the governance department in the Trust on integrating junior doctors into Trust governance structures. Initiatives that the post holders will take forward include:

- serious incident review groups meeting to ensure a focused discussion on recent illustrative serious incidents involving 'failure to rescue'
- registrar volunteers on serious incident panels. Registrars have been invited through the departmental education clinical leads to site on serious incident review panels
- registrar attendance at medical director's Friday morning serious incident meetings - excellent management experience.

The patient safety registrars in conjunction with the patient safety team run small focus groups of junior doctors to examine recent serious incidents. The sessions involve presentations and discussions of serious incidents and suggestions for changes to practice. This gives the junior doctors perspective on lessons that could be learnt from serious incidents and hopefully give constructive feedback and ideas for the future. The feedback will be fed back to the quality and safety governance teams with the aim to

Dementia CQUIN

This CQUIN aims are to improve *dementia* care, including sustained improvement in **F**inding people with dementia, **A**ssessing and **I**nvestigating their symptoms and **R**eferring for support (FAIR);

There are three indicators that measure compliance of this CQUIN:

1. Find, assess, investigate and refer (90 per cent compliance rate required)
2. Clinical leadership and delivery of a comprehensive training programme
3. Completion of a monthly audit of carers with dementia

The Trust considers that the data is as described for the following reasons: we have met all elements of this CQUIN scheme. The data for the FAIR element of the CQUIN is being reviewed by internal audit (report pending) as part of the business as usual internal assurance process.

Actions

We have taken the following actions to improve this percentage and so the quality of its services:

- Recruited to the dementia team to replace existing vacancies.
- Re-launching the consistent use of the blue stickers (dementia screening tool label)
- By introducing dementia training for all ward based nurses and health care. assistants. We introduced this training this year and have trained 1,112 registered nurses and health care assistants to date.
- Delivering dementia awareness training as part of the junior doctor's induction programme and have including this as part of their rolling (ongoing) training programme.
- We aim to introduce this for allied health professionals (physiotherapists, occupational therapist, radiographers, dieticians, podiatrists and speech and language therapists) next year.
- All new staff now attend a dementia awareness session as part of their induction. The dementia training has been welcomed by staff and below are some of the key feedback themes and comments we received from our people who attended the training. The larger the word, the more often it was used in feedback. The 'word cloud' overleaf highlights key words used by staff in their feedback on the dementia awareness sessions. The larger the word, the more often it was used.

- We are currently piloting a questionnaire that will help us to seek feedback from carers. We hope to use this questionnaire throughout the Trust. Once established, we will use the feedback to help us focus on what is important to carers. We will report our findings to the board twice a year
- We are providing more information for our people on dementia care. We have a network of 45 'dementia champions' of our people across our Trust, including nurses; doctors; therapists and facilities staff. The 'champions' will help us to work on different projects to improve the care we provide to patients with dementia. Our dementia website provides information for all staff on many different aspects of dementia care. We held a National Dementia Awareness Week in May across all sites that was well

received and attended. We had the opportunity to have private sessions with carers of people with dementia.

Our people told us:
"Enjoyed the day and learned a lot about dementia and how I can improve my practice." **Registered general nurse (RGN)**

"NHS staff, both clinical and non-clinical should be given dementia training as this will be very useful in dealing with patients with dementia which staff will come across all the time." **Health care assistant**

"Well structured, gradual introduction of topics. Educative and informative. Subject matter is well presented and the tutor is very good, engaging and well informed." **RGN**

"I will be more vigilant and aware. I was very pleased I attended as there were things I was unaware of." **Ward administrator**

"Thank you for a very interesting and useful session." **Pharmacist**

"Clear and useful information on dementia. Good information regarding symptom recognition and expectations. Well presented and good scope covered."**Junior doctor**

We were recently inspected by the Care Quality Commission (CQC) as part of the national themed work looking at dementia care. CQC looked at how we were caring for our patients; how we were cooperating with other providers and how we were assessing and monitoring the quality of our services. They found we had met all of these outcomes and gave examples of how staff are trained and supported to care for people with dementia and their families.

The CQC spoke with our patients and families and were told:

"They (the nursing staff) are always there for me."

"I'm looked after absolutely perfectly."

The CQC reported that 'we saw that family members were involved in discussions about their relatives'.

Priority 2: Clinical effectiveness priorities

To remain better than the national average for mortality rates as measured by the Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicators (SHMI), is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died whilst having treatment in hospital or within 30 days of being discharged from hospital. One of the characteristics that are measured is the palliative care indicator. This tells us the percentage of patients who died that were recorded as palliative care at diagnosis or speciality level. The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care.

Results

The Trust considers that the data is as described for the following reasons: our score of 78.4 indicates that we are in the top four trusts in the country (data published on the Health & Social Care Information Centre for the period 1 July 2012- 30 June 2013). When we compare ourselves with our peers, that being the Shelford Group (comprises of ten leading peer NHS multi-speciality academic healthcare organisations who are dedicated to excellence in clinical research, education and patient care), we have the third lowest SHMI for the period July 2012-June 2013.

At our Trust, 28.8 per cent (national range of 4.2-44.1) of patients who died were recorded as being palliative care patients. This number reflects the specialities that we have at the Trust and is comparable to similar NHS trusts such as Guy's and St Thomas' NHS Foundation Trust (36.2) and King's College Hospital NHS Foundation Trust (36.1).

The table below indicates site specific information.

Site	SHMI
St Mary's Hospital	80.25
Charing Cross Hospital	74.28
Hammersmith Hospital	84.81

We note that across our organisation, the site with the highest SHMI is Hammersmith Hospital (84.81). This may be a reflection of the types of services located at our sites as a large proportion of our cancer and specialist services are located at Hammersmith Hospital.

Action
The Trust has taken the following actions to continue to improve this rate and so the quality of its services by:

- continuing to focus on our failure to rescue work to improve the recognition and escalation of the deteriorating patient through the ongoing training of staff
- introducing the NEWS observation chart (that is the National Early Warning Score) and have set up a task force group to monitor, develop and support this work
- establishing the SBAR (Situation-Background-Assessment-Recommendation) communication tool across all areas to provide nursing staff with a structured approach to raising concerns
- reviewing by an appropriate clinician all patients that are stepped down from the major trauma ward within two hours
- carrying out daily consultant-led ward rounds
- working to reduce our failure to rescue incidents and anticipate this will positively impact further on our mortality rates.

To reduce the number of emergency readmissions to hospital within 28 days of discharge

The unplanned readmission rate for adult patients treated at Imperial College Healthcare NHS Trust is similar to the NHS average. We believe our performance reflects that we are a large Trust that treats both local patients and patients with specialist or complex medical conditions.

Results
The number of emergency readmissions to hospital within 28 days of discharge results 2013-14

Indicator	Q1	Q2	Q3	Q4	Target
To reduce the number of emergency readmissions to hospital within 28 days of discharge age 0-14 years	4.55%	4.50%	5.55%	4.69%	
To reduce the number of emergency readmissions to hospital within 28 days of	6.79%	6.78%	6.96%	6.81%	

discharge aged > 15 years					
To reduce the number of emergency readmissions to hospital within 28 days of discharge	**6.59%**	**6.57%**	**6.84%**	**6.60%**	National average not available but peer comparator reported as 6.53 per cent (to be updated in May 2014)

Action

We are taking the following actions to reduce the number of patients requiring readmission:

- We are working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.
- We have established an Older Persons assessment clinic that ensures we can provide rapid ambulatory access to assessment and planned care.
- We have extended the hours of the discharge team to provide support in the evening and at weekends.

To increase patient satisfaction as measured by Patient Related Outcome Measures (PROMs)

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of the four clinical procedures:

- hip replacement
- hernia repair
- knee replacement
- varicose vein treatment.

Patients who have these procedures are asked to complete the same short questionnaire at two different time points; before and after surgery. The difference between the two is used to determine the outcome of the procedure as perceived by the patient.

Data published 8th May 2014 referring to patients questioned between April 2012 and March 2013

Indicator	Year Total	Target
To increase PROMs participation rate for hernia surgery	55.1%	Above 80%
To increase PROMs participation rate for hip surgery	66.9%	Above 80%
To increase PROMs participation rate for knee surgery	66.4%	Above 80%
To increase PROMs participation rate for vein surgery	62.1%	Above 80%

There was an issue with the methodology used by the company who collects the PROMS data. The after surgery questionnaire was not being sent to patients until 9 months after the

before surgery questionnaire had been sent. The company have changed their practice to reducing the time difference between the two questionnaires to 6 months.

The results from the questionnaires in terms of patient outcome were

Indicator	Number	Health Improvement	Health Unchanged	Health Worsened
Hip replacement	91	78 (85.7%)	4 (4.4%)	9 (9.9%)
Hernia repair	80	46 (57.5%)	17 (21.3%)	17 (21.3%)
Knee replacement	105	83 (79.0%)	13 (12.4%)	9 (8.6%)
Varicose vein treatment	199	102 (51.3%)	63 (31.7%)	34 (17.1%)

Action

We are taking the following actions to improve our response rates:

- Ensuring each PROM has a clinical lead to regularly review the scores at service level and to promote the completion of PROMs.
- Ensuring quarterly reporting of PROMs data to the divisional quality boards.
- Ensuring quarterly reporting of PROMs data to the quality committee.
- Piloting a new online system with Imperial College academic department, for all patients who have undergone knee and hip surgery called 'JointPRO'.

JointPRO is an on-line system that allows the Trust to interact with our patients to:

- score and track patients health over time
- set motivational targets
- share scores with clinical staff
- share experiences with similar patients, offering practical advice.

We anticipate that this new interactive tool will directly impact on our patient's experience and in the longer term will:

- support real time access to PROMS
- actively monitor patients
- support clinical decision making reducing the need for hospital appointments
- enable 'smart' targeted patient reviews
- engage patients in their own care.

Priority 3: Patient experience priorities

To improve patient satisfaction with waiting times to be seen in outpatient clinics

The Trust considers that the data is as described for the following reasons: we have not been able to report against our target as we intended to measure this through the National Outpatient Survey and this has not been undertaken in 2013-14.

We did however, continue to survey local views across our outpatient clinics and review our results using the Trust's own I-track system, asking the question 'how long after the appointment time did the appointment start?'. We found that we had improvements in this area with 60-75 per cent of appointments starting on time.

Although we cannot report against this priority, we have been working to improve our waiting times and communication within the departments. We are rolling out new 'check-in booths' in all outpatient departments, to reduce queuing and speed up the 'check in' process. We have worked with our people to identify ways of improving communication with patients that are waiting. We will roll out the patient Friends and Family Test (FFT) outpatient test in all outpatient areas by October 2014 and will look to include this data for our 2015-16 Quality Accounts.

To improve the responsiveness to inpatients' needs

We measure responsiveness to inpatients' needs through the National Inpatient Survey. This enables us to make direct comparisons with other NHS trusts. In addition, we monitor important aspects of this through our own real-time feedback patient survey using the I-track device, that is an electronic system, including hand held devices and booths, that are used to collect the data.

Responsiveness to inpatient results 2013-14
The Trust considers that the data is as described for the following reasons: we have met our target to improve on our responsiveness to inpatients' needs.

National Inpatient Survey results

Indicator	2012-13	**2013-14**
Responsiveness to inpatient needs	6.64	**6.78**

Action
The Trust has taken the following actions to continue to improve these scores:

- Actively monitoring performance against key questions using the real-time (I-track) devices.
- Initiated a high profile poster campaign indicating our commitment to making the patient experience better.
- In cancer wards, implementing a project focusing on embedding the behaviours outlined in the Macmillan Values Based Standard.

- The Trust is also revising its patient centredness strategy with a view to launching this in May 2014.

We have been and continue to closely monitor our reporting and include these measures as part of the compliance monitoring of the Trust's patient and carer strategy. In addition, we intend to continue work around patient discharge, including information given to patients.

To have caring and compassionate staff

The Trust considers that the data is as described for the following reasons: we measured this target for the first three-quarters of the year and the last two quarters of the previous year as shown in the table below). In December 2013, we reviewed all of our I-track questions as we have been implementing the FFT tests and wanted to include more specific questions related to areas of concern raised by the chief inspector of hospitals. This included focusing on pain and eating and drinking. In light of the number of questions we were asking our patients, we decided to remove this question for quarter 4 and to include those areas identified as a result of feedback from the chief inspector of hospitals inspection. We have therefore reported our data for this priority, for the quarters it was collected.

Caring and compassionate staff results 2013-14

	2012-13		2013-14				
Indicator	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Target**
To have caring and compassionate staff	94%	94%	94%	95%	94%	Not recorded	

We have taken the following actions to continue to improve these scores:

- Patient stories are now part of our Trust board reports.
- Since May 2013, six patient stories have been shared with the board. Below is an extract from one families experience at one of our hospitals that was presented to the board in May 2013.

A family's experience
In June, a pregnant couple attended Queen Charlotte's Hospital. The patient's waters had broken and were meconium stained and they were obviously very anxious.

On arrival at the delivery suite they were introduced to their first midwife. The couple described that she was fantastic and spent time addressing their fears and concerns and getting them settled. They expressed that they felt confident in her and reassured that everything was under control and proceeding as expected. Without exception, she was always professional, caring and understanding, which is difficult to achieve in a busy environment like the delivery suite, in their experience.

At shift change, another midwife was allocated to look after them. Again, they expressed that she was amazing, spending time explaining the process, making sure the patient had a chance to discuss her wishes for the birth. When baby arrived, it was all relatively sudden and he had the cord around his neck. In their view, the midwife was very calm, dealt with it efficiently and only told them about it after baby was safely out (which was absolutely the right time to tell them in their opinion).

They describe that their care in the delivery suite was absolutely faultless and especially the work of the midwives who they would like to know what a great job they did and that it is really appreciated.

Key features that gave a positive experience:

- personalised care
- explanation
- involvement in decision making and care

To remain above tha national average for staff who recommend the Trust as a place to work/receive treatment

We have reported against this indicator using the National Staff Survey findings. This indicator is calculated based on the findings of question 12d from the national survey, that being 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'. We will now begin rolling out the Friends & Family staff test from April 2014 ahead of national guidance, within our own Trust engagement survey that was launched in October 2013 and which surveys a quarter of our people each quarter.

Staff survey results – recommend as a place to work/receive treatment

The Trust considers that the data shown in the table below demonstrates that we have met our target to be above the national average for staff who would recommend the Trust to friends/family as a place to work or be treated, based on question 12d from the national staff survey. We believe the willingness of our people to recommend the Trust as a place to work or be treated is a strong and positive indicator of the standard of care provided to our patients.

Indicator	National average for all acute Trusts	Imperial College Healthcare NHS Trust 2012	Imperial College Healthcare NHS Trust 2013
Question 12.d: If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	**64**	**69**	**69**

Action
We intend to take the following actions to further improve this result and so the quality of our services. We will do this by sharing our Trust quarterly survey findings with each division to ensure there is local ownership and engagement of our people. We have developed our Trust engagement survey to enable us to closely monitor our people's views and have identified three key priorities as a result of our first two quarters' results. These are:

- **Improving staff health and wellbeing**
  The health and wellbeing of our people is vital to the Trust. Research shows healthy, happy staff are more productive and deliver better patient care. In the coming months, the Trust will be launching a new health and wellbeing programme, which will give people better access to resources such as training and support. This will build on the iMove programme which is already helping people stay fit and healthy. We will also be implementing changes to our occupational health services this year which will enhance the service for our people.
- **Empowering and inspiring our staff**
  We are actively discussing the results from our first two quarters' engagement surveys with all our people. Divisions and departments have established open forums and communication tools over the last quarter, and we will continue to work with teams to build on this.
- **Making opinions count**
  We launched a new monthly people and organisation development forum in January 2014. It is open to all our people to seek views and feed back on a range of initiatives within people and organisation development. In addition, director of people and organisation development, Jayne Mee has hosted her second live web chat. This was very well attended and has given our people the chance to talk to Jayne on the issues which matter most to them.

We are now working towards delivering on these priorities and are continuing to monitor our people's feelings about working in the Trust, whether that is quarterly, or as new joiners and leavers, who will be invited to share their initial and final thoughts with us.

"These results have given us an insight into how our people feel about working at our Trust. The senior leadership team is fully committed to making changes so our people feel valued and supported, and that they have a positive experience.

"As we get more responses we will continue to analyse the themes and changes in the feedback and report back on what we learn from these. Importantly, we will also describe the actions being taken as a result of what we've heard.

"We have quite a way to go, and together I believe we can make the Trust a great place to work."

Our surveys are completely anonymous and confidential. We do not know who is being sent them or who replies – but we're counting on our people to tell us what more we need to do. I look forward to hearing real and honest views as I am out and about in the Trust and also on the next webchat".

Jayne Mee, director of people and organisation development

To achieve the minimum Department of Health target* of 15 per cent response rate for the Friends and family test (FFT) – Patient perspective

The Trust launched the national Friends and Family Test (FFT) on 1 April, 2013 to obtain feedback from patients in our acute inpatient services and A&E departments. As of the 1 October 2013, this requirement extended to include maternity services. All inpatient wards, A&E's and maternity services must now ensure that all eligible patients are given the opportunity to respond to the question and each ward or department must collect a minimum of 20 per cent (although this was 15 per cent up until the end of December 2013). Going forward, this will be used as a key measure of patient experience with all wards expected to achieve a target level.

We capture this data through our I-track device and more recently though booths located throughout the hospital. Patients are asked to complete this in the A&E department and the wards and we have recently begun rolling this out in our outpatient departments.

FFT results – patient perspective

The Trust considers that this data is as described for the following reasons; we have met the DH target of a greater than 15 per cent response rate to the FFT question in A&E and in-patient areas as displayed in the table below.

Indicator	Q1	Q2	Q3	Q4	YTE	Target
FFT combined response rate (A&E and inpatient areas)	20%	22%	20.4%	28.3%	22.6%	>15%

Whilst our target currently relates to response rates, we measure and share our scores with wards and departments in the Trust. Over the past year, our scores have been:

- 68-72/100 for inpatient areas
- 43-69/100 for A&E departments
- 53-65/100 for maternity departments (based on an incomplete year of data).

We are currently above average when compared with other London trusts.

Actions

We have taken the following actions to improve this percentage:

- Reviewing the I-track questionnaire and including the FFT question in this to make it more accessible.
- Reviewing the questions we ask our patients to avoid asking them too many questions and focusing on key questions.
- Including results and response rates in divisional and ward based scorecards to identify areas of poor compliance and enable our people to focus on improving response rates in these areas.
- Displaying themes from FFT comments such as those shared in the word cloud overleaf. The larger the word, the more often the comment was used.

Sample of comments received through our patient FFT test:

"Very good response time, extremely attentive team of doctors and nurses, considerably friendly".

"Very caring staff from reception to nurses and doctors."

"The service is very good. I am 75 years old and never been in hospital but treated with extreme love. V clean, extremely satisfied in all areas."

"Treated very well staff explained to me the problem very clear I am very happy with

Current view of the Trust's position on quality

During 2013-14 we continued in our commitment to making quality central to all we do. We developed, published and implemented our new quality strategy including agreeing our new meeting structures based on Berwick's six domains of quality. Over the next year we will be working on embedding these new structures into practice and setting divisional level targets for improvement.

We provided services that met Care Quality Commission (CQC) essential standards as evidenced through three inspections. We have continued to report and learn from patient safety incidents, developing new divisional roles to lead on this.

All of our inpatients have been cared for in single sex accommodation and we have maintained one of the lowest mortality rates in the country.

Working as an academic health science centre (AHSC) with our academic partner Imperial College London, we have harnessed clinical care, innovative practice, research and development.

Below are some examples of our continued work to improve the quality of healthcare in our Trust. These are reported under the new key headings of our Quality Strategy.

Quality Strategy

Hospital Standardised Mortality Ratio (HSMR)

The Trust has been recognised as a centre of very safe care. The Dr Foster Guide 2013 listed the Trust as among the best in the country for the Hospital Standardised Mortality Ratio (HSMR). This measures the expected number of deaths in a hospital against the actual number, taking into account many details and variable. It is used as a trusted measure to evaluate the safety of a hospital. In addition, the Trust is proud to report that mortality rates were also lower than expected for patients admitted as an emergency, during both weekdays and weekends.

Never events

The National Patient Safety Agency has developed a list of 25 'never events' that are applicable to acute trusts. These are events that should never happen during a healthcare episode as they are largely preventable and can have serious consequences for the patient if they do occur.

Two incidents occurred in the past 12 months which met the criteria and were reported as a 'never event'. These were categorised as wrong site surgery and a misplaced nasogastric tube. All of the 'never events' are treated as serious incidents and are fully investigated using

Root Cause Analysis (RCA). Actions have been put in place to reduce the risk of the wrong site surgery 'never event' happening again include:

- revision of the WHO checklist to provide specific accountability for each part and to include checking and written consent
- a process for formal handover of patients from ward areas to theatres in the Riverside suite using the pre-intervention checklist
- preference cards for consultant surgeons now include locums so as to avoid late requests and redeployment of staff to collect equipment.

The second 'never event' is currently being investigated. The patient is now home without any associated problems, but we need to learn and understand how the event happened and what we need to do differently.

Effectiveness

Surgery first
In a world first, interventional radiologists used new robotic technology to treat fibroids, a common condition which affects one in three women. The robotic system means patients can potentially avoid excessive radiation and is safer, as it enables more precise treatment and shorter procedure times.

Pioneering brain scan
In December last year, the Trust became the first centre in the UK to perform a new type of brain scan which can lead to more accurate diagnosis of Alzheimer's disease and other dementia conditions. This marked a significant breakthrough in diagnosis as the test identifies amyloid plaques in the brain which is one indication of Alzheimer's disease. Until now diagnosis has been impaired as there has not been a test to show whether someone has the condition.

Patient experience
Below are examples of work we have already started over the past few months:

- Patient experience toolkit
  The toolkit was designed in April 2013 to provide staff with important and useful patient information templates to help provide patients and visitors with essential information about their stay.

- Information and photo boards
  All wards now have information boards and photo boards to say who's who and a welcome board with photos of the staff patients will be most likely to interact with on the ward.

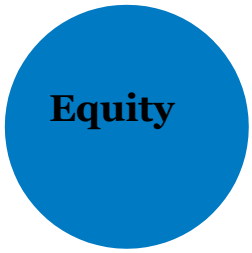
- Patient headboards
  In order to improve patient experiences, and in response to the Francis Inquiry recommendations, headboards which record a patient's preferred name, anticipated discharge date (ADD), consultant and named nurse were launched in December 2013.

Complaints
Over the past year, the Trust has focused on its complaints management following the Francis Inquiry report and Ann Clwyd MP and Professor Tricia Hart's review into NHS complaint handling. The Patient Advice and Liaison Service (PALS) and the central complaints team reviewed each recommendation.

Following an internal restructure, four patient safety managers now lead complaint management in each of the four clinical divisions. This allows the Trust to consider information not only from complaints and PALS but also claims and incidents to help ensure that we learn from various forms of feedback.

The management of the central complaints team has been strengthened by the appointment of the Trust's first service quality manager, who works closely with the PALS manager and patient safety leads. This has established a strong foundation which will help ensure the Trust continues to place the patient at the centre of everything we do.

We have ensured that our patients and their families know who they can speak with by making complaints information accessible at ward level. During 2013-14 the Trust investigated 884 formal complaints, 93 per cent of which were responded to within the timescale agreed by the patient. PALS dealt with 3,519 informal concerns in the year.



Award winning work

In January 2014 a team of six midwives won the Lansinoh Team Award from the Royal College of Midwives for their work with vulnerable women at St Mary's Hospital.

The team work with women with several complex risk factors, such as severe mental illness, domestic abuse, drug and alcohol misuse and learning difficulties. Many of the women are from traveller, refugee, and asylum seeker communities. The midwives are key coordinators of care for all the women and liaise with obstetricians, doctors, health visitors, social workers and other agencies.

The judges said: "This is an inspirational model of midwifery care, which demonstrates choice and one-to-one care throughout the whole maternity pathway for a group of vulnerable women. It addresses local priorities for local women working in a multi-agency way – a well-deserved winner."

Divisional director of nursing and midwifery, Professor Jacqueline Dunkley-Bent and head of midwifery, Pippa Nightingale were at the ceremony to see the team receive their award.

Professor Dunkley-Bent said: "Pippa and I are both extremely proud of the team who are an inspiration and a real credit to our maternity service. Their passion, dedication and expertise ensures women who have complex social needs are provided with continuity of midwifery care throughout their pregnancy, birth and postnatal period. This is a model of care we aim to provide for all women in the future."

Chief executive of the Royal College of Midwives, Cathy Warwick said: "To win an award is a real achievement. Without midwives, their teams and colleagues from other health professions pushing at the boundaries of practice we would not see the care they are able to give to women, babies and their families improve and move forward. This is innovation in action which will help maternity services everywhere to deliver safer, better and continually improving care. I congratulate the team on this achievement and thank them and their colleagues for their dedication, skill and commitment to women and their babies."

Improvements to outpatient flow
We have introduced patient self-check-in kiosks in the reception areas of outpatient departments enabling more stream-lined check-ins, as well as providing useful demographic information about our patients. This helps to reduce queuing at the reception areas of outpatients, enabling patients to get to the right area quicker.

Improvements to our cancer services
The Trust appointed a new oncology consultant at Charing Cross Hospital to help us to develop more cancer ambulatory care services, meaning patients do not have to spend the night in hospital.

This year the Trust breast cancer nurse, Victoria Harmer, triumphed at the Nursing Times Awards winning the esteemed Cancer Nurse of the Year award. Victoria was nominated by the breast cancer support group which she has been running for several years now. One of Victoria's latest projects is an innovative disposable MP3 player which provides information as a pre-recorded podcast to help patients undergoing chemotherapy.

The Macmillan Information Centres at Charing Cross Hospital and the Macmillan pod at Hammersmith Hospital are providing patients with information about their condition and treatment and explaining where they can get further help and information.

Implementing Cerner

In 2013-14 the Trust worked towards the milestone of implementing Cerner, an electronic patient administration system.The transfer took place over the 2014 Easter period to take advantage of a lower level of planned activity during the holiday period.

The new system affects both clinical and non-clinical staff across the Trust and was supported by a significant communication programme. During the preparations for the launch, the system was rigorously tested and the planning incorporated lessons learnt from other implementation programmes. The Trust also rolled out a module for electronic maternity patient records. The new system will ultimately allow the Trust to improve data quality and patient care. It also provides the opportunity to get patient records based on a single NHS number, and giving the Trust a foundation to move towards electronic patient records

Case study illustrating how a timely, efficient service can improve the patient experience

Over the past year we have reviewed and redesigned some of our patient pathways. One example is the development of rapid access clinics for patients with suspected prostate cancer. The purpose of this new pathway is to provide a 'one stop' service for our patients. This means that patients can visit the hospital once to have a specialist review, an examination, an ultrasound and biopsies all taken on the same day.

In order to support this new pathway, the Trust has recruited a clinical nurse specialist to manage the patient pathways. The clinical nurse specialist works closely with the consultant to ensure a high quality service is delivered.

The new pathway is being evaluated from a patient and operational perspective. Our initial findings (based on a small sample size of 34 patients) suggest that the new pathways have impacted positively on both the patient and operational experience. We have noted that follow up and 'did not attend' (DNA) rates have improved dramatically and that patient satisfaction has increased.

In our patient questionnaires, we found the patients' experience had significantly improved for every question. They told us: they had enough information about the clinic; the length of time of their appointment; the majority received their results before leaving the clinic; they would recommend the service to family or friends and that overall they rated the service as very good or excellent.

We will continue to monitor our patients experience and continue to develop this service. We are currently working through the London Cancer Alliance to

Quality strategy

We are in the process of reviewing our Quality Goals and will report against these in our next Quality Accounts, to ensure that people that use our services know the areas we will continue to focus on and that our people that work within the organisation are focused on the same.

Statements from stakeholders

Independent auditors' limited assurance report to the directors of Imperial College Health NHS Trust on the annual Quality Accounts

Appendix 1 – Statement of directors' responsibilities in respect of the Draft Quality Account

The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010 and the National Health Service (Quality Accounts) Amendment Regulations 2011).

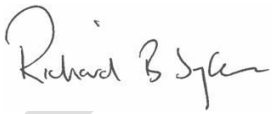
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

1. the Quality Account have been prepared in accordance with Department of Health guidance and present a balanced picture of the Trust's performance over the period covered
2. the content of the Quality Account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2013 to March 2014
    - papers relating to Quality reported to the Board over the period April 2013-March 2014
    - feedback from NHS Central London, West London, Hammersmith and Fulham, Ealing and Hounslow Clinical Commissioning Groups (CCGs)
    - feedback from local scrutineers including HealthWatch; local authority overview and scrutiny committees
    - the Head of Internal Audit's Annual Opinion April 2014
    - the national inpatient survey 2013
    - the national staff survey 2013
    - CQC Registration 'without conditions' across all Trust sites
    - mortality rates provided by external agencies (Health & Social Care Information Centre and Dr Foster).
3. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, and those controls are subject to review to confirm they are working effectively in practice
4. The data underpinning the measures of performance reported in the Quality Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors have reviewed the Draft Quality Accounts at the Management Board meeting on April 22nd and confirm to the best of their knowledge and belief they have complied with

the above requirements in preparing the Quality Accounts. The Quality Accounts will be reviewed at the Trust board meeting held on **28 May 2014**, where the authority of signing the final Quality Accounts document will be delegated to the chief executive and chair.

By order of the Trust board



Chief Executive

Chairman

Appendix Two

Organisation chart May 2014

Imperial College Healthcare NHS Trust

BOARD OF DIRECTORS

Chairman
Sir Richard Sykes

Non executive directors


Jeremy Isaacs


Sir Gerald Acher


Dr Rodney Eastwood


Dr Andreas Raffel *


Sir Thomas Legg


Professor Sir Anthony Newman Taylor


Sarika Patel

Executive directors


Chief executive: Dr Tracey Batten


Director of nursing: Professor Janice Sigsworth


Chief operating officer: Steve McManus


Medical director: Chris Harrison (acting)


Chief financial officer: Bill Shields

EXECUTIVE TEAM (includes executive directors)


Director of communications: Michelle Dixon


Director of governance and assurance: Cheryl Plumridge


Chief information officer: Kevin Jarrold


Director of people and organisation development: Jayne Mee


Director of strategy: Ian Garlington

CLINICAL DIVISIONS (report to chief operating officer)

Investigative sciences and clinical support


Divisional director: Dr Julian Redhead

Divisional director of operations: Ellis Pullinger

Divisional director of nursing: Teresa McHugh

Finance business partner: Mike Lyons

HR business partner: Jen Simpson

Imaging
COS: Andrew Wright (interim)
GM: Patricia Reyes

Pathology
COS: Kikkeri Naresh
Head of laboratories: Stephen Snewin

Theatres (including pre-op and decontamination)
COS: William Harrop Griffiths
GM: Paula Goode

Outpatients, pharmacy and therapies
GM: Bruno Botelho

Medicine


Divisional director: Professor Tim Orchard

Divisional director of operations: Claire Braithwaite

Divisional director of nursing: Sally Heywood

Finance business partner: Anil Pursooth

HR business partner: Gemma Glanville

Specialist medicine
COS: Frances Bowen
GM: Max Eldin-Taylor

HIV/sexual health/ infection
COS: Linda Greene
GM: Nicola Costin-Davis

Renal
COS: Tom Cairns
GM: Carol Toogood

Emergency medicine and ambulatory care
COS: Ruth Brown
GM: Iain Taylor

Stroke and neurosciences
COS: David Peterson
GM: Helen Williamson

Acute and care of the elderly
COS: Horace Williams
GM: Iain Taylor

Surgery, cancer and cardiovascular


Divisional director: Professor Jamil Mayet

Divisional director of operations: Martin Lerner

Divisional director of nursing: Lesley Powis

Finance business partner: Sandra Easton

HR business partner: Louise Clark

Surgery
COS: Barry Paraskevas
GM: Nina Griffith

Orthopaedics/plastics/ MTC/ENT and pain
COS: Shehan Hettiaratchy
GM: Anne Hall
MTC lead: Mike Jenkins

Clinical haematology
COS: Jane Apperley
GM: James Thomas

Cancer
COS: Katie Urch
GM: James Thomas

Critical care and anaesthetics
COS: Helgi Johannsson
GM: Merlyn Marsden

Circulation sciences
COS: Andrew Chukwumeka
GM: Graham Lomax

Women's and children's


Divisional director: Mr TG Teoh

Divisional director of operations: Martina Dinneen

Divisional director of midwifery and nursing: Professor Jacqueline Dunkley-Bent

Finance business partner: Doyin Ogunbiyi

HR business partner: Louise Lester

Paediatrics and neonates
COS: Hermione Lyall
GM: Sophia Hami

Gynaecology
COS: Deborah Gould
GM: Janette Harper

Obstetrics
COS: Mandish Dhanjal
GM: Janette Harper

Respect our patients and colleagues | Encourage **innovation** in all that we do | Provide the highest quality **care** | Work together for the **achievement** of outstanding results | Take **pride** in our success

The latest version of the chart is available on the Source. If there are changes to personnel, please contact Keith Loveridge or Dawn Morris in HR.
Updated: May 2014

* Non-voting designate NED
COS: chief of service
GM: general manager

Appendix Three: Performance indicators 2013-14

The table below sets out the Trust's national and local indicators performance managed during 2013-14. Data is for the full year except where indicated. These are based on standard NHS calculations.

TO BE ADDED IN MAY ONCE ALL DATA VERIFIED

Glossary

Anti-infectives – drugs that are capable of acting against infection.

Aseptic Non-Touch Technique (ANTT) – how staff perform a number of clinical procedures, this involves correct hand washing, wearing of gloves and aprons at appropriate time to maintain sterility of key parts to prevent infections by not touching them.

Clinical Programme Group (CPG) – is the name given to the way we used to use to refer to how we divide our services, as they are divided according to different specialities.

Clostridium difficile – is an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

Clot – a soft thick lump or mass.

Dementia – dementia is a syndrome (a group of related symptoms) that is associated with an ongoing decline of the brain and its abilities. It is used to describe a collection of symptoms including memory loss, problems with reasoning and communication skills, and a reduction in a person's abilities and skills in carrying out daily living activities. Dementia affects the whole life of a person who has it as well as their family.

Duty of candour – full disclosure, not to withhold information.

Emergency readmissions - unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

Failure to rescue – failed to prevent a clinically important deterioration.

Falls – unintentionally coming to rest on the ground floor/lower level, includes fainting, epileptic fits and collapse or slip.

Methicillin-resistant *Staphylococcus aureus* (MRSA) – is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems.

Patient safety incidents – is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. (National Patient Safety Agency).

Pressure ulcer – sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Grade One – Discolouration of intact skin not affected by light finger pressure
Grade Two – Partial thickness skin loss or damage
Grade Three – Full thickness skin loss involving damage of subcutaneous tissue
Grade Four – Full thickness skin loss with extensive destruction and necrosis (dead tissue).

Patient reported outcome measures (PROMs) – tools we use to measure the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health.

Root Cause Analysis (RCA) – is a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened (NPSA 2004).

Safety thermometer – is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time. The safety thermometer records pressure ulcers, falls, catheters with urinary tract Infections and venous thromboembolisms (VTEs).

Standardised hospital mortality indicator (**SHMI)** – is a new national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge. This measurement takes into accounts factors that may be outside of a hospitals control, such as those patients receiving palliative care.

Stakeholder – a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

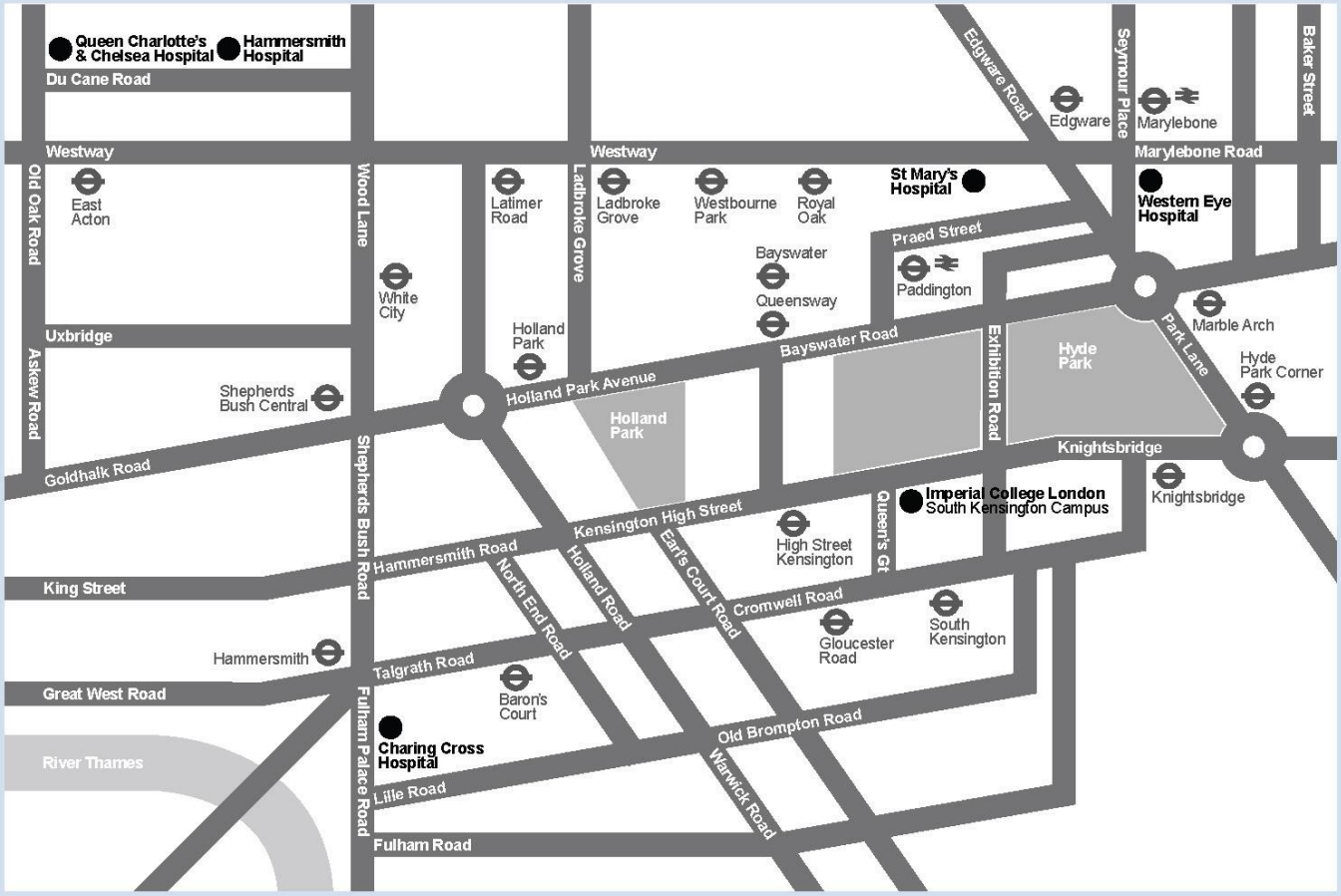
Urethra – a tube that connects the bladder to the outside of the body.

Urinary tract infection (UTI) – an infection that can happen anywhere along the urinary tract. Urinary tract infections have different names, depending on what part of the urinary tract is infected. They are caused by bacteria entering the urethra and then the bladder which can lead to infection.

Venous thromboembolism (VTE) – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood. A blood clot can occur anywhere in the body's bloodstream. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein; and arterial thrombosis which is a blood clot that develops in an artery.

Vein – blood vessel that carries blood towards the heart.

Contact us and map of Trust sites



Contact us

Charing Cross Hospital
Fulham Palace Road
London W6 8RF
Tel: 020 3311 1234

Hammersmith Hospital
Du Cane Road
London W12 OHS
Tel: 030 3313 1000

Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12)HS
Tel: 020 3313 1111

St Mary's Hospital
Praed Street
London W2 1NY
Tel: 020 3312 6666

Western Eye Hospital
Marylebone Road
London NW1 5QH
Tel: 020 3312 6666

Imperial College London
South Kensington Campus
London SW7 2AZ
Tel: 020 7589 5111

Imperial College
Academic Health
Science Centre

AHSC Directorate Annual Review 2013-14

Trust Board draft V0.5

Executive Summary

2013-14 was an important year for Imperial College Academic Health Science Centre (AHSC). It saw the AHSC submit an application to the Department of Health in a competitive process to designate new AHSCs. The application was successful and the AHSC became one of six organisations designated for 5 years from the 1st April 2014. Considerable progress was made in the lead up to the designation and in the period from the confirmation of AHSC status to the end of March 2014.

This first AHSC annual review sets out the achievements of the AHSC Directorate and presents a detailed breakdown of costs for the period April 2013 to March 2014 in order to provide assurance to the founding AHSC partners, Imperial College and Imperial College Healthcare NHS Trust that the investment in the Directorate has been well managed and that it demonstrates value for money.

The total annual cost of the AHSC Directorate was £696,934, against a budget of £1m with 6.39 staff recruited against a total funded establishment of 10.08 posts. The Directorate supported the delivery of the following key achievements at around a 30% reduction on the budget;

- Successful AHSC designation application
- Achieving the Directorate objectives
- Establishing the AHSC governance arrangements
- Improving AHSC communications
- A programme of stakeholder events
- Furthering the relationship with Imperial College Health Partners, notably developing an innovation pipeline of projects for wider adoption and diffusion
- Establishing the Centres For Translational Medicine infrastructure
- Ensuring the effective management of all AHSC Committee
- Effective management of the AHSC budget

1. Introduction

The Joint Working Agreement (JWA) describes the appointment of a single individual to act as the AHSC Director, to be jointly accountable to the CEO of the Trust and the Vice President (Health) Faculty of Medicine (FoM), Imperial College. With the approval of the Joint Executive Group (JEG) the AHSC Director's remit includes the appointment of staff and the establishment of 'delivery groups'.

The AHSC Director (Professor David Taube) was appointed and took up office in September 2012 and was supported by an office manager. An AHSC Budget of £1m per annum, initially for a two-year period was agreed in September 2012. The AHSC Director of Operations (Anne Mottram) took up the post in February 2013.

The AHSC establishment showing how the budget would be used to fund staff and all non-pay costs was approved by the JEG and the Trust Management Board in March 2013 and the FoM Board in June 2013, reflecting planning cycles.

A further meeting of the JEG in April 2013 approved the provision of expert advice and support in relation to communications to be provided as a shared service by the College Communications Directorate through the transfer of funding allocated to two posts.

In-year budget management meetings have occurred with College and Trust senior finance leads to agree the process, scrutiny and frequency of re-charge arrangements and are detailed in section 3.

In preparing this first full year AHSC annual budget review, the Audit Commission's definition of Value for Money (VFM) with the principles of economy, efficiency and effectiveness has been used as a guiding framework.

2013-14 was a significant year in the life of the AHSC; there was a seven month period of heightened activity in preparing for and submitting the AHSC designation application, the Pre-qualifying questionnaire (PQQ) and a final application, and a requirement to rapidly finalise the governance arrangements and the completion of a portfolio of supporting project structures and processes.

The following report presents a detailed breakdown of AHSC costs and achievements. The evidence, along with illustrative examples, is presented to provide assurance to both the College and Trust that the joint investment in the AHSC has been well-managed, meets all probity requirements and demonstrates VFM through the delivery of all objectives and key deliverables and does so with around a 30% reduction on the funded budget.

2. AHSC Directorate Objectives

Annual objectives were set by the AHSC Directorate. These were integrated into the individual appraisal of the team and were subject to regular internal reviews.

1. Lead the successful designation of the AHSC

2. Establish the AHSC infrastructure outlined within the JWA and ensure that this operates effectively and efficiently

3. Develop the framework for the Centres for Translational Medicine (CTMs) as the 'AHSC Delivery Groups' recommended in the Darzi AHSC Review, 2012

4. Develop a close working relationship with the Academic Health Science Network (AHSN), identifying areas for collaboration and in particular developing and implementing a process to identify innovations ready for wider adoption and diffusion by the network

5. Seek to define ways to measure AHSC success for inclusion in a public annual report

6. Plan and evaluate stakeholder engagement events, including enhanced multi-media communications and further academic links in this area

7. Ensure the funds invested in the AHSC Directorate are spent wisely and deliver value for money

All objectives were achieved.

3. Breakdown of Costs 2013-14

3.1 Establishing the AHSC Budget

The AHSC establishment was developed using clean-sheet design to reflect the skills and experience necessary to both develop an AHSC designation application and to take forward the objectives within it.

Regular budget meetings occurred throughout 2013-14 providing opportunities to scrutinise spending and review management of the budget as follows;

- April 2013 (College)
- July 2013 (College)
- December 2013 (Joint review College and Trust)
- January 2014 (Trust)
- April 2014 (Year-end review College)

- A final review with College and Trust finance teams has been requested for May.

A presentation of the year-end report is planned for the JEG on the 27th May 2014. In addition the report will be made available for review by the Faculty of Medicine (FoM) Board and the Trust Management Board.

3.2 AHSC Costs 2013-14

The total AHSC costs for 2013-14 are £696,934 against the budget of £1m.

The full costs incurred by the Trust are £456,071 and the total costs incurred by the College are £240,863.

A detailed breakdown of all pay and non-pay costs has been provided to the Trust and College finance teams and the chair of the JEG. The costs have been agreed in principle, however small changes may arise as late invoices are paid but these costs are not thought to be material.

The total staffing establishment on the budget was 10.8 posts, some of which are on a sessional basis. During the year the AHSC Directorate recruited to a total of 6.39 posts. The responsibilities and tasks of the established posts not recruited to were distributed among the AHSC team.

Appendix 1 shows the funded establishment versus posts in place and appendix 2 shows the organogram of AHSC staff.

4. Key Areas of Work and Achievements

4.1 Establishing the AHSC Governance Infrastructure

Job descriptions were drafted for all posts and those in prioritised areas were banded and recruited to. 100% of staff in post had an appraisal and agreed their annual objectives. The AHSC Director was appraised by the Vice President (Health) FoM and the Trust CEO.

AHSC Directorate weekly team briefings and monthly team meetings were established and were supplemented by weekly 1:1 meetings with the AHSC Director and the Director of Operations.

4.2 The Establishment and Management of AHSC Committees

The Directorate produced terms of reference (ToR) to establish two pivotal AHSC committees and throughout the year provided full secretariat support ensuring compliance

with the ToR, an annual schedule of business and supported the effective flows of information and the follow up of actions.

- **The JEG** met 14 times. While the ToR state that the frequency of meeting should be monthly, it was determined helpful for the JEG to meet fortnightly. Where meetings were not held these were due to requirements to be quorate. Rotating the chairmanship of the JEG between Trust CEO and Vice President (Health) was revised with the SPB approving the change of chair to the Vice President (Health) in September 2013.

  Key items of business included; Agreeing the JEG ToR and AHSC budget, regular reviews of the AHSC designation application, agreement on AHSC branding and logo, approval of the CTM framework, the appointment of the first CTM Chairs (November 2013), the ToR for the CTM Executive Committee and a review of IP. The JEG supported a number of areas of focus such as promoting the need to increase the number of examiners for medical trainees, MRes student access to clinical areas and systems resulting in an access policy and raising standards in Trust medical education. Throughout the year the JEG focused attention on developing a process to agree the allocation of funded programmed activities to reflect the research and education commitments of NHS Consultants.

  It received regular reports from the Vice President (Health), Trust CEO, Director of Research, the leads for Education, the Foundation Trust application, Shaping a Healthier Future, business cases of specific interest such as Pathology and through the AHSC Director's report each month the JEG received a summary of each meeting of the CTM Executive Committee.

- **The SPB** met a total of three times during 2013-14 (May, September and January). It will meet the requirements to hold meetings four times in a rolling year with its meeting scheduled for 19th May 2014.

  Key items of business included; Approving the SPB and JEG ToR, and approving the AHSC designation application. The SPB also carried out a detailed review of IP key metrics and it received a summary of JEG activities at each of its meetings.

The remaining committee outlined in the JWA is the IP Arbitration Committee. The ToR were drafted proactively and await approval so that this committee, which is expected to meet as issues arise, can be enacted as soon as it is required.

4.3 AHSC Designation Programme

The competitive call for applications to be designated as an AHSC was launched in March 2013 and ran until the final interview at the end of October 2013. The process required the submission of a PQQ to determine the shortlisting of applicants and a final full application which ran to over 50 pages.

This was a challenging process that required the production of a 5-year strategy, governance arrangements that demonstrated integration, alignment and effective decision-making processes, plans for economic growth, inclusivity and diversity, strategic partnerships, arrangements for working collaboratively with NHS infrastructure, including the Academic Health Science Network (AHSN), integration of service, education and research (and evidence to support excellence in these areas) and sound financial performance.

A key requirement of the application was the description of six work themes. Our application submitted the following examples of AHSC flagship clinical and academic services; Surgery and technology, brain sciences and diseases, infectious diseases, inflammatory diseases, metabolic medicine, population health and primary care. These themes were primarily based on the groupings brought together as the AHSC CTMs, which build on the Biomedical Research Centre (BRC) themes through the inclusion of additional non-BRC, funded research priorities, educational activities, their alignments with clinical services and examples of past translational excellence. Each theme also presented plans for clinical informatics and the generation of health policy and economic growth.

While there were some excellent sources of information to support the development of these plans, it was a considerable undertaking to deliver the requirements as fully finished plans and to a high standard. A small team, including valuable support from the IC Director of External Partnerships, worked on the application and no additional consultancy or locum support was used.

To manage the designation process the AHSC directorate used a programme management approach, comprising specific work streams and an overall plan that was monitored weekly by the team with fortnightly scrutiny by the JEG.

An important part of the programme was the delivery of an effective process to support the JEG members in preparing for the final designation interview with an international panel of experts. To this effect 3 ‘mock interviews’ were held during October 2013, briefings and potential interview questions were prepared for the assessors and a series of frequently asked questions, headline facts and summaries of learning points from each of the interview sessions were made available to the AHSC team for interview.

The AHSC was notified by the Department of Health (DH) at the end of November 2014 that it had been successfully awarded a second designation period of 5-years commencing the 1st April 2014. During a conference call with the DH and NIHR leads on the 20th January 2014 the application was commended as well written and for displaying strength and depth in its plans across all areas.

An overall AHSC 5-year master plan to operationalise the objectives within the designation application was noted by the Directorate as the necessary platform from which to take forward the AHSC mission.

4.3 CTMs

The framework for the CTMs sets out their purpose, scope and responsibilities. It was approved by the JEG, with final revisions, in November 2013. Notwithstanding the complexities in establishing the CTMs, in particular a review of BRC and AHSC structures to be carried out in the autumn of 2014, there is notable progress to report in this area; The Appointment of 12 CTM Chairs (including the enabling programmes) and drafting of their job description, the establishment of the CTM Executive Committee chaired by the AHSC Director, approval of the ToR for this sub-committee by the JEG and the management of its meetings.

The CTM Executive Committee met six times during the year; September 2013 (x two), October, November, January and March 2014 and focused on the following items of business; advice on the designation application and agreement of the content of the work themes, the need for alignment with BRC funds and leaders, proposals for establishing local forums, participation at the AHSC away day and as exhibitors at the AHSC Event.

The next stage of development for the CTMS is the incremental establishment of local forums for the key enabling programmes such as Stratified Medicine and Population Health and a core CTM for Women's and Children's. The AHSC Directorate is supporting the development of the forums and bringing together colleagues across research, education and service with local CTM inaugural meetings planned for early June 2014.

4.4 Programmes of Excellence (PoE)

An important responsibility delegated to the CTMs is to put forward PoEs for designation by the JEG. These are examples of AHSC flagships services delivering excellence across a range of measures such as clinical care, research, education and championing innovation and technology transfer. They are likely to be at speciality or sub–speciality level or based within a research, educational or technological specific area of expertise and will be areas with

strong national or international referral bases and reputations and should have the ability to influence the way in which academic healthcare is delivered.

PoEs are awarded their status of distinction by an internal designation process based on a review of AHSC metrics. The criteria for awarding PoE status was developed and presented to the JEG.

4.5 AHSC Identity and Branding

A number of workshops were held which involved staff from the College and Trust in a branding exercise. Imperial College Business School provided expert advice gleaned from their experiences of working with international high performing healthcare organisations. The Directorate developed a branding specification and ran a competitive tendering process with the work awarded to SEA Design. The logo and branding guidelines are in use across the AHSC.

4.6 Communications

From the agreed funding envelope for communications support and advice of £60,390 (Communications Manager AfC 8a 1WTE, New Media Manager AfC 7 0.5WTE) a total of £15,936 was spent on staff costs. The Director of Operations, supported latterly by the Impact Writer post, primarily led on communications outputs for the Directorate with expertise from the College Director of Communications, the Executive Officer (and full access to skills within their team), thereby reducing the initial estimated staff costs and realising a saving of £44,454 in this area.

4.7 Website

The original AHSC Website from 2009 was reviewed and deemed insufficient to promote the AHSC's role, sign-post new essential areas of work and to further the AHSC profile. A new website was developed and included updated information on our governance arrangements, plans and the CTMs; including interview film clips with the CTM Chairs articulating their local plans and vision. The website had 11,000 hits in the past six months.

4.8 e-bulletin

This monthly e-communication was launched in March 2014, initially to 500 stakeholders and as an open access publication through the AHSC website. The plans for 2014-15 include the development of CTM specific e-bulletins.

4.9 AHSC App Store

To consolidate the varied and innovative apps developed by the College and Trust, an 'AHSC App Store' was introduced. This internet-based resource allows the promotion of available apps and also has a facility for designers and stakeholders to share ideas/collaborate on areas of need through the apps in development networking section of the site. In the two months of its introduction seven AHSC developed apps have been promoted.

In addition an AHSC Communications Forum was established comprising staff from the AHSC Directorate, College, Trust and the AHSN. It is chaired and managed by the Director of Communications, Imperial College.

4.10 Engagement Activities

Stakeholder interviews

A series of semi-structured interviews with 60 stakeholders from health, commissioning, research, industry, education and patient representatives were carried out and the findings used in developing the AHSC plans for communications and in specific areas of focus.

AHSC Designation and CTM Launch

The designation process was launched at an event attended by around 40 senior staff. It was a useful opportunity to reaffirm a commitment to the AHSC, seek assistance in developing the application and notably to introduce the concept of the CTMs to an enthusiastic, internal audience.

AHSC Event and Exhibition of Innovations

The first AHSC Event was held on the 20th February 2014 at the Wolfson Centre. Over 150 people attended, including leaders from Imperial College AHSC and stakeholders from a variety of public and private sector organisations across North West London and beyond.

The event featured presentations from senior staff and exhibitions showcasing AHSC developed health innovations including the 'pop up theatre' demonstrating a simulated angiography, a number of robotics displays, neuro-rehabilitation computer games and various health apps. Attendees were invited to provide feedback via an electronic survey. Very positive feedback was received and there was a clear message that further events would be welcomed. Further events are being planned for the summer.

AHSC Away Day

Three overarching themes were identified by the JEG for discussion at the Away Day on the 25th March 2014;

- AHSC Vision; where do we need to be in five years and determinants of success
- Education and training
- Impact of future developments, approach to capital planning and funding models

A total of 30 senior staff attended the session; The chair of the SPB, Vice Dean (Health) FoM, and Chair JEG, JEG members, Dean of the Faculty of Engineering (FoE), Vice Deans FoM, AHSN Managing Director, CTM Chairs, Divisional Directors, Heads of Division.

The key themes arising from the session were;

I. Joined up capital planning – to establish a new forum
II. Clinical Academic appointment process with areas of investment identified as Cancer, Imaging, Stratified medicine, Out of hospital care, an increased AHSC role in commercial studies, and the appointment of 'superstar leaders' to take forward recruitment in these areas
III. Education and Training to be fixed quickly
IV. Role of the AHSC in community/public health

Additional areas of focus were identified as being the need for increased transparency in the allocation of research and education funds, increased awareness of the AHSC and the creation of a clear identity, benefits and value added across both organisations with targeting of the 'middle layers' of staff. A full thematic analysis of the table discussions was circulated to attendees.

The AHSC Directorate has commenced work on establishing a capital investment forum.

Collaboration with Professor Roger Kneebone, IC and a Welcome Trust Engagement Fellow

As included as one of the objectives within the AHSC designation plans, the Directorate established a joint research assistant post with Professor Kneebone's team, initially as a short- term contract for ten months from March 2014, with a view to establishing a PhD post to contribute to the academic debate on stakeholder engagement. The post is supporting a specific focus on 'patient directed involvement in their care', initially using simulation in a number of elective procedures. It is hoped to draw on Professor Kneebone's considerable expertise in engagement to take forward not only the AHSC stakeholder plans but also to work closely with the Trust in their plans to improve patient care and with the Joint Research Office to complement their work in increasing patient and public involvement in research. The post was funded as a research award of £38,000 to the Faculty of Medicine.

4.11 Innovation and Adoption

An effective working relationship with the AHSN and CLAHRC was further developed in 2013-14. This has involved collaborations around strategic plans, supporting the designation application, establishing regular meetings and of note, the development of a process to identify innovations in research, educational initiatives, clinical care and service evaluations. This review process supports the development of a pipeline of projects and seeks to deliver improvements to patients over a shorter period as possible. The AHSC Directorate using an agreed information proforma to identify clinical and cost effectiveness carries out the reviews of innovations for consideration. The process excludes innovations related to research (or other) projects that are still in progress and therefore do not have sufficient data to demonstrate their effectiveness.

Projects put forward for consideration included; the Home Based Stroke Rehabilitation Device, Embody-Personalised Surgery Instrumentation, Joint Pro-Electronic Patient Reported Outcome Measures, Patient Information podcast for Breast Cancer, My Action-Cardiac Rehabilitation, Paired Learning Scheme for Registrars, and discussions around the wider use of the MDT Diabetic Foot model of care.

The process was revised in-year to include a 'Dragon's Den' style presentation by the inventors. Several areas for improvement were also uncovered with the introduction of this work, namely; a need to promote the work much wider across both College and Trust, to minimise silo working by facilitating networking opportunities between academics, clinicians and managers and to broaden the expertise on the panel who review the innovations by extending invitations to the AHSC Director of Research and to the Trust's Medical Services Directorate.

4.12 Examples of Specific AHSC Supported Projects

The AHSC Directorate has supported a number of specific projects during the year and will continue to work on these during 2014-15;

JointPRO

The Directorate is working with the clinical academics involved in a pilot of this on-line system to capture patient reported outcomes and return of function for orthopaedic patients, with a view to developing JointPRO as a viable option to compete with the national PROMs system.

'LinkedIn' style e-networking for innovators, academics, clinician and NHS managers

This is a developing initiative to enhance networking using on-line resources to support local innovations by joining up innovators and their target audiences.

AHSC Scorecard

A means of identifying metrics that capture success across the AHSC mission was produced and a number of local subject matter experts participated in identifying the measures and the data sources that would support a 5-year historical profile of impact and influence. Baseline data for 2013-14 has been collected (where the performance data period has closed) and this exercise is due to be completed at the end of the College's financial year with the next steps to collaboratively agree benchmarks. The scorecard measures AHSC performance in areas of impact and innovations and brings together existing separate data on research, education and clinical service. It is hoped that the scorecard will be available at multiple levels of analysis such as the CTMs and ultimately sub-specialities within these delivery groups.

AHSC Annual Report

In advance of the publication of the DH requirements for the annual report that all AHSCs must produce, the Directorate has developed the AHSC scorecard as a means of collecting outcome data and has started an early iteration of content for consideration and approval by the JEG.

5. Promoting the AHSC; Hosting External Visits, Lecturers and Presentations

As part of raising the national and international profile of the AHSC, the Directorate hosted a number of visits, and gave several presentations and lectures, examples include;

Hosting Visits

- The University of Melbourne, April 2013
- Professor Steve Wartman, CEO of the Association of AHSC USA, June 2013
- Liverpool Health Partners Visit, July 2013
- Brian Fitzgerald CEO Dublin Hospital, September 2013
- Tasmanian Health Delegation, arranged by Lord Darzi's office, September 2013
- Senior Health Authority Officials and Fujian Province Hospital China Delegation Visit, November 2013
- Karolinska Institute visit, innovations demonstrations and dinner with Oxford AHSC/N, January 2014
- The James Lind Alliance, March 2014
- Monash Partners AHSC Visit, March 2014

In addition the Directorate participated in two visits organised by the FoM; Quatari Delegation Visit, November 2013 and Mauro Ferrari Visit, President and CEO of Houston Methodist Research Institute, January 2014.

Lectures and Presentations

- First Middle East Conference on Patient Safety, Abu Dhabi* (AM), April 2013
- International Conference on Quality and Safety, BMJ, April (AM) 2013
- CPSSQ Annual Conference (DT) June 2013
- CIPM Annual Symposium (AM) July 2013
- Westminster Briefing presentation 'Current and Future Policy; Bridging the gap between research lab and NHS ward' (DT) January 2014
- Association of Faculties of Medicine Annual Academic Health Science Network Symposium in Canada* (DT) March 2014

*All travel fees paid by sponsors and included in hospitality/register of interests declarations

Appendix 1

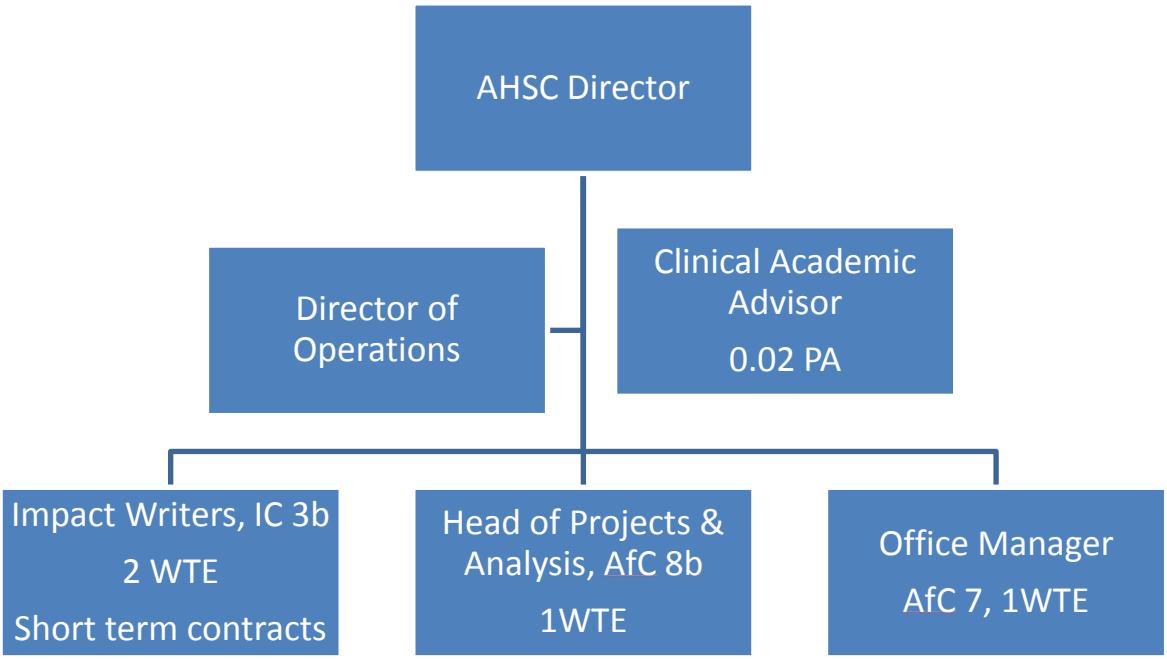
Posts funded on original establishment versus posts recruited

Grade	Post Title	WTE Funded	WTE Actual in Post	Comments
	AHSC Director	1.00	1.00	Management allowance only paid by AHSC budget
			0.00	Consultant salary on AHSC Budget not claimed as charged to Renal for clinical activities provided as per job plan
	Director of Operations	1.00	1.00	Recruited
BAND 8B	Head of Projects & Analysis	1.00	1.00	Recruited
BAND 8D	Head of Communications	1.00	0.00	Not Recruited
BAND 8a	Communications manager	1.00	0.00*	Not Recruited
BAND 7	Office Manager	1.00	1.00	Recruited
3B ICL	Impact Writer	1.00	2.00**	**Recruited on short term contracts
3A ICL	Researcher	1.50	0.00	X1 Research award to FoM from March 2014 for 10 month contract
	Clinical advisor	0.30	0.20	1PA removed
BAND 8A	Statistician	0.50	0.00	Not Recruited
BAND 7	New Media Manager (inc Web)	0.50	0.00	Not Recruited
BAND 5	Project Coordinator	1.00	0.00	Removed
	SPB Chair		0.19	Post recruited after initial establishment budget prepared.
Total		**10.08**	**6.39**	

Total staff in post 6.39 WTE

Appendix 2

AHSC Directorate Organogram Staff in Post 2013-14



Imperial College Healthcare NHS
NHS Trust

Working in Partnership

Response to consultation on our NHS foundation trust application

//Introduction

Imperial College Healthcare NHS Trust carried out a public consultation in support of our application to become a foundation trust between November 2013 and February 2014.

We see achieving foundation trust status as a means towards:

- bringing our Trust closer to our patients and local communities
- further strengthening engagement with our people
- providing greater freedom to innovate and develop our services

Local and national users of our services, the public, partner organisations and the people who work for us were asked for their views on our plans and proposals for becoming a foundation trust. The consultation process also allowed us to assess levels of support for our application. We asked for comments on a range of specific issues such as membership and governance arrangements, and the Trust's vision and strategic objectives.

During the consultation period we also offered the opportunity to sign up as a member of the prospective foundation trust as a way of becoming more involved in the way that healthcare works.

Your responses have helped to shape our plans. The views of patients, the public, partner organisations and people who work for us have been taken into account, and we have made changes to several areas of our plans based on your feedback.

Overall, we believe that the consultation has proved very useful both in developing relationships and strengthening our model of membership and governance.

We are grateful to everyone who participated and provided us with their feedback on our proposals.

//How did we consult?

The consultation on the proposals for becoming a foundation trust was carried out between 11 November 2013 and 10 February 2014.

As part of the consultation process we contacted 550 individual stakeholders in 145 organisations, including, local MPs, local authorities, other NHS organisations, professional and staff representatives, and voluntary organisations, inviting them to take part in the consultation and give their views.

To ensure as many people as possible were able to give their views, we tried to make the process as easy and accessible as possible. We produced a consultation document with a questionnaire that was available online through our website. Over 4,000 copies of the consultation document were sent to individuals and organisations, particularly across north west London. The document was also available in languages other than English, large print and audio format upon request.

We used a range of consultation methods, including:

- a consultation letter sent to 550 individual stakeholders in 145 organisations
- a letter sent to 1,200 GP practices
- a letter sent to 1,700 shadow foundation trust members
- a letter sent to 10,000 patients treated at the Trust
- over 4,000 consultation documents sent to individuals and organisations
- a helpline and designated email address available for sharing views and submitting any queries
- three public meetings held in local communities, attended by 135 people
- regular updates to the Trust's 4,750 followers via Twitter
- regular updates at staff meetings 'Chief Executive Open Hour' and 'Chief Operating Officer Team Brief' sessions
- regular updates via the Trust communication channels, including articles in the Trust's newspaper 3600, newsletters GP Bulletin and Partner Update, together with updates via the internal email briefings, InBrief and Team Brief
- consultation materials made available at contact points – main receptions and Patient Advice and Liaison offices – at main hospital sites
- promotional materials including banners and posters displayed across the main hospital sites
- representatives from the Trust attending a number of meetings with local authority overview and scrutiny committees and clinical commissioning groups, and a dedicated event was organised with Healthwatch Central West London

//Who responded?

A total of 545 formal responses were received from individuals and partner organisations, using the following methods:

Online questionnaire:	305
Response form:	231
Email/letter:	9
Total:	**545**

Three local authorities submitted formal responses: Royal Borough of Kensington and Chelsea; London Borough of Hammersmith & Fulham; and Westminster City Council.

Responses from other organisations were provided by email and letter, including: Bucks New University; Healthwatch Central West London; London Borough of Harrow; Macmillan Cancer Support; North West London Hospitals NHS Trust; Ealing Hospital NHS Trust; and NHS West London Clinical Commissioning Group.

//What did people say?

Overall there was general support for our plans and proposals for becoming a foundation trust. We asked 13 questions in the consultation. Responses ranged between 48.5 and 78.5 per cent in favour for the 13 questions asked.

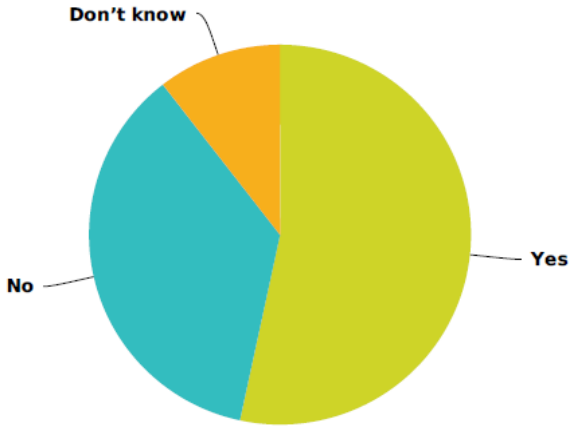
The following questions in particular received majority (over 50 per cent) support:

Q1: Do you agree with our vision and strategy for the future?
Q2: Do you agree that the minimum age for membership should be 16?
Q3: Do you agree that the public constituency should encompass the whole of Greater London?
Q4: Do you agree that we should have a public and a patient constituency?
Q6: Do you agree that staff members should automatically become members of the Trust unless they choose to opt out?
Q7: Do you agree that only staff directly employed by the Trust should be eligible for staff membership?
Q8: Do you agree that the staff constituency should be sub-divided as clinical and non-clinical?
Q9: Do you agree with the proposed levels of engagement with our members as described?
Q11: Do you agree with the minimum age of governors being 16?
Q12: Do you agree with our proposed arrangements for elections?
Q13: Do you agree with our proposed plan for the board of directors?

A breakdown of the responses for each question is shown on the following pages.

Q1 Do you agree with our vision and strategy for the future? (Page 12)

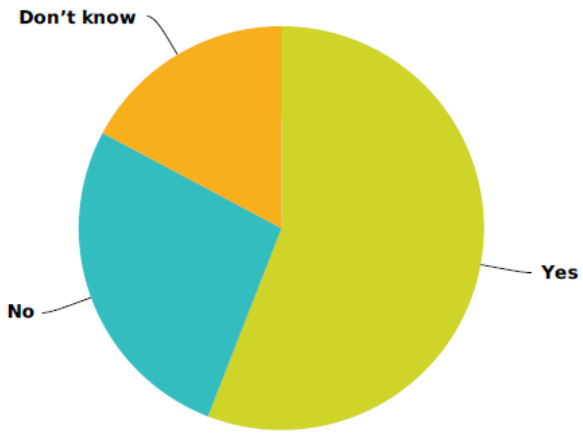
Answered: 534 Skipped: 4



Answer Choices	Responses	
Yes	53.37%	285
No	36.14%	193
Don't know	10.49%	56
Total		534

Q2 Do you agree that the minimum age for membership should be 16? (Page 16)

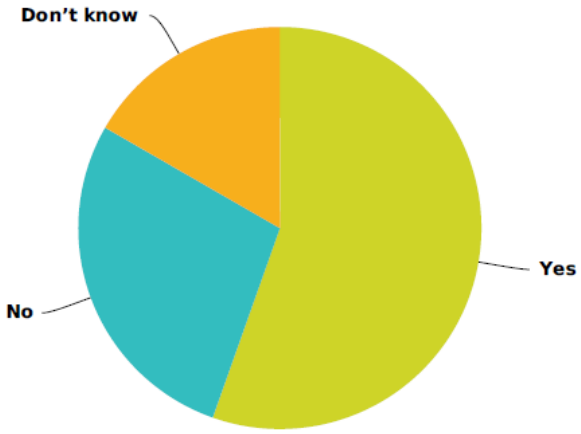
Answered: 483 Skipped: 55



Answer Choices	Responses	
Yes	55.90%	270
No	26.92%	130
Don't know	17.18%	83
Total		483

Q3 Do you agree that the public constituency should encompass the whole of Greater London? (Page 17)

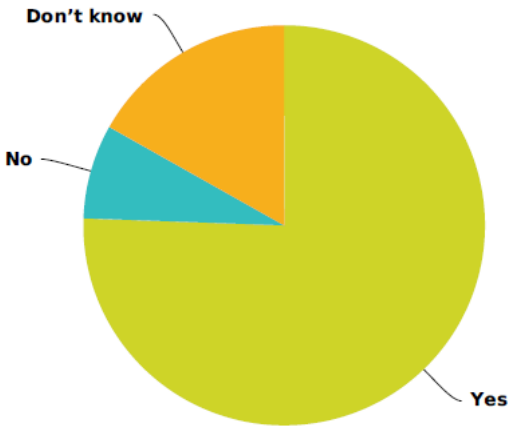
Answered: 462 Skipped: 76



Answer Choices	Responses	
Yes	55.41%	256
No	27.92%	129
Don't know	16.67%	77
Total		462

Q4 Do you agree that we should have a public and a patient constituency? (Page 17)

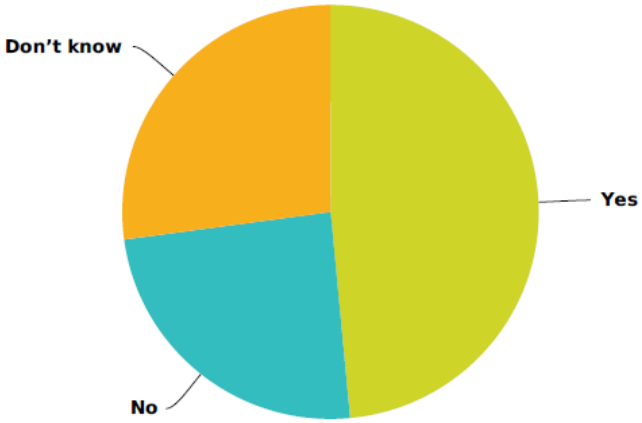
Answered: 446 Skipped: 92



Answer Choices	Responses	
Yes	75.56%	337
No	7.62%	34
Don't know	16.82%	75
Total		446

Q5 Do you agree that the patient constituency should not be sub-divided to include carers? (Page 17)

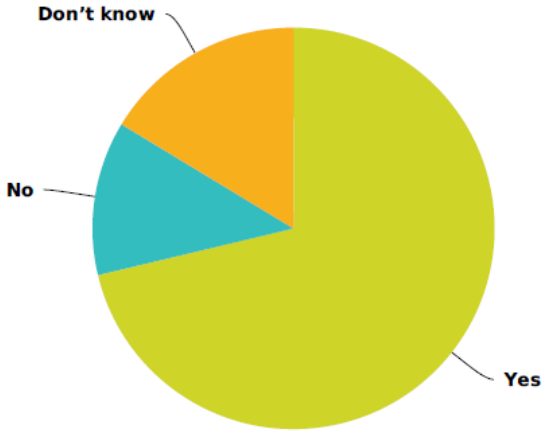
Answered: 435 Skipped: 103



Answer Choices	Responses	
Yes	48.51%	211
No	24.37%	106
Don't know	27.13%	118
Total		435

Q6 Do you agree that staff members should automatically become members of the Trust unless they choose to opt out? (Page 17)

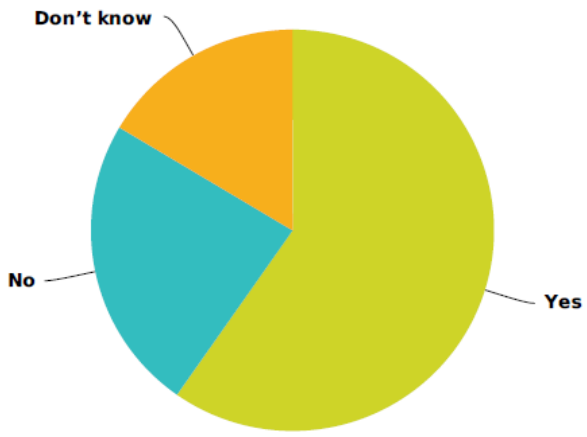
Answered: 435 Skipped: 103



Answer Choices	Responses	
Yes	71.26%	310
No	12.41%	54
Don't know	16.32%	71
Total		435

Q7 Do you agree that only staff directly employed by the Trust should be eligible for staff membership? (Page 17)

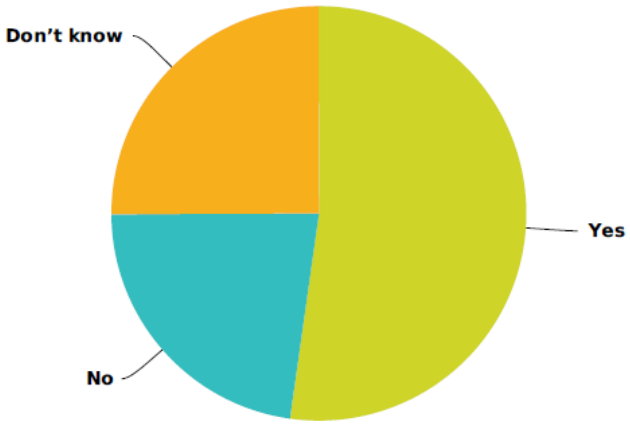
Answered: 432 Skipped: 106



Answer Choices	Responses	
Yes	59.72%	258
No	23.84%	103
Don't know	16.44%	71
Total		432

Q8 Do you agree that the staff constituency should be sub-divided as clinical and non-clinical? (Page 17)

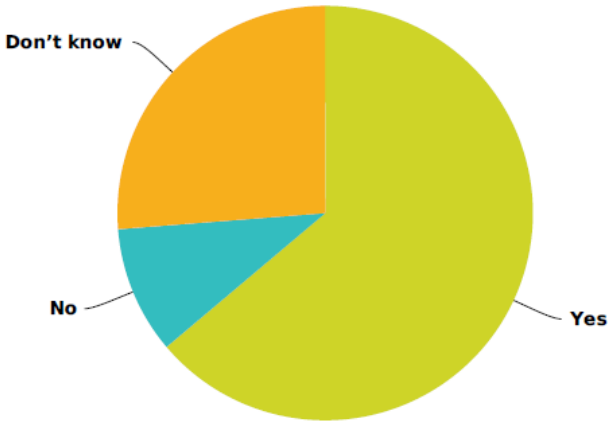
Answered: 427 Skipped: 111



Answer Choices	Responses	
Yes	52.22%	223
No	22.72%	97
Don't know	25.06%	107
Total		427

Q9 Do you agree with the proposed levels of engagement with our members as described? (Page 17)

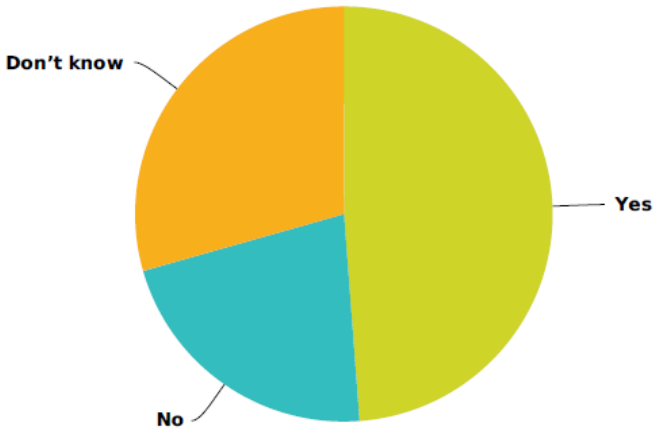
Answered: 423 Skipped: 115



Answer Choices	Responses	
Yes	63.83%	270
No	9.93%	42
Don't know	26.24%	111
Total		423

Q10 Do you agree with the proposed size and composition of the council of governors? (Page 19)

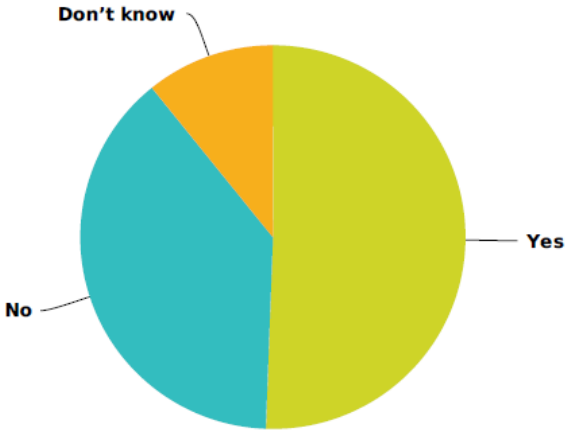
Answered: 418 Skipped: 120



Answer Choices	Responses	
Yes	48.80%	204
No	21.77%	91
Don't know	29.43%	123
Total		418

Q11 Do you agree with the minimum age of governors being 16? (Page 19)

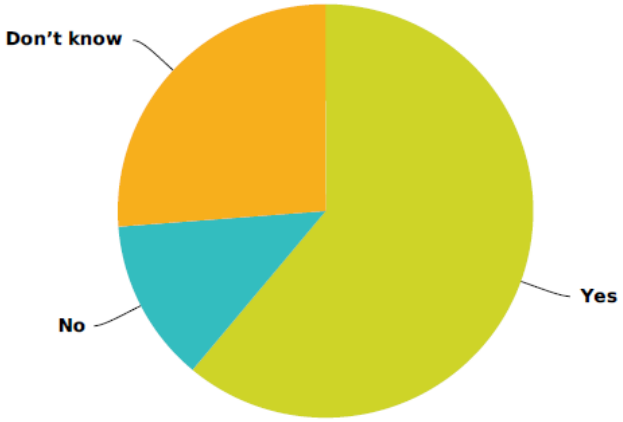
Answered: 417 Skipped: 121



Answer Choices	Responses	
Yes	50.60%	211
No	38.61%	161
Don't know	10.79%	45
Total		417

Q12 Do you agree with our proposed arrangements for elections? (Page 19)

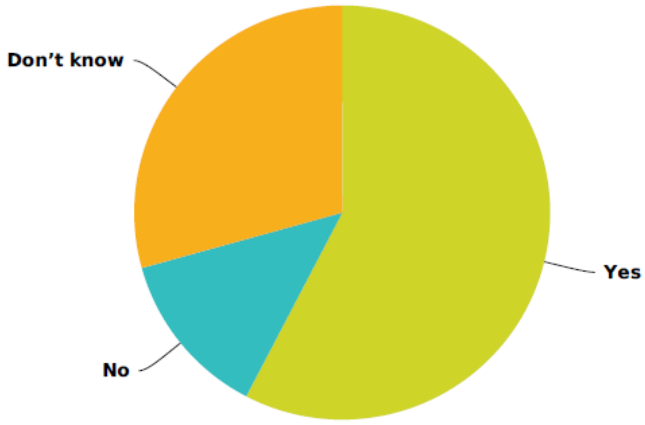
Answered: 416 Skipped: 122



Answer Choices	Responses	
Yes	61.06%	254
No	12.74%	53
Don't know	26.20%	109
Total		416

Q13 Do you agree with our proposed plan for the board of directors? (Page 21)

Answered: 406 Skipped: 132



Answer Choices	Responses	
Yes	57.64%	234
No	13.05%	53
Don't know	29.31%	119
Total		406

//Our response to your comments

We analysed and reviewed all the feedback received via the consultation. The findings were considered by the Trust board of directors at their public meeting in March 2014, with a view to helping shape the final application for foundation trust status.

The full outcome report on the consultation can be read at **www.imperial.nhs.uk**

As shown above, 11 out of 13 questions received majority support of 50 per cent. There were two questions where supportive responses were in the majority, but were slightly lower than 50 per cent of the total:

Sub-division of the patient constituency for carers

Of the respondents, 48.5 per cent were in favour of not sub-dividing the patient constituency to include carers; 24.4 per cent disagreed with the proposal; and 27.1 per cent responded 'don't know'.

We recognise the valuable role and contribution made by carers and the potential benefits from their involvement in our activities. However, we feel that the sub-division of the patient constituency would increase the complexity of the governance arrangements.

After consideration of the point, we see the encouragement of carers as members of the public constituency as a means of ensuring their involvement. The Trust board of directors also agreed that the one governor seat allocated to a voluntary organisation will be specifically 'ring-fenced' to be filled by an organisation representing carers.

Size and composition of the council of governors

Of the respondents, 48.8 per cent were in favour of the proposed size and composition of the council of governors; 21.8 per cent disagreed with the proposals; and 29.4 per cent responded 'don't know'.

The council of governors is the body through which the membership maintains dialogue with the Trust board of directors, and it is important that it can fulfil its role and responsibilities effectively. While increasing the number of seats in certain constituencies, and for specific nominated partners, may appear responsive to suggestions for increased representation, this should be weighed against the need for the council to operate effectively.

The Trust provides over 55 specialist services for both adults and children, and in 2012/13 we provided specialist care for patients from over 80 commissioners nationwide. While providing the same comprehensive range of healthcare services to the local population of nearly two million people resident in north west London, the Trust believes that it would benefit from the involvement of governors elected from across Greater London who share an interest in our services.

Being an academic health science centre (AHSC) brings significant benefits for our patients, the people who work for us, students and the local population. This we believe warrants allocating three seats for AHSC partners. For similar reasons, the Trust's close integration with Imperial College London means we wish to proceed with one allocated seat for this university.

We see achieving foundation trust status as a means towards bringing the Trust closer to our patients and local communities, and partner organisations including Healthwatch who work on behalf of patients and the public to ensure they have their say about the NHS. The Trust sees the continued development of a strong working relationship with Healthwatch as an important part of our approach to improving the experiences of our patients and their carers while in contact with our services.

We are keen to ensure that governors with an active interest in our activities are able to contribute over a suitable length of time, which will provide the opportunity to develop an individual governor's expertise and maintain appropriate continuity for the governance of the organisation. We therefore intend to proceed with a maximum term of office of up to nine years.

After consideration of the various points raised about the size and composition of the council of governors, we have responded with a series of changes which are subject to the formal agreement of the new foundation trust's constitution:

- Sub-divide the eight seats allocated to the public constituency so that five are elected from members living in north west London (eight boroughs) and three are elected for the rest of Greater London (24 boroughs and the City of London).
- Increase by one the number of seats allocated to the patient constituency, giving a total of nine seats for this constituency.
- Increase by one the number of seats allocated to clinical commissioning groups, giving a total of two seats for this constituency.
- Increase by two seats the total number of seats on the council of governors, giving a total of 33 seats for the council.
- Specify that the two seats allocated to clinical commissioning groups (CCGs) are specifically in relation to the eight CCGs in north West London and that the process for deciding how these seats are filled is their responsibility.
- Specify that the two seats allocated to local authorities are specifically 'ring-fenced' to the two local authorities in which the Trust's three main hospital sites are geographically located – the London Borough of Hammersmith & Fulham and Westminster City Council – and that the process for filling the one seat allocated to each local authority is their responsibility.
- Specify that the one seat allocated to an independent medical charity is specifically 'ring-fenced' to the Association of Medical Research Charities and that the process for deciding how this seat is filled is their responsibility.
- Specify that the one seat allocated to a voluntary organisation is specifically 'ring-fenced' to be filled by an organisation representing carers.

Proposed size and composition of the council of governors		**Final size and composition of the council of governors**	
Public seats	8	Public seats	8
Patient seats	8	Patient seats	9
Staff seats	5	Staff seats	5
Partners	10	Partners	11
Total	**31**	**Total**	**33**

Partners			
Clinical commissioning groups	2	AHSC partners	3
NHS England	1	Independent medical charity	1
Local authorities	2	Voluntary organisation	1
University: Imperial College London	1	**Total**	**11**

//Conclusion

The consultation on our foundation trust application has demonstrated overall support for our plans and proposals. As a result of this feedback we have been able to revise and strengthen our plans. It has been an opportunity for us to further engage with our local communities and strengthen relationships, which is a fundamental reason for becoming a foundation trust.

We would like to thank everyone who took part in our consultation and look forward to working in partnership with our members and local communities in the future.

//Alternative formats

Alternative formats for this report
This document is also available in other languages, large print and audio format on request. Please contact the communications directorate on 020 3312 7674 for further details.

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Este documento encontra-se também disponível noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Dokument ten jest na życzenie udostępiany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Este documento también está disponible y puede soliitarse en otros idiomas, en letra grande y formato de audio.

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Sipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madhe dhe në formë dëgjimore.

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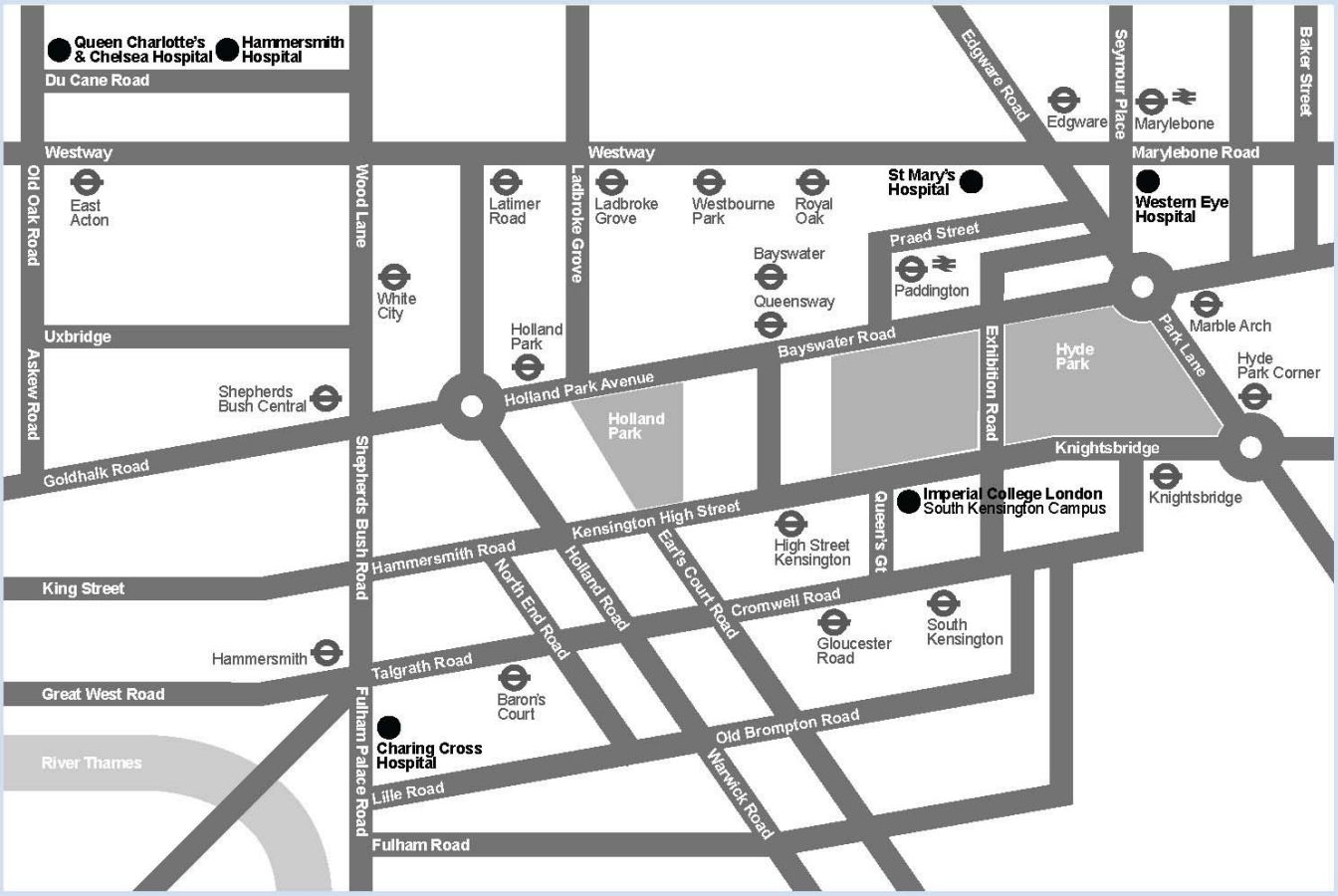

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