TRUST BOARD IN PUBLIC AGENDA
10.00am – 12.30pm
Wednesday 29 January 2014
Oak Suite,
W12 Conference Centre, Hammersmith Hospital,
London W12 0HS

		Paper	Presenter
1	**General Business**		
1.1	Chairman's Opening Remarks	**Oral**	Chairman
1.2	Apologies	**Oral**	Chairman
1.3	Board Members' Declarations of Interest and Conflicts of Interest	**1**	Chairman
1.4	Minutes of the meeting held on 27 November 2013	**2**	Chairman
1.5	Matters Arising and Action Log	**3**	Chairman
1.6	Chairman's Report	**4**	Chairman
1.7	Chief Executives' Report	**5**	Chief Executives
2	**Quality and Safety**		
2.1	Director of Nursing's Report	**6**	Director of Nursing
2.2	Medical Director's Report	**7**	Medical Director
2.3	Infection Prevention and Control Report	**8**	Director of Infection Prevention & Control
3	**Performance**		
3.1	Integrated Performance Report and Scorecard Month 9 2013/14	**9**	Chief Operating Officer
3.2	Dementia Care Audit	**10**	Chief Operating Officer
3.3	Finance Report • 2013/14 Month 9 Report	**11**	Chief Financial Officer
3.4	Emergency Planning Update	**12**	Chief Operating Officer
3.5	Director of People and Organisation Development's Report	**13**	Director of People & Organisation Development
3.6	Director of Governance and Assurance's Report	**14**	Director of Governance & Assurance
3.7	Corporate Risk Register	**15**	Director of Governance & Assurance
3.8	Board Assurance Framework	**16**	Director of Governance & Assurance

3.9	NHS Trust Development Authority Self-Certifications: • October Compliance • October Board Statement • November Compliance • November Board Statement	**17** **17A** **17B** **17C** **17D**	Chief Financial Officer
4	**Strategy**		
4.1	Immediate tasks / Key priorities	**18 Presentation**	Chief Executives
4.2	2014/15 Integrated Planning Framework	**19**	Chief Financial Officer
4.3	Outcome of approval of Academic Health Science Centre (AHSC) accreditation by Department of Health (DoH)	**20**	Chief Executives
4.4	Board Governance Assurance Framework (BGAF) Approval of Board Governance Memorandum	**21**	Director of Governance and Assurance
4.5	Quality Governance Framework Approval of Board Governance Memorandum Self Assessment & Quality improvement plan	**22**	Medical Director
5	**Papers for information**		
5.1	Finance & Investment Committee • Report of meeting on 23 January 2014.	**Oral**	Sarika Patel
5.2	Quality Committee • Report of meeting held on 5 December 2013	**Oral**	Sir Anthony Newman-Taylor
5.3	Foundation Trust Programme Board • Report of meetings on 17 December 2013 and 21 January 2014.	**Oral**	Dr Rodney Eastwood
5.4	Audit, Risk and Governance Committee • Report of meeting held on 11 December 2013	**Oral**	Sir Gerald Acher
6	**Any Other Business**		
		Oral	Chairman
7	**Date of Next Meeting:**		
Trust Board Meeting in Public: Wednesday 26 March 2014, 10am – 12 noon, New Boardroom, Charing Cross Hospital, Fulham Palace Road, London, W6 8RF			
8	**Questions from the Public relating to Agenda Items**		
9	**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

Report Title: Declarations of Board Members' Interests

To be presented by: Cheryl Plumridge, Director of Governance & Assurance

Executive Summary: The Department of Health's "Code of Conduct and Accountability" requires that the Chairman and Board members should declare any conflict of interest that arises.

To comply with this requirement a note of all Declarations made by the Board will be taken to each Public Board meeting as a formal record and is attached as Appendix A.

A full register of all Declarations made by all staff, including the Board, will continue to be kept in accordance with the requirements of the Register of Interests Policy.

The relevant extract relating to Declarations of Interests from the Standing Orders is attached as Appendix B.

Action: For noting

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

Sir Richard Sykes Chairman
- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Member, Bristol Advisory Council since 2006
- President, Institute for Employment Studies since 2008
- Chairman, Careers Research Advisory Centre since 2008
- Non-Executive Chairman of NetScientific
- Non-Executive Director of ContraFect since 2012
- 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

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

Jeremy M Isaacs Non-Executive Director
- JRJ Group Limited – Director
- JRJ Jersey Limited - Director
- JRJ Investments Limited – Director
- JRJ Team General Partner Limited - Director
- JRJ Ventures LLP – Partner
- JRJ Partner 1 LP – Partner
- JRJ Partner 2 LP – Limited Partner
- JRJ Carry LP – Partner
- Food Freshness Technology Holdings Ltd – Director
- United Jewish Israel Appeal – Director
- Kytos Limited - Director
- Support Trustee Ltd – Director
- LSBI LLP - Member
- Marex Spectron Group Limited – Director/NED Chairman
- Member, Bridges Ventures Advisory Board (Privately owned Venture Capital Company with a social mission)
- 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
- Trustee, CORDA, Preventing Heart Disease and Stroke
- 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

Professor Nick Cheshire Chief Executive
- Hansen Medical: Scientific advisory board Member (Endovascular Robotics programme)
- Hansen Medical: Dept level research support.
- McKinsey Company. Member of Medical Directors Advisory Group
- Medtronic Inc: Scientific Advisory Board Member (Branch AAA stent programme), Institution level grant support. .
- Veryan Medical (IC spin out) Shareholder (0.5%)
- NICE: Member of TOPIC Selection Committee
- Cook (UK) Speakers Bureau
- Member, Organising Committee of the Multidisciplinary European Endovascular Therapies Conference (MEET) Rome, Italy
- Member, Scientific Advisory Committee of the Controversies and Updates in Vascular Surgery (CACVS) conference Paris France
- Organiser & speaker, Medtronic University course
- Gore Company - Consulting agreement for advanced endovascular therapies

Cook, Medtronic and Gore are endovascular equipment suppliers to the Trust
Hansen Medical manufactures the only commercially available endovascular robot and supplies hardware and disposable robotic equipment to the trust.

Bill Shields Chief Executive
- Honorary Colonel, 243 (Wessex) TA Field Hospital:
- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Board member, NHS Shared Business Services

Dr Chris Harrison Medical Director

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

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

Marcus Thorman Director of Finance

Nil

Extract from Standing Orders **Appendix B**

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
d) A position of authority in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services;
f) Research funding/grants that may be received by an individual or their department;
g) Interests in pooled funds that are under separate management.
h) Funding received from a third party, excluding Imperial College London, for a staff member.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 27 November 2013

Clarence Wing Board Room
St Mary's Hospital, Paddington

Present:	
Sir Richard Sykes	Chairman
Sir Thomas Legg	Senior Independent Director
Sir Gerald Acher	Non-Executive 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
Prof Nick Cheshire	Chief Executive
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:	
Ian Garlington	Director of Strategy
Stephen Guile	Head of Corporate Services & Trust Secretary
Prof Alison Holmes	Director of Infection Prevention and Control *(for item 2.3)*
Prof Dermot Kelleher	Principal of the Faculty of Medicine of Imperial College.
Jayne Mee	Director of People and Organisation Development
Cheryl Plumridge	Director of Governance and Assurance
Prof Jonathan Weber	Director of Research *(for item 4.4- 4.1)*

1	**General Business**
1.1	**Chairman's Opening Remarks**
	The Chairman welcomed Board members, staff and members of the public to the meeting.
1.2	**Apologies for Absence**
	None.
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 25 September 2013**
	The minutes of the meeting held on 25 September 2013 were agreed as a true record.

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1.5	**Matters Arising and Action Log**
	The Board noted the updates to actions in the log. Updates were discussed where necessary during the meeting.
1.5.1	**Min 4.2.2 Cost Improvement Plan:** Trust over-performance on income. Marcus Thorman said that a process had been agreed at the 19 November Finance and Investment Committee meeting in relation to the costs associated with increased activity and income; a report on service line reporting would be brought to the Committee's January 2014 meeting.
1.6	**Chief Executive's Report** The Board noted the Chief Executive's report which was presented by Nick Cheshire and Bill Shields. In particular:
1.6.1	**Director of Communications** Michele Dixon had been appointed as the Director of Communications. As part of Michele's induction, one-to-one meetings would be arranged with Non-Executive directors. **Action: Jayne Mee**
1.6.2	**Performance Summary** Steve McManus acknowledged that the Trust had failed to meet the Cancer waiting times targets for 62 day first treatment standard, with 27 patients having been delayed. The Trust was now meeting 7 out of the 8 cancer standards. He advised that with improved treatment times, it was a matter of achieving these treatment times consistently, for long enough to achieve target overall. Bill Shields advised that with improved diagnostics he expected the target for 62 days to be reached by the end of the quarter.
1.6.3	**Winter Planning** Steve McManus would be reporting more fully under agenda item 3.2: Winter Planning, on the operation of the Trust's 'Winter office' managing pressures in emergency treatment and bed-occupancy periods.
1.6.4	**Finance Summary** Bill Shields confirmed that he expected the planned surplus for the financial year of £15.1m to be achieved. Bill Shields confirmed that some of the shortfall in the cost improvement programme (CIP) had been made up.
1.6.5	**Trust Strategic Objectives** The Board approved the revised Trust Strategic Objectives, as follows: • 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.
2	**Quality and Safety**
2.1	**Director of Nursing's Report**

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	Janice Sigsworth presented her report, and in particular:
2.1.1	**Nursing Times Nurse of the Year**
	Janice Sigsworth Introduced Victoria Harmer, who had won the Nursing Times Nurse of the Year award for her work on Cancer in the Trust. Victoria is a team leader and clinical nurse specialist in breast care. Sir Richard Sykes warmly commended Victoria for her dedication and congratulated her on her award.
2.1.2	**Out of hours spot Checks**
	Janice Sigsworth reported on the out-of-hours night and weekend spot checks. In response to a question from Sir Gerald Acher, Janice Sigsworth said that new Patient Information Boards were used to help patients to understand what care they could expect and encourage them to talk to staff about any concerns. In response to a question from Sir Richard Sykes, Janice Sigsworth said that ward managers names, contact details and photographs were displayed. Staff were encouraged to introduce themselves and their role to patients.
2.1.3	**Update on progress against the Trust's action plan following the Mid-Staffordshire NHS Foundation Trust inquiry (2013)**
	The Board noted the Trust's action Plan attached as Appendix A to the report. In response to a question from Dr Andreas Raffel on Action No. 25: Review Feedback and Learning from Complaints, Cheryl Plumridge advised that a report on the Trust's response to the report by Ann Clwyd MP on complaints and the Government's report "Hard Truths, The Journey to Putting Patients First", would come to the Audit, Risk and Governance Committee at its meeting on 11 December 2013. Janice Sigsworth said that she would continue to review and update the Action Plan as progress was made.
2.1.4	**Savile investigation**
	The Board noted that further assurance had been requested from all Trusts, in particular focusing on employment checks, training for contractors and internet access. The Trust was currently drafting its response.
2.1.5	**Patient Experience: Patient Story**
	Janice Sigsworth presented the slides in Appendix B to the Report, which gave an example of care for a dangerously ill baby and her parent's delight that their child had survived to begin to grow up within the family. In response to a question from Sir Gerald Acher, Janice Sigsworth said that she was working with the Communications Director on communicating examples of good care, subject to anonymity and confidentiality.
2.1.6	**Equality and Diversity Strategy 2013/15**
	Janice Sigsworth presented the Equality and Diversity Strategy 2013/15 that had been approved by the Board's Quality Committee. Health inequalities were being reviewed, including physical and mental health and, in particular, dementia to establish what these meant for patients and patient care. The Board welcomed the Strategy and its implementation.
2.2	**Medical Director's Report**
	Chris Harrison presented the report, and in particular:
2.2.1	**Quality Strategy**
	The Board endorsed the Quality Strategy presented as appendix A to the Report.
2.2.2	**Care Quality Commission Intelligent Monitoring Report**
	The Board noted the CQC report on 87 indicators, for the Trust, attached as appendix B to the Report. In response to a question about whistleblowing, Chris Harrison said that the CQC scored this according to the number of whistleblowing reports it received. He

	confirmed that the 'tell us what you think' campaign lead by Jayne Mee continued to be promoted to encourage staff to voice their concerns. The CQC have applied a proportional score for each trust The Trust had been judged at risk band 4, on a scale of 1 to 6 with 6 being the lowest risk. Appendix C showed our results compared with other English hospitals.
2.3	**Infection Prevention and Control Report**
	Alison Holmes presented the Report. There had been 41 Trust-attributive cases of *C.Difficile* to date, against a target limit of 65 for the year 2013/14. Each case received forensic review. Some cases which had occurred in the community had non-the-less been allocated to the Trust. Regular reports on infection control were also made to the Quality Committee. The Trust continued dialogue with the Department of Health about the allocation of cases. The Board noted the update on winter preparedness, especially in relation to Norovirus. Alison Holmes outlined work being undertaken on antibiotic stewardship; hand hygiene (with c7000 staff having been trained in 'non-touch' techniques; and surgical site infection prevention. Figure 8 in the supporting Appendix showed distribution of *E.Coli* by Speciality, as requested at the September Trust Board meeting. Figure 10 set out infection from catheter lines against target. In response to a question from Sir Richard Sykes, Alison Holmes said that there were strict governance arrangements for decisions to use high level antibiotics.
3	**Performance**
3.1	**Executive Performance Report – Month 7 2013/14**
3.1.1	Steve McManus presented the report. The Trust was now meeting seven out of the eight cancer standards and work continued with the Cancer Management team to track patient pathways to ensure that patients receive treatment within the target time. The Trust was seeking to meet the Cancer waiting times targets for 62 day first treatment standard by the end of the quarter. Referral to treatment times for elective patients was being achieved above the targets at a Trust aggregate level. The Trust underperformed against 3 TFLs. It was noted that the RTT programme in November is also likely to see a level of underperformance in Cardiology and Rheumatology. Capacity reviews have been instigated for these specialities in order to recover performance.
3.2	**Winter Planning Presentation**
3.2.1	Steve McManus presented the slides distributed within the Board papers, which set out the governance arrangements for the management of services during the busy Winter period. The 'Winter Office' will co-ordinate delivery of the winter plan across the Trust. Following planning and detailed modelling of capacity and demand, an additional 20 beds had been opened in November and there were plans to open to a maximum capacity of an additional 50 beds by end-December. The models of care and staffing had been carefully considered. In response to a question from Sir Richard Sykes, Steve McManus confirmed that the profile of patients had been considered, with age appropriate care, especially for over those aged 75 years and over. The acute patient pathway for older persons included 'step down' care, to enable rehabilitation and rapid discharge. This required close working Social Services and community care providers. Commissioners were providing some £700,000 of funding support to enable 7 day/week availability of social services at ICHT to aid discharge planning. Arrangements were in place for rapid clinical decision making. Cases of delayed discharge were being managed and at the time of the meeting there were no cases of a patient awaiting repatriation to another hospital. Beds would open only when there was sufficient medical and nursing staffing. Central London Community Health (CLCH) was providing community beds at Charing Cross Hospital, a collaboration that included the Chelsea and Westminster Trust. These beds, which would be staffed by the three trusts, would augment existing community bed capacity, operating from within the acute hospital. The

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	CLCH beds would open only when the appropriate governance arrangements were in place. Nick Cheshire said that the community beds must provide good quality care. Sarika Patel said that the Trust needed to be able to discharge patients appropriately into the community.
3.2.2	In response to a question from Sir Gerald Acher, Janice Sigsworth said that appropriate levels of staff were being recruited. Steve McManus confirmed that beds would be opened only in line with availability of appropriate staff levels. In response to a question from Sir Gerald Acher, Bill Shields said that the identified costs pressures, amounting to £600,000, were being worked through. Bill Shields commended Steve McManus for the regular reporting he was providing to the Management Board.
3.2.3	Sir Richard Sykes asked that the new Performance Dashboard include a few key indicators for Winter management for monitoring by the Trust Board. Steve McManus confirmed that he would be bringing the proposed new Integrated Dashboard to the Trust Board Seminar on 18 December 2013 for review, ahead of reporting the first set of live date (M9) at the 29 January 2014 Trust Board meeting. **Action: Steve McManus**
3.3	**Finance Report**
	2013/14 Month 7 Report
	Marcus Thorman presented the report.
3.3.1	The Trust had achieved a year to date surplus of £10.9m at the end of October (after adjusting for impairments and donated assets), an adverse variance against the plan of £0.5m. The surplus for October had been £4.2m, which was a favourable variance against plan of £0.3m. CIPs were behind plan by £4.0m, an improvement in month and so continuous improvement in delivery of the CIPs was necessary. Monthly targets were now being achieved but the backlog needed to be caught up. The Trust still expected to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets. Regular detailed reports were made to the Management Board which included information on bank and agency staff spend.
3.3.2	Marcus Thorman advised that commissioner funding for the Trust was now almost evenly split. NHS England income and expenditure had both increased due to additional ‘pass through’ drugs that were not included in tariff payments. CCG income was increased by over achievement on activity. There had been a one-off effect of transfer of drugs to Lloyds, who now provide pharmacies on all three main sites.
3.3.3	Marcus Thorman advised that the Finance and investment Committee had, at its meeting the previous week, reviewed the draft Three-Year CIP Plan. Plans to achieve 70% of the total savings required had been identified, with the gap continuing to be closed.
3.3.4	Marcus Thorman advised that cash was behind plan. Debts were being pursued. The Department of Health had still not advised who would pay monies outstanding on Project Diamond (top-up for specialist activity in London trusts) and Research and Development. Some £7.7 million was expected in 2013/14. In 2012/13 this had not been paid until February 2013. Sarika Patel advised that there was an active lobbying group in relation to Project Diamond. Bill Shields advised that he sat on the Project Diamond Group and that this matter had been taken up at high level with the DH. These monies had been budgeted for receipt earlier in 2013/14 but payment was now more likely to take place around February 2014.
3.4	**Director of People and Organisational Development’s Report**
	Jayne Mee presented her report, highlighting the following:

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3.4.1	**Staff Engagement** Progress was noted in the Trust's own Local Engagement Survey, a more flexible tool than the annual NHS Staff Survey, for reaching a cross section of staff, with questions and frequency chosen by the Trust.
3.4.2	**Leadership Development** Sir Richard Sykes welcomed Prof Dot Griffiths, of Imperial College, who was supporting the Certificate in Medical Leadership, who was attending the meeting. Sir Richard Sykes encouraged the involvement of Trust Board Members and other leaders in the Trust and the College the senior development programmes. Jeremy Isaacs expressed his enthusiasm for such development programmes. He would expect a cost/benefit return. Jayne Mee said that People KPIs would be included in the new Integrated Dashboard and these would include engagement and capability. Dermot Kelleher said that international benchmarking would help to show how improved healthcare was delivered. In response to a question from Sir Richard Sykes on the Foundations programme, Jayne Mee confirmed that the Trust participates on the NHS Graduate Training Scheme but does not have its own scheme; she would consider that further. **Action: Jayne Mee**
3.4.3	**Employee Relations** The Trust's employee relations advisory service went live on 1 November 2013. Responsibility for advising managers on the application of the disciplinary, sickness absence and other workforce polices would completely transfer from Capsticks to the Trust shortly.
3.4.4	**Trust Vacancy Rates** The Board noted that target vacancy rates for different types of staff could be set. Janice Sigsworth said that she reviewed vacancy rates for, for example, band 2-6 nurses.
3.4.5	**Statutory and Mandatory Training** Jayne Mee advised that regular monitoring by management and progress chasing took place.
3.5	**Director of Governance and Assurance's Report**
	Cheryl Plumridge presented her first Governance and Assurance Report
3.5.1	**Complaints** A review was being undertaken of the Trust's processes for responding to, and for learning from complaints as part of patient feedback, in the light of the report by Ann Clwyd MP and the Government's 'Hard Truths' report. The review would be considered by the Audit, Risk and Governance Committee at it's meeting on 11 December. A report on an analysis of complaints and lessons learned was intended for the Trust Board, probably in February 2014. **Action: Cheryl Plumridge**
3.5.2	**Inquests** Cheryl Plumridge highlighted the rise in the number of Inquests involving the Trust, following changes in coronial law and recommendations form the Francis Inquiry.
3.5.3	**Establishment of in-house legal services** The Board noted progress in establishing a small in-house legal team to promote efficiency, learning and advice in promoting the quality agenda with less reliance on external advisors. Sir Thomas Legg offered his advice in the setting up of this service. In response to a question from Sarika Patel, Cheryl Plumridge said that the medico-legal team should save the Trust money but also contribute to improved learning and performance: the driver for setting up a small commercial team was purely financial.

	Savings would be tracked for both teams.
3.5.4	**Healthcare internal campaigns** In response to a question from Sir Richard Sykes, Janice Sigsworth confirmed that concentration upon avoiding pressure ulcers had resulted in significant avoidance and showed the results of such a sustained clinical campaign.
3.5.5	**CQC Inspection: Western Eye Hospital** The Board noted that the factual accuracy draft report had found the Trust to be compliant with the five CQC outcomes inspected. There were some areas for the Trust to consider reviewing. The final report was awaited.
3.5.6	**CQC registration** CQC had been notified of changes to the nominated individual at the Trust which henceforward would be Professor Nick Cheshire.
3.5.7	**CQC application for the regulated activity Management of Blood.** The Board approved an application to register the regulated activity, the 'management and supply of blood and blood products,' which is conducted at Hammersmith Hospital and St. Mary's Hospital sites. An amended statement of purpose will be submitted with the application in accordance with CQC processes.
3.6	**NHS Trust Development Authority Self-Certifications**
	Marcus Thorman presented the report.
3.6.1	In response to a question from Dr Andreas Raffel, Dr Chris Harrison said that progress had been made on the processes for medical revalidation decision making. Dr Raffel asked for information to be provided to Board Members, whilst recognising that reports on individual doctors would be signed off by Trust Management. **Action: Chris Harrison**.
3.6.2	The Board confirmed that it would continue to approve submissions to the TDA, as now, with any significant changes to be reported to the Board before submission.
3.6.3	The Trust Board approved the following Self-certifications: • August Compliance • August Board Statement • September Compliance • September Board Statement
4	**Strategy**
4.1	**Director of Research Report**
4.1.1	Prof Jonathan Weber presented the report. He outlined how research is co-ordinated and some of the significant achievements set out in his report. Some of the most significant advances in healthcare due to research were to be published in poster form. The Board noted the Trust's selection to host the NIHR Clinical Research network - worth around £15 million per annum, for five years. The NIHR Biomedical Research Centre will, by April 2014, have been running for two years of its five, before a renewal decision is due; Prof Weber emphasised that evidence of outcomes will be crucial. The outcome of the application by the Trust and the College for AHSC status was awaited.

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	Prof Weber commended Kevin Jarrold, Chief information Officer, for his support in relation to Performance Metrics. Sir Richard Sykes thanked Prof Weber for his attendance and for his report, which had provided evidence of the key links between research and patient healthcare that were at the heart of the Trust's purposes.
4.2	**Non-Executive Directors' Operational Visits**
	Cheryl Plumridge presented the report. The Board supported the principle of formalising visits by NEDs to clinical areas in order to develop knowledge of operational activity and to link this to The Trust's objectives and strategy. Comments made included: • Keep the resources required under review • Visits to all key sites, including the Western Eye • Some visits to be undertaken at weekends and evenings • Some caution over extending board meetings beyond half a day particularly given the increased requirements associated with the FT application. Sir Richard Sykes said that attendance would be optional • Means of capturing, reporting - perhaps jointly by a NED/Exec Director - and acting upon feedback, without over-formalising the process • Some members favoured individual-type visits The Board decided that more systematic organised visits, bringing involvement with local staff, be progressed, whist still enabling some ad hoc visits to take place. **Action: Cheryl Plumridge**
5	**Papers for Information**
5.1	**Finance & Investment Committee** **Report of the meeting on 21 November 2013:** Sarika Patel highlighted the following matters that the Committee had considered: • the work plan for the next twelve months • the Trust's financial position and forecasts • Three Year CIP Plans • Private Patients' Services • The Long Term Financial Plan - due to be considered at its 23 January 2014 Committee meeting - she invited all Board Members to attend for that item. **Action: Stephen Guile to invite all Trust Board Members** **Committee Terms of Reference** The Finance & Investment Committee Terms of Reference were approved by the Trust Board, as recommended by the Committee.
5.2	**Foundation Trust Programme Board** **Report of meetings on 22 October and 19 November 2013** Dr Rodney Eastwood highlighted the following significant matters: • The FT Membership Strategy • The FT Programme: preparation for the Chief inspector of Hospitals' Visit - timing and effect on the FT programme to be confirmed. **Foundation Trust (FT) Membership Strategy** The FT Membership Strategy was approved by the Trust Board, as recommended by the FT Programme Board. Sir Richard Sykes asked for the Plan for building up the

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	Membership and the creation and development of the Council of Governors to come forward via the FT Programme Board. **Action: Cheryl Plumridge** **Foundation Trust Programme Board Terms of Reference** The Foundation Trust Programme Board Terms of Reference were approved by the Trust Board, as recommended by the FT Programme Board
5.3	**Quality Committee** **Report of meetings held on 8 October and 13 November** Sir Anthony Newman-Taylor highlighted the following: • The Committee was developing its agenda and was receiving good quality information • The value of the involvement of the Divisional Directors, Director of Infection Control and Director of Governance and Assurance as committee members - being formalised in the amended terms of reference before the Board for approval **Committee Terms of Reference** The Quality Committee Terms of Reference were approved by the Trust Board, as recommended by the Committee.
5.4	**Audit, Risk and Governance Committee** **Committee Terms of Reference** The Audit, Risk and Governance Committee Terms of Reference were approved by the Trust Board, as recommended by the Committee.
6	**Any other business**
	Terms of Reference Dr Andreas Raffel asked for a single document of Committee terms of reference to be provided. **Action: Stephen Guile**
7	**Questions from the Public:**
7.1	In response to a question from a member of the public, Janice Sigsworth confirmed that the establishment of each ward, and ward shift were reviewed for the balance between registered nurses/midwives and healthcare assistants. The Trust used national guidelines to determine staffing. She intended reporting on staffing levels to the Management Board and Trust Board by April 2014 and publicising the results on the Trust's website.
7.2	In response to a question from a member of the public, Janice Sigsworth advised that staff uniforms had been standardised to identify nurses, ward managers and healthcare assistants. Patient information boards were being updated with details of ward managers and staff were being encouraged to introduce themselves and explain their role.
7.3	In response to a question from a member of the public, on whether a date had been set for moving the hyper stroke unit from Charing Cross Hospital to St Mary's Hospital, Nick Cheshire advised that no decision had yet been made. Any decision to move the unit would require an outline business case to be drawn up and would be a significant move.
8	**Date and time of next meeting:**
	Trust Board Meeting in Public: Wednesday 29 January 2013, 10am -12 noon, Maple and Ash Suite,W12 Conference Centre, Hammersmith hospital, London W12 0HS

DRAFT

9	**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 I960

Imperial College Healthcare NHS
NHS Trust

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
27 November 2013

Minute Number	Action	Responsible	Completion Date	January 2014 Update
3.3.3	**Performance Report:** A few key indicators for winter management would be included in the new Performance Dashboard.	**Chief Operating Officer**		**Completed.** The revised Trust Board scorecard is part of the main agenda for TB this month
3.4.2	**Leadership Development** Consideration to be given to implementing The Trust's own Graduate Training Scheme	**Director of People and Organisation Development**	**26.11.14**	A feasibility analysis as to whether this would be helpful or complimentary to the NHS Graduate scheme will be undertaken as part of the on-going leadership development work. This action will be put on the forward plan for an update at the November Board Meeting.
3.5.1	**Complaints** An analysis of complaints and lessons learned was intended for the Trust Board, probably in February 2014.	**Director of Governance & Assurance**		**Completed.** A paper is going to the Trust Board on 29 Jan covering complaints, SIs, etc
3.6.1	**NHS Trust Development Authority Self-Certifications** Information to be provided to the Board on the decision making processes for medical revalidation.	**Medical Director**		**Completed.** Included in Medical Director's report.
4.2	**Non-Executive Directors' Operational Visits** Systematic organised visits, involving local staff, to be arranged.	**Director of Governance & Assurance**	**TBC**	The intention was to hold visits after Trust Board meetings but these slots are now filled with Board Development meetings. To be discussed further with the Chairman.
5.1	**Finance & Investment Committee** All Board Members to be	**Trust Secretary**		**Completed.** Invite sent out on 9 January 2014.

	invited to the 23 January FIC Meeting.			
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**	Paper to go to the FTPB in February 2014.
6	**Terms of Reference** A single document of Committee terms of reference to be provided.	**Trust Secretary**	**26.3.14**	FIC Terms of Reference (ToR) finalised. Single document will be produced once Remuneration and Appointments Committee ToR agreed in February. It will be presented to the Trust Board at their March meeting.

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
25 September 2013

Minute Number	Action	Responsible	Completion Date	January 2014 Update
2.3.10	**Infection Prevention and Control** E Coli: A report would be brought to the next Trust Board which broke down figures into site and speciality.	**Director of Infection Prevention & Control**	**27.11.13**	**Completed**. The report on E.coli was included within the overall report- and was discussed at the Trust board.

Imperial College Healthcare NHS
NHS Trust

Trust Board: 29 January 2014 **Agenda number: 1.6**

Report Title: Chairman's Report

To be presented by: Sir Richard Sykes, Chairman

Executive Summary:
As part of the preparation for the Board Governance Memorandum and the evidence collation it has become apparent that there are one or two areas of good practice that have not been correctly documented and this paper sets out to rectify this.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Link to the Trust's Key Objectives:
1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Recommendations and Actions Required:
To note

Introduction

As part of the preparation for the Board Governance Memorandum and the evidence collation it has become apparent that there are one or two areas of good practice that have not been correctly documented and this paper sets out to rectify this.

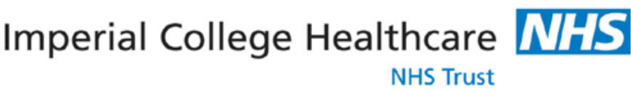
Deputy Chairman and Senior Independent Director (SID)

The position of Deputy Chairman and SID has not been formally recorded and referenced in the Trust Board minutes. Sir Thomas Legg currently holds both positions and will continue to hold them until the 30 September 2014 when his term of appointment comes to an end, and he retires from the Trust. Upon his retirement I am pleased to announce that Sir Gerald Acher has agreed to take on both these roles.

Committee Reporting

Currently the Trust Board receives committee minutes but does not receive a summary report of key issues discussed. It is proposed that from the March Trust Board meeting a summary report will be provided along the lines of the template attached as Appendix A. This report should enable the Trust Board to efficiently identify areas for further discussion by the Board as a whole thereby enabling it to use its time more effectively.

In addition, from March, the Trust Board will receive all its Committee minutes at the public meeting and will only take the Committee minutes at the private meeting where there is business of a confidential nature contained within them that would be prejudicial to the public interest if taken at the public meeting.



Chief Executive's Report

29th January 2014

1 TRUST BUSINESS

1.1 Update on Trust Development Authority (TDA) Planning Guidance

The TDA sent its planning guidance out on 23 December 2013, "Securing Sustainability" a guide for NHS Trust Boards. The focus is on the longer term and therefore for the first time NHS Trusts are required to produce two-year and five-year plans as per the following timetable

13 January 2014:	First draft submission of Operating Plan
5 March 2014:	Full two-year plan
4 April 2014:	Final two-year plan
20 June 2014:	Providers submit five-year Board signed off and commissioner aligned IBP and LTFM

This aligns with the Trust's Foundation Trust application timetable, of which the Board is aware of the process.

In addition to this, a joint letter from the TDA and NHS England (NHSE) received on 24 January 2014 set out a number of key issues to be considered alongside the planning framework, these are:

- Alignment of financial parameters across the community including contract values and adoption consistent planning criteria;
- Joined up nature and realism of QIPP initiatives, investment and disinvestment plans and how transitional costs will be managed;
- The implementation of business rules including transparency with regard to reinvestment of the 70% retained funds from the application of the marginal rate emergency tariff rule and clarity as to whether funding is to be invested with trusts or in demand management schemes elsewhere;
- CQUIN schemes have been agreed as part of the contracting process;
- Processes to triangulate with other criteria including activity and quality outcomes;
- Mutual assurance of plans including involvement in the development and assurance of Better Care Fund proposals;
- Sign up to mutual strategic planning proposals and intentions.

The Trust will work with Commissioners over the next few weeks to ensure this guidance is adhered to and an update will be provided at the March Trust Board alongside the draft two-year plan for approval by the Board.

Lead Director – Marcus Thorman, Director of Finance

2 PEOPLE AND ORGANISATIONAL DEVELOPMENT

2.1 Talent Development - Engagement

We launched our first local engagement survey in October 2013 to provide us with real local information about how our people feel about working here. Results have now been received and are in the process of

being reported across the Trust. The survey had a 27% response rate which is not atypical for a first survey of this sort. Around 35% would have been expected. Some of this can be explained by a problem that has been identified among the 400 junior doctors who were sent the survey, but did not pick up on their Imperial email account. Work is now underway to establish the very best means of communication with junior doctors.

The survey gives us an overall Engagement Index score, which summarises level of possibility in the organisation. Our Engagement Index is 42% which is slightly higher than we might have expected it to be.

The results show that 42% of our people responded positively, 26% were neutral and 22% were negative. There are variations amongst the Divisions and Directorates. The questions with the lowest scores were:

- The senior leaders here empower and inspire me to deliver exceptional performance;
- In general my job is good for my health;
- My organisation takes positive action on health and well being;
- At work my opinions seem to count.

All Divisions and Directorates are now briefing their people about the results and developing their actions plans to respond to this.

The next quarterly survey went live on January 20th.

2.2 Leadership Development

Our four new Leadership programmes continue to run successfully with over 55 people participating in programmes. Our second cohort of Horizons and Aspire commence in January and we are also now well into the design of our fifth programme for middle managers, Headstart, which will launch in April 2014.

Our Certificate in Medical Leadership programme ran the first of two days devoted to Finance in January and speakers included not only expert speakers from Imperial Business School, but also a Finance Director from a first wave Foundation Trust and a Finance Director from NHSLA to help develop financial awareness and acumen amongst our senior leaders.

2.3 Performance and Development Review

In February 2014, we will be launching a new Performance and Development Review process for the Trust which will replace the current non-medical appraisal process. This is an essential step in our development of a performance culture, a key part of our People and OD Strategy.
The most notable change in the new PDR process is the introduction of performance ratings which will be centrally recorded. This is a significant change for the current appraisal process and to support it, we will be creating a Managers Guide and a comprehensive training programme to support our managers in having effective performance conversations, providing feedback and using performance ratings.

The roll out of this important Trust cultural change programme will coincide with changes to the national NHS terms and conditions (Agenda for Change) which will, from April 2014 enable us to base incremental point rises on satisfactory performance rather than solely on length of service, which has previously been the case.

Lead Director – Jayne Mee, Director of People and Organisation Development

3 PERFORMANCE

Month 9 - Performance Summary

The Trust has sustained good performance in Quality Performance Indicators such as Mortality, Stroke Care and reporting no mixed sex accommodation breaches. The Trust also continued to deliver the Referral to Treatment standards and continues to meet the 95% target for VTE risk assessments. Each month in 2013/14 the Trust has continued to meet the Accident and Emergency 4 hour maximum waiting times standard. The Trust has implemented a range of initiatives to build capacity and resilience over the winter period to ensure that we continue to meet the 4 hour standard and that elective throughput is not affected by increased emergency demand.

There have been 10 cases of recognised Trust attributed MRSA BSI's year to date against a zero tolerance for 2013/14. An action plan is in place to minimise further infections.

In November the Trust under performed against the Cancer waiting times targets for 62 day first treatment standard with 22 patients having delayed treatment and also underperformed against the 31 day first cancer treatment standard (cancer data is reported one month in arrears). Whilst these two standards under performance in month, it is still forecast that the Trust will achieve 7 out of 8 measures against the quarterly cancer standards. Work continues with the Cancer Management team to track patient pathways to ensure that patients receive treatment within the target time.

Lead Director – Steve McManus, Chief Operating Officer

4 FINANCE

The Trust has achieved a year to date surplus of £13.7m at the end of December (after adjusting for impairments and donated assets), an adverse variance against the plan of £0.1m. This is based on a surplus in month of £0.5m, which was a favourable variance of £0.1m. CIPs are cumulatively behind plan by £3.0m. However, this has been offset by over-performance income on CCG contracts.

The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' anticipated income and expenditure for the year. The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets

Lead Director – Marcus Thorman, Director of Finance

5 FOUNDATION TRUST APPLICATION

5.1 Update on Programme Timescales

At the Foundation Trust Programme Board (FTPB) in November 2013, a paper was presented which outlined the critical path for Imperial College Healthcare Trust (ICHT) to achieve FT status by December 2014. Subsequently on 6th December 2013, a meeting was held with the TDA to agree the detail of the programme plan and to ascertain whether the TDA could facilitate the plan. At this meeting, the TDA outlined a number of developments which may impact the Trust's application, but which were still subject to formal sign off. These were:

- That there will be a focus on whether an aspirant Trust is "well led". Examination of this point will be a major theme of the TDA Board to Board meeting which will follow the Chief Inspector of Hospitals' (CIH) visit.
- That the 'shelf life' of a CIH report is expected to be six months, after which a new report will need to be obtained.

- That the CIH visit is earmarked for Q1 of FY14/15 (i.e. April – June 2014). It remains unclear exactly when the CIH will visit, however, mid-May to June seems most likely at this stage since the Trust will be undertaking Cerner implementation in April.

The updated indicative timescale is now as follows:

Milestone	Timescale
BGAF/QGF external assessment	Starts 23 Jan, reporting to March Board
TDA conducts Board interviews	February
HDD 1	Starts 24 Feb, reporting to March Board
TDA observes Board & committee meetings	March
HDD 2	Starts 24 Apr, reporting to May Board
Draft IBP/CIP and other submissions	By 1 May
TDA Readiness Review	May
CIH visit	Mid May – June
TDA Board to Board	July
TDA Executive sign off	August*
TDA Board sign off	September*
Monitor phase of the assessment process	Late September or October onwards

* TDA Executive and Board signoff may be possible in August, depending on the exact timing of the CIH visit and the willingness of the TDA Board to approve the Trust's application by Chairs' Actions. Clarity on this will be obtained later in the year.

5.2 Board preparation

There are a number of key documents that the Board will need to become familiar with and work is on-going to ensure that appropriate briefing documents and development sessions are arranged.
Specifically, the Board will be required to understand the following documents:

- *Integrated Business Plan (IBP)* – a detailed business plan outlining the current state of the Trust and its strategic plans and developments for the future (see section 3 for more detail)
- *Long Term Financial Model (LTFM)* – a financial model which details the previous three years of finances, the current year and forecasts the next five years, the key outputs of which are summarised in the IBP.
- *Board Governance Memorandum (BGM)* – is a self-assessment document enabling the Trust to look at how effectively it is governed. It concentrates on the key elements of functioning for Board members and it is supported by evidence which is externally validated.
- *Board Assurance Framework* – is the means by which the Trust holds itself to account by clarifying which risks exist that will compromise the Trust's strategic objectives
- *Quality Governance Framework (QGF)* – a framework to assess the Trust's values, behaviours and the structures and processes that need to be in place to enable the Board to discharge its responsibilities for quality
- *Quality Strategy* - outlines the quality goals (also known as QG15) which the Trust aims to achieve between now and 2015, and the Trust's approach to driving improvements across all its hospitals including the governance processes.

5.3 Integrated Business Plan (IBP)

An integrated business plan is an overarching plan that connects the strategies and objectives across all the divisions and directorates within the Trust for the next five years. The IBP must be owned by all those involved in the Trusts' future.

In order to attain FT status, a Trust must demonstrate that it is places quality at the forefront of everything that it does, is legally constituted, well governed, financially viable and has a clear strategy for success. An Integrated Business Plan demonstrates that the Trust has accomplished all these points.

The role of the Trust Board is key to the success of the FT application and it will need to be involved at every stage in the production of the IBP.

The next iteration of the IBP will be the final iteration and will be taken to the Foundation Trust Programme Board in April where it will be reviewed prior to its submission to the Trust Board in May. The final iteration of the IBP will be presented to Trust Board in May for final sign off before being submitted to the TDA in June.

Lead Director – Marcus Thorman, Director of Finance

6 NWL BUSINESS

6.1 "Shaping a Healthier Future"

Work on the Trusts response to the SaHF continues at pace, with the preparation of the outline business case as the manifestation of many streams of work and collaboration.

Work continues with our commissioning partners on realising the full clinical potential of the Charing Cross Hospital site and establishing its future local hospital status as a unique but complementary part of the trusts healthcare provision.

Equally at Hammersmith, Western Eye and St Mary's, discussions with the clinical divisions continue at pace to ensure that where possible benefits outlined within SaHF can be enhanced and delivered early and indeed within the business planning rounds all services start to prepare their plans to transform clinical care and understand how they will demonstrate to our patients and communities how these have improved outcomes.

The trust also continues to support the health economy in the long term solution for the provision of high quality services from the Central Middlesex Hospital.

It is expected on current planning guidance, that the Trust Board will receive for its consideration the outline business case for the Trust's response to 'Shaping a Healthier Future' in March 2014.

Lead Director – Ian Garlington, Director of Strategy

6.2 Whole Systems Integrated Care - Pioneer Status

Working with colleagues across North West London (NWL) and attaining one of 14 pioneer status places nationally, the trust is working with all members of health and social care to develop 'early adopter' sites for trailing new ways of delivering care, centred around the patient and their needs, planning in a truly multi-agency way to ensure care is appropriate and cohesive, meeting the needs of each patient.

The wider system is presently courting bids for earlier adopter bids, and the trust has made representations to participate in pilots it wants to initiate and also those created by others that are strengthen by our involvement.

Pilots will be selected during February.

Lead Director – Ian Garlington, Director of Strategy

7 RESEARCH

7.1 Clinical Research Network for North West London

After successfully applying to host the new NIHR (NWL) Clinical Research Network (CRN) for 5 years from 1 April 2014, we have continued to work on governance, workforce transition, and forward planning. ICHNT will receive approximately £13.5m per annum to grow the regional research study portfolio, increase numbers of patients recruited into studies, improve study set-up times and delivery, and increase commercial investment. The Royal Marsden will remain in the South London Clinical Research Network.

The two senior posts of Clinical Director and Chief Operating Officer have been recruited to. Dr Robina Coker (Clinical Director) began on 1 January and Joanne Holloway (COO) begins on 3 February.

Weekly transition meetings are held via the Medical Directorate with all relevant Trust departments. Detailed consideration is being given to the transition of existing CLRN workforce to a new structure – a formal HR consultation will be launched shortly. It is expected that 20-25 core network posts will transfer to ICHNT employment, and will be located in identified office space in the clock tower at Hammersmith Hospital.

Financial and activity planning has been initiated for 14/15, based on the NIHR baseline commitment that no network will see a change of more/less than 5% of the provisional allocation indicated earlier.

A number of engagement events are planned for partner organizations in NWL during the coming months. The first of these took place on 21 January and a formal NWL CRN launch event will take place on 18 March 2014 at the Hammersmith – Jonathan Sheffield (NIHR CEO) will give the keynote presentation.

Recruitment has begun for the 30 Clinical Research Specialty Leads and 6 Clinical Research Leads who will work with the Clinical Director to grow activity and delivery studies in each specialty.

A new Executive Committee has been established and will meet for the first time on 21 February. The NWL CRN will sit within the Medical Director’s office and report through there, with the CEO/Medical Director as Host Organization Accountable Officer.

Lead Director(s) – CEO/Medical Director as LCRN Host Organization Accountable Officer

7.2 NIHR Imperial Biomedical Research Centre (BRC)

As of 1 April 2014, two years of the current NIHR Imperial BRC programme will have passed, with three years remaining until a renewal decision. It is essential to be able to demonstrate sufficient outcomes within this period and, as such, the next two years will be crucial to delivery of BRC plans and to our renewal application.

BRC Themes are therefore currently engaged in planning for 2014/15 and beyond, and to consider priorities, e.g. new projects, core facilities/platforms, cross-BRC initiatives, training schemes, health economics, sequencing / metabonomics / imaging / biobanking, industrial collaborations.

Discussions are ongoing as part of the Trust’s planning round to agree the BRC project budget envelope for 2014/15.

Lead Director – Professor Jonathan Weber, Director of Research

7.3 NIHR Performance Metrics for Initiating and Delivering Clinical Research

The Trust 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. The DOCUMAS clinical trials database has been fully launched to investigators/study teams, containing all studies, accruals, alerting functionality, and reporting capabilities. ICHNT performance for initiating and delivering clinical research is now above sector average for the first time.

Q2 performance was reported in November and we are currently in the middle of the Q3 return (due end of January 2014). We are now in a position to move from reporting of performance data to active management of performance through Trust Divisions.

A broader picture of ICHNT R&D performance and activity is presented below (as reported in the most recent scorecard), comparing Q3 in the current financial year with Q3 last year;

Key Performance Indicator	Q3 Performance (2013/14)		Q3 Performance (2012/13)	
Mean and median time (in days) elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Q2 data is latest available)	***Mean***	***Median***	***Mean***	***Median***
	101	78	144	116
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	30.0% (36 studies)		13.6% (18 studies)	
Percentage of closed commercially-sponsored interventional studies that recruited to time and target	57.6% (34 out of 59)		Not available	
Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days (December NWL CLRN report)	78.3% (101 out of 129)		Not available	
Total number of NIHR CRN Portfolio studies to which ICHNT has recruited (cumulative YTD)	284		259	
Total number of ICHNT participants enrolled in NIHR Portfolio Studies (cumulative YTD) (COSMOS study not incl.)	8165		7696	
Number of **commercial** NIHR CRN Portfolio studies to which ICHNT is recruiting (cumulative YTD)	48		32	
Number of ICHNT participants enrolled in **commercial** NIHR Portfolio studies (cumulative YTD)	557		195	

Lead Director – Professor Jonathan Weber, Director of Research

7.4 Divisional Research Structures

The post of Divisional Director of Research (DDoR) has been developed and a role description drafted. The role of the DDoR is to develop the quality and quantity of clinical research within each Division, in line with the over-arching strategic priorities set out by the AHSC Research Committee, and to ensure delivery of research against national and local performance benchmarks. In particular, DDoRs will be responsible for increasing awareness of, and improving performance against, NIHR metrics for initiating and delivering research.

DDoRs will also ensure appropriate feasibility, financial, regulatory, and performance oversight for all clinical research studies within their Division. Working through their respective Divisional Research Committee (DRC), and with the support of a Divisional Research Manager, they will develop an overview of research activities falling within their remit, identify potential areas for growth, and develop efficient and effective local research support infrastructures, focusing resource where it is required.

DDoRs will be full members of the AHSC Research Committee and will chair the DRCs, wherein the budgets for the NIHR Imperial BRC and other NIHR programmes are held. They will be directly accountable to the Divisional Directors but will also have 'dotted line' accountability to the Trust Director of Research.

A replacement Divisional Research Manager has been recruited (starting March 2014) and interviews for the Senior Research Manager post took place on 24 January.

Lead Director – Professor Jonathan Weber, Director of Research

8 AHSC - REDESIGNATION UPDATE

The Imperial College Academic Health Science Centre (AHSC) designation was announced by the Department of Health on the 29th November 2013 for the next five years, from April 2014. Imperial College AHSC is one of only six centres to have been designated nationwide.

Specifically, the international Panel described our Research and Science, Patient Care, ability to Translate our Research into Patient Care, Strategy and Wealth Creation as "excellent, very good, very good, strong and strong", respectively. Health Education was described as being "sufficiently strong" but requiring a more multi-disciplinary focus. Our Governance Arrangements were judged to be "satisfactory" and the panel stated that our application could have benefitted from further information.

More generally, the Panel recommended that AHSCs should concentrate on the delivery of appropriate, interoperable e-Health informatics platforms and that this might be a criterion for subsequent AHSC designation.

Lead Director – Professor David Taube, AHSC Director

9 COMMUNICATIONS UPDATE

9.1 Media coverage

Over the past few weeks the Trust has received some very positive media coverage including widespread national media coverage following the announcement that the Trust was pioneering the use of a new scan to diagnose Alzheimer's disease, Sky News coverage of a Trust cardiologist researching a heart stutter condition which can lead to stroke and, of course, our involvement in treating patients injured by the collapse of the ceiling at the Apollo Theatre which received international media coverage not least in the US.

9.2 New Communications Director

Michelle Dixon will be joining the Trust on 24 February as the new Director of Communications and External Relations. Michelle has considerable experience in the health sector. She is currently the Director of Communications for the British Medical Association and has previously been the Interim Director of Communications at the Cabinet Office and Director of Communications at the health policy and analysis centre, the King's Fund. She has also worked within the NHS and her particular fields of

expertise include media relations, issues management and organisational change. A full induction programme is being planned for Michelle including time with executive and non-executive board members.

9.3 Trust people

Lead stroke clinician Dr Diane Ames was made an MBE in the New Year's Honours for services to stroke. This honour featured significantly in the Daily Telegraph. Trust nurse Katie Scales was invited to help develop NICE guidance on the use of IV drips which led to positive media coverage in the Nursing Times. And we were pleased to host Royal College of Nursing deputy president Cecilia Anim when she visited staff and patients at St Mary's Hospital on Christmas Day.

Finally, Professor the Lord Ara Darzi has been awarded the highest honour available in Qatar to foreign nationals. Lord Darzi received the Sash of Independence in recognition of his continuing contribution to developing the health sector in Qatar. The Sash of Independence is awarded only to senior members of government, to Qatari citizens for outstanding service to the country and to foreigners for exceptional services to the country.

Lead Director – John Underwood, Interim Director of Communications

10 PARTNER ENGAGEMENT ACTIVITIES

Partner engagement activities during December 2013/January 2014 have focused on the public consultation on the Trust's application to achieve foundation trust status. The Trust launched its public consultation on 11 November 2013 and it is due to run for a period of up to 12 weeks closing on Monday 10 February 2014. Details on the proposals for becoming a foundation trust are set out in the consultation document entitled 'Working in Partnership'.

As part of the foundation trust consultation the Trust has contacted external stakeholders and partner the local authorities in NW London. Local authorities have been contacted to offer attendance at health overview and scrutiny committee (HOSC) meetings, presentations, submissions and invite their feedback. To date the Trust has attended HOSC meetings at Westminster (21 January) and Harrow (16 December) with a 'tri borough' (Kensington and Chelsea, Hammersmith & Fulham, and Westminster) special meeting (8 January). In addition a Trust report was submitted and considered by HOSCs at Ealing Council (5 December) and Kensington and Chelsea (23 January). The Trust is invited to attend a further HOSC meeting in Hounslow (4 February).

Three well-attended public consultation meetings on the foundation trust application have been held in: Kensington (11 December); Hammersmith (17 December); and Paddington (16 January). A further open meeting on the foundation trust application has been organised with the 'tri borough' Healthwatch Central West London (30 January).

Several face-to-face meetings have been held with the local MP, councillors and commissioners representing residents in the boroughs of Kensington and Chelsea, Hammersmith & Fulham and Westminster. The Trust's bi-monthly electronic newsletter 'Partner Update' was sent out in late December.

Lead Directors – Professor Nick Cheshire, Chief Executive and Bill Shields, Chief Executive

11 IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

11.1 Grants

The charity's general grants committee unreservedly recommended awarding a total of £379,836 to seven grants with an additional four awards totalling £363,312 subject to certain conditions being met. If so, the total amount awarded by the charity to its annual general grants round would be £743,148, an increase of 26.6% over the previous financial year.

The charity received a huge amount of interest in this round of general grants, with 50 Expressions of Interest (the first stage of application) received, over 60% higher than the amount received in 2012/13. The conditions for this round of general grants from the charity had changed slightly, with the maximum period of funding increasing from 12 to 18 months and the maximum level of funding rising from £100,000 to £150,000 in exceptional cases.

11.2 Communications

The charity's latest annual review was completed and is available to download on the new website. It takes a look back on the charity's activities over the last financial year, focusing on some of its achievements, the outcomes from charity funded pieces of research and supporter fundraising activities.

Work continues apace on supporting the public launch of the charity's £1million appeal in February for St Mary's Major Trauma Centre through internal communications, local media, the London press and social media outlets.

11.3 Fundraising

The charity launched its Imperial Children's Winter Appeal at the start of December 2013, which aims to raise money for paediatric services.

The charity has also been working collaboratively with COSMIC on its upcoming PICU appeal in the summer.

11.4 Art

The Bridget Riley murals on the tenth floor of the QEQM building were completed shortly before Christmas 2013 and are set for a public launch in February 2014. The charity's art team also launched their art workshops schedule for the first quarter of 2014, with drop-in workshops open to staff, patients and the public, as part of their on-going audience development programme.

Crucially, the art team are currently on schedule to complete their audit of over 1600 artworks across the trust in April 2014. The completion will mark a further milestone in the charity gaining MLA (Museum, Libraries and Archives) accreditation for their collection.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For information

Report Title: Director of Nursing's Report
Report History: Regular report
To be presented by: Janice Sigsworth, Director of Nursing
Executive Summary: The attached paper is a consolidated report covering the following areas: • Quality and Safety • Patient Experience • Equality and Diversity • External visits and reports • Other updates for information
Key Issues for discussion: Please refer to the attached paper which summarises the key issues for discussion.
Legal implications or Review Needed: a. No
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: N/a
Recommendations and Actions Required: To note the updates for information

1. QUALITY AND SAFETY

1.1. Safe Nurse Staffing - How to ensure the right people, with the right skills, are in the right place, at the right time

Following the publication in November 2013 of the Government's full response to the Mid-Staffordshire Inquiry, the National Quality Board has 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 expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for patients. Key implications for the Trust include:

- Board sign off of establishments for all clinical areas, every six months (no later than June 2014)
- The Board should receive monthly updates on staffing; set vs. actual levels and capacity and capability, which should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels and the impact this has had on relevant quality and outcome measures.
- The publication of monthly staffing information which will be collated alongside an integrated safety dataset that will provide information down to ward level and will be available via a single national website covering the key aspects of patient safety (due to go live in April 2014).
- Setting staffing levels using evidence, evidence based tools, the exercise of professional judgment and a truly multi-professional approach. NICE will soon review the evidence and accredit evidence-based tools to further support decision-making on staffing.
- Displaying information about nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
- Ward sisters to be in a supervisory capacity

Appendix A sets out:

- How the Trust ensures it has the right nursing establishments set
- The Trust's approach to setting safe staffing levels on adult wards
- Current position on staffing
- How the Trust is assured that we have sufficient staffing to meet patient care
- How the Trust will strengthen its assurance

A paper on Safe Nurse staffing was presented to the Quality Committee in December 2013 and was also shared with the NHS Trust Development Authority as part of the regular Integrated Delivery Meetings with the Trust. The Management Board also received an update on Nurse staffing in September 2013.

Work is underway to look at how the Trust can meet/is meeting the wider expectations outlined in the National Quality Board publication and a paper summarising the Trust's nurse staffing establishments and its current position against the expectations, will be taken to Management Board (Quality), the Quality Committee and the Trust Board in the coming months, no later than June 2014.

Please refer to Appendix A for a copy of the full report.

1.2. Update on the Trust's quality impact assessments (QIA) for cost improvement programmes (CIP)

As part of the scheduled quarterly CIP QIA clinical review meetings, the Medical Director and Director of Nursing met with colleagues from Estates in mid-January. Existing schemes

and new schemes were discussed, in particular the re-tendering of soft facilities management where it was agreed that additional stakeholders would attend the project board to ensure that the impact on quality and patient experience is robustly considered. 2013/14 schemes such as linen reductions have been closely monitored post-scheme implementation using key performance indicators. A scheme relating to the ISS Central Help Desk at night at the St. Mary's site has been trialled midweek but will not be introduced at weekends due to the potential adverse impact on patient services. This has been identified from DATIX submissions graded as 'low harm', where people reported they could not get through to the helpdesk to resolve any issues.

Currently, there are no CIP QIAs across the Trust that have a risk assessment score above 12 (on a scale where the highest (worst) possible score is 25) and where risk has been identified, mitigating actions are in place.

The next quarterly CIP QIA clinical review meetings will take place with Divisions and remaining corporate areas in February where the focus will be to discuss schemes for 2014/15.

2. PATIENT EXPERIENCE

2.1. Cancer Patient Experience

The results of the 2013 National Cancer Patient Experience Survey (CPES) results, which were published by NHS England in August 2013 and presented to the Board at its meeting on 25th September 2013. ICHT performed poorly in this survey particularly when benchmarked against other trusts. When last presented, a programme of work was outlined and this is now well underway. A number of improvements have been implemented and extensive tracking of performance is undertaken using a combination of real-time feedback and locally commissioned surveys that replicate the data collected in the national surveys. The sampling for the 2014 national CPES survey is currently underway and will survey patients who received treatment at ICHT during September, October and November 2013. A paper on cancer patient experience will be presented at the Quality Committee in February and an update will be brought back to the Trust Board at its meeting in March. The next 100 day cancer event will take place on 14th February 2014.

2.2. Maternity patient experience survey results 2013

The 2013 National Maternity Survey was published in December 2013 by the Care Quality Commission (CQC). 137 acute maternity units were involved in the survey, with a total of 23000 women responding it; a response rate of 44%. Imperial's response rate was 46%. The report focuses on three areas: labour and birth, staff and postnatal care. ICHT performed well in the labour and birth section performing as expected or better than expected in all areas; involvement of partners was a particularly high scoring aspect. This is consistent with the focus and investment that these services have had over the last two years. Post natal care scored as expected in all sections, but there were areas for improvement. This aspect of care also required further investigation as many of those women surveyed did not receive their postnatal care from ICHT. The staff area was the poorest performing section and, although ICHT scored within the expected range in all sections, overall the performance was worse than expected. We will benchmark midwifery staffing against other Trusts.

Please refer to Appendix B for a copy of the full report

2.3. Review of the PALS service

Following the publication of 'Hard Truths' and a desire to improve patient experience, a review of the PALS service will be undertaken. This will be a 2-phased process;
- Phase 1: Increase the hours of cover
- Phase 2: Review of the national guidance (expected in Spring 2014), use of volunteers as 'way finders' or employees as volunteers to support patients and families, align changes with the review of complaints management.

2.4. Patient Story

Please refer to Appendix C for the patient story

2.5 Healthcare Innovation Exchange (HELIX) project

The HELIX Centre for Design in Healthcare is a joint collaboration between the Royal College of Art and the Institute of Global Health Innovation at Imperial College London, under the leadership of Professor Lord Darzi as Co-Director. In the summer of 2014, the Helix Centre will open a pop up studio in Norfolk Place which will be a place for designers, clinicians and patients to work together on innovative products and services for the provision of healthcare. The aim is to respond quickly to complex healthcare issues, turning ideas into prototype products, processes and services

3. EQUALITY AND DIVERSITY

3.1. NHS Equality Delivery System 2013

In 2011 the Trust adopted the NHS Equality Delivery System (EDS), a four year equality and diversity performance improvement programme across a range of patient and workforce issues.
The Trust held an EDS grading event for local stakeholders in December to attribute 'grades' to each of the three service-focused outcomes selected for delivery in 2013/14. These were:
- Outcome 1.4 the safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all
- Outcome 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised
- Outcome 2.4 Patients and carers complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently.

A total of 52 stakeholders were invited, of whom 10 indicated interest in attending (Healthwatch, H&F Mencap, Age Concern, Stroke Association, Refugee Council, Full Figured Fitness, Sickle Cell Association, Community Interpreting Translation and Access Service, K&C Forum for Older People, Tri-Borough Joint Commissioners). Four colleagues did attend and represented Healthwatch, the Refugee Council and the Community Interpreting Translation and Access Service.
From a possible four grades (**Excelling**, **Achieving**, **Developing**, **Undeveloped**) the stakeholders graded the outcomes as follows:
- 1.4 (Safety) **Developing**
- 2.3 (Patient Experience) **Developing**
- 2.4 (Patients and Carers Complaints) **Achieving**

At the start of 2013 all three outcomes had been graded by stakeholders as **Developing.** The Trust has therefore improved its position in outcome 2.4 (Patients and Carers Complaints).

4. EXTERNAL VISITS

4.1. Central West London (CWL) Healthwatch visit

In August 2013 CWL Healthwatch carried out an assessment of the quality of the patient experience in four wards at St Mary's. This was against Department of Health Dignity Standards. Findings were largely positive but identified potential for improvement in staff-patient communication; provision of information on treatment and medication; facilities; communication on discharge; and implementation of protected mealtimes. The Trust submitted a response within the required timeframe and a subsequent action plan following feedback from Royal Borough of Kensington and Chelsea (RBKC) Overview and Scrutiny Committee.
As a follow-up activity, Healthwatch spoke to 45 patients at the St Mary's site in December 2013 about hospital discharge. Their views were considered as part of a bigger piece of work examining hospital discharge across Royal Borough of Kensington and Chelsea that included the views of 153 patients from Imperial and 44 from Chelsea and Westminster. The Trust will be invited to respond to a summary report with key recommendations in January 2014 but initial feedback indicates; the need to improve discharge planning, communication with patients and their families, access to medication, patient transport and community links.

4.2 Healthwatch Dignity Champions 'enter and 'view' visit

In December 2013, Healthwatch Dignity Champions carried out an 'enter and view' patient experience assessment of patients on the Trust's cancer wards. The Trust is currently awaiting the report from Healthwatch.

5. OTHER UPDATES FOR INFORMATION

5.1. Strengths based recruitment

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, the Trust will work with Shelford to create staff nurse and nursing assistant profiles.

5.2. Chief Executive of the Royal College of Midwives visit

Cathy Warwick, Chief Executive Royal College of Midwives visited maternity services at St. Mary's Hospital on the 6th December 2013. The visit began with a brief overview of maternity services and concluded with a tour of the maternity unit and birth centre. Cathy expressed that she enjoyed the visit and was heartened by the plurality of care provision for women and their families and the commitment from the Trust to improve the engagement and contribution of midwives.

5.3. Deputy President of the Royal College of Nursing visit

Royal College of Nursing (RCN) Deputy President Cecilia Anim visited staff and patients at St Mary's Hospital on Christmas morning. Ms. Anim a clinical nurse specialist working in

Camden, met frontline staff and health care assistants when she was shown around the major trauma and intensive care units and the elderly medical care ward.

Celilia Anim said: "The nursing staff I met on Christmas day showed me again the dedication and commitment of NHS staff. Christmas is a difficult time for anybody to be in hospital but the nurses at St Mary's went out their way to do that extra bit to help patients and their families. "We should never stop being proud of the hard work, compassion and commitment that nurses put into their work, continuing to provide the best possible care they can for patients, at Christmas and all year round."

5.4. New appointments

The Nursing Directorate has welcomed two staff members who started with the Trust in early January:

- Senga Steele: Deputy Director of Nursing
- Guy Young: Deputy Director of Patient Experience

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For information

Report Title: Medical Director's Office Report
Report History: Regular report
To be presented by: Professor Chris Harrison, Medical Director
Executive Summary: The attached paper is a consolidated report covering the following areas; 1. Quality Governance 2. Neurosurgical Review 3. Consultant Revalidation 4. Education 5. Local Clinical Research Network
Key Issues for discussion: Please refer to the attached paper which summarises the key issues for discussion
Legal implications or Review Needed: a. No
Link to the Trust's Key Objectives: _Please identify which and how_ 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.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: NA
Recommendations and Actions Required: NA

1. Quality Governance

1.1 Quality Strategy

The communication and engagement programme to support implementation of the strategy has commenced. This will continue on a rolling basis during the lifetime of the strategy. Examples of activities are as follows:

- Feedback campaign in progress with 4000 postcards distributed – themes and ideas will be addressed by the Quality boards
- ICHT Quality calendar distributed to all departments – this sets out the quality goal which we will focus our communication and engagement programme on during each month (attached in **appendix A**)
- ICHT Charity bid in progress to fund a quality improvement and innovation programme. This "Quality dragons den" will award support for projects and their implementation will be managed through the appropriate Quality board

The communication programme will fit with the timescales for the Quality Governance Assurance Framework (QGAF) assessment as part of the Trust's FT application process.

1.2 Safety & Effectiveness Board

The Safety & Effectiveness Board first met in November 2013 (convened to deliver 2 of the quality goals). It is chaired by the Medical Director and reports to the Management Board (Quality), with approved terms of reference. Actions arising from meetings so far include:

- Mortality alert investigation process now commenced with monthly outcome reporting by Divisional Directors
- Business case approved to upgrade incident reporting system
- Serious incident action plan implementation will now be reported to this board

A project plan for the improvement work agreed in the Quality Strategy for this board to oversee will be presented to the Management Board in February 2014.

1.3 Mortality reporting

The Trust's mortality report for month 6 is attached in **appendix B**. The report describes mortality using Dr Foster methodology which includes Hospital standardized mortality ratios (HSMR) and Summary hospital mortality indicators (SHMI). These measure mortality in hospital and post discharge and give an overall indication of how safe our care is.

In summary, both mortality rates remain consistently within the top ten best performing when compared nationally.

The Trust monthly HSMR is showing a downward trend with improvement between April to September 2013. The lowest HSMR for the last year of data was recorded in July (63) with the annual figure currently recorded at 76. All hospital sites are showing a cumulative annual rate which is lower than expected.

The current SHMI ratio is 77.78.

In both data sets the national benchmark is set at 100 with lower figures indicating better performance.

1.4 Medical Director's Incident Review Panel

The weekly incident review panel continues to review all moderate and above incidents that occur within the Trust. Actions arising from these meetings include:

- A local policy for escalation of incidental findings on imaging implemented by the Division of Investigative Sciences and Clinical Support
- Pathway review undertaken and new process implemented in Orthopaedic Surgery
- Review of handover between clinical site managers and medical teams commenced

Where a potential cluster of incidents have occurred a number of benchmarking reviews have been undertaken to ensure there are no concerns which require further intervention. Examples of this are:

- A review of perforation rates in endoscopy against national figures, following two perforations by the Division of Medicine. This has confirmed that ICHT are significantly below national rates
- Benchmarking of the rate of third degree tears undertaken by the Division of Women's and Children's services. ICHT was found to be a high performer against peers

2. Neurosurgical Trauma Review

An invited review by the Royal College of Surgeons was commissioned by the MD in 2013. The review was conducted in June and the report, along with a series of recommendations, was returned in Q3 2013. A review of actions is underway and a full report will be presented to Management Board in February and to the next Trust Board.

3. Consultant Revalidation

A summary of the Trust revalidation process was requested at the November Board.

The Trust has statutory responsibility for revalidation and the Senior Responsible Officer (SRO) is Dr David Mitchell, Associate Medical Director.

The deadline for all doctors in the UK to complete their first GMC revalidation cycle is April 2016. This will then continue on a five yearly cycle. Compliance is monitored by the Department of Health's Revalidation Support Team.

The Trust has a system in place to undertake local evaluation of the mandatory elements required for revalidation which includes documented appraisal. The SRO submits either: a positive recommendation that the doctor is up to date and fit to practise; a request to defer the revalidation date; or notification of non engagement.

The Trust has made 150 recommendations since December 2012, 90% of which were positive. The remaining 10% were deferred for additional information with only 1 non-engagement recorded (which is now been addressed).

20% of doctors will have been through revalidation by 2013/14 with the remaining doctors split evenly in the following two years.

The Trust received a RAG rated report showing organizational readiness for revalidation in December 2013 (**appendix C**). The main issue which is being addressed is the number of trained appraisers in place.

4. Education

An external review of medical education has been completed by Dr Fiona Moss, previous Director of Medical and Dental Education Commissioning for London. A detailed report will be submitted and an action plan implemented by the Medical Director. Work has already commenced to improve the experience of our trainees including

- A bullying and undermining project board has been convened with support from Health Education England (Dr John Launer) – the SRO is the Medical Director
- Trust-wide trainee forums with the MD commenced in December 2013 with follow up actions with the Divisions
- A detailed action plan is being finalized and includes, a statement of commitment from the MD to tackle undermining, policy review, trainee engagement programme

The detailed action plan will be presented to the next Trust board.

Running parallel to the above external review, an internal review of consultant teaching commitments per specialty is being carried out by a member of the Medical Director's team. This will determine how programmed activities (PAs) are being allocated to educational activity. This data will be used to agree what PA tariffs should be assigned to each activity so that they are fair, transparent and standardised across the organisation. Shadowing speciality medical teams will be undertaken in phase two to ascertain how time for training is split between direct bedside/clinic/theatre teaching versus non-clinical based teaching. This will help to determine the principles of time allocation for the future.

5. Local Clinical Research Network

In August 2013, ICHT was selected to host the NIHR Clinical Research Network (see **appendix d**). Dr Robina Coker, Consultant and Honorary Senior Lecturer in Respiratory Medicine at ICHT and Lead Clinical Director for the London (North West) Comprehensive Local Research Network since 2010, has been appointed to the post of Clinical Director, with Joanne Holloway, formally Assistant Director of the NIHR Diabetes Research Network Coordinating Centre, as Chief Operating Officer. The LCRN will be based at Hammersmith Hospital and transfer will be completed by April 2014.

The LCRN will report to the Office of the Medical Director through Dr Coker.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public
For information

Report Title: Infection Prevention Summary
Report History: Regular Trust Board Report
To be presented by: Professor Alison Holmes

Executive Summary: This report includes the Trust's monthly mandatory reports of HCAI for November and December 2013.

Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)
In November there were no Trust attributable cases.
In December a Trust attributable case was reported from a patient who required treatment for lymphoedema secondary to amyloidosis. The source of this bacteraemia was phlebitis related to a peripheral vascular access device. Actions have included educating clinical staff on the requirements for peripheral vascular access device management. This brings the total number of 'cases' reported against the Trust to ten for the year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced this year.

C. difficile
For 2013/14, the annual ceiling for the Trust is 65 cases of C*. difficile* infection.
In November there was one Trust attributable case.
In December there were five Trust attributable cases.
Year to date 47 Trust attributable cases have been reported to the PHE.
Of the six Trust-attributable cases in November and December, four occurred in patients aged over 65 with one of these patients being over 75 years of age. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in the case in November and in three of the five cases in December. Four had exposure to antibiotics, in three cases the antibiotics were in line with policy or approved by infection clinical team.

Norovirus
In December the Trust experienced an increase in cases of norovirus with six wards being affected across two sites. This affected both patients and staff and resulted in one ward being closed to admissions and transfers until symptoms had resolved. The remaining five wards were managed by partially closing the affected patient areas in line with PHE guidance and Trust policy.

Surgical site infection (SSI) prevention and surveillance
A trust wide surgical site surveillance committee has been formed, it will be the overarching group linking the existing SSI work to Trust wide quality improvement initiatives, AHSC research themes and international collaborations with the Trusts partnership work with the WHO on patient safety. The group will be responsible for monitoring the Trusts compliance against the NICE quality standard 49, Surgical site infection (November 2013).

Vascular Access
Since its inception, the Trusts vascular access group has driven significant change specifically around policy development and implementation, process and practice development and product review and standardisation. Following external review it was recommended that the group be rebranded to focus on patient safety and quality improvement with greater clinician involvement, the group membership has now been reviewed to ensure more senior clinical engagement and divisional representation. A focused work programme has been developed which will ensure further sustainability of best practice and support the Trusts MRSA action plan.

A detailed monthly Infection Prevention and Control summary is attached as an appendix.

Key Issues for discussion:

- 'Trust attributed' MRSA BSI cases year to date
- C.*difficile* infections year to date, the reduction in rates and preventive actions taking place.
- Other issues requiring input, investigation or reporting in November and December 2013, including Norovirus activity and the developments in SSI prevention and in vascular access.
- Applied research and the NIHR award to become a Health Protection Research Unit with PHE.

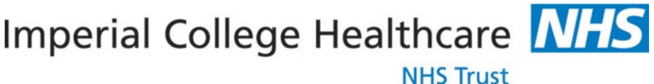
Legal implications or Review Needed: N/A

Link to the Trust's Key Objectives:

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.

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: Management of risks described

Recommendations and Actions Required: Continued activity and vigilance, ensuring infection prevention is a core aspect of patient safety and quality of care



January 2014
(December 2013 data)

Key Indicators December 2013

			Divisions				
	Threshold	**Trust**	**1**	**2**	**3**	**4**	**PPs**
MRSA BSI (>48hrs)	0	1	1	0	0	0	0
MSSA BSI (>48hrs)	0	1	0	0	0	1	0
E.coli BSI (>48hrs)	0	5	3	2	0	0	0
C. difficile (>72hrs)	5	5	4	1	0	0	0

Year to Date 2013/14	**YTD 2013/14**			**Divisions**				
	Threshold		**Cases**					
	Year	**YTD**	**Trust**	**1**	**2**	**3**	**4**	**PPs**
MRSA BSI (>48hrs)	0	0	10	5	5	0	0	0
MSSA BSI (>48hrs)	N/A	N/A	30	10	15	0	5	0
E.coli BSI (>48hrs)	N/A	N/A	51	14	24	0	11	2
C. difficile (>72hrs)	65	48	47	29	17	0	0	1

Key:
Division 1 = Medicine
Division 2 = Surgery, Cancer and Cardiovascular
Division 3 = Investigative sciences and clinical support
Division 4 = Women's and Children's
N/A = Not applicable

= Above threshold value
= Below threshold value
= Equal to threshold value

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

There is a national expectation of zero MRSA blood stream infections for all Trusts for 2013/14. In November there were no Trust attributable cases and one non-trust attributable case reported. In December there was one non-Trust attributable case and one Trust attributable case reported from a patient who required treatment for lymphoedema secondary to amyloidosis. The source of this bacteraemia was phlebitis related to a peripheral vascular access device.

The final allocation of the Non-Trust attributable case in November is currently being decided through the arbitration process. This patient had surgery at another hospital and the source of this bacteraemia was the surgical wound.

Year to date the ‘cases’ reported against the Trust is ten. Four of these represent cases re-allocated to the Trust through the post infection review process (PIR) introduced this year.

1.1 Update on key elements of the MRSA BSI prevention action plan

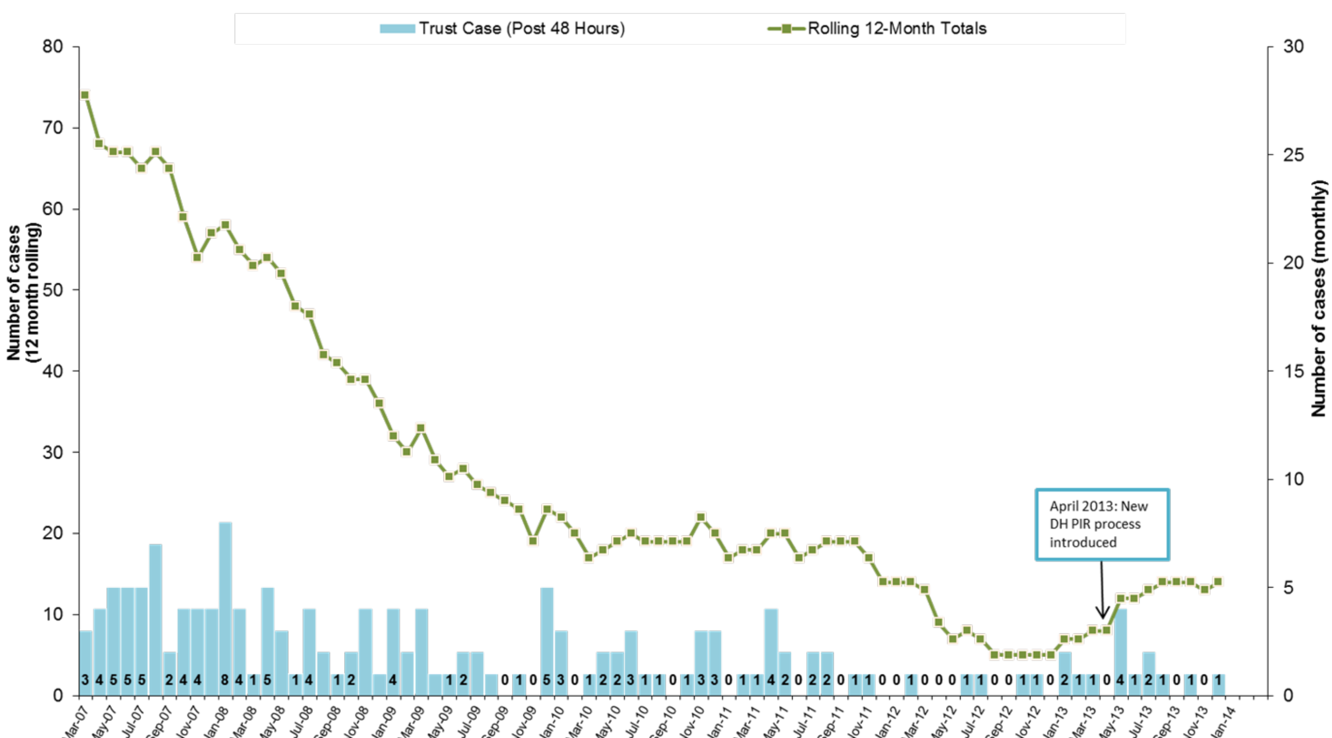
Actions from the cases detailed above:

There were no actions identified that could have prevented the Non-Trust attributable cases in November and December.

Actions from the December Trust attributable case have included educating clinical staff on the requirements for peripheral vascular access device management, and a Trust wide focus on peripheral vascular access safety.

This now brings the total number of cases reported against the Trust to ten for the year to date.

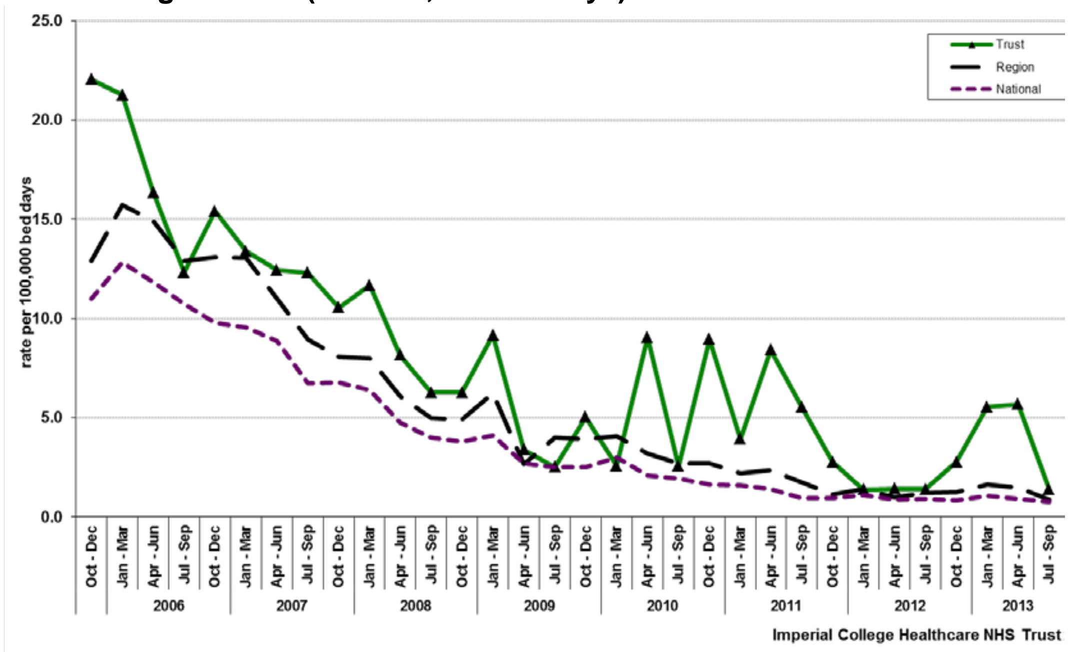
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



1.2 Benchmarking Trust-attributable MRSA BSI rates

Provisional data presented by Public Health England (PHE) in Figure 2 shows that the Trust had a quarterly Trust apportioned rate of 1.4 per 100,000 bed compared to a regional rate of 0.85 and national rate of 0.76.

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



Source: PHE Trust reports January 2014

2. *C. difficile* infections

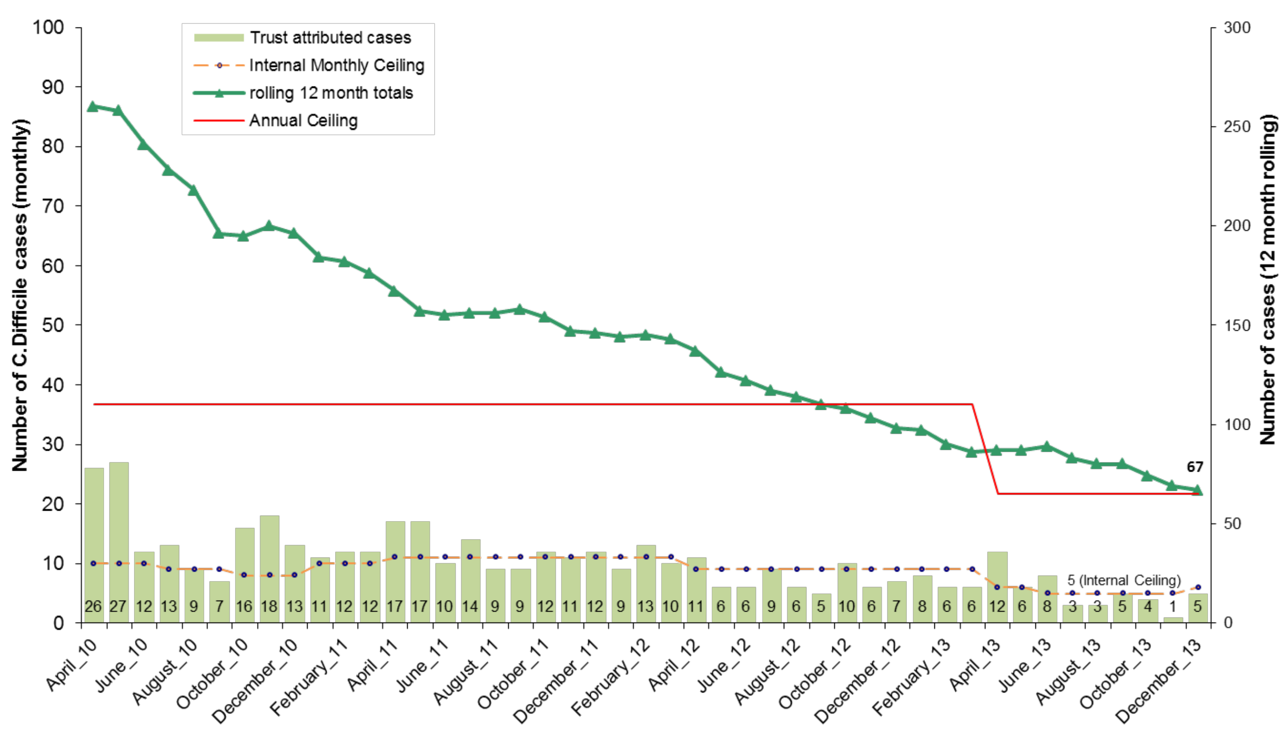
For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of *C. difficile* infection.
In November there was one Trust attributable case out of six cases reported to PHE.
In December there were five Trust attributable cases out of 15 reported to PHE.
Year to date 47 Trust attributable cases have been reported to the PHE.

Of the six Trust-attributable cases in November and December, four occurred in patients aged over 65 with one of these patients being over 75. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in the November case and in three of the five cases in December. Four had exposure to antibiotics, three were in line with policy or approved by infection clinical team.

2.1.1 Update on key elements of the *C. difficile* prevention action plan

A Trust taskforce meets weekly to address healthcare associated infections (HCAI) with specific reference to MRSA blood stream infection and *C. difficile*. A standard operating procedure has been written and disseminated which sets out the requirements for isolating patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea. In addition to the detailed clinical review of each case, the time taken to isolate is being monitored. A monthly MDT review of all cases is undertaken in which risk factors for each case are collated and learning shared with primary care colleagues. Findings of this ongoing review include: 83% (39/47) of our patients with *C. difficile* are aged over 65,74% received a proton pump inhibitor (23% initiated in hospital),83% had exposure to antibiotics, most of which were within policy or according to infection specialist advice, 11/47 (23%) had had a hospital stay longer than one month at the time of the diagnosis of *C. difficile*, and of the 36 who had a length of stay shorter than one month, 17/36 (47%) had had an admission to the Trust within the previous three months. There is great diversity of ribotyping indicating minimal patient to patient transmission, in common with recent published literature. These findings are shared monthly with the Commissioning Quality Group.

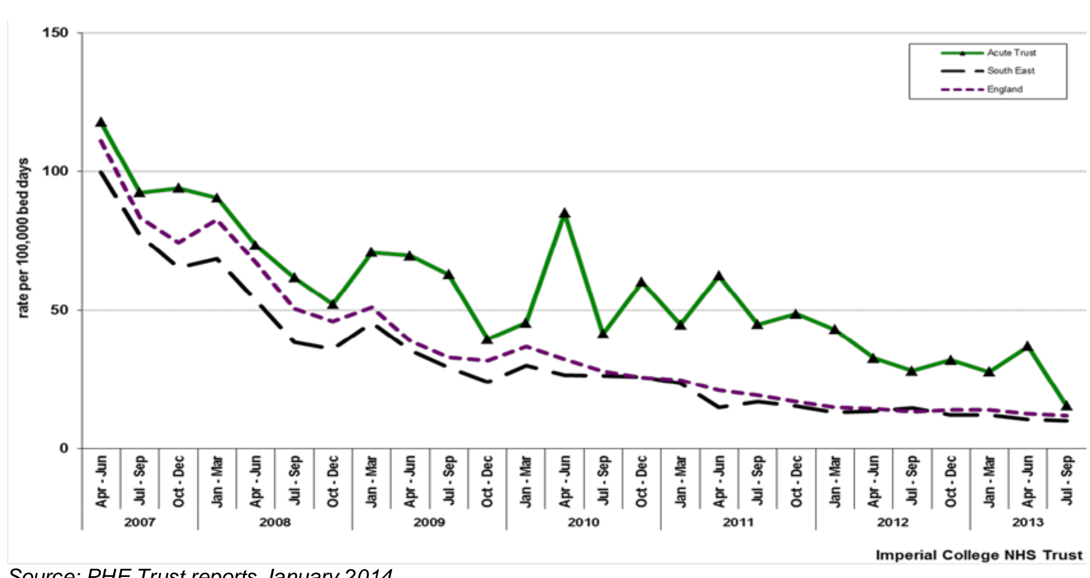
Figure 3: Trust- attributable *C.difficile* Infections and 12 month rolling totals, April 2010 - December 2013



2.2 Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by Public Health England in figure 4 shows a Trust quarterly rate of 15.4 per 100,000 bed days compared to a regional rate of 10.2 and national rate of 11.9.

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



Source: PHE Trust reports January 2014

3. MRSA Screening

The Trust remains compliant with the Department of Health population MRSA screening requirements. Analysis at an individual patient level identified 7999 patients admitted in December 2013 who required screening, of which 7279 (91 percent) were screened.

Figure 5: MRSA screening compliance rate from April to December 2013

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

There is no threshold for this indicator at present. In November 2013 there were five cases of MSSA BSI reported to Public Health England (PHE), of which two were Trust attributable (i.e. post 48 hours of admission), in December six cases were reported of which one was Trust attributable.

In November, one case was related to skin and soft tissue infection and the second case was related to cellulitis associated with a peripheral vascular access device.

The case in December was related to chorioamnionitis.

Figure 6a: Monthly MSSA BSI cases

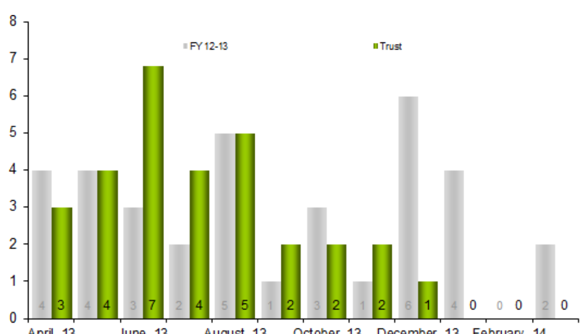
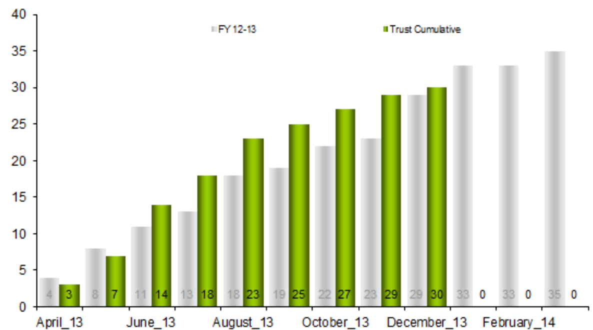


Figure 6b: Cumulative MSSA BSI cases



5. *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 November 2013 there were 20 cases reported to the Public Health England (PHE), of which 6 were Trust attributable. In December 29 cases were reported to the PHE including five Trust-attributable cases.

In December two cases were related to urinary tract sources, one due to neutropaenic sepsis, one secondary to an infected knee joint and one in a patient undergoing a hepatectomy for a liver abscess and empyema.

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

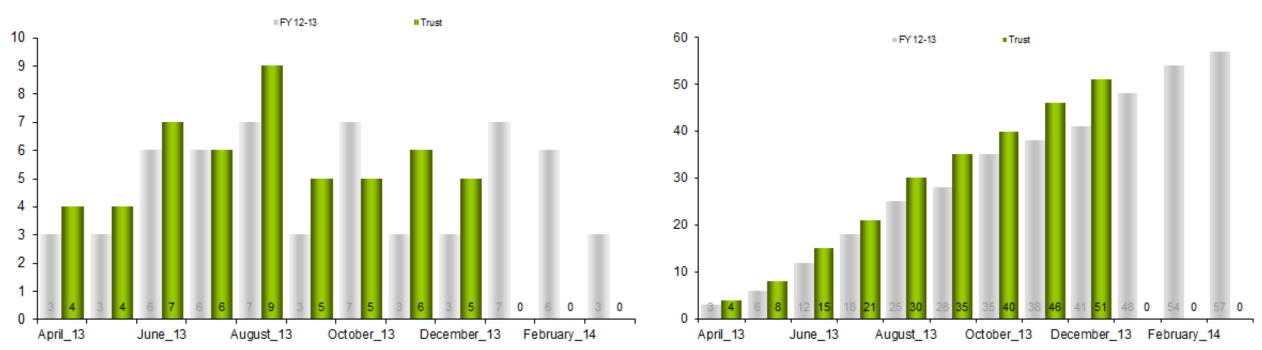
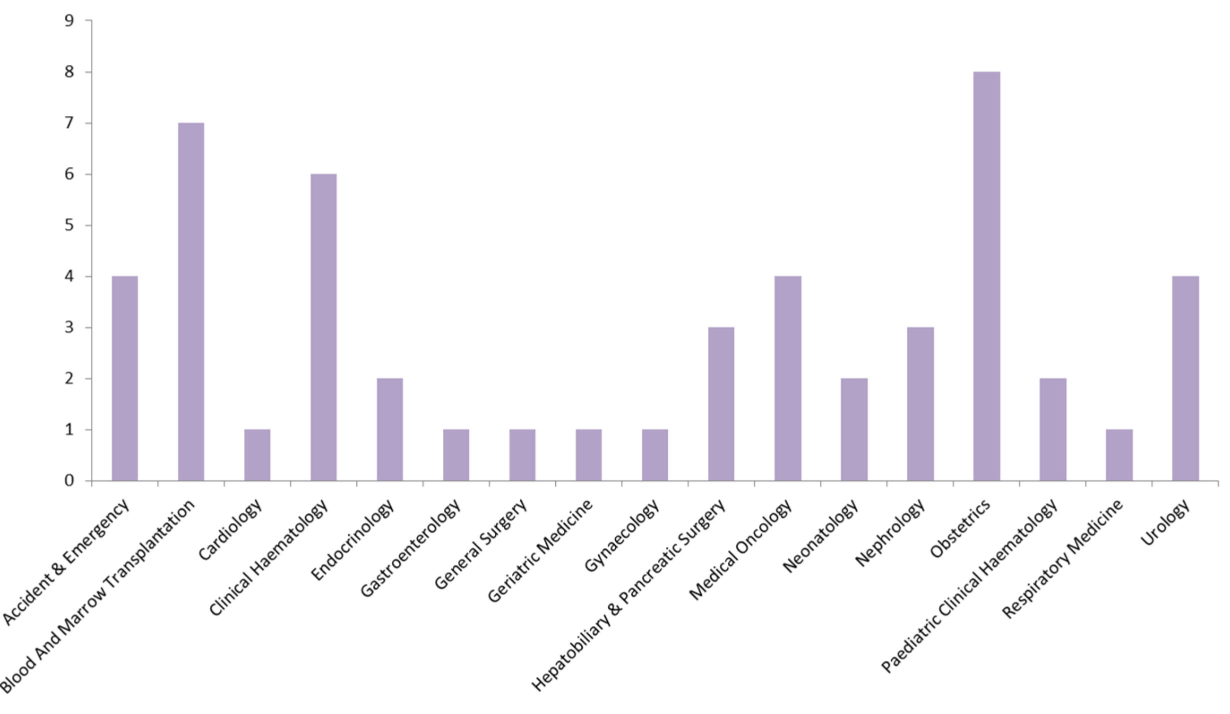


Figure 8: Distribution of Post 48 hour *E. coli* BSI cases by speciality (April - December 2013)

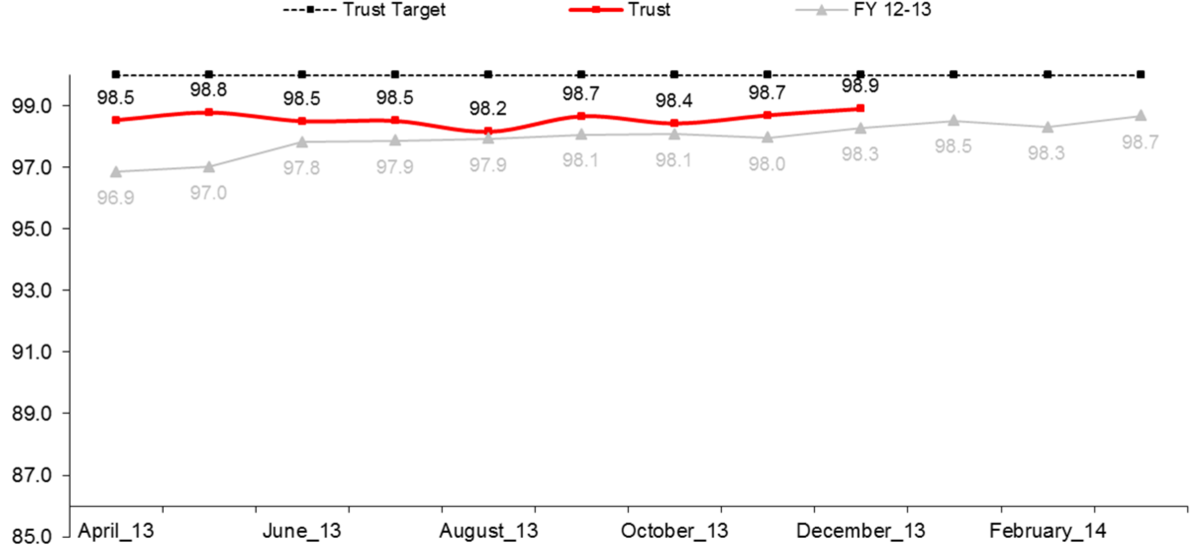


6. Hand hygiene compliance

In December 2013, 84.1% percent of clinical areas submitted a total of 6080 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week). Hand hygiene was 98.8% percent, and compliance with bare below elbows was 98.8% percent.

Hand hygiene compliance audit process: Hand hygiene is one of the most effective methods to prevent health care associated infections. Audits of hand hygiene compliance measured against the WHO 5 moments of hand hygiene are currently undertaken by each ward monthly and a more detailed and rigorous validation audit is undertaken by the infection prevention and control team.

Figure 9: Average performance of hand hygiene practice



7. ANTT

The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at Divisional level as part of the infection prevention and control plan and the two yearly reassessment programme for assessors commenced in December 2013. Completion of assessments has steadily been increasing from 75% in March to 89.5% (5673 clinical staff) at the end of December 2013. Junior doctors are now assessed for ANTT competency on the day of induction in a skills lab setting with these assessments now being undertaken using medical assessors from the Divisions.

8. Antibiotic stewardship

8.1 Antibiotic point prevalence survey (PPS)

The point prevalence surveys provide reassurance to the Trust on appropriate antibiotic use and on particular key anti-infective prescribing indicators. Every quarter, the pharmacy department surveys all inpatients prescribed a systemic anti-infective. The results of the survey are disseminated via clinical and managerial structures with detailed suggested action plans where needed. In addition, the results of the key anti-infective prescribing indicators form part of Quality Accounts. The last point prevalence survey was conducted in October 2013.

The three Trust Anti-infective Prescribing Quality Indicators are shown below and are set at 90% compliance:
Indicator 1: Percentage of anti-infectives in line with policy or approved by the infection team
Indicator 2: Percentage of anti-infectives with a documented indication in the medical notes or drug chart
Indicator 3: Percentage of anti-infectives with a documented stop or review date on the drug chart

The average results for the Trust for October 2013 for the three Trust anti-infective prescribing quality indicators was 77%, which was a reduction compared to the June 2013 results, which had an average of 83%. The results for each of the Trust quality indicators including additional patient safety indicators are detailed in figure 10.

Figure 10: Trust anti-infective prescribing practice

Figure 1: Trust Anti-infective Prescribing Practice 2008 to 2013

Allergy status on drug chart
Indicator 2 (notes + chart)
Indicator 1
Indicator 2 (chart only)
Indicator 3
% Compliance

Date	Oct 08	Jun 09	Nov 09	May 10	Nov 10	May 11	Nov 11	Jun 12	Nov 12	Jun 13	Oct 13
No. of pts seen	1126	1221	1139	1181	1055	1080	1001	1051	1063	1071	1084
Pts on anti-infective(s)	39.4%	39.0%	38.4%	40.8%	42.9%	39.8%	39.7%	40.2%	40.5%	42.5%	40.7%
Anti-infectives prescribed IV	45%	52%	48%	55%	52%	53%	58%	50%	59%	51%	n/a
Total No. of doses prescribed	n/a	n/a	n/a	n/a	n/a	6229	5550	5202	4634	5691	n/a
Total No. of missed doses	n/a	n/a	n/a	n/a	n/a	173 (3%)	329 (6%)	80 (2%)	110 (2%)	53 (1%)	n/a
Total No. IV missed doses	n/a	n/a	n/a	n/a	n/a	47 (0.8%)	233 (4.2%)	28 (0.5%)	84 (1.4%)	14 (0.3%)	n/a

*n/a – not assessed

The results of the October PPS have been disseminated to divisional and clinical leads in all 4 divisions. They have been asked to review the results of this study and focus on ways to improve the documentation of stop or review dates on prescriptions and ensure prescribing is either in line with policy or has approval by the Infection team. Compliance is currently being reassessed in January 2014 to look for improvement particularly around indicator 3.

Revision of medication charts

In response to the reduced compliance with the PPS Indicator 3, the main adult & paediatric inpatient medication chart have been reviewed and updated to include the following changes:

- A new “frequency” box to enhance clarity over how often medication should be given throughout a 24 hour period.
- The “stop date” section for each medicine has been amended to “Stop/Review date”
- Under the “additional instructions” section for each medicine it now says “Additional instructions including indication and proposed duration for anti-infectives”

Antibiotic stewardship within paediatrics

Following the successful update of the Trust adult antibiotic smartphone app, developmental work has begun on creating a Trust Paediatric version. This is envisaged to be ready by April 2014.
Paediatric multidisciplinary antibiotic stewardship meetings have commenced. These occur monthly and focus on antibiotic education and surveillance.

9. Intensive Care Catheter Line Associated Bloodstream Infections (CLABSI)

The measurement of CLABSI in intensive care is an important patient safety indicator. The latest CLABSI rate from November, which takes into account all CLABSI episodes in the adult intensive care units across the Trust, is 1.05 per 1000 catheter line days. The Trust therefore achieved the target of 1.4 per 1000 catheter line days for November, as achieved in the Michigan Keystone Project (*Bion J, et al. BMJ Qual Saf. 2013; 22: 110-123).*

Figure 12: Adult Intensive Care CLABSI rate per 1000 catheter line days FY 2013

**Source: ECDC Annual Epidemiological Surveillance Report 2012*

The rate takes into account CLABSI episodes in patients staying more than two days in ICU, as per the latest European Centre for Disease Control, Annual Epidemiological Surveillance report (2012).

10. Other matters

10.1 Carbapenemase producing gram negative organisms (CPGNB)

The Trust has experienced ongoing instances of patients being identified with these drug resistant organisms on each of the three main sites.

PHE issued interim guidance for acute Trusts in Feb 2013 (to which Trust colleagues had contributed) for managing patients identified with these drug resistant organisms. In late 2013, additional supportive recommendations were issued in the form of a toolkit. The emphasis is on risk assessment of patients transferred from abroad or from other healthcare centres, isolation in single rooms with en suite facilities until screening results prove absence of carriage of or infection with such organisms. The IPC policy on multidrug resistant organisms is being reviewed to account for these recommendations and in parallel a Trust plan for CPGNB has been drafted and will be presented at TIPCC.

10.2 Winter preparedness

10.2.1 Norovirus

In December the Trust experienced an increase in cases of norovirus with six wards being affected across two sites. This affected both patients and staff and resulted in one ward being closed to admissions and transfers until symptoms had resolved. The remaining five wards were managed by partially closing the affected patient areas in line with PHE guidance and Trust policy. The outbreak was recognised promptly and infection prevention and control measures implemented rapidly to control and limit transmission. All patients were managed appropriately and symptoms resolved as expected. Staff were excluded from work for 48 hours following the resolution of symptoms as per Trust policy. The outbreak was reported to PHE via the norovirus outbreaks in hospitals reporting scheme.

10.2.2 Respiratory viruses

The Imperial Health at Work team launched the annual flu vaccination programme on the 14th of October 2013 which includes drop in sessions and Occupational Health staff visiting clinical areas to vaccinate staff. Guidelines for the initial management of patients with suspected influenza has been updated and communicated. In addition, the importance of recognising and managing patients with diarrhoea and/or vomiting during the winter months was highlighted at the Trusts Team Brief sessions.

Up to the end of December only small numbers of patients have had laboratory confirmed influenza (A or B), consistent with the low level of activity reported by PHE in the community. However, since October, three patients who have tested positive for influenza have required management in adult ICUs. We continue to report these incidents externally.

In addition, the annually updated influenza algorithm has been amended to included advice on risk assessing and testing for MERS CoV and is available on the Trust intranet.

10.3 Surgical site infection (SSI) prevention and surveillance

A trust wide SSI committee has been formed, it will be the overarching group linking the existing SSI work to Trust wide quality improvement initiatives, AHSC research themes and international collaborations with the Trusts partnership work with the WHO on patient safety. The group will report into the Trust Infection Prevention Committee. It will also have links with CIPM and the CPSSQ at Imperial College. The group will be responsible for monitoring the Trusts compliance against the NICE quality standard 49, surgical site infection (November 2013). In addition to the existing surveillance in orthopaedic, Cardiothoracic and neurosurgery further surveillance work will focus on obstetrics and colorectal surgery.

10.4 Vascular Access

Since its inception, the Trusts vascular access group has driven significant change specifically around policy development and implementation, process and practice development and product review and standardisation. Following external review from an international vascular access expert it was recommended that the group be rebranded to focus on patient safety quality improvement and the group membership has now been reviewed to ensure more senior clinical engagement and divisional representation. A focused work programme has been developed which will ensure further sustainability of best practice and support the Trusts MRSA action plan.

11. Applied Research, Innovation and Education.

The UKCRC Centre of Infection Prevention and Management (CIPM)

NIHR Health Protection Research Unit
Imperial was successful in a recent NIHR competition and Professor Alison Holmes, CIPM Co-Director, will direct a new national NIHR funded Health Protection Research Unit in Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR). The Unit, one of 13 national partnership grants with PHE across a number of priority areas was one of four awarded to Imperial.
The HCAI and AMR partnership consists of Imperial College London, Wellcome Sanger Institute, NWL Academic Health Science Network, and Cambridge Veterinary School.
http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_20-12-2013-14-27-3

House of Commons Select **Committee**
CIPM's work was cited at the House of Commons select committee on AMR on day one of the enquiry by Dr Pat Goodwin, Society of Biology and previous Head of pathogens at the Wellcome Trust, as a positive example of on-going funded work in the area.
Alison Holmes was invited to give evidence to the Select Committee on 8 January. Along with an expert panel consisting of three others, she provided evidence relating to antimicrobial resistance. Topics covered included the education of healthcare professionals, prescribing practices, diagnostics, public awareness and community infection. The Science and Technology Committee ensures that Government policy and decision-making are based on good scientific and engineering advice and evidence. Alison was part of the second panel of the hearing which answered questions regarding clinical practice.

Imperial College Healthcare NHS
NHS Trust

Board Meeting
For information and discussion

Report Title: *Executive Performance Report Month 9 2013/14*
Report History: *Regular report presented to the Trust Board*
To be presented by: Steve McManus, Chief Operating Officer

Executive Summary:

This month is the first time this report and integrated performance scorecard is published in this format. 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 scorecard begins with an overview of the shadow Monitor performance framework and then the published indicators are subdivided into the six quality domains as well as People and Finance indicators.

The top 8 indicators for each domain have been specifically selected and agreed by the quality domain leads as those that the Board should be sighted on.

Foundation Trust governance risk rating (shadow): Amber
Rationale: Cancer 62 day standard has consecutively breached for three or more quarters

In month 9 (end quarter 3), against the shadow Foundation Trust governance risk rating, the Trust is rated as Amber.

The Trust failed to meet the cancer 62 day standard to first treatment from urgent GP referral and the 31 day standard from diagnosis to treatment. However, the cancer standards are assessed quarterly and the Trust expects to achieve 7/8 standards for quarter 3. Cancer performance is reported one month in arrears so this represents the November position and Q3 is forecast at this stage.

2013/14			Performance to date 13/14				*Forecast*		
Area	Indicator	Threshold	Q1	Q2	Q3	*YTD*	*Qtr 4 13/14*	*Qtr 1 14/15*	*Qtr 2 14/15*
Finance	Capital Servicing Capacity		4	4	4		4		
	Liquidity Ratio		4	2	2		2		
	Continuity of Services Risk Rating		4	3	3		3		
Access	18 weeks referral to treatment - admitted	90%	92.50%	93.35%	93.18%	92.99%			
	18 weeks referral to treatment - non admitted	95%	96.85%	96.80%	95.88%	96.59%			
	18 weeks referral to treatment - incomplete pathway	92%	95.96%	95.96%	95.05%	95.73%			
	2 week wait from referral to date first seen all urgent referrals	93%	98.27%	98.37%		98.38%			
	2 week wait from referral to date first seen breast cancer	93%	97.60%	97.60%		97.50%			
	31 days standard from diagnosis to first treatment	96%	94.43%	96.89%		95.85%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%	99.47%		99.80%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.50%	98.73%		98.38%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.07%	95.47%		95.33%			
	62 day wait for first treatment from NHS Screening Services referra	90%	91.30%	95.60%		92.20%			
	62 day wait for first treatment from urgent GP referral	85%	74.27%	74.00%		75.39%			
	A&E maximum waiting times 4 hours	95%	96.24%	96.68%		96.29%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	26	11	10	47			
	Governance Risk Rating		**2**	**2**	**1**	**n/a**	**1**	**0**	**0**

In future months, it is anticipated that a summary of the non-Foundation Trust frameworks will also be included (NTDA/CQC).

Key Issues for discussion:

Performance overview

A summary of the areas of key concern are provided by exception only.

Quality

- 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 December there were five Trust attributable cases. Year to date 47 Trust attributable cases have been reported to the PHE and the Trust remains on trajectory for year end.
- MRSA blood stream infections are not currently included within the Monitor governance rating score. However, any cases will continue to reported above the threshold (currently 0) to the Trust Board. In December, a Trust attributable case was reported from a patient who required treatment for lymphoedema secondary to amyloidosis. The source of this bacteraemia was phlebitis related to a peripheral vascular access device. Actions have included educating clinical staff on the requirements for peripheral vascular access device management. This brings the total number of 'cases' reported against the Trust to ten for the year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced earlier this year.

- In November 2013 the Trust failed 2 Cancer Waiting Time standards: 62-day 1st treatment (after GP referral) and 31-day subsequent surgery.
- 62-day 1st treatment (after GP referral): 80 patients were treated within the month and 22 patients breached (17 patients after adjustments for shared pathways with other Trusts have been applied). Performance was 78.8% against an 85% target. Of the 22 breaches, 6 related to late transfers between Trusts (Inter-hospital transfer (ITR) sent after day 42), We expect to achieve the standard in December 2013 but we will fail Q3 2013/14.
- 31-day subsequent surgery: 82 patients were treated in the month and 6 patients breached. Performance was 92.7% against a 94% target. We will pass this standard in December and achieve Q3.

- The Accident & Emergency 4 hour wait standard continues to be delivered with performance in December at 95.6% against the 95% standard and performance was 96.0% for the whole of quarter 3.
- Actions from the winter plan in place include:
- Capacity and demand modelling completed to understand additional capacity needed
- Additional bed capacity on all three sites;
- Winter site office established;
- Surgical rehabilitation facility fully operational;
- 7-day rehabilitation and discharge support services in place;
- CLCH step-down ward at Charing Cross opened;
- 24/7 urgent care centres open on all three sites.

Finance

- In future months, any finance key areas of risk will be reported here

People

- December saw a continued reduction in our reported sickness absence rate with 3.68% of our working hours to illness compared to 3.76% in November and 4.04% in October. Across the current 12-month rolling period, the Trust sickness absence rate is 3.43% against our full-year target of 3.40%. When compared to the same 12-month period last year, we see a 7% decrease in sickness absence. Trust Managers have been working to the new Sickness Absence Management policy for a year now following its launch in December 2012.
- The Trust vacancy currently stands at 11.04%, an increase from 10.86% reported in November; due in totality to additional new nursing posts being added to the ESR post establishment. Vacant post reviews are currently underway within our Corporate Directorates with a full vacant post review for all Trust areas planned for the beginning of February to ensure that we are only reporting on posts which are required for current service delivery.
- The voluntary turnover rate of 10.25%, whilst showing an improvement over the past 3 month, is still a cause for concern. On average, 80 of our people choose to leave Imperial each month, of which, 38% have been with us for less than 2 years. The HR Business Partners are working within their Divisions to understand why our people are choosing to leave our organisation within this time frame.

Regulatory reforms

Each month in this section, any future changes to standards or the way the Trust is assessed will be documented so that the Trust Board has early sight of these. These will remain within the report for two consecutive Trust Board meetings before they are removed from the report.

Monitor revised its performance framework in August 2013 and published the Risk assessment framework http://www.monitor.gov.uk/sites/default/files/publications/RAF_Final_August2013_0.pdf

This framework differs from the previous Compliance Framework in that there are only three ratings assigned:

Rating	Description
Green	• No governance concern is evident
Amber*	• Potential materal causes for concern (requiring further informaiton or formal investigation) identified (see table for examples of governace concern) • * in the Risk assessment framework, there is no 'amber' category. If there are potental governance concerns, the 'green' rating would be replaced by a description of the issues and steps being taken to address these.
Red	• Red rating assigned if regulatory action taken

The following diagram illustrates what could give Monitor cause for governance concerns (presented by category). Information that comes to light from other areas of governance oversight may lead to overrides in the governance rating. These include corporate governance statements, the annual governance statement, forward plans and regular

governance reviews.

Category	Metrics	Governance concern triggered by
CQC information	• CQC judgments	• CQC warning notice issued • Civil and/or criminal action initiated
Access and outcome metrics	For acute trusts, metrics including: • Referral to treatment within 18 weeks • A&E (4 hours) • Cancer waits (62 days) • C.difficile – national target	• Three consecutive quarters' breaches of a single metric *or* a service performance score of 4 or greater • Breaching pre-determined annual C.difficile threshold (either three-quarters' breach of the year-to-date threshold or breaching the full year threshold at any time in the year) • Breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters.
Third party reports	• Ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc.	• Judgment based on the severity and frequency of reports

Quality governance indicators	• Patient metrics
	  • Patient satisfaction
	• Staff metrics
	  • High executive team turnover
	  • Satisfaction
	  • Sickness/absence rate
	  • Proportion temporary staff
	  • Staff turnover
		• Material reductions in satisfaction, or increases in sickness or turnover rates
		• Material increases in proportion of temporary staff
		• Cost reductions in excess of 5% in any given year

Financial risk	• Continuity of services risk rating	• Breaching any continuity of services licence condition as a result of governance • Inadequate planning processes

<u>Scorecard update</u>

In this section the Board will be notified or consulted of any proposed changes and amendments.

Leading/lagging indicators

This month is the first month where each indicator is shown as 'leading' or 'lagging'.

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.

QlikView roadmap

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 August/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.

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:

- Many of the indicators included require development of data feeds and by the next Trust Board meeting in March it is anticipated that these will all be complete;
- Include further comparison data, where available to allow benchmarking to be made with other London Trusts, the Shelford Group and against the national average;
- Development of indicators for the Equality and Diversity quality domain;
- Inclusion of a RAG rating for forecasting future quarters performance.

Legal implications or Review Needed: *delete as required*

a.
b. **No**

Details of Legal Review, if needed:

Link to the Trust's Key Objectives:

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.

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:

Recommendations and Actions Required:

The Board are asked to:

- Review the paper and scorecard
- Note key areas of risk and planned mitigations
- Discuss content/format of scorecard regarding any future amendments.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public
For information

Report Title: Dementia Care & CQUIN – Supporting Carers
Report History: to be reported twice-yearly
To be presented by: Steve McManus, Chief Operating Officer
Executive Summary: There are four national Commissioning for Quality and Innovation (CQUIN) goals for 2013/14, including the national Dementia CQUIN goal. The dementia goal consists of three indicators, one of which requires the Trust to conduct a monthly audit of carers of people with Dementia to test if they feel supported. The CQUIN requirements also state that the findings from this audit are presented to the Trust board on a twice-yearly basis. This paper contains the details of the audit that Trust is undertaking as well as some its initial findings.
Key Issues for discussion: The Board are asked to be sighted on the contents of this report.
Legal implications or Review Needed: a. No **Details of Legal Review, if needed:** n/a
Link to the Trust's Key Objectives: 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.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: This paper provides the Board with an assurance that the Trust is compliant with the requirements of the national Dementia CQUIN goal.
Recommendations and Actions Required: 1. For the Board to note the contents and findings in the report 2. For the Board to agree that this report can be shared with commissioners

Dementia Care and CQUIN at Imperial – Supporting Carers of Patients with Dementia

The Dementia Care Team has been in place in the Trust since December 2012, primarily to ensure Imperial College Healthcare NHS Trust (ICHT) meets the requirements dementia CQUIN (Commissioning for Quality and Innovation) but also to improve dementia care across the Trust.

CQUIN Pre-qualification

In order to quality for Commissioning for Quality and Innovation (CQUIN) payments in 2013/14, ICHT had to satisfy at least 50% of national CQUIN pre-qualification criteria based on the six NHS *High Impact Innovations*. One of these criteria was ensuring 'carers of patients with dementia are sign-posted to relevant advice and that they receive the relevant information to help and support them'.

Imperial College Healthcare NHS Trust has signed up to the Dementia Action Alliance to signify its strong commitment to improving the lives of people with dementia. To support this aim and meet the requirements of one of this year's CQUIN indicators, the Dementia Care Team has implemented a strengthened dementia training programme across the Trust.

Supporting Carers of People with Dementia

There are four national CQUIN goals for 2013/14. The national Dementia CQUIN goal consists of 3 indicators, the details and requirements of these indicators are as follows:

1. *Find, Assess, Investigate and Refer* (FAIR): this indicator is a composite of dementia screening, risk assessment and onward referral for specialist diagnosis for patients aged 75 years and over admitted as an emergency (all elements have a 90% target)
2. *Clinical Leadership*: Providers must confirm a named lead clinician and a planned training programme for dementia to be delivered in-year.
3. **Supporting Carers of People with Dementia**: This indicator requires the completion of a monthly audit of carers to test whether they feel supported. The content of the audit is to be agreed with local commissioners. Findings from these audits are to be reported to the Board two times in the year.

To meet the requirements of the third indicator, the Dementia Care Team, with input from stakeholders both internal and external to the Trust, has devised an audit questionnaire to be given to carers of patients with dementia at least 24-48 hours prior to discharge.

Audit of Carers of Patients with Dementia

The audit is currently being piloted on five wards (one admission ward, three care of the elderly wards and one rehab ward) and is to be rolled out to other wards once established.

The questionnaire consists of five questions and can be completed either alone, face-to-face, or over the phone. The questions focus, as required, on whether the carer felt supported during the stay in hospital of the patient for whom they are caring, and whether they received sufficient information regarding patient diagnosis, physical health and discharge care planning. There is also a 'free text' box at the end of the questionnaire where carers can provide additional comments.

The audit responses and findings will be collated monthly and reported to the board biannually. A total of thirty responses have been collected so far. A copy of the questionnaire is attached at the end of this report.

Initial findings

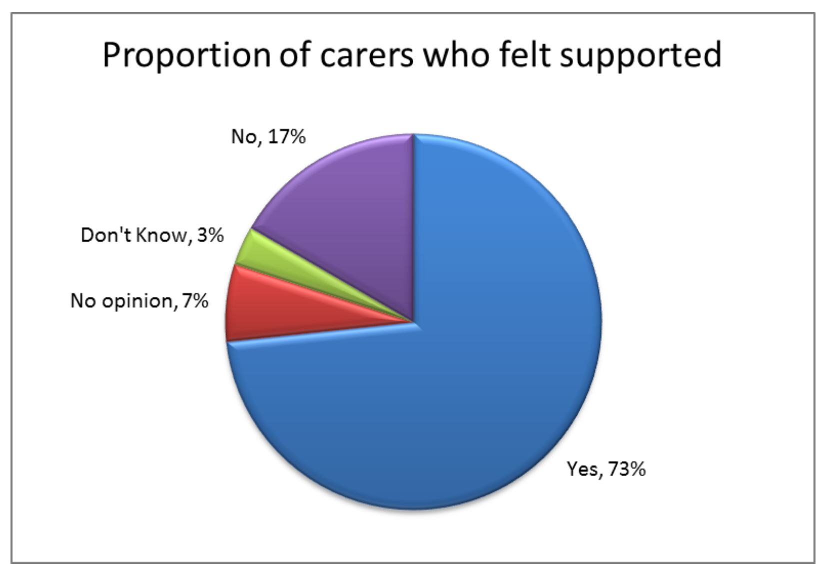
The monthly breakdown of responses is presented in the table below. 60% of surveys were completed by telephone, 20% were completed face-to-face and for the remaining 20% the carer completed the questionnaire alone.

Year	Month	Total Responses
2013	October	9
	November	3
	December	11
2014	January	7
Grand Total		**30**

The key question in relation to the CQUIN indicator is question 2: *During the patient's admission in hospital, do you feel that you have been supported in relation to their existing diagnosis of dementia?* 70% of recipients said that yes, they felt supported. The responses to this question are presented in the graph below.

Of the 30 respondents, 19 reported that health professionals (HCP) spoke to them about the patient's diagnosis of dementia (*question 3*). Of those 19, all stated that they had received sufficient information.

70% of respondents stated they had received enough information in relation to how patients' physical health impacts on their dementia (*question 4*). In terms of discharge planning and onward care, 21 out of 30 carers surveyed stated they were involved in this process and provided with information about services (*question 5*).



Of those carers who felt supported, the majority (18 out of 22) stated they had been spoken to by a health professional in relation to the patient's dementia, whereas of the 5 respondents who stated they did not feel supported only one had been spoken to by a health professional.

In addition to the five core questions in the audit questionnaire, respondents are also given the opportunity to provide additional comments. A selection of these comments is presented below.

"I was very relieved that the hospital staff to allow me to stay with my mother out of visiting times as necessary as she can become very confused and anxious. Nurses particularly have been very understanding and helpful"

"Apart from receiving a diagnosis of dementia no specific information has been provided about the condition or of services available"

"Very pleased with the care on the ward given to patient. Doctors have been willing to speak to family member on request"

Where appropriate, any 'negative' comments that are received are being relayed to the services in question.

Next steps

The Dementia Care Team has developed a Carer's Pack consisting of useful information for carers of people with dementia. This pack is now available on *The Source* for staff to access and also available on the Trust's website.

The audit will continue throughout the year, with subsequent findings being reported to the Trust Board on a twice-yearly basis.

The Audit Questionnaire

Date:

Imperial College Healthcare NHS
NHS Trust

☐ **Phone** ☐ **Face-to-face** ☐ **Completed alone**

Dear Carer,
We are committed at Imperial College Healthcare NHS Trust to improving the quality and standard of care we give to patients with dementia and their carers and families. Your feedback and comments are very important and can help us improve our services.

In the questionnaire below, 'the patient' refers to the person your care for, or your family member.

Carer questionnaire (please tick)

Q1. Would you be willing to complete this questionnaire?

☐Yes ☐No

Q2. During the patient's admission in hospital, do you feel that you have been supported in relation to their existing diagnosis of dementia?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q3. Did any health professionals talk to you about the patient's diagnosis of dementia during this admission?

☐Yes ☐No

If yes,

Do you feel that you received sufficient information?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q4. Do you feel that you had received enough information about how the patient's physical health can impact on their dementia during this admission?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q5. Prior to the patient's discharge, were you involved with care planning and given information about services regarding their dementia?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Additional comments regarding the above questions and dementia care:

Please return this questionnaire to the nurse in charge, and thank you for your time

innovation respect care achievement pride

Imperial College Healthcare NHS
NHS Trust

FINANCE REPORT – DECEMBER 2013

Report Title: Finance Performance Report

To be presented by: Marcus Thorman, Chief Financial Officer

Chief Finance Officer's message:
The Trust has achieved a year to date surplus of £13.7m at the end of December (after adjusting for impairments and donated assets), an **adverse** variance against the plan of £0.1m. This is based on a surplus in month of £0.5m, which was a **favourable** variance of £0.1m. The in-month position includes an asset impairment charge to I&E of £117.1m for the devaluation of buildings.

CIPs are behind plan by £3.0m. However, this has been offset by over-performance income on CCG contracts. It should not be expected that the over-performance on income will continue and therefore persistent improvement in delivery of the CIPs is required in order to achieve the financial plan target.

The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' anticipated income and expenditure for the year. The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets.

Key Issues for discussion:
Continued improvement required in future months through improved performance against CIPs.

Legal Implications or Review Needed

a. Yes ☐
b. No ✓

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objective
Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

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

Building world class finance

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FINANCE REPORT – DECEMBER 2013

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st December 2013.

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 for further explanation.

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

2.1 **Statement of Comprehensive Income (I&E Account)** - The Trust's financial position for the month is a **surplus** of £0.5m, with a year to date surplus of £13.7m. This was a **favourable** variance of £0.1m in month.

2.2 **CCGs/NHS England Service Level Agreement (SLA) Income** – The CCG & NHS England SLA contract monitoring report for the month was calculated using the month 8 actual data and adjusted for the planned monthly profile within the SLA. Over-performance against plan is £19.8m and is associated mainly with CCGs' QIPP plans to reduce patient flows into hospital not being achieved.

2.3 **Expenditure** - Pay expenditure shows an **adverse** variance of £9.7m year to date as result of under-achievement of CIPs and a failure to reduce agency costs. Non pay expenditure is showing an **adverse** variance year to date of £10.1m which is mainly due to the purchase and sale of drugs for £2.8m to Lloyds Pharmacy as part of them running the outpatient pharmacies. In December there was a significant increase in the run rate on pay relating to additional medical staff within A&E causing an overspend of £0.4m in month.

2.4 **Financing costs** - Impairment on buildings of £117,142k has been charged to I&E Account this month following a comprehensive valuation review of the Trust's estate.

3 Monthly Performance (Page 4)

3.1 Divisional financial performance has been assessed against the Financial Risk Rating. The metrics shown in the tables above reflect the five key themes and summarise performance against 25 detailed metrics. The FRR is supporting improvements in financial management and engagement within Clinical Divisions and plans are on track to expand the FRR to Directorates.

3.2 Medicine and Women & Children Divisions continue to show increased deficits against plan and forecast. Forecast deficits against plan have increased by £0.8m to £9.7m (Medicine) and £0.4m to £1.5m (Women & Children). CIP performance has also deteriorated in Medicine with a forecast deficit to CIP plan of £5.2m. Women's and Children's CIP forecast deficit remains at £0.9m.

3.3 There needs to be continued focus on CIP delivery thereby reducing unit costs and securing a reduction in the current expenditure run rate which is key to delivering the financial plan targets. Shortfalls against CIP delivery have been mitigated by improved operational financial management and contribution earned from additional income.

4 Cost Improvement Plan (Page 5)

4.1 The CIP plan for the year is £49.3m. Expected forecast outturn is £46.6m which is £0.9m improvement on last months' forecast.

4.2 Year to date delivery of CIP was £33.5m (a deficit of £3.0m against plan)

4.3 The Transformation Board is closely monitoring the position and significant work has taken place to ensure plans are robust in delivery of the 2013/14 target.

5 Statement of Financial Position (Balance Sheet - Page 6)

5.1 The overall movement in balances when compared to the previous month is a decrease of £114.4m and is predominately due to the revaluation of the Trust's property portfolio resulting in a net reduction of £114.8m. There continues to be significant outstanding payments for SLA over-performance, Project Diamond and R&D MFF due from NHS England and Department of Health respectively.

6 Capital Expenditure (Page 7)

6.1 Expenditure in month was £0.6m (£12.3m year to date) which is £7m behind plan.

6.2 The variance is largely due to previously-reported changes in Endoscopy and Imaging. A new project to roll out self-check-in kiosks in all outpatient departments was approved by Investment Committee in December and has now been included.

6.3 The contingency allowance of £2.5m remains available for any urgent requirements that may arise from winter pressures or advancing medical equipment purchases from next year.

7 Cash (Page 8)

7.1 The cash profile has been set out as per the TDA plan. Cash is behind plan due to organisational changes in the NHS and delays in agreeing funding for Project Diamond and R&D MFF.

8 Monitor metrics – Financial Risk Rating (Page 9)

8.1 The presentation of the Financial Risk Rating has changed to a tabular format and includes the new Monitor Continuity of Service risk rating (CoSRR). All risk metrics are on track.

9 Conclusions & Recommendations

The Board is asked to note:

- The **surplus** of £0.5m for the month of December; the cumulative **surplus** of £13.7m, a cumulative **adverse** variance of £0.1m against the plan.
- Actual achievement of CIP schemes year to date was £33.5m which is behind plan by £3.0m. It is therefore recommended that discretionary expenditure and new projects are stopped until it is confirmed the Trust is back on track with delivery of the financial plan.
- Forecast outturn remains at a surplus of £15.1m.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Chief Financial Officer

Imperial College Healthcare NHS
NHS Trust

Board Meeting In Public

For information

Report Title: 2013 Emergency Preparedness, Resilience and Response (EPRR) assurance process
To be presented by: Nicola Grinstead, Director of Operational Performance
Executive Summary: NHS Trusts are expected to participate in an annual Emergency Preparedness, Resilience and Response assurance process carried out by NHS England in line with the requirements of the "*NHS Commissioning Board Emergency Preparedness Framework 2013*". In London, the 2013 assessment was carried out in August with results published in November. Against 115 measures, 107 of which were officially rated, ICHT scored 88 'green' ratings, 19 'amber' ratings and zero 'red' ratings placing the Trust as one of two 'highly performing' organisations in the sector. Only one other London Trust provided greater assurance than ICHT. 14 areas of 'best practice' were identified within ICHT. An action plan for the 'amber' ratings has been prepared and its delivery will be co-ordinated and overseen by the Emergency Planning Committee.
Key Issues for discussion: • Acknowledgement of the new NHS Commissioning Board Emergency Preparedness Framework 2013 • Acknowledgement of the 'high performing' status of the ICHT 2013 EPRR Assurance Assessment • Acknowledgement of the key areas where improvements are required and identification of any further assurance required by the committee in relation to the 'amber' rated standards
Legal implications or Review Needed: No
Link to the Trust's Key Objectives: *please identify which and how* 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.

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:

- An action plan has been developed setting out how the Trust can improve compliance with the 19 amber rated standards and will be co-ordinated and overseen by the Trust's Emergency Planning Committee
- The Trust will liaise with other acute providers where 'best practice' examples have been identified to explore how we can adapt and improve our EPRR

Recommendations and Actions Required:
The Trust Board is asked to;

1. Acknowledge that the new NHS Commissioning Board Emergency Preparedness Framework 2013 details 7 core standards (measured through achievement of 115 indicators) which are measured through an annual assurance assessment co-ordinated by NHS England
2. Note that the outcome of the ICHT 2013 EPRR Assurance Assessment is that out of 115 indicators, 107 were rated with 88 scoring green, 19 scoring amber and zero scoring red placing the Trust as one of 2 'highly performing' Trusts in the sector. Only one other London Trust provided higher levels of assurance than ICHT.
3. Note that in relation to the amber rated indicators an action plan is in place and will be co-ordinated and overseen by the Trusts Emergency Planning Committee.

Emergency Preparedness, Resilience and Response (EPRR)
2013 Assurance Assessment

1. Introduction and Context

1.1. The Civil Contingencies Act (2004) requires category one responders, such as ICHT, to show they can deal with a wide range of incidents such as a prolonged period of severe pressure, extreme weather conditions, an outbreak of an infectious disease or a major traffic accident.

1.2. On 1st April 2013 new arrangements for EPRR came into being as part of the changes that the Health and Social Care Act (2012) made to the health system in England. Specifically that the responsibilities of the strategic health authorities have been transferred to the NHS Commissioning Board and to Clinical Commissioning Groups and that local health resilience partnerships will be the forum for co-ordination, joint working and planning across all relevant bodies.

1.3. Previous EPRR guidance has now been replaced by the "NHS Commissioning Board Emergency Preparedness Framework 2013" which sets out 7 core standards (NHS CB Core Standards 2013) that must be met by Trusts. Adequate assurance must be provided through an annual assessment process.

2. Emergency Preparedness, Resilience and Response Core Standards

2.1. The 7 core standards (NHS CB Core Standards 2013) are detailed in the table below.

1	All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management
2	All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency
3	All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to coordinated planning for emergency preparedness and resilience (for example surge, winter and service continuity) across the area through LHRPs and relevant sub-groups
4	All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sectors EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations reporting structures
5	All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies
6	All NHS organisations must provide a suitable environment for managing a significant incident or emergency (ICC) This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently
7	All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisatins will maintain continuity in the services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301

2.2. The 7 core standards are comprised of 115 measures against which a Trust's performance is assessed.

3. 2013 EPRR Assurance Assessment

3.1. In August 2013, the NHS England London EPRR team undertook a review of the emergency preparedness activities in all London NHS organisations against the 7 nationally defined EPRR core standards.

3.2. Trusts were required to submit evidence in relation to the 7 core standards by demonstrating how they meet 115 indicators. Out of the 115 indicators Trusts have been provided an official rating for 107 indicators. ICHT achieved 88 ‘green’ ratings (82%), 19 ‘amber’ ratings (18%) and zero red ratings.

3.3. NHS England officially categorised ICHT as one of two ‘high performing’ Trust’s within the North West London sector.

3.4. The assessment process identified areas of ‘best practice’ within NHS providers and these examples have been highlighted and shared with all Trust’s to allow for sharing of ideas and to encourage collaboration and learning. ICHT was highlighted for 14 examples of ‘best practice’;

- EPRR Workplan
- Governance arrangements around EPRR
- EPRR Risk registers
- EPRR Risk assessments
- EP section in 2012-13 Annual Report
- COO EP Brief
- EPRR Training Slides
- Cascade Test Report
- Recovery Plan
- Information for patients after a MI
- Use of London and South East of England Burn Network – Burn Major Incident Plan
- Heatwave, action cards with clear actions to be taken at each alert level
- Cold Weather Plans, action cards with clear actions to be taken at each alert level
- Lockdown plan, assigns tasks to action cards

3.5. The 19 amber areas include; provision of appropriate training now the new management structure is in place, communications to the public in relation to our plans (i.e. web-page), update of our plans to reference the new NHSE governance framework, resilience in relation to establishing helplines and managing surges in telephone calls, strengthening business continuity plans at service level and completion of evacuation plans.

4. Action Plan

4.1. A detailed action plan has been put in place to ensure all amber rated indicators can be improved. The action plan will be further developed, co-ordinated and implemented by the Emergency Planning team and through the Trust's Emergency Planning Committee.

4.2. The key components of the action plan include;

Completed;

- Exploration of the possibility of formally creating MoU's with local independent sector providers
- Testing Trust capability to implement helplines and effectively manage a surge in volume of calls.
- Inclusion of a section in the emergency plans detailing how resources will be released to fund/respond to unexpected incidents and how the financial consequences will be tracked (relates to 2 of the amber rated indicators)

Within 2 months;

- Provision of training relevant to the new management structure and the new on-call rota
- Publication of our emergency plans and processes in an format appropriate for the general public through the website etc
- Modernisation and updating of plans to reflect changes to NHS governance structures i.e. NHSE, CCG's (relates to 7 of the amber rated indicators)
- Revision of Business Continuity action cards to reflect changes in both NHS and ICHT governance structure
- Completion and sign-off of the currently draft Trust evacuation plan
- Completion and official sign-off of currently draft business continuity plans such as overnight accommodation plans for staff
- Further development of plans on how extended working hours will apply and be sustained in the event of a major incident

Within 6 months

- Strengthened business continuity plans in place at a service level
- Update of the Flu Pandemic plan to reflect in more detail specific actions for key staff groups in line with new assurance guidance from NHSE – on track for completion in April 2014 in line with NHS England sign-off requirements.

5. Recommendations

The Trust Board is asked to;

5.1. Acknowledge that the new NHS Commissioning Board Emergency Preparedness Framework 2013 details 7 core standards (measured through achievement of 115 indicators) which are measured through an annual assurance assessment co-ordinated by NHS England

5.2. Note that the outcome of the ICHT 2013 EPRR Assurance Assessment is that out of 115 indicators, 107 were rated with 88 scoring green, 19 scoring amber and zero scoring red placing the Trust as one of 2 'highly performing' Trusts in the sector. Only one other London Trust provided greater levels of assurance than ICHT.

5.3. Note that in relation to the amber rated indicators an action plan has been put in place and will be co-ordinated and overseen by the Trusts Emergency Planning Committee.

Imperial College Healthcare NHS
NHS Trust

Report Title: Director of People & Organisation Development Report

To be presented by: *Jayne Mee*

Executive Summary: *This report updates on the People & Organisation Development strategy developments.*

Key Issues for discussion:
For information

Legal Implications or Review Needed
a. Yes ☐
b. No ☒

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives: *please identify which of the following key objectives this report supports or advances and how.*

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

Assurance or management of risks associated with meeting the relevant key objective(s): *please identify the relevant risks and the assurance that the proposals provide*

Actions required: *please list recommendations/action required as a result of this report*

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

1. TALENT DEVELOPMENT

1.1. Engagement

We launched our first local engagement survey in October 2013 to provide us with real local information about how our people feel about working here. Results have now been received and are in the process of being reported across the Trust. The survey had a 27% response rate which is not atypical for a first survey of this sort. Around 35% would have been expected. Some of this can be explained by a problem that has been identified among the 400 junior doctors who were sent the survey, but did not pick up on their Imperial email account. Work is now underway to establish the very best means of communication with junior doctors.

The survey gives us an overall Engagement Index score, which summarises level of possibility in the organisation. Our Engagement Index is 42% which is slightly higher than we might have expected it to be.

The results show us that 42% of our people responded positively, 26% were neutral and 22% were negative. There are variations amongst the Divisions and Directorates. The questions with the lowest scores were:

- The senior leaders here empower and inspire me to deliver exceptional performance
- In general my job is good for my health
- My organisation takes positive action on health and well being
- At work my opinions seem to count

All Divisions and Directorates are now briefing all their people about the results and developing their actions plans to respond to this.

The next quarterly survey goes live on January 20th

1.2. Leadership Development

Our four new Leadership programmes continue to run successfully with over 55 people participating in programmes. Our second cohort of Horizons and Aspire commence in January and we are also now well into the design of our fifth programme for middle managers, Headstart which will launch in April 2014.

Our Certificate in Medical Leadership programme ran the first of 2 days devoted to Finance in January and speakers included not only expert speakers from Imperial Business School, but also a Finance Director from a first wave Foundation Trust and a Finance Director from NHSLA to help develop financial awareness and acumen amongst our senior leaders.

1.3. Performance and Development Review

In February 2014 we will be launching a new Performance and Development Review process for the Trust which will replace the current non-medical appraisal process. This is an essential step in our development of a performance culture, a key part of our People and OD Strategy.

The most notable change in the new PDR process is the introduction of performance ratings which will be centrally recorded. This is a significant change for the current appraisal process and to support it, we will be creating a Managers Guide and a comprehensive training programme to support our managers in having effective performance conversations, providing feedback and using performance ratings.

The ratings we will be using are:

Rating Indicator	Rating	Definition
A	Outstanding	Performance is outstanding in all areas
B	Exceeds	Performance Exceeds expectations
C	Good	Performance is consistently good, meeting expectations in a majority of areas
D	Development	Performance is below expected levels in some areas and specific development can be identified (may also be new to role)
E	Unacceptable	Performance is significantly below accepted levels in the majority of areas. Not responding to development provided
U	Too New to assess	Has been in roe for less than 3 months

A second major change will be a phased move towards undertaking PDRs in a set "timeframe" or "window". Previously the NHS terms and conditions required that appraisals were conducted on the anniversary of start date and an increment awarded at that date. An agreed window for conducting PDRs will enable better management of the process, effective calibration of the process and will tie into the Business cycle more smoothly.

Bands	2014/15	2015/16 and onwards
2 - 6	April - December	April - September
7 - 8B	April - September	April - June
8B - 9	April - June	April - June

Thirdly, the PDR will collect more data than we currently have regarding career aspirations which will be an essential step in our Talent Management Strategy.

The roll out of this important Trust cultural change programme will coincide with changes to the national NHS terms and conditions (Agenda for Change) which will, from April 2 2014 enable us to base incremental point rises on satisfactory performance rather than solely on length of service, which has previously been the case.

2. EMPLOYEE RELATIONS

2.1. Pay Progression

At the January meeting of the Partnership Board we agreed with our trade union colleagues new arrangements for linking performance to pay for people on agenda for change (AfC) contracts. From 1 April 2014:

- Incremental pay increases for people employed on all AfC pay bands will only be awarded if the performance of our people is assessed as good or better at their annual performance & development review.
- Pay progression through the last two pay points in pay bands for senior people (8C, 8D and 9) will be non-recurring and reviewed on an annual basis.
- Irrespective of the level of performance, incremental pay increases will not be awarded to people who are issued with formal disciplinary warnings or for, no good reason, are not up to date with their statutory & mandatory training.

This is the first step towards replacing old ideas about grading structures and pay progression. As a foundation trust we will be able to modernise our pay structures further including making greater use of variable pay to focus reward our highest performing people.

2.2. Change Management

Trust's rules for managing the impact of organisational change on our people are contained within our change management policy. In January we initiated a review of the policy with a view to introducing more flexible, less bureaucratic processes so that we can manage change more quickly and respond more sensitively to the needs of people affected by change. A draft document has been sent to our management teams and trade union representatives for comment and a new version of the policy will take effect from April.

2.3. Employee Relations Advisory Scheme

Our new in-house Employee Relations Advisory Service has taken on responsibility for advising line managers on disciplinary, sickness absence and other workforce issues. The new service will significantly improve our management of sensitive people issues. Feedback from managers to date has been very positive. Of the 180 live cases logged with the service half relate to sickness absence and a third relate to misconduct. Good ER processes are dependent upon line managers having the confidence and skills to apply employee relations policies effectively. To this end, our

workforce policies and procedures course will become mandatory for all new line managers from 1 April 2014.

2.4. Dignity and Respect

We are consulting on a new Dignity and Respect Policy. The policy emphasises the types of positive behaviours we expect from our people and replaces the current Bullying and Harassment Policy. We have had positive feedback about the proposed policy from managers and trade union colleagues and it is anticipated that the new policy will go live from February.

2.5. Uniform Policy

A new uniform policy will be published in February to reflect changes to infection control measures and uniform rules for the different professional groups.

3. RESOURCING

3.1. Senior Recruitment

The following started working in the Trust in January

- Dr. Senga Steel, Deputy Director of Nursing
- Gemma Glanville, new HR Business Partner for Medicine
- Guy Young, Deputy Director of Patient Experience
- Dr. Christopher Wadsworth appointed as Consultant in Gastro HpB and will start on 20th January
- Dr. Susannah Long appointed substantively to Consultant in Elderly Medicine following a period working in the Trust on a locum basis.

3.2. Nursing & Midwifery Recruitment

- The drive to reduce vacancies amongst Nursing & Midwifery posts in bands 2 – 6 continues. Between 1 April and 31 December of this year 472 nurses, nursing assistants and midwives have joined the Trust, of whom 30 started in December. In the period between April and December, 639 offers have been made and accepted.
- The 37 ICU nurse recruited from India in November 13 are expected to join the Trust in 3 batches between March and August 14.
- 17 Nurses were appointed for Medicine following an open day in December.

3.2.1. Overseas Recruitment

Following a successful recruitment campaign in India further overseas campaigns are planned during the year:

- March 14 - Trip to India for ICU & Clinical Haematology Nurses
- Mid February – Trip to Philippines for PICU & NICU nurses and Clinical Haematology
- Currently advertising in Ireland for Bands 5,6 & 7 nursing vacancies for Medicine.

3.2.2. Open Days

The following open days are planned:

- 28 January for band 5 nurses for Medicine and Theatre nurses for the ISCS Division. Rolling monthly open days for Medicine in between March & June 14.
- Feb/March open day for W&C Division
- Quarterly recruitment of HCA’s commencing March 14.

3.3. Volumes and Time to Recruit

The average number of nurses (all bands), *recruited from outside the Trust*, per month between April and December were 58, compared to an average of 26 per month across the whole of 2012/13; an increase of more than 120% (12/13 total: 313; 13/14 total for nine months ytd: 521) Despite considerably increased volumes we are managing to maintain the time period between a conditional offer of employment and an agreed start date (i.e. the time it takes to complete all the pre-employment clearances) at around 30 days. The current KPI target is 40 days.

3.4. Temporary Staffing/E-Roster

Bank and Agency (Clinical)

- The number of bank shifts being requested in December 13 was 25% higher than in December 12. The fill rate continues to increase but as a percentage figure it remains the same as last December. The opening of additional winter pressure beds has increased the demand for bank and agency. Agency usage has increased to 18% in December (target should be no more than 10%).
- Pay rates are impacting on the ability to attract more bank workers; however, agreement has been reached in the Trust to increase bank rates from 20th of January 2014 for bands 2 – 6 general nurses and for nurses in PICU/NICU/ICU & CICU. This is expected to make a significant impact on our ability to fill shifts.

4. PEOPLE PLANNING & INFORMATION TEAM

4.1. Trust Vacancy Rate

Across the Trust, the current vacancy rate is 11.0% (equivalent of 1,081 WTE). We have completed a review of all Divisional post establishments and are currently reviewing corporate areas to ensure that posts which are not relevant to current service requirement are closed. Moving forward, a full review will take place each quarter to ensure that we have an accurate and meaningful view on our vacancies. We are working closely with Divisions and Directorates to drive this vacancy rate down.

4.2. People Planning

Work continues to create a people plan to support the Trusts SaHF, OBC and Clinical Strategy through collaborative working with Clinical, Finance and Performance colleagues. January has also seen work to complete a TDA Workforce Plan outlining our people, by month, for 14/15.

4.3. People Reporting

The development of a 'Your People' application in Qlikview commenced at the beginning of January. This will provide managers, in one place, key information about all of their people including key people metric information such as performance and development review and sickness.

5. HEALTH & WELLBEING

5.1. Vaccinations

We have currently given 3872 doses of vaccines. We have advised both the weekly capacity conference call and HCAI task force of the availability of another 100 more vaccines and this is being cascaded through the divisions. Our pages on the Source were updated with this information just before New Year. Here in the UK levels of flu reported by HPA are still low:
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140607028.
Flu is circulating but local activity has been low. We will spread the message that we are still encouraging staff to be vaccinated until at least the end of the month, via drop in appointments. We are keeping a close eye on the external situation and would modify our plans if levels of flu start to rise significantly.

5.2. Heath Foundation Shared Purpose Programme

The Shared Purpose Programme, funded by the Health Foundation aims to develop a toolkit based on potential links between workforce predictors and clinical outcome data. The quantitative project is at the data collation and cleaning stage, in preparation for the analysis of three-years of retrospective ICU data. Workforce data cleaning is largely complete and collation of the clinical outcomes data has commenced, with the support of intensive care areas. Professor Scholtes from the University of Cambridge is providing statistical collaboration on the data analysis process and will be meeting the team on 10th February 14. Meetings with the Health Foundation to extend the toolkit development and testing phase into the final year of the programme (2015) have been successful and the extension of funding is agreed. The qualitative project, that includes an interview study and systematic review, is on track. The interview study to understand staff perceptions of risk and safety in relation to staffing has progressed with 22 out of 40 interviews completed. The systematic review to understand links between staffing factors and clinical outcomes has commenced and a draft search strategy prepared.

Imperial College Healthcare NHS
NHS Trust

Trust Board Meeting in Public

Report Title: Director of Assurance & Governance Report

To be presented by: Cheryl Plumridge

Executive Summary:

The attached paper is a consolidated report covering the work of the Director of Governance & Assurance area including quality and safety, service quality, legal issues and CQC activity.

On CQC there are no issues of concern to report. There has been one whistleblowing incident since our last report to the Board: this has now been dealt with to CQC's satisfaction. There has also been one unannounced themed CQC inspection of dementia care at Charing Cross Hospital on 22 January: we will not receive a formal readout until the end of March but immediate feedback from CQC was extremely positive with some glowing endorsements of the caring attitude of our nursing staff and the initiatives that were taking place in this area.

The report includes a periodic deep dive into serious incidents, complaints, inquests and claims to provide the Board with analysis of trends together with evidence of actions and organisational learning. Of note is the fact that the number of complaints has increased (but coupled with a decrease in the number of low grade complaints dealt with by PALS), and the number of claims and inquests is also up significantly on the previous year. This has had a financial impact in terms of increased insurance premiums, and is something to be monitored in terms of quality. The new legal section that is being created should improve our ability to respond effectively (both in terms of organisational learning, investigating incidents etc) and more cost efficiently to these developments. The number of serious incidents remains roughly constant but we are under reporting incidents compared with data from other comparable Trusts: it is hoped that a new Datix (IT reporting system) plus improved processes, top level ownership and oversight of the issue, and improving organisational learning will address this issue. On the plus side, actual harm resulting from incidents is lower than comparable data from other Trusts.

Key Issues for discussion: N/A

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
3. Conduct world-class research and deliver benefits of innovation to our patients and population

4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

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

Director of Governance & Assurance Report

January 2014

1. REGULATORY COMPLIANCE

1.1 Care Quality Commission (CQC)

1.1.1 Registration

The Trust remains 'registered without conditions' across all sites. Since the last report there has been an unannounced themed review inspection on dementia at Charing Cross Hospital at 22 January. A formal readout will not be provided until the end of March but in a post visit meeting, the CQC said they had been extremely impressed with the nursing care they witnessed, the staff they interviewed and initiatives that were underway. There were no causes for concern.

Following approval at the last Trust Board, the Trust submitted an application to add the regulation activity 'management of blood and blood related products' on 20 December 2013 for services provided at Hammersmith Hospital and St. Mary's Hospital. Our application is still being processed by the CQC.

1.1.2 Whistleblowing

Since the last report in November, there has been one further CQC whistleblowing alert, bringing to a total of two the number of alerts received in this financial year.

This second alert was reported on 2 December and concerns staffing in the day surgery unit on Victor Bonney ward amidst worries that staff could not raise their concerns for fear that 'their jobs would be at risk'.

A comprehensive investigation has been undertaken including conducting 1:1 interviews with the majority of staff. It was found that staffing levels were safe but largely due to the use of bank and agency staff or by moving staff within the unit. The unit is actively recruiting to their vacancy positions and has uplifted their establishment. We also identified some communication issues within the team and actions are underway to share this with the staff and manage these concerns. An action plan has been developed as a result and has been shared with CQC. CQC are satisfied with our actions and we will report progress against the action plan in February 2014.

1.1.3 Trust Leadership Walkarounds – Key Themes

Leadership Walkarounds involving a multi – professional team of Trust staff continue to be carried out on a monthly basis. A number of themes have been identified where improvements are required including:

- On-going estates issues
- Cleanliness of equipment
- Inconsistent documentation of peripheral cannula care
- Signposting
- Noise at night
- Security of records

Actions plans have been developed and fed back to the Divisional Governance Leads to follow up as part of their assurance processes.

1.1.4 Looking Ahead

Looking forward, a key priority for the Trust will be to ensure we are well prepared for the CQC/Inspector of Hospital visit that we are likely to receive in the first quarter of next year. Such visits are substantially different to previous CQC visits in terms of scope and duration and will be conducted under new guidelines still being formulated. It has been necessary to increase staffing over and above the one individual currently covering CQC issues (and other regulatory areas), in order to ensure we are prepared for this inspection and have the logistical resources in place to enable us to respond appropriately to an inspection lasting several days across all clinical areas and our five hospitals simultaneously.

2. PATIENT SAFETY

The Board is required to receive periodic reporting on serious incidents, complaints, inquests and claims and the following is designed to provide the Board with a periodic deeper dive into these issues to present an analytical overview of trends, actions and organisational learning in these areas. The Quality Committee's meeting on 12 February will also receive this information but in greater detail.

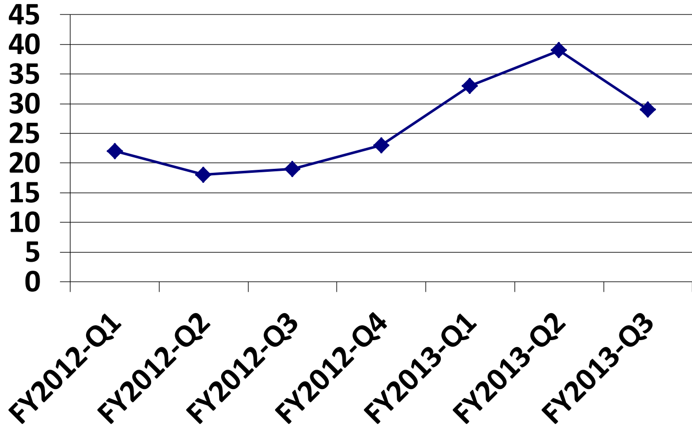
From the end of January clinical governance, which includes responsibility for Serious Incidents (as well as for clinical audit), will be passing to the Medical Director's office from the Director of Governance & Assurance. This will improve the clinical focus on the area. Complaints, inquests, and claims will remain with the Director of Governance & Assurance and the two Directorates will continue to work closely together including on identifying trends and areas for concern.

2.1 Serious Incidents

2.1.1 Number reported

The following graph shows the trend for the number of Serious Incidents in the Trust.

Number SI's by Quarter ICHT



The top three Serious Incident themes for 2013/14 remain as reported at the previous Trust Board:

- Maternity Service,
- Pressure Ulcer
- Infection Prevention and Control

Examples of actions taken as a result of incident monitoring and investigation include:

Maternity Serious Incidents

- Individual feedback and supervision
- Purchase of new equipment
- Increase in consultant cover

Pressure Ulcers

- Tissue viability led ward walk rounds
- Focused training and education for staff
- Ensuring cameras available and working
- Improving reporting and monitoring at the point of entry e.g. A&E
- Ward manager accountability
- Review of the pressure ulcer policy to include the reporting of grade 2 ulcers

Infection prevention and Control

- Improved awareness of chickenpox symptoms
- Review of water management processes
- Rolling program of equipment replacement
- Feedback to GP regarding early recognition of TB
- Focused ward based teaching
- Changes in process in out-patients for potentially infected patients
- Patient awareness leaflets for chicken pox

There had also been a focus on improving organisational learning from Serious Incidents, with measures including:

- Circulation of all executive summaries of serious incidents on the Clinical Governance website
- Plans to include learning from serious incidents in a regular Patient Safety bulletin
- Discussion of incidents at junior doctors 'lessons learned' forums
- Inclusion of junior doctors at serious incident panel review meetings for learning purposes
- Weekly review of all open moderate and above incidents by the Medical Director and Director of Governance & Assurance to facilitate and quality assure organisational response and solutions
- Regular review of outstanding actions from serious incidents at divisional level Quality boards led by divisional governance leads
- The appointment of seven registrar level patient safety officers to work closely with the divisional governance leads on agreed projects, and to act as key links in ensuring feedback and learning from serious incidents is disseminated to all junior doctors
- Root cause analysis train the trainer planned for 2014 to provide Trust wide training
- Linking priority clinical audits to serious incident learning

2.1.2 Never Events

Never Events are often serious, largely preventable patient safety incidents that should not occur. They are reportable events to the Commissioners and to NHS London. They include: retained swabs, wrong site surgery, wrong procedure and miss-placed naso – gastric tube. Never Events and all other types of performance notices are reviewed by the Commissioners with the Trust at monthly meetings.

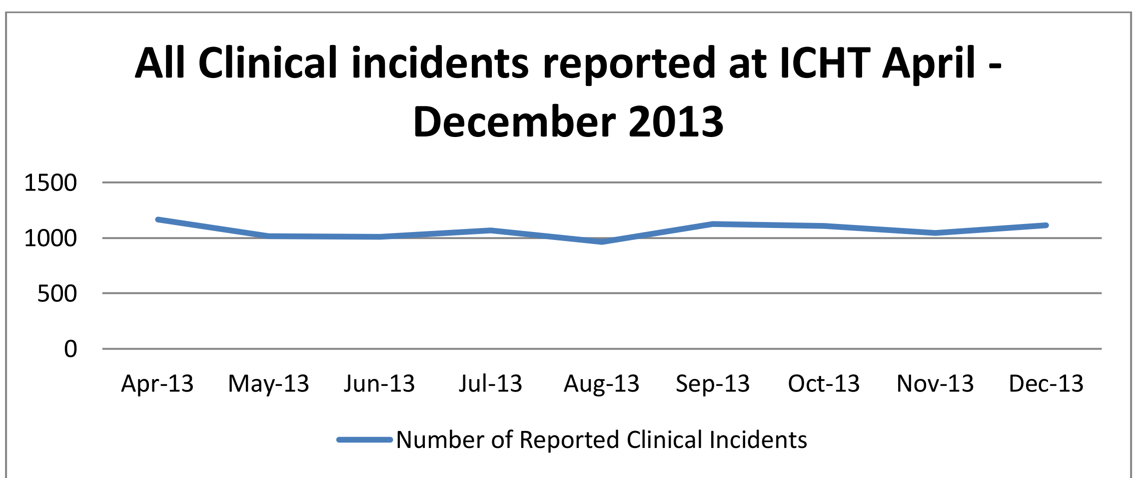
There was one Never Event in Q1. This occurred in June at CXH and was a wrong site surgery where bunion surgery took place on a patient who required surgery on both feet. Consent was for the right foot but the left was operated on. There was no harm to the patient.

2.1.3 Clinical incident reporting

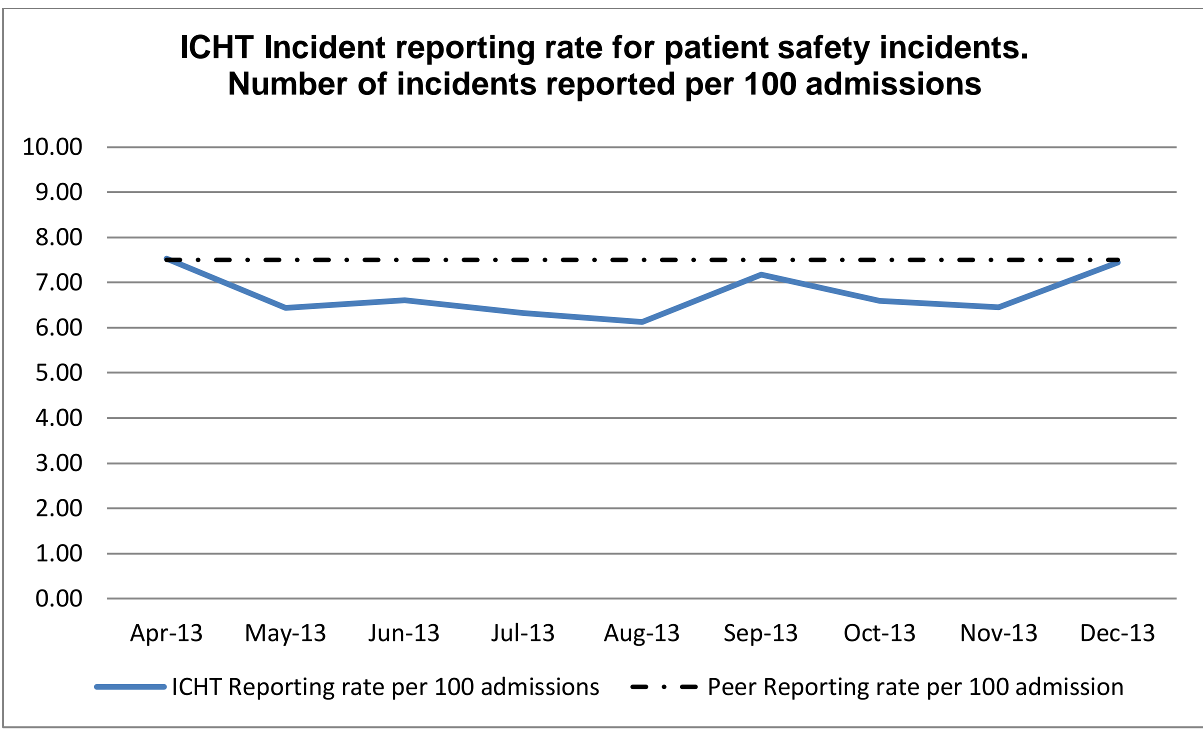
Higher rates of reporting are associated with safer organisations. The rate of incident reporting at ICHT remains below the cluster (London acute Trusts) median of 7.5 per 100 admissions. It is hoped that the newly agreed upgrade to the Datix incident reporting system will improve this rate as a result of the following:

- Improved training and education
- A more user- friendly system
- Live real time reporting enabling easy access to themes and trends to facilitate service improvement
- Feedback to reporters
- Integration with complaints/PALS/claims and inquests

The graph below shows the number of clinical incidents reported by month at ICHT.



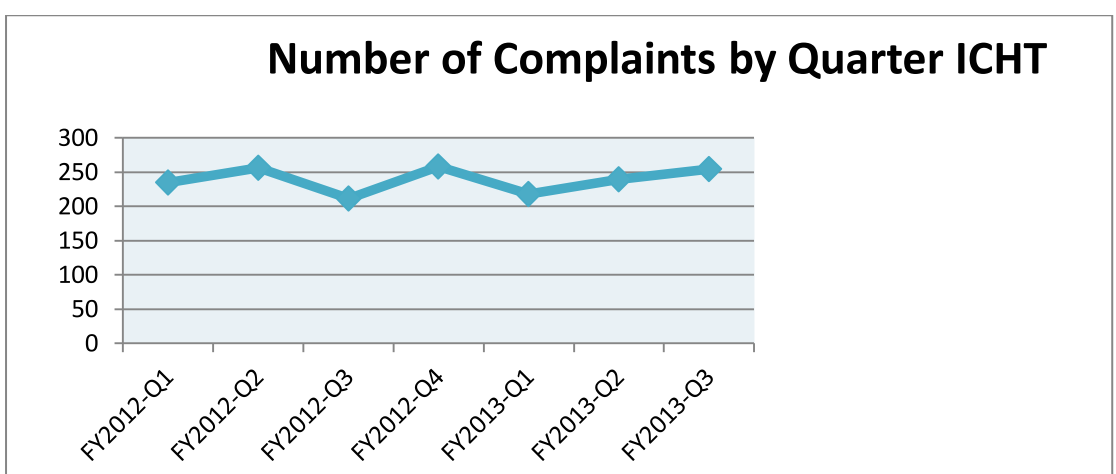
This graph demonstrates ICHTs reporting rate per month in comparison to our peers. The reporting rate in December increased to 7.45 incidents per 100 admissions.



Approximately 90% of incidents at ICHT result in no harm to the patient. In comparison, on average 78% of incidents within our peer group result in no harm to the patient.

3. COMPLAINTS, CLAIMS AND INQUESTS

3.1 Complaints



3.1.1 Number reported

This reflects data as of 4 January 2013. A total of 254 formal complaints were received in Q3 of which 232 were formally investigated. Some 24 low risk grade cases were investigated by PALS. The number of formal complaints managed by the Complaints Department has increased throughout 2013/14, with an increase in 9% in Q3.

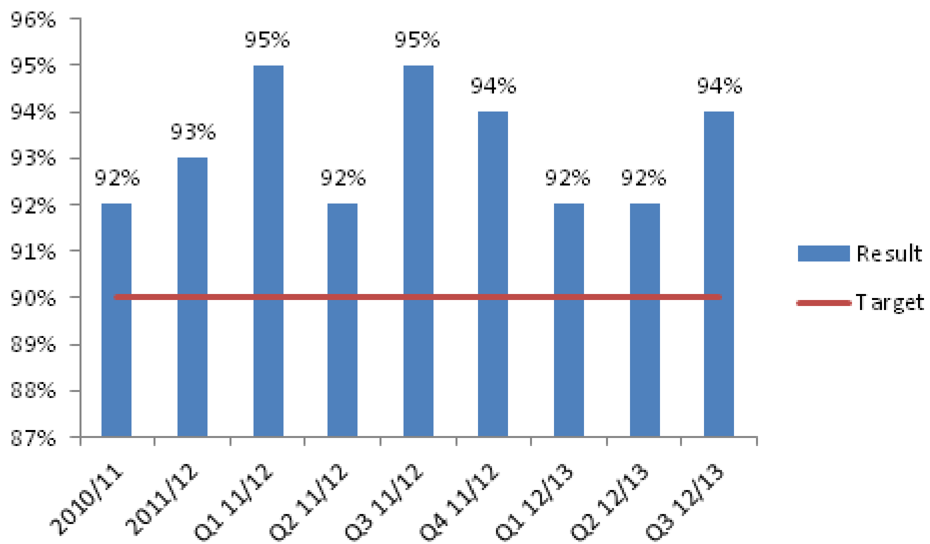
Compared to this time last year, the number of complaints has increased by 1.6%. There has also been an increase in the number of complex complaints that require a formal investigation. In parallel, PALS has seen a decrease in the number of low risk grade complaints it deals with, down by 19%. A breakdown of formal complaints received until December 2013 is shown in the following table.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Medicine	14	34	14	24	23	30	25	29	23	**216**
Surgery, Cancer & Cardio.	42	30	28	37	24	23	27	34	38	**283**
Investigative Sci. & Clinical Support	1	2	3	1	1	3	3	3	0	**17**
Women's & Children's	7	10	8	15	15	5	7	17	12	**96**
Private Pts.		1				1	1	1	0	**4**
Other	3	4	3	3	6	4	6	1	5	**35**
Trust	**67**	**81**	**56**	**79**	**68**	**66**	**69**	**85**	**78**	**649**

Following the divisional restructuring in Q2/Q3 the majority of complaints are now dealt with in two divisions: Medicine now accounts for 33% of all the complaints the Trust receives, whilst Surgery, Cancer and Cardiology accounts for 44%. This together, with a similar pattern for Serious Incidents, is resulting in a significant increased workload for the governance staff in those areas.

3.1.2 Response rate

The Trust has an internal target of responding to 90% of complaints within a timescale agreed with the complainant (upward of 25 working days depending on complexity). The Trust can ask for one extension of this timescale. Complaint responses sent out after the response date (if not extended) or after the extended response date are recorded as a 'breach' of this target. For 2013/14 to date, 95% of all formal complaint responses were responded to within time with a performance rate of 96% for Q3. (See comparison of performance over the last 3 years in the table below.) There is now a drive led by the Director of Governance & Assurance to focus increasingly on quality of response and to ensure each complaint response is bespoke rather than a more generic 'one size fits all' approach and on which the Board was briefed recently.



3.1.2 Organizational learning from complaints 2013/14

There is also organisational learning from complaints and an increased focus on joining up handling of complaints, incidents, inquests and claims to ensure we are able to spot trends and take early remedial action where appropriate. Some examples of actions that have been taken as a consequence of a formal complaint investigation are as follows:

Medicine

- The management of the Chest Clinic has been reviewed to ensure patients are seen in a timely fashion, including better use of all clinical resource (ie patients to be seen by any available doctor rather than a specific named doctor)
- Nurses have been reminded to be more empathetic in their approach to conversations regarding visiting hours
- The junior doctor induction programme now reminds doctors that all eye injuries must be discussed with ophthalmologists and reviewed at the Western Eye Hospital
- A weekly MS Clinic will be established with its own consultation rooms
- A thorough review of the Breast Service has now taken place to help improve the patient experience

Surgery, Cancer & Cardiology

- Customer care courses have been organised for various staff
- The guidance for patients on warfarin and clopidogrel is being reviewed
- Staff have been reminded of the importance of clearly informing patients about their discharge arrangements
- The Pain Clinic has created extra clinic lists and appointed another full time consultant to help reduce the waiting list. Nursing support has also been expanded to help provide patients with a more holistic approach to pain management
- New heel troughs have now been introduced on Valentine Ellis Ward and have proven to be very effective. Additionally, an educational programme for all nursing staff has been organised to help further educate staff on pressure area care and the use of pressure relieving equipment to help prevent future pressure sores developing

Investigative Sciences & Clinical Support

- To help ensure two clinic letters are not placed in the same envelope the administrative processes has been reviewed. This included exploring the use of automatic letter machines to reduce the incidence of errors in loading multiple letters into envelopes and talking to all administrative and clerical staff of the importance of checking the content of each envelope before posting appointment letters
- Staff have been reminded that after two failed attempts at cannulising a patient they are required to escalate this to the person in charge of the area, or the relevant Radiologist if this occurs out of hours

Women's & Children's

- A new consultant led ward round on the post natal ward has been instigated
- All midwives working in the antenatal clinic have been reminded of the process for booking women for homebirth, and the team responsible for undertaking homebirth have designed new posters to help inform women of their choices. The homebirth team are also now running monthly drop in sessions on the first Sunday of the month for women considering home birth
- The maternity service has now changed the process for checking blood results in the Antenatal Clinic. A senior midwife in the Antenatal Clinic has now been allocated to check through the blood results daily and ensures that they are followed up
- The maternity service is finalising a midwifery group practice model to offer antenatal care to low risk women in the community, which should be more convenient for women in terms of their travel time. This will help reduce the waiting time in clinic
- The paediatric service has reviewed the information that is given to parents when they are referred to the Child Development Service to make sure they fully understand how we share information with other agencies and make decisions based on the information given to us by referrers

3.1.3 Complaint Top Themes 2013/14

The top three themes for 2013/14 were: all aspects of clinical treatment (52%), appointments, delays/cancellation (outpatients) (12%) and communication /information to patients (8%). These percentages have been broadly consistent throughout the year.

The following table looks at the top three sub-categories for all aspects of clinical treatment by Division for 2013/14.

Division	1st Sub Category	2nd Sub Category	3rd Sub Category
Medicine	Poor Clinical Care (41)	Ineffective treatment (21)	Poor Nursing Care (19)
SCC	Poor Clinical Care (51)	Poor Nursing Care (23)	Ineffective treatment (21)
ISCS	Poor Clinical Care (2)	Misdiagnosis (1)	Poor Nursing Care (1)
W&C	Poor Clinical Care (25)	Poor Nursing Care (16)	Ineffective treatment (6)
Trustwide	Poor Clinical Care (119)	Poor Nursing Care (64)	Ineffective treatment (54)

The table below demonstrates what sites and specific locations generated the most number of complaints relating to clinical care for 2013/14. (Please note the volume of complaints for Investigative Sciences and Clinical Support are too low to generate meaningful data.)

Division/Site	Number	Percentage	Highest no. of clinical care complaints from location
Medicine	122		
CX	41	34%	6 West generated 6 complaints with A&E minor generating 10
HH	24	20%	De Wardener Ward 4 complaints
SMH	35	29%	Manvers Ward 3 complaints with A&E minor generating 9 complaints
Outpatients	23	19%	CX 10 HH 5 and SMH 10 complaints
SCC	166		
CX	46	28%	Riverside Wing 13 complaints
HH	23	14%	A7 Ward 6 Complaints
SMH	53	32%	Charles Pannett Ward 6 complaints
WEH	12	7%	A&E 6 complaints
Outpatients	40	24%	CX 27 HH 2 and SMH 13 complaints
W&C	69		
SMH	24	35%	Samaritan Ward and Alec Bourne1 both 5 complaints
QCH	29	42%	Edith Dare Ward 9 complaints
Outpatients	15	22%	SMH 11 and Queen Charlotte 4 complaints

The Quality Committee will be provided with a more granular breakdown of complaints by area at its meeting on 12 February.

3.1.4 Top Five Areas for complaints

The following two tables indicate which areas generate the most complaints. The first table looks at wards and specific areas whilst the second table reviews our outpatient service.

	Ward / Specific area	Numbers	Percentage of all received
1	Riverside Wing	21	3.22%
2	A&E Minor CX	15	2.30%
3	A&E Minor SMH	12	1.84%
4	Edith Dare Ward	10	1.53%
5	Ophthalmology Clinic WEH	9	1.38%

	Outpatient Specialty	Numbers	Percentage of all received
1	Neurology	18	2.76%
2	Gynecology	16	2.45%
3	Ophthalmology Surgery	15	2.30%
4	Oncology	13	1.99%
5	Urology	13	1.99%

Please note the Divisional Director and Director of Nursing for Surgery and Cancer has reviewed the Riverside Wing, which now has a change of management. We are also about to fund an independent review of Riverside in direct response to complaints received.

3.1.5 Parliamentary and Health Service Ombudsman (PHSO) for 2013/14

The PHSO has asked to review 9 files so far this year compared with 18 this time last year. Although the overall number of reviews is down, the number of associated investigations is up. This is as a direct result of Francis. Historically, 80% of our complaints referred to the PHSO where not investigated. Now nearly every case reviewed by the PHSO is investigated, some of which include interviews with the clinicians involved in the patients' care. A breakdown of the 9 cases is below:

Medicine	One file – investigation currently on-going.
SCC	Six files – Four investigations are currently on-going, one file was declined for investigation and the other investigation was upheld with the Trust agreeing to pay compensation.
ISCS	One file – the complaint was upheld and the Trust agreed to refund medical expenses.
W&C	One file – investigation currently on-going.

3.2 Inquests for 2013/14

The Trust has dealt with 113 inquests so far this year, up some 51% when compared to this time last year. Clinicians were summoned to 16 of these inquests to provide evidence.

The Trust has now received its first Prevention of Future Death letter (the old Rule 43 Letter) in Q2, which requested that we demonstrate how we have learnt from the care provided to a child with acute myocarditis (a rare inflammatory disorder).

As a consequence the following actions have been undertaken to ensure we learn from this case:-

- A Paediatric Grand Round 'Look and Learn' has now taken place where all aspects of this case and the SI were discussed
- Simulation training undertaken by nursing and medical staff for life threatening scenarios now include a myocarditis scenario
- At the twice yearly induction of new junior doctors, the case is mentioned both in a 'Misdiagnosis' session and in a three hour 'Communication in clinical scenarios' session and
- The St Mary's handbook 'Seizing the Golden Hours of Paediatric Emergencies: Algorithms & Guidelines' now includes a chapter on myocarditis and a recommendation to consider an ECG and troponin level in all cases of haemodynamic instability

We have been told by Coroners to expect more Prevent Future Death letters in future: some may include specific recommendations, others may be speculative in terms of actions the Trust may wish to explore. Coroners have explained to us these should be seen as less punitive in nature compared with the former Rule 43s.

The November Trust Board heard of plans to create a small in-house legal team. This will assist in particular with inquests and claims and will hopefully reduce both the increasing amount spent on external legal support at inquests and help ameliorate the growing number of claims the Trust is receiving. The team will also have a key role to play in assisting with organisational learning, on improving the quality and timeliness of our investigations and assisting Trust staff with difficult medico-legal issues. Interviews were held on 23 January for the first of these legal posts.

3.3 Claims

3.3.1 Clinical Negligence Claims Received

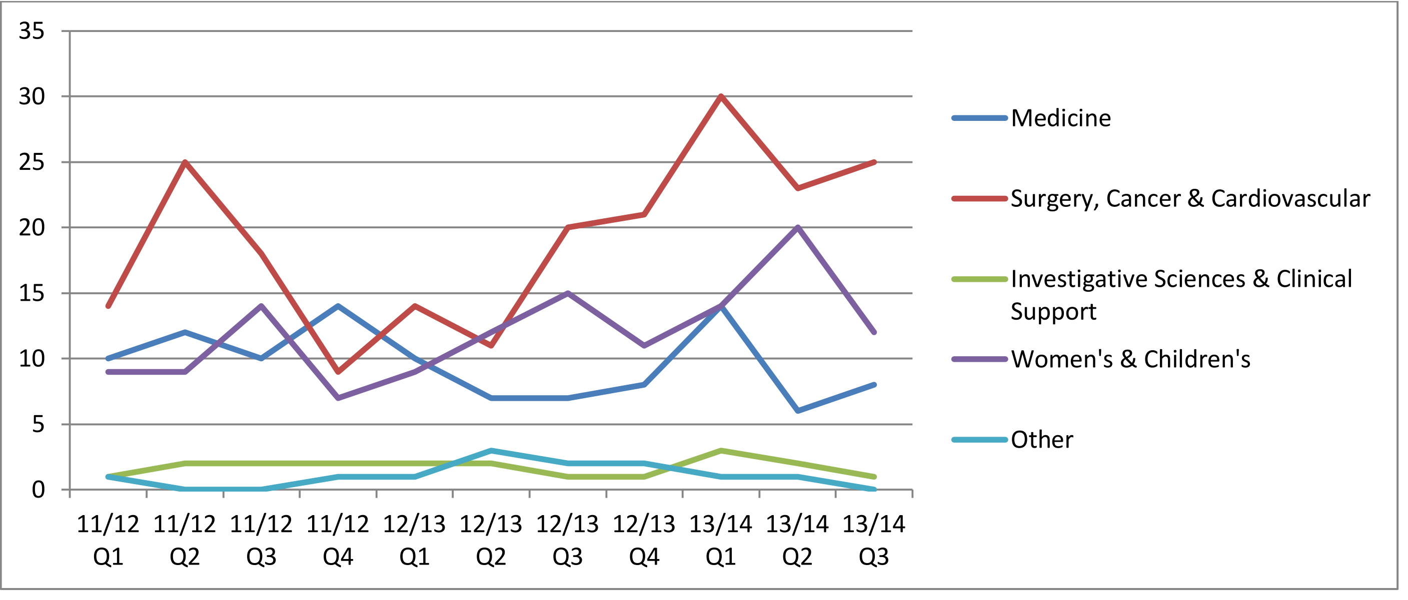
The Trust has received a large number of new claims since the beginning of this financial year. The largest increase was in Q1 and Q2 2013/2014 when the number of claims received at the Trust increased by 72% and 49% respectively compared to Q1 and Q2 of the previous financial year. The table below outlines the total number of clinical negligence claims received by Division.

New Claims Received

	11/12	12/13					13/14				Grand Total
	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Total YTD	
M	46	10	7	7	8	32	14	6	8	28	106
SCC	66	14	11	20	21	66	30	23	25	78	210
ISCS	7	2	2	1	1	6	3	2	1	6	19
W&C	39	9	12	15	11	47	14	20	12	46	132
Other	2	1	3	2	2	8	1	1	0	2	12
Trust:	160	36	35	45	43	159	62	52	46	160	479

The rise in new claims can be partly attributed to the change in funding arrangements which occurred on 1 April 2013 and led to a rush of Claimants being signed up under the conditional fee arrangements in operation prior to that date. As is illustrated in the graph below, the increase affected all divisions across the Trust, but especially that of Surgery, Cancer and Cardiovascular, which experienced a significant rise in Q1 2013/2014.

New Claims Received by Division



3.3.2 Top Themes for New Claims

The top three themes Trust wide for new claims received since 01 April 2014 are: failure to diagnose/delay in diagnosis; failure to recognise complication of treatment; failure/delay in treatment. The figures for these top three themes are provided below:

Top Three Themes Trust wide

	11/12	12/13	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 YTD
Failure to diagnose/delay in diagnosis	**34**	**16**	4	3	9	8	5	**22**
Failure to recognise complication of treatment	**19**	**20**	5	5	8	4	1	**13**
Failure/ delay in Treatment	**13**	**11**	6	0	2	0	1	**3**

3.3.3 Settled Claims

A total of 32 claims have been settled in this financial year. This is in keeping with the number of settlements made in previous financial years. The greatest number of settlements made so far this year related to Surgery, Cancer and Cardiovascular Division, while the highest valued settlement was agreed at £2.3 M.

	11/12	12/13	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 YTD
Medicine	**5**	**11**	3	5	2	4	3	**9**
Surgery, Cancer & Cardiovascular	**2**	**23**	4	12	10	7	1	**18**
Investigative Sciences & Clinical Support	**0**	**2**	0	0	0	1	0	**1**
Women's & Children's	**8**	**12**	3	3	0	2	1	**3**
Other	**1**	**0**	0	0	0	0	1	**1**
Totals:	**36**	**48**	10	20	12	14	6	**32**

3.3.4 Learning from Settled Claims

A number of improvements to service have been suggested following settlement of the Trust’s claims from 1 April 2014:

- A Claimant’s case has been used anonymously as part of teaching for staff in the future to ensure that similar incidents do not recur
- Standard Operating Procedure developed to support the implementation of a checklist to include using a consent form as a prompt during a procedure. This should be read aloud and made explicit as the responsibility of the operating surgeon
- .All requests for tests should be clearly documented and filed in a patient’s medical records. Review and outcome of test results should also be included.

Report Title: Risk Report

To be presented by: Cheryl Plumridge, Director of Corporate Governance & Assurance

Executive Summary: Following a revision of the Risk Management Strategy, the Corporate Risk Register has been revised in terms of format and refreshed. The Risk Register has been approved by the Management Board and a slightly earlier version considered by the last meeting of the Audit, Risk & Governance Committee. Drawn from the risk registers produced by Directors and Divisional Directors, the Risk Register highlights the key risks that, were they to materialise, could have a significant impact on the Trust. The covering report includes a risk matrix, indicates what risks have been dropped from the Risk Register since it was last viewed, and indicates areas for discussion.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Link to the Trust's Key Objectives:

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

Purpose of Report

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

Risk Report

Executive Summary

The Risk Management Strategy was approved by the Trust Board at its meeting in July 2013. Since that time significant work has been undertaken to review risk registers within the Trust to enable the production of a more relevant and realistic Corporate Risk Register. Further work to roll out the new methodology for dealing with and articulating risk will continue. The Corporate Risk Register will enable the Trust Board to review its most significant risks, to consider the risks in terms of likelihood and impact, to view these in the context of the Board's appetite for risk, and to hold Risk Owners to account in mitigating the risks.

Ownership of the day to day management of the Corporate Risk Register belongs to the Management Board and the attached paper and Corporate Risk Register was presented to the Management Board on 20 December 2014 for comment. The Register has been updated accordingly. In addition, a previous version was reviewed and commented upon by the Audit, Risk & Governance Committee at its meeting on 11 December 2013.

The report highlights key areas of risk, setting out the most significant risks, those risks that have either increased, or decreased since the last report, any imminent risks, and any new risks faced by the Trust. It also comprises a risk profile to enable the Trust Board visually to comprehend the most significant areas of risk that the Trust currently faces. . The Board may want to consider whether the risks included intuitively feel the right ones: are there other risks that should have been included and does the marking of the risks look about right?

Comments would be welcome from the Board in terms of how risk should be reported to the Board going forward. The Trust Board is asked for its view on the new style report, and to consider how often the Board would want to discuss the Risk Register eg at every Board meeting or quarterly. .

Risk Register

The most significant risks the Trust faces are shown at paragraph 2 and in the matrix below. The most significant risk in terms of impact, if the Board agrees the scoring, is the inability to deliver the CIP programme albeit the likelihood of non-delivery is not considered to be high.

In terms of likelihood, the most significant risk is the level of Healthcare Acquired Infection. The Board will be familiar with the issues from the regular reports it receives, including on the work being taken to mitigate this risk.

The risk of failing to maintain operational performance is judged to be almost certain with a corresponding moderate impact. The Board will be familiar with the work being undertaken to mitigate the risk including on winter planning, on changes to the performance management system, the pressure on resources not matching demand and will wish to note the significant number of controls in place to flag up key concerns early. Although the likelihood is judged to be possible and a number of controls and contingency plans are in place, the Board should view this risk in the context of the imminence of Cerner implementation (Easter).

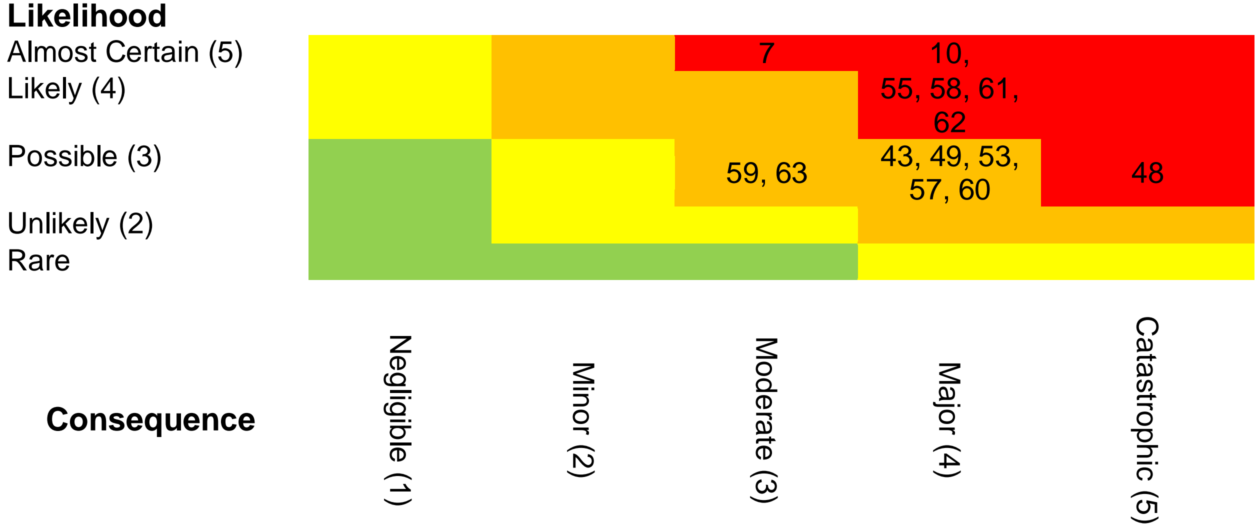
1 Highest Scoring Risks

Risk ID / Owner	Description	L	C	Action and progress
7 COO	Failure to maintain operational performance	5	3	Controls in place and backlog reduced to just over half a week's worth of activity. Risk movement is downwards.
10 DIPC	Increased levels of HealthCare Acquired Infection (HCAI)	5	4	Between 01/04/13 – 30/11/13 the Trust reported nine 'Trust attributable MRSA BSI's', the DH target is zero. The Trust reported 42 Trust attributable cases of C.*difficle* this is within trajectory for the year. Key Controls are in place and the risk movement is static.
48 CFO	Failure to deliver Cost Improvement Programmes (CIPs)	3	5	Progress on delivery of the CIP programme is reviewed monthly at the performance review meetings and the Board and bi-monthly by the Finance and Investment Committee. Risk movement is downwards.

Risk ID / Owner	**Description**	**L**	**C**	**Action and progress**
55 D of Estates & Facilities	Insufficient historic and current investment in the Estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably	4	4	Completion of work to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out. However, the cost of remedial works may turn out to be significant in some cases and may need to call on Trust contingency funds. This work is on-going. Risk Movement is increasing.
58 DD for Women's and Children's	PICU Risk to patient transmission of a multi-drug resistant infection between patients resulting in colonisation from VIM resistant Pseudomonas isolated on PICU which carries up to 75% mortality with bacteraemia	4	4	A full business case to relocate PICU to a larger footprint has been compiled. Risk movement is static.
61 DD for Women's and Children's	Consultant presence on Delivery Suite does not meet recommended benchmarks for the number of births	4	4	6 out of 8 posts have been recruited, due to commence in post by March/April 2013. Risk movement is static.
62 DD for Medicine	Insufficient Level 2 beds on the Hammersmith Hospital Site.	4	4	Key controls are in place. Newly identified risk.

2 Risk Matrix

Risk Profile as at 22 January 2014



No	Description
7	Failure to maintain operational performance
10	Increased levels of HealthCare Acquired Infection (HCAI).
43	Failure successfully to implement the new EPR system (Cerner)
48	Failure to deliver Cost Improvement Programmes (CIPs)
49	Inability to achieve Shaping a Healthier Future (SaHF) activity changes due to failure to deliver associated estate change.
53	Failure to transfer patients to, from and between hospitals/wards in a safe and timely manner appropriate to their clinical need.
55	Insufficient historic and current investment in the Estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably
57	Risk to patient safety in the EU at Hammersmith Hospital as a result of insufficient/inadequate middle grade medical cover for the Department.
58	PICU Risk to patient transmission of a multi-drug resistant infection between patients resulting in colonisation from VIM resistant Pseudomonas isolated on PICU which carries up to 75% mortality with bacteraemia
59	Lack of senior clinicians at Charing Cross to review emergency cases
60	The introduction of a single Radiology Information System (RIS) and Picture Archive and Communication System (PACS) has increased time to effectively undertake imaging in a timely way
61	Consultant presence on Delivery Suite does not meet recommended benchmarks for the number of births
62	Insufficient Level 2 beds on the Hammersmith Hospital Site.
63	Non-Compliance for NHS England Commissioner's requirements for neurosurgical services.

3 New Risks

The following new risks have been identified since the Trust Board received the Corporate Risk Register:

Owner	Description	L	C	Action and progress

For the purposes of this first report this section remains blank but will be completed as appropriate in reports going forward.

4 Significant Changes to Existing Risks

4.1 The following risks have de-escalated and been removed from the Corporate Risk Register:

Owner	Description	L	C	Update supporting de-escalation of risk
D of Estates & Facilities	Uncertainty over future of Trust sites causes "planning blight" so that condition deteriorates excessively	4	4	Risk was duplicated and merged into risk 55 as the issue is in both historic and relates to under investment
CFO	Inability to sub-let the current property lease for Ravenscourt Park Hospital	3	5	Advice received and controls in place reduced the level of risk to enable it to be removed from the Corporate Risk Register.

4.2 The following risks have escalated and been added to the Corporate Risk Register:

For the purposes of this first report this section remains blank but will be completed as appropriate in reports going forward.

Owner	Description	L	C	Action and progress

Imperial College Healthcare NHS
NHS Trust

Trust Board : 29 January 2014

Report Title: Board Assurance Framework
To be presented by: Cheryl Plumridge, Director of Governance & Assurance
Executive Summary: The Board Assurance Framework (BAF) is the second part of the programme to develop how the Trust manages risk. It has been developed with a view to enabling the Trust Board effectively to understand the level of assurance associated with its understanding of the risks the Trust faces. Following approval of the Trust Objectives, work has been undertaken to map the risks currently identified on the Corporate Risk Register to achievement of the agreed objectives. This template has been producing in conjunction with risk owners and is designed to detail the assurances that are available together with any gaps. The Trust Board is asked to review and discuss the current version of the BAF. The BAF will be updated and presented to the July meeting of the Trust Board and thereafter will be seen by the Trust Board twice a year.
Legal implications or Review Needed: No **Details of Legal Review, if needed:** None required
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Recommendations and Actions Required: The Trust Board is asked to review the BAF, discuss and comment upon its contents, and suggest any amendments for the updated version to be presented to the Trust Board in July 2014.

Board Assurance Framework

1 Introduction

1.1 The Board has overall responsibility for ensuring systems and controls are in place sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance can be obtained from a wide range of different sources, but where possible these should be systematic, supported by evidence, independently verified and incorporated within a robust governance process.

1.2 The Board achieves assurance primarily through the work of the Committees of the Board whose primary purpose is to provide assurance that the process and systems within the Trust are appropriate and fit for purpose. In addition, it gains assurance through the use of both internal and external audit and other independent inspections together with the collection of evidence which demonstrates the achievement of the objectives.

2 The Trust's Strategic Objectives for 2013/14 are:

Corporate Objective Number	Corporate Objective Definition
CO1	To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
CO2	To develop recognised programmes where the specialist services that the Trust provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners
CO3	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
CO4	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

3 Assurance Framework Legend

The Assurance Framework includes details from the Corporate Risk Register together with new subject headings for assurance purposes which are:

Column Heading	Description
Sources of Assurance	Where can the Board obtain evidence relating to the effectiveness of the controls upon which the Trust is relying?
Assurance on the Effectiveness of controls	Does the evidence demonstrate that the controls are effective?
Gaps in Control	Gaps are identified which show that adequate controls are not in place, or that are they not sufficiently effective.
Gaps in Assurance	There is a failure to gain evidence demonstrating that the controls are effective.
Action plans for gaps in control or assurance	The Plans that are in place to address the identified gaps in control and/or assurance including appropriate timelines and indicative completion dates.

4 Current Board Assurance Framework

The current BAF has been developed following a Board Seminar session in December and significant input from risk owners. The current version was discussed at Management Board on 20 January 2014 and amendments have been incorporated.

5 Action Required

The Trust Board is asked to review the BAF, discuss and comment upon its contents, and suggest any amendments for the updated version to be presented to the Trust Board in July 2014.

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Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For decision

Report Title: NHS Trust Development Authority Self-Certifications: for October and November 2013.
Report History: Regular
To be presented by: Marcus Thorman, Chief Financial Officer.
Executive Summary: As part of the ongoing 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 Board is asked to approve the October and November 2013, submissions for ratification. The October and November 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.
Key Issues for discussion: • No changes to the compliance monitor returns since July; • Board Statement question 7 updated to reflect approval of the revised Risk Management Strategy by the Board in July; • Board Statement question 10 updated to reflect performance on MRSA and cancer targets for August; • Board Statement question 10 updated to reflect MRSA, C.difficile and cancer targets for the month of September; • Board Statement 12 updated to reflect approval of the revised committee structure by the Board in July.
Review Needed: a. Yes √ b. No

Details of Legal Review, if needed:

Link to the Trust's Key Objectives:

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.

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:

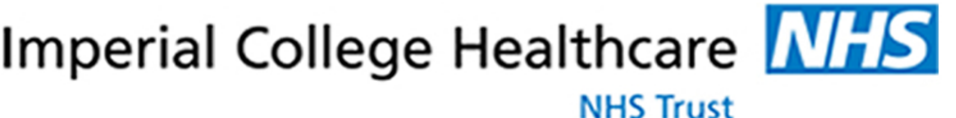
Continued registration of CQC, without having any conditions or non-compliant inspections recorded against the Trust.

Monthly reporting of the Trust's performance and action plans being put into place to ensure improvement is measured and monitored by management, where targets are not being achieved.

Recommendations and Actions Required:

a. For review and approval √

Immediate tasks / Key priorities – January 2014



Immediate task/key priority	Lead executive (Supported)	Supporting executives	Status
Winter performance	Steve McManus	Jayne Mee (workforce) Marcus Thorman (finances/funding) John Cryer (Estates)	On-going. 71 beds open. Qtr 3 target achieved. Qtr 4 on track.
GMC Junior Doctor Survey	Chris Harrison	Jayne Mee	On-going.
Patient Experience (Cancer)	Janice Sigsworth	Chris Harrison Steve McManus	Implementation on plan.
TDA score (CIPs)	Marcus Thorman	Steve McManus Chris Harrison Janice Sigsworth	Improved score due to CIP performance and outturn being back on plan.
TDA score (HCAI)	Chris Harrison	Steve McManus Alison Holmes	Cdiff. Performance below trajectory.
TDA score (Cancer performance)	Steve McManus		All 8 targets met in December and on track for Qtr 4.
Cerner	Steve McManus Kevin Jarrold		Implementation on plan.
AHSC application	Nick Cheshire		Achieved.
Site leadership & responsibility	Steve McManus		On-going.
Clinical Strategy	Nick Cheshire	Ian Garlington	To be approved at Board.
Royal Marsden	Nick Cheshire	Chris Harrison	On-going.
External meeting preparation	Ian Garlington	Chris Harrison	New process in place.
Political stakeholder process	John Underwood	Nick Cheshire Bill Shields	New process agreed and in place.
FT Applications	Cheryl Plumridge	Marcus Thorman Janice Sigsworth	FT application process to run smoothly, Board prepared and briefed. Lead - MT supported by JS & CP. FT preparations – governance (membership, governors, constitution) Lead - CP CIH visit – planning and preparation Lead - CP

Imperial College Healthcare NHS
NHS Trust

Trust Board

Report Title: 2014/15 Integrated Planning Framework

To be presented by: Marcus Thorman, Chief Financial Officer

Executive Summary:
In relation to prior years, the Trust's approach to business planning in 2013/14 represented significant progress towards integrated planning, with financial plans more closely aligned to organisational and local priorities.

Whilst the plans developed for 2013/14 demonstrated a greater level of integration and local ownership, the 2014/15 planning round will need to be based on a yet more transparent and cohesive approach. This paper is designed to review the efficacy and output of the 2013/14 planning round and set out the proposed approach to integrated planning for 2014/15 and beyond which is in alignment with the initial guidance published jointly by the NHS Trust Development Authority (TDA), Monitor, NHS England and the Local Government Association (LGA).

The paper sets out the proposed approach to:

- Strategic planning;
- Operational planning;
- Financial planning;
- People planning;
- Contract negotiations;

This approach has been endorsed by Management Board and Finance & Investment Committee

Action required:

Trust Board is asked to note the principles underpinning the 2014/15 integrated planning framework and the approach to delivery including timescales.

2014/15 Integrated Planning Framework

1. Introduction

In relation to prior years, the Trust's approach to business planning in 2013/14 represented significant progress towards integrated planning, with financial plans more closely aligned to organisational and local priorities. The paper presented to Management Board in January 2013 described a process whereby CPG and Non-Clinical Directorate business plans for 2013/14 would be aggregated into the Trust's Annual Business Plan, which would in turn become the first year of its five year Integrated Business Plan (IBP) to support its Foundation Trust (FT) application.

The framework for 2014/15 builds on this approach to support a more integrated approach to planning matching strategic objectives with locally developed plans.

2. Summary of 2014/15 planning guidance published to date

On 4 November 2013, TDA, Monitor, NHS England and the LGA jointly published some initial guidance for the coming planning round.

The key points for the Trust Board to note are:

- Providers will be required to produce ambitious but realistic plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans;
- Providers and commissioners are expected to work together to agree levels of ambition against a common set of indicators taken from the domains of the NHS Outcomes Framework;
- Providers and commissioners are expected to work together to agree how funds should be reinvested in demand management and improved discharge schemes, where Trusts are reimbursed at less than 100% of national tariff (including non-payment for readmissions and marginal rate emergency tariff);
- Commissioners and Local Authorities are expected to work together and engage with providers to agree plans for the use of Integration Transformation funding
- The efficiency requirement for 2014/15 is set at 4.0%, determined from:
    - Tariff deflator is -1.5% (-1.2% for PbR to adjust for +0.3% Clinical Negligence (CNST) cost inflation)
    - Cost Inflation = +2.5% (+1.5% pay, +7.2% drugs, +2.1% other operating costs, +3.8%capital)
- The assurance and challenge process will include an additional step to reconcile activity and revenue figures between commissioners and providers, conducted jointly by NHS England, Monitor, the TDA and the LGA;
- A refresh of the CQUIN scheme by NHS England.

Key dates for the Trust Board to note are:

Initial high level plans submitted to TDA	13 January 2014
Contracts signed	28 February 2014
Refresh of plans post contract sign off and full draft plan submitted to TDA	5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans and draft 5 year plans	4 April 2014
Submission of final 5 year plans	20 June 2014

3. Proposed approach to planning for 2014/15 and beyond

The significant development in the Trust's clinical and site strategies and the IBP during 2013/14, together with the observations recorded above, make it clear that a one year planning horizon for ICHT is no longer optimal. For this reason, a more strategic approach to business planning will be adopted from 2014/15 onwards, with the objective of facilitating "bottom up" business planning over a five year period and the requirements of the FT application, enshrined in the IBP and Long Term Financial Model (LTFM). As such, each Division and Non-Clinical Directorate will be initially required to develop a three year plan that describes its priorities for the first years in detail with the following two years described at a higher level, (with Trustwide planning assumptions used for years 4 and 5)

To support the development of robust, locally owned business plans across the Trust, the corporate functions will undertake to:

- Digest and disseminate all planning guidance published by NHS England, Monitor and the TDA;
- In partnership with Divisional colleagues and corporate management teams, design a planning framework and business planning template that serves the purposes of all concerned as far as possible;
- Work in an integrated manner to ensure that guidance related to strategic, financial, operational and workforce planning is joined up as far as possible, through the establishment of a "task and finish" core planning team led by the Head of Planning & Business Development;
- Develop and agree with Divisions a mechanism for risk rating business plans, to include a manageable set of KPIs that cover engagement in the planning process together with financial, operational and quality-based performance;
- Agree business planning requirements collaboratively with Divisional and corporate management teams for maximum clarity and value;
- Provide tailored advice and technical support to Divisional and corporate management teams as required;
- Report progress on business planning regularly to the Management Board, flagging risks and issues in a timely fashion;
- Design and facilitate a value adding process for in-year review of progress against plans.

3.1. Strategic planning

Divisional and Non-Clinical Directorate business plans will need to take full account of local plans to underpin delivery of:

- The Trust's clinical strategy and revised strategic objectives;
- The Trust's Quality Strategy (QG15);
- The service developments described in the IBP, specifically:
    - *Shaping a Healthier Future* (SaHF)*;*
    - North West London Pathology Modernisation Programme;
    - Growing ICHT's Private Patients business;
    - Implementing Cerner;
- The revised Board Assurance Framework;
- Other corporate priorities e.g. delivering operational excellence, patient experience, staff engagement, external stakeholder engagement.

3.2. Operational planning

External support has been put in place to facilitate sub-specialty level activity and capacity planning to ensure delivery of performance targets. This will produce an agreed activity and capacity plan by point of delivery at clinical service level, which will in turn drive the development of an agreed financial and people plan for the service, which can be aggregated up to directorate or Divisional level as required.

Additionally, the Chief Operating Officer will be developing an Operational Risk Rating as a tool with which to monitor and manage performance of the Divisions in year. Given the requirement to complete draft Divisional business plans within the same timeframes, the integrated planning team will work together with Divisional management leads to agree an appropriate level of detail on the basis of which to plan in the interim.

3.3. Financial planning

3.3.1. Fundamental Principles

The following principles underpin the 2014/15 financial planning process for clinical Divisions and Corporate Directorates:

- Financial plans are developed by Divisional and Corporate Directorate leadership teams working collaboratively with managers and clinicians and are underpinned by detailed planning assumptions;
- A 36 month plan is required from clinical Divisions and Corporate Directorates;
- Plans are developed which deliver the strategic financial objectives set by the Executive team;
- Plans are subject to a formal review by the Executive team at bi-lateral meetings supported by standard documentation to ensure consistency and transparency;
- Income, expenditure, capacity, activity and workforce are fully aligned;
- The external plan published to the TDA is consolidated from the plans from clinical Divisions and Corporate Directorates;
- CIPs are based on opportunities and costed programmes and not on top-sliced allocated values;
- CIPs are supported by detailed project plans and Quality Impact Assessments recorded in the StratPro project management system;
- There are no unallocated balances reconciling summary and detailed plans;

- There is a clear and objective basis on which to measure the risk of financial plans;
- Financial plans are consolidated within the Collaborative Planning system and approved online by staff at all levels within the organisational hierarchy for clinical Divisions and Corporate Directorates;
- A range of unit costs and financial ratios are developed and formalised within the Financial Risk Rating for 2014/15 with targets derived from the financial plan;
- All staff with responsibility for the management of resources within clinical Divisions and Corporate Directorates have personalised financial objectives.

3.3.2. Strategic financial objectives

All financial plans must underpin the following strategic objectives:

- To deliver a Continuity of Services risk rating which is sufficient to ensure a successful Foundation Trust application;
- All Divisions and Corporate Directorates to demonstrate a minimum 4% efficiency improvement either by reduction of costs accounted for directly within their budgets, contribution to cost reductions in other budgets, margin on increased NHS activity levels or margin on other income streams;
- For clinical Divisions, a minimum reduction in unit cost per activity unit equivalent to the decrease for NHS Payment by Results PbR tariffs of 1.5%;
- Average cost per WTE to increase no more than national pay awards through proactive management of incremental progression, recruitment and banding reviews;
- Ward, midwifery and high dependency nursing ratios to be agreed with the Director of Nursing;
- Premium pay costs no greater than 5% of total pay costs for operational activity (excluding projects);
- Non-recurring and project related costs are separately identified from operational costs with project outline documents for all project related costs;
- All deferred income for Research & Development relating to 2013/14 and earlier Research & Development is planned to be released and matched with expenditure in 2014/15;
- Non-NHS income to be increased by a minimum of 2.5% (unless determined by long term contracts);
- For Corporate Directorates, profit and loss accounts for trading services (e.g. nurseries);
- Planned education and training costs to be managed within education and training income;
- All financial plans to be approved online within the Collaborative Planning system;
- No unidentified CIPs.

3.3.3. CIP planning

The approach of measuring CIPs for the 2013/14 financial year will be further developed to incentivise improvements in profitability and productivity and reward Divisions and Corporate Directorates for schemes where cost savings are delivered elsewhere in the Trust. This approach will be refined to include the following items:

- Year on year reductions in costs incurred by Divisions and Corporate Directorates (after accounting for known cost changes e.g. inflation);
- Contribution to reduction in costs not incurred by the Divisions and Corporate Directorates leading the CIP programme (e.g. procurement savings led by the finance teams where cost reductions rate to other Divisions and Corporate Directorates' budgets);
- Contribution from NHS clinical income as a result of a service development or improvement in clinical coding (note increased income associated with changes in tariff prices will not be counted);
- Contribution from increased non-NHS income.

This will lead to an increased internal productivity & efficiency target as, for both the TDA and Monitor, only cost reduction savings are categorised as CIP (with contribution from increased income reducing the overall CIP target).

3.3.4. Format and attendance of bi-lateral meetings

Bi-lateral meetings provide the opportunity for the Executive team to receive, review and approve financial plans. To ensure these meetings are effective:

- Standard templates and presentation formats need to be used;
- Papers are provided at least seven days before meetings with questions provided to Divisions and Non-Clinical Directorates in advance of the bi-lateral meetings;
- Consistent attendance at meetings by Executive team members (or representatives);
- Approval reached at the meeting or specific actions agreed;
- Attendance is required from leadership teams of Clinical Divisions and Non-Clinical Directorates and Executive Directors (or representatives)

3.4. People planning

The integrated planning approach within the Divisions and Non-Clinical Directorates will include people planning reflective of the business requirement and service delivery of the Trust. These plans need to underpin the high-level "top-down" people planning assumptions that the Trust has made to support the IBP, LTFM and Outline Business Case for SaHF by providing the "bottom-up" detail and granularity.

Current assumptions for future people requirements have been made at Trust level and broad occupational group level based on CIP requirements, Length of Stay efficiencies and agreed service developments. The Divisions and Corporate Directorates will, through the integrated planning process, need to understand the implications of those assumptions and ensure that their own plans for service development, reconfiguration and efficiency generation support the Trust level assumptions.

3.5. Capital planning

All capital investments proposals to be included in business plans for 2014/15 and beyond need to demonstrate alignment with some or all of the following criteria:

- Improvements to operational and/or patient safety;
- Clinical benefit;
- Statutory/regulatory compliance;

- Patient experience benefit;
- Alignment with Trust and Divisional/Departmental strategy;
- Reasonable return on investment.

It is envisaged that asset replacement programmes will be developed for the following by Investigative Sciences and Clinical Support Division:

- Major imaging equipment (e.g. MRI);
- Theatres;
- Pathology.

Other asset replacement programmes will be developed by Estates and Facilities:

- Other imaging equipment (e.g. ultrasound);
- Medical devices;
- Estates backlog maintenance.

The ICT asset register will continue to be developed and maintained by the ICT Directorate.

To mitigate the risk of deviation from the Trust's capital plan in 2014/15 and beyond and underpin a transition to more strategic investment planning based on greater foresight, from April 2014, the Investment Committee will only review business cases for investment in foreseeable initiatives that are clearly articulated and indicatively costed in 2014/15 business plans. Some flexibility will be reserved for investments required to mitigate significant clinical risk.

3.6. Contract negotiation

The Trust will follow the usual process of developing a list of counting and coding and service development proposals for discussion with commissioners during contracting negotiations. CQUIN targets will also require agreement through this process.

4. Conclusion

Trust Board is asked to note the principles underpinning the 2014/15 integrated planning framework and the approach to delivery including timescales.

Imperial College Healthcare NHS
NHS Trust

Trust Board : 29 January 2014

Report Title: Board Governance Memorandum
To be presented by: Cheryl Plumridge, Director of Governance & Assurance
Executive Summary: As part of the Foundation Trust (FT) process the Trust has completed the Board Governance Assurance Framework (BGAF). This will assist the Board through a combination of self and independent assessment processes to ensure that it is appropriately prepared to achieve FT authorisation. The work undertaken as part of the BGAF is then formally recorded within the Board Governance Memorandum (BGM) which the Trust is required to approve before being signed off formally by the Chairman. Thereafter an independent assessment of the BGM will be undertaken by Grant Thornton during February/March the outcome of which will be brought to the Trust Board at their meeting in March 2014
Legal implications or Review Needed: No **Details of Legal Review, if needed:** None required
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Recommendations and Actions Required: The Trust Board is asked to review the BGM document and confirm that it is in agreement with the statements made and authorise the Chairman to sign the document on behalf of the Trust to enable the independent assessment to take place.

Board Governance Memorandum

1. Introduction

1.1 As part of the Foundation Trust (FT) process the Trust has completed the Board Governance Assurance Framework (BGAF). This will assist the Board through a combination of self and independent assessment processes to ensure that it is appropriately prepared to achieve FT authorisation.

1.2 The work undertaken as part of the BGAF is then formally recorded within the Board Governance Memorandum (BGM) which the Trust is required to approve and which is then signed off formally by the Chairman.

1.3 Thereafter an independent assessment of the BGM will be undertaken by Grant Thornton during February/March the outcome of which will be brought to the Trust Board at their meeting in March 2014.

2 BGM

2.1 The BGM is split into five sections. The first four sections are for the Trust to self assess against individual areas of good practice. The fifth section contains four case studies.

2.2 For each area of good practice the BGM references whether or not the Trust complies with the area. Where gaps are identified, action plans have been set out to comply with the area of good practice unless it is an area that the Trust does not intend to comply with in which case the reasons for non compliance have been clearly stated.

2.3 Each of the areas is then RAG rated according to a metric included in the BGAF. Of the 15 areas the Trust has self assessed as follows:

1. Board Composition and commitment		
Ref	**Area**	**Self-Assessment rating**
1.1	Board positions and size	Amber/Red
1.2	Balance and calibre of Board members	Amber/Green
1.3	Board member commitment	Green
2. Board evaluation, development and learning		
2.1	Effective Board-level evaluation	Green
2.2	Whole Board development programme	Amber/Green

2.3	Board induction, succession and contingency planning	Amber/Green
2.4	Board member appraisal and personal development	Amber/Green
3. Board insight and foresight		
3.1	Board performance reporting	Amber/Green
3.2	Efficiency and Productivity	Green
3.3	Environmental and strategic focus	Amber/Green
3.4	Quality of Board papers and timeliness of information	Amber/Green
4. Board engagement and involvement		
4.1	External stakeholders	Green
4.2	Internal stakeholders	Amber/Green
4.3	Board profile and visibility	Amber/Green
4.4	Future engagement with FT Governors	Red

2.4 The BGM has been seen and approved by the FT Board, subject to some minor amendments which have been incorporated in the revised version. Once the BGM has been approved by the Trust Board, an action plan setting out all the actions from the BGM will be produced. This will be owned by the Director of Governance and Assurance and will be updated on a regular basis to ensure that the actions are dealt with in a timely way. Updates will be brought back to the Trust Board by the Director of Governance & Assurance's.

2.5 The fifth section of the BGM contains a series of case studies as follows:

Case study	**Subject**	**Executive Lead**
Performance failures in the areas of quality	Performance turnaround (cancer/infection control etc)	Steve McManus
Performance failures in the areas of finance	Financial turnaround	Marcus Thorman
Organisational culture change	Quality Strategy	Janice Sigsworth (with assistance from Chris Harrison)
Organisational strategy	Clinical Strategy	Chris Harrison

3 Recommendation

3.1 The Trust Board is asked to review the BGM document, confirm that it is in agreement with the statements made, and authorise the Chairman to sign the document on behalf of the Trust to enable the independent assessment to take place.

Imperial College Healthcare NHS
NHS Trust

Trust Board: 29th January 2014

Report Title:

Quality Governance Assurance Framework (QGAF) Assessment : Progress & Next Steps

To be presented by: Professor Chris Harrison – Medical Director

Executive Summary:

The Foundation Trust (FT) application process involves an external assessment of the Trust's performance against the QGAF. A number of self-assessments have been presented to the appropriate boards and the external assessment is due to start in February 2014. The Trust Board is asked to review the following:

- Final self-assessment scoring
- Quality improvement plan
- Board memorandum (draft) – which summarises the QGAF scoring evidence

Self-assessment

As part of the organisation's FT application process, the Trust is required to complete a self-assessment against the QGAF using 'good practice examples as defined by Monitor'. The assessment is based on the Trust's performance against 10 questions relating to strategy, capabilities and culture, processes, structure and measurement. Each question is scored using a risk rating matrix with numeric differentials between 0 – 4 (lowest being "best"). The maximum score allowed prior to FT authorisation (at the Monitor stage of the process) is 3.5 with a clear quality improvement plan of how the Trust will get to a score of zero.

Two scoring sessions have taken place in July 2013 and October 2013 with representation from divisions and appropriate corporate directorates. When reassessed in October 2013 the score was reduced due to significant progress made particularly within the new divisions

A Board development session was held on 16th December 2013 where the self-assessment was reviewed. The session featured good discussion and constructive challenge which led to a decision to undertake a third self-assessment in January 2014. This took place with the Executive management team on 13th January 2014 and a final score of 5.0 agreed. This was presented to FT Programme Board on 23rd January 2014.

The overall scores from the self-assessments are as follows:

Month and year	Score	Trend
July 2013	7.5	⬇
October 2013	3.5	
January 2014	5.0	⬆

The Board will undertake further self-assessment/s prior to the Trust entering the Monitor stage of the FT application process.

- **Quality Improvement Plan**

The quality improvement plan includes the actions that are required to be undertaken to reduce the Trust's self- assessment score and to improve how well governed it is for quality. The plan will be updated throughout the FT application journey and beyond.

- **Board Memorandum**

Monitor require that the Board of Directors of an NHS Trust applying for Foundation Trust confirm, that:

- They are satisfied that the Trust has, and will keep in place, effective leadership arrangements for the purposes of monitoring and continually improving the quality of healthcare delivered to its patients;
- Due consideration has been given to the implications of future plans on quality.

A Board Memorandum has been prepared to provide the Board with assurance:

- On coverage of the four domains of quality governance which are covered by the QGAF:
    - Strategy
    - Capabilities and Culture
    - Processes and Structure
    - Measurement

- That the Trust Board has appropriate quality governance arrangements in place (Guide to Applicants, Monitor, July 2010)

The Board memorandum provides narrative about our self- assessment and about how we are governed for quality at the Trust. The memorandum will be updated prior to the Trust entering the Monitor stage of the FT application process.

Next steps:
Once approved, these documents will be submitted to external review by Grant Thornton as part of the FT assessment process.

Action required:

- Approve the self-assessment score of 5 at this stage in the FT application process
- Approve the Quality Improvement Plan and Board Governance Memorandum at this stage in the FT application process
- Approve the submission of all three documents for external review as part of the QGAF review

Public Trust Board Meeting on 29 January 2014
Supporting Documents

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Trust Board: xxxxx **Agenda number:**

Report Title: XXX Committee Chairman's Report

To be presented by: xxx, Chairman xxx Committee

1. Introduction

The XXX Committee met on XXX 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:

3. Key risks discussed

The following risks were discussed:

4. Key decisions taken

The following key decisions were made:

5. Agreed Key Actions

The committee agreed actions in relation to:

6. Future Business

The Committee will be focusing on the following areas in the next three months:

7. Recommendation

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

APPENDIX A

Director of Nursing Report: Safe Nurse Staffing – How to ensure the right people, with the right skills, are in the right place, at the right time

1. Introduction

Following the publication in November 2013 of the Government's full response to the Mid-Staffordshire Inquiry, the National Quality Board has 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 nine expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for patients. Key implications for the Trust include:

- Board sign off of establishments for all clinical areas, every six months (no later than June 2014)
- The Board should receive monthly updates on staffing capacity and capability which should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels and the impact this has had on relevant quality and outcome measures.
- The publication of monthly staffing information which will be collated alongside an integrated safety dataset that will provide information down to ward level and will be available via a single national website covering the key aspects of patient safety (due to go live in April 2014).
- Setting staffing levels using evidence, evidence based tools, the exercise of professional judgment and a truly multi-professional approach. NICE will soon review the evidence and accredit evidence-based tools to further support decision-making on staffing.
- Displaying information about nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
- Ward sisters to be in a supervisory capacity

This paper sets out to provide the Board with an update on current nurse staffing, as a pre-cursor to a further paper it will receive in the coming months outlining how the Trust is meeting the expectations detailed in the National Quality Board publication. A paper on safe nurse staffing was presented at the Quality Committee in December 2013 and was also shared with the NHS Trust Development Authority as part of the regular Integrated Delivery Meetings with the Trust.

The paper addresses the following in light of themes from the Francis Inquiry (2013) and the learning from the inspections of hospitals (Keogh Report, 2013):

- How does the Trust ensure it has the right nursing establishments set?
- The Trust's approach to setting safe staffing levels on adult wards
- Current position on staffing
- How the Trust is assured that we have sufficient staffing to meet patient care
- How the Trust will strengthen its assurance

Recommendations related to Nurse staffing from the 'Review into the quality of care and treatment provided by 14 hospital trusts in England' (Keogh, 2013) can be found in **Appendix 1.**

2. Abbreviations

- **RN:** Registered Nurse
- **HCA:** Healthcare Assistant
- **ICHT:** Imperial College Healthcare NHS Trust
- **CPG:** Clinical Programme Group

3. Overview of what is currently in place

3.1. The Trust has a policy in place for the provision of safe nurse staffing and skill mix establishments which was ratified at the Trust's Board meeting in May 2013. This policy outlines the principles and methodology for setting and agreeing nurse staffing levels and ward/department nursing establishment and skill mix. It sets out when and how staffing levels should be reviewed and the approvals process. The policy states that the skill mix of RN/HCA must be no less than 65%:35% in line with RCN guidance 2010 and the reiterated 2012 guidance.

3.2. Rostering policy – this is built on existing practices and a well-developed set of KPI's. The policy is used to monitor effective use of the roster and identify gaps in rostering. The Trust has an electronic roster system in place – eRoster- which is currently in the process of being upgraded to a newer version.

3.3. Summary of Nursing Ratios – the usual method is to calculate a nurse to bed ratio. Following media publicity in 2013, a review of nurse ratios was completed in Spring 2013. It assessed the ratios of nurse to patient for every ward against the recommendation that there should be no greater than one nurse to eight patients (1:8) in general adult care. This was presented to the Management Board at its meeting in June 2013.

4. How do we ensure we have the right nursing establishments set?

4.1. The Trust Safe Nurse Staffing policy (2013) sets out when and how staffing levels should be reviewed. The policy identifies triggers for when a review may be required even if it has been done within the agreed principles, e.g.

- A change in profile and number of beds, or
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover; or
- A Serious Incident (SI) where staffing was identified as a contributing factor, or
- Harm Free Care report indicating a change (increased complaints, infections, pressure ulcers)
- At least annually.

5. Our approach to setting safe staffing levels on adult wards

5.1. The Trust adopted the 'clean sheet review' process since 2010, requiring the divisions to assess each ward on a six monthly basis using patient acuity to determine the amount of full-time equivalents (FTEs) required to deliver day to day patient care using the acuity levels from the national Safer Nursing Care Tool (2013).

5.2. The clean sheet process determines the amount of nursing FTEs required for the clinical area/ward. A further 22% 'uplift' is factored in for when staff are unavailable due to annual leave, sickness, maternity leave and training. This results in an agreed nursing establishment and is signed off by the Divisional Board and used as part of electronic rostering.

5.3. This 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. Gaps in available staffing can occur when the Nurse Bank is unable to provide additional staff, resulting in short term gaps in the operational rota.

5.4. The monitoring of the agreed establishment against the actual number of nurses available occurs daily within divisions and is led by the Divisional Nurse Directors to ensure adequate staffing. This information is discussed at Divisional Performance reviews.

5.5. The nurse staffing is also reviewed retrospectively on a monthly basis using the 'Trifold' approach. The 'Trifold' reviews what the establishment should be and what the ratios of RN to HCA and nurse to bed are. It also looks at the set establishment against the used establishment; the review is retrospective and undertaken monthly. Where staffing has exceeded establishment further reviews are undertaken.

5.6. The nursing workforce indicators are then matched against nurse sensitive clinical indicators and patient experience results as a means of triangulation. These are used as part of Divisional Monthly Performance reviews as well as by divisions to proactively manage staffing (this is achieved through review of the Harm Free Care Report).

6. Current position on staffing

6.1. The recent ICHT review of nurse to patient ratio identified the majority of areas were compliant with the recommended level of 1:8. The review recommended that the Divisional Director of Nursing undertake a review of Ward 8 South and similar reviews will also take place in areas where the registered nurse to patient ratio is above 1:6. These include; Ward 8 West, John Humphrey Ward, Victor Bonney Ward and Westway Ward. This is under review by the divisional Nurse/Midwife Director.

6.2. The recent ICHT review of RN:HCA skill-mix ratio identified the majority of areas were compliant with the recommended level of 65%:35%. However, the Stroke Unit/New 9 West ward currently has a ratio below the recommended level and is at 63.5%:36.5%. It was recommended that the Divisional Director of Nursing undertakes a review of this area. This is underway.

7. How do we currently assure we have sufficient staffing to meet patient care?

7.1. Our approach had been a retrospective examination of our ward staffing using the 'trifold' monthly reviews.

7.2. Operationally the approach to assuring adequate staffing levels to meet day to day care lies with divisions who are responsible for on-going management of staffing and ensuring resources are deployed where needed.

7.3. Roster management is essential to managing staff. Establishments are agreed into operational rosters; in turn this is managed through the eRostering system which has agreed KPIs to ensure effective use, including ensuring competencies for the nurse in charge, under and over hours used and even distribution of annual leave.

7.4. Divisional Nurse Directors and their Lead Nurses assess daily staffing levels. These are proactively managed through a daily divisional conference call where Lead Nurses and Divisional Directors of Nursing assess current staffing, addressing shortfalls through redeployment of staff and work with our temporary staffing supplier to escalate where short falls in staffing cannot be rectified.

7.5. In addition to this, incidents related to staffing levels from the Trust's Datix system (incident reporting) identify where staffing levels have potentially contributed to incidents and the impact this has on care delivery. This is managed at divisional level and reporting through existence governance arrangements.

7.6. Whilst these actions are undertaken, a number of areas require day to day management, such as bank and agency fill rate, which can be variable when demand exceeds supply, established vacancy rates, which when high create demand on bank areas and increasing acuity and dependency of patients in our care. We have set a target of 5% vacancy rates for bands 2-6.

8. How we intend to strengthen assurance

8.1. Recognising the need to automate real-time reporting we have embarked on developing a more sophisticated approach to bringing key pieces of information together, including as close to real-time as possible to support rapid decision making and identifying potential risk, and adjust staffing accordingly. The upgraded eRoster system is critical to ensuring this.

8.2. As cited earlier, acuity is used to identify staffing levels, but currently only twice a year. Patient acuity is dynamic while establishment levels are fixed and if the daily operational staffing is lower than the required establishment, staff are re-allocated or moved.

8.3. The e-roster system has an acuity dashboard, it is recommended that the Trust implement this. The Trust nursing teams are currently using an adaptation on iward to achieve this with no direct link to staffing.

8.4. The acuity dashboard is driven from patient acuity which is entered by ward staff on a daily basis. It calculates the 'hours of care' needed from the acuity and takes the eRostering data (in hours) and then shows hours needed against hours of nursing time. This will enable real time management of the nursing resource to meet patient needs and to deliver quality care as well as enable the redeployment of nursing resource.

8.5. The dashboard shows the following information in a graphical format:

- % of patients with acuity entered into iWard
- % Registered / Unregistered mix
- Nurse to patient ratio and RN to patient ratio
- Hours variance (i.e. hours of care versus hours of staffing)

8.6. **Out of Hours -** The Keogh Report highlights concerns of poor staffing levels found in the visited organisations at night and at weekends. The Trust will implement a programme of spot-checks led by divisions to assess the number of staff on duty. This will assess current staffing levels from rotas against actual staff in post and assess what escalation processes have taken place to ensure staff staffing.

8.7. By integrating information from the duty site manager logs and Datix incident and patient acuity, this will provide easier identification of those ward areas where there may be a potential risk to safe staffing levels and will enable divisions to manage this accordingly.

9. Analysis of current ratios

An analysis of the nurse:patient ratios were completed earlier in June 2013 (which was CPG based). Following the Keogh review a number of themes emerged that the nurse:patient ratio out of hours, at night & weekends in the reviewed hospitals, was low.

9.1. A further analysis of the Trust's 78 inpatient areas (excluding maternity) took place in October 2013 which specifically looked at nurse:patient ratio over weekdays, weekends and at nights. Divisions have produced and shared this information which also includes whether the ward manager or nurse in charge was included in the numbers of nurses per ward.

A summary of the findings is outlined below:

- **Total Nurse to patient ratios (the recommended level is 1:8 during the day and no specific ratio has been recommended for at night):**
    - **High acuity:**
        - **Level 3**: Ratio was 1:1 nurse to patient ratios throughout the 24-hour period.
        - **Level 2:** Ratio was 1:2 and 1:1.2 at weekends
        - **Paediatric ward areas**: 1:4

Nurse to patient ratios across areas

Time period	Total Nurse to patient ratio	Registered nurse to patient ratio
Weekday	This ranged from 1:1 for HDU level areas to 1:5.	This ranged from 1:1 - 1:1.65, extending to 1:7.3 when the Nurse in Charge was excluded from the numbers as they would be supervisory.
Weekend	This ranged from 1:2.5 to 1:6 in general areas with 1:1.8 on HASU.	This ranged from 1:1.3 to 1:6, with Riverside being below the recommended 1:8 level on a Sunday.
Night	This ranged from 1:3 to 1:6.5 across the Divisions	This ranged from 1:1.3 to 1:12.5 with the nurse in charge in most cases was included in the numbers, with HDU areas being the exception.

Registered Nurse to patient ratios exceeding 1:8 at night

Division	Area	Registered Nurse to patient ratio
Surgical	Riverside	1:9.5 (Saturday & Sunday)
	7 South	1:8.3
	6 South	1:8.6
Medicine	8 West	1:11
	8 South	1:12.5
	9 West	1:10
	9 South	1:8.6
	Fraser Gamble	1:9.6
	John Humphrey	1:10.5
	Christopher Booth	1:9.3
	Thistlewaite	1:10

The RCN guidance recognises that the RN:patient ratio is lower at night and does not recommend a ratio, however in 2009 it found the average RN:patient ratio in acute hospitals was 1:10.6. In the absence of guidance the Trust should agree a RN:patient ratio for night time of 1:10.

- **Registered Nurse to Healthcare Assistant (unregistered) ratio** (**the recommended ratio is 65%:35%)**
  - **High acuity:** 95%:5% and 100% Registered Nurses in paediatrics.

Area	Registered Nurse to Healthcare Assistant (unregistered) ratio
All areas	This ranged from 70%:30% to 100%. No areas are currently below 70%:30%.

- **Role of the ward manager**

RCN guidance and national guidance has recommended that the nurse in charge/ward manager should be supervisory and not counted 'in the numbers'. Analysis of how the ward manager is utilised in the numbers was also undertaken with the following findings:

Division	Number of areas the Ward Manager is Supervisory	If Ward manager is supervisor, number of areas where another person takes charge of the shift	Number of areas where the Ward manager is 'counted' in the numbers
Medicine	All wards	8 of 32 areas	7 of 32 areas
Surgical	All 22 areas	All 22 areas	12 of 22 areas
W&C	All wards	4 of 7 areas	1 of 7 area
PP	All 3 wards	None	None

9.2. In most cases the ward manager for all wards was supervisory, in principle. Across the Divisions with the exception of Private Patients, some or all of the areas' ward managers would also not take charge. This means that while they are supervisory, the coordination of the shift would be led by another member of staff. Further analysis of this is required. We will standardise the daily activities of ward sister/charge nurse and matron.

9.3. Agreement on how we utilise the ward manager as supervisory is required to ensure a standardised approach across Divisions and reduce any potential impact on nurse to patient ratios and outcome of care.

9.4. In conclusion, of the 78 areas reviewed:
- All inpatient ward areas have a RN:HCA ratio exceeding the minimum recommended level of 65%:35%.
- All maintain at least a ratio of 70%:30%. Of the areas where RN:HCA are at 70% only three also have nurse to patient ratio's over 1:8 at night, and only 1 over 1:8 during the weekend.

10. Conclusion

10.1. The 'trifold' review has proved useful in identifying developing issues, achieving a real time acuity and dependency picture which will help to have the right staff in the right place at the right time.

10.2. While there is considerable information available on a monthly basis to support the best use and efficient management of the nursing workforce, Divisions are ultimately responsible for the management of their resources in a way that ensures continual improvement and safe staffing levels. This is achieved on a daily basis through 'staffing conference calls'.

11. Key actions being undertaken

- An escalation algorithm for the management of Nursing and Midwifery staff shortages has been drafted.
- Notice boards to publicly display nursing and midwifery staffing levels for each ward have been ordered and will be implemented by February 2014.
- The completion of the eRoster upgrade is currently planned for April 2014.
- Policies and guidelines relating to safe nurse staffing will be updated to reflect these changes.

12. Next steps

- Board sign off of establishments - May 2014
- Monthly reporting to Trust Board on staffing; set vs. actual, by ward
- Publish monthly staffing information online
- Update safe nurse staffing policy and include escalation flowchart

Divisions
- Agree clean sheet review timetable and sign off process with divisions
- Staffing levels to be displayed daily (set vs. actual)
- Review supervisory role of ward sister

13. The Board are asked to:
- Note the information and next steps.

References

- Hard Truths; The Journey to Putting Patients First – Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: DH (2013)

- How to Ensure the Right People, with the Right Skills are in the Right Place at the Right Time: NHS England and the National Quality Board (2013)

- Francis Inquiry: The Final Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry London: HMSO (2013)

- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, NHS England (2013)

- Imperial College Healthcare NHS Trust *Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments (2013) –*

- Imperial College Healthcare NHS Trust Rostering Policy (2012 Rev)

- NHS Commissioning Board and the Department of Health (DH) Compassion in Practice London: DH,(2012)

- Royal College of Nursing Mandatory Staffing Levels. London (2012)

Appendix 1 – Recommendations related to nurse staffing levels from the Review into the quality of care and treatment provided (Keogh review 2013)

Recommendation From Keogh report (2013)	How currently demonstrated	How being taken forward	Being led by
As set out in the Compassion in Practice, Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis.	Trust uses Safer Nursing Care Tool to set staffing levels in line with local policy.	To review current approach in line with the waited '*How to' guide from the National Quality board.*	Director of Nursing
Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.	Staffing levels are reviewed on a monthly basis with Divisions. DON to take staffing levels to Board.	Divisions to produce staffing levels on 6-monthly basis to management Board	Director of Nursing
Inadequate numbers of nursing staff in some ward areas. The reported data did not provide a true picture of the numbers of staff actually working on the wards	Monthly establishment reviews being held with Divisional Directors of Nursing	• To continue and build any further guidance from the NQB 'How to guidance' • Implement real time reporting of staff levels	Divisions & Director of Nursing
Insufficient nursing establishments, Differences between the funded nursing establishments and the actual numbers of registered nurses and support staff available to provide care on a shift by shift basis.	Monitored via monthly establishment reviews and performance reviews	• Monitoring via monthly establishment reviews • Develop a rolling calendar of ward reviews (in line with 6-monthly requirement)	Divisions
Poor staffing levels on night shifts and at weekends	• Utilising intelligence from Site Management Team eRostering provides information on gaps & staffing. • Monitoring of fill rates with agency suppliers • Using DATIX (incidence reporting) to identify 'hot spots'	• Planned 'spot checks' to be led by divisions to check rosters against actual staff available. • On-going analysis of DATIX reporting on insufficient staffing levels	Divisions to lead with input from Nursing directorate
Over-reliance on unregistered staff and temporary staff, with restrictions often in place on the clinical tasks temporary staff could undertake.	• Monitoring of sickness/absence and vacancy rates which impact the drive for temporary staffing occurs at monthly performance reviews. • Monitoring of fill rates of temporary staffing	• Adding additional hours over template on Trust Board scorecard	Divisions to lead management of rosters/use of temporary staffing

Imperial College Healthcare NHS
NHS Trust

APPENDIX B

Director of Nursing Report: Maternity patient experience survey results 2013

1. Background

The 2013 National Maternity Survey was published on the 12 th of December 2013 by the Care Quality Commission (CQC). 137 acute maternity units were involved in the survey, with a total of 23000 women responding it; a response rate of 44%. Imperial had 283 women respond to the survey which is a response rate of 46%.

2. Summary of ICHT's Results

a. Labour care

There were 17 questions relating to labour care. The questions relate to care in labour, staffing and the stay on the postnatal ward. All the scores at ICHT demonstrated performance as expected or above expectation.

b. Antenatal care

There were 9 questions in this category these related to pregnancy care. In this section we performed worse than expected in 6 questions and as expected in 3 questions. The worse than expected scores all relate to women not feeling they had enough time in their appointments to ask questions and discuss their concerns.

c. Postnatal care

There were 18 questions in this category that relate to community postnatal care. These are new questions that have never been asked in a CQC survey before, they relate to support and advice provided by the midwives in the community. The scores demonstrated performance as expected for 6 of the questions and below the expected range for 12 of the questions.

It is recognised that although we delivered all the women surveyed we only provide postnatal community care for 52% of our women, the remaining 48% of women are out of area, and therefore we do not have any influence in the quality of care they receive postnatally in the community, although their responses were part of this survey.

3. Comparison between the 2010 survey and 2013 survey

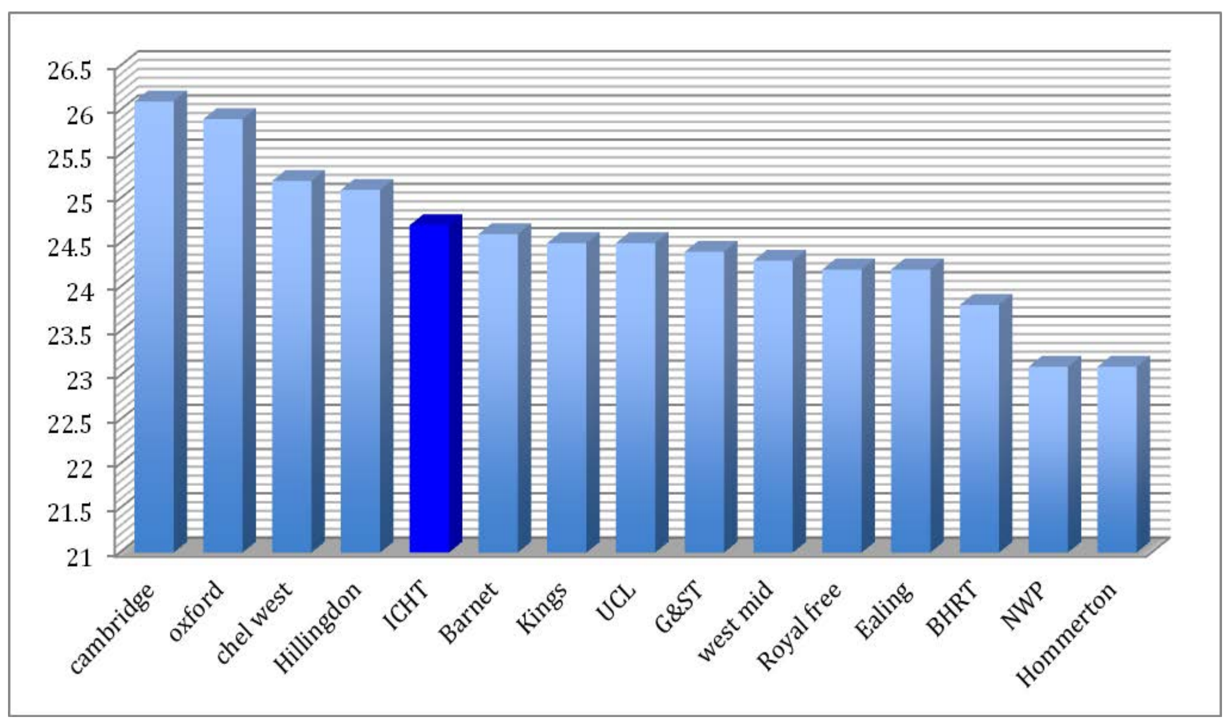
It is not possible to directly compare the results from the 2010 survey as only 19 questions were asked, in the 2013 survey they are 44 questions therefore it is far more in depth. There are eight questions that were asked in the 2010 survey and the 2013 survey these have been compared. Of the 8 questions that are comparable 6 have remained the same and 2 have improved.

4. ICHT Overall score

- **Labour and Birth** 8.7
- **Staffing** 8.3
- **Care in hospital after birth** 7.7

The red staffing score was challenged with the CQC as other Trusts with a score of 8.3 showed as Amber. Their explanation was that the score of 8.3 was a rounded up score, the cut off from red to amber was 8.29 ICHT's score was 8.26 therefore 0.03 below an amber score.

Figure 1: Benchmark amongst NWL trusts, the Shelford group and other tertiary units in London using the combined overall score with a maximum possible score of 30.



5. Summary

The results do reflect the priorities and strategy that has been undertaken in maternity at Imperial in the past 2 years. The biggest resource and service developments have been in labour care, this was prioritised as it is the area that carries the most clinical risk; had the poorest patient experience and highest complaints. It is therefore reassuring to see this area average or above and improved from the 2010 survey.

In comparison with other Trust's outlined in figure 1, the Trust sits in 5th position. It is recognised that comparing the midwifery ratios across peers will be a helpful benchmark.

The maternity strategy is now to implement a new model of community care to be able to provide continuity of care to women in a community setting close to their homes. The model of care which is being implemented is group practices. The first 2 group practices of 14 midwives were rolled out into the community in November with a further 5 teams of midwives moving out in February. It is envisaged that this will improve the quality of care women receive in the community antenatal and postnatal setting which we would expect to see demonstrated on the next CQC survey. To provide this model of continuity of care

to all women delivering at Imperial there would need to be a further investment in the Midwifery establishment.

6. Next steps

- Develop a detailed project plan
- Continue the Implementation of the community Group practices
- Progress business plan for further midwifery investment based on benchmarking data.

APPENDIX C

Director of Nursing Report: Patient Story

In December 2013, a woman wrote to PALS about her husband's treatment for stage IV pancreatic cancer at the Gary Weston Centre at Hammersmith Hospital. She praised the nursing staff in the chemo day unit but said that all three appointments had started late:

'Whilst we fully appreciate the complexities involved in high level patient care, we are also as a young couple acutely aware that time is against us and very precious. So far after three treatments (during which we have arrived as scheduled at 10.30am) chemo has not started until 14.30 at the earliest. Today it was 15.30 when his treatment which lasts 4hrs in the hospital and a further 46 at home actually began.'

In addition, an oncology appointment had been delayed for ninety minutes, before the oncologist ordered chemo for the wrong day. They raised this with their Macmillan key worker, and again at an outpatient appointment, but wanted to know if anything else could be done to improve matters.

The Lead Nurse contacted the patient's wife, who was happy with the remedial actions that she put in place, and that staff were reviewing the operational difficulties around chemotherapy preparation and delivery. She offered to follow this up with both the patient and his wife when they next came in for treatment.

Investigating the concerns, the Lead Nurse noted a significant recent increase in the haematology chemotherapy workload, with the late prescribing of chemotherapy requiring urgent attention.

1.1 Action Taken

The Lead Nurse for Clinical Haematology took the following actions:

Key issue	Action Taken/To be taken
Prescriptions not correctly completed and submitted to pharmacy in time.	Weekly chemotherapy planning meetings, coordinated by Senior Charge Nurses on CWW with SpRs, one week before scheduled treatment.
Patient felt uninformed about reasons for delays.	A timeline for the chemo prescription was produced to understand the delays, before PALS responded to the complaint. It was suggested that 10.30am may not be realistic and that it may be better to schedule future appointments slightly later.
Increased workload in haematology and chemotherapy	A meeting to discuss this took place, including oncology as a result of the patient's complaint. PALS wrote back to the patient's wife, informing her that oncology and pharmacy had acknowledged the issues around medication delivery and waiting times.

1.2 Improvements

The complainant was happy to report that her husband's next chemo session went well:

'It is just after 2pm and we are leaving. Normally we haven't even been hooked up yet so it makes an enormous difference to our precious time and ability of district nurses to come. Thank you!'

Imperial College Healthcare NHS
NHS Trust
Safety
Effectiveness
Patient centredness
Equity
Timeliness
Efficiency
Quality
2014

Imperial College Healthcare **NHS**
NHS Trust

Goal:

Our patients will be as safe in our hospitals as they are in their own homes

Safety

January

"Look after the detail and the big picture takes care of itself."

Nigel Mendoza, consultant neurosurgeon

M	T	W	T	F	S	S
30	31	New Year's Day Bank Holiday 1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	Chinese New Year 31	1	2

Our people will minimise the use of ineffective care and maximise the use of evidence based care

Effectiveness

February

"Quality is providing care which meets all the necessary needs of the patient."

Rose Adjei, senior healthcare assistant

M	T	W	T	F	S	S
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	1	2

Goal:
Our people will respect the individual patient and his/her choices, culture, and specific needs

Patient centredness

March

At the heart:
Place the needs of patients, families and carers at the centre of all your work, treating them as individuals.

M	T	W	T	F	S	S
24	25	26	27	28	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
Holi (Hindu) 17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Goal:
We will seek to ensure that everyone we care for has the same high quality outcome, regardless of status

Equity

April

The NHS is for everyone. Treat individuals fairly.

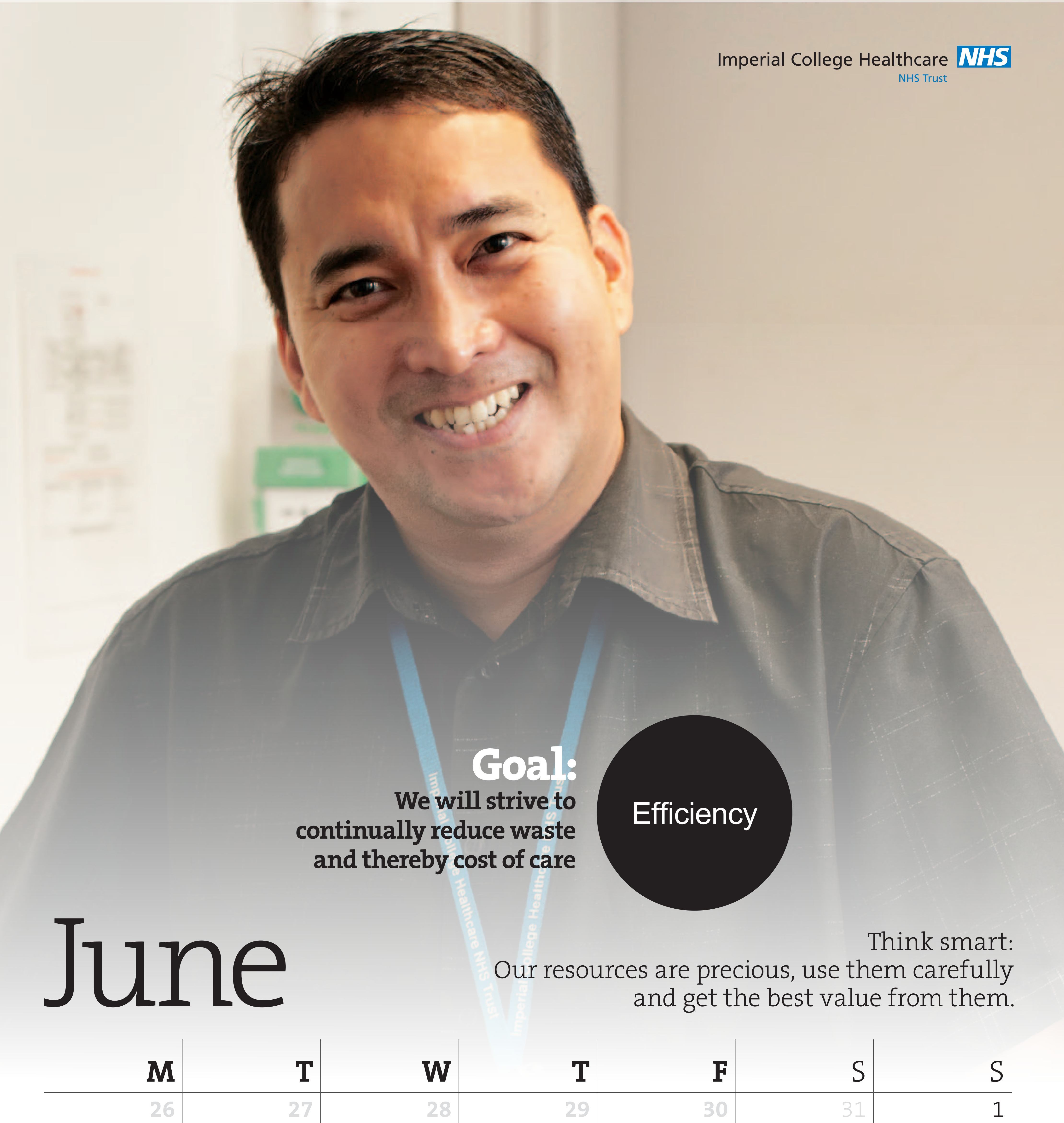
M	T	W	T	F	S	S
31	1	2	3	4	5	6
7	8	9	10	11	12	Vaisakhi (Sikh) 13
14	Passover begins (Jewish) 15	16	17	Good Friday Bank Holiday 18	19	Easter Sunday (Christian) 20
Easter Monday Bank Holiday 21	22	23	24	25	26	27
28	29	30	1	2	3	4

May

"It is about fulfilling the needs of our patients by serving them the food and beverages they require to enhance their recovery."

Alicia Nagrampa, ward hostess

M	T	W	T	F	S	S
28	29	30	1	2	3	4
May Day Bank Holiday 5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
Spring Bank Holiday 26	27	28	29	30	31	1



Goal:
We will strive to continually reduce waste and thereby cost of care

Efficiency

June

Think smart:
Our resources are precious, use them carefully and get the best value from them.

M	T	W	T	F	S	S
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	Ramadan begins (Islam) 28	29
30	1	2	3	4	5	6

Imperial College Healthcare **NHS**
NHS Trust

Goal:

Our patients will be as safe in our hospitals as they are in their own homes

Safety

July

Be one step ahead:
Prevent risk by creating a safe environment and use equipment correctly.

M	T	W	T	F	S	S
30	1	2	3	4	66th birthday of the NHS 5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
Eid-Ul-Fitr (Islam) 28	29	30	31	1	2	3

Goal:
Our people will minimise the use of ineffective care and maximise the use of evidence based care

Effectiveness

August

Tried and tested:
Use current best evidence for making decisions about patient care and treatment.

M	T	W	T	F	S	S
28	29	30	31	1	2	3
4	5	6	7	8	9	Raksha Bandhan (Hindu) 10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
Summer Bank Holiday 25	26	27	28	29	30	31

Imperial College Healthcare NHS
NHS Trust

Patient centredness

Goal:
Our people will respect the individual patient and his/her choices, culture, and specific needs

September

"We are 'guests in patients' lives'. It is an enormous privilege which we should honour."

Mando Watson, consultant paediatrician

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	Rosh Hashanah (Jewish New Year) 25	26	27	28
29	30	1	2	3	4	5

October

Closing the gap:
Reducing health inequalities by making our services accessible to all people.

M	T	W	T	F	S	S
29	30	1	2	3	Eid-Ul-Adha (Islam) 4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	Diwali (Hindu, Sikh) 23	24	25	26
27	28	29	30	31	1	2

November

Goal:
We will strive to continually reduce waiting times and delays for patients and our people

Timeliness

"Quality is making sure patients are not late for their appointments and are supported through their journey."

Marlon Mangoba, ISS porter

M	T	W	T	F	S	S
27	28	29	30	31	1	2
3	4	5	Birthday of Guru Nanak (Sikh) 6	7	8	9
10	Remembrance Day 11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Goal:
We will strive to continually reduce waste and thereby cost of care

Efficiency

December

"Coming together is a beginning; keeping together is progress; working together is success."

Francesca Rubulotta, anaesthetist

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	Hanukkah (Jewish) 17	18	19	20	21
22	23	Christmas Eve 24	Christmas Day Bank Holiday 25	Boxing Day Bank Holiday 26	27	28
29	30	New Year's Eve 31	1	2	3	4

Imperial College Healthcare NHS
NHS Trust

2015

January

M	T	W	T	F	S	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February

M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March

M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April

M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May

M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July

M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September

M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October

M	T	W	T	F	S	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November

M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

December

M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Quality: We value your feedback.

Each and every member of the Trust is key to the achievement of a high quality service – whether you work in the front line of our business or in a support role. We want to know what quality means to you? And how can we improve it? Please tell us your ideas and thoughts by emailing quality@imperial.nhs.uk

Imperial College Healthcare NHS
NHS Trust

Mortality Report (October 2012 to September 2013 data)
QUALITY COMMITTEE

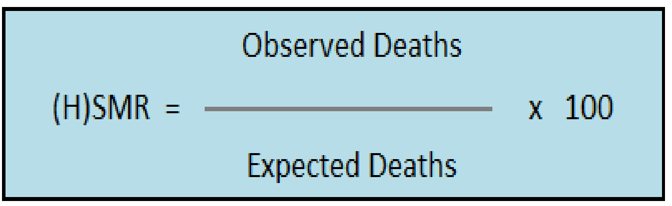
Report Date: December 2013

Ben Jones
On behalf of

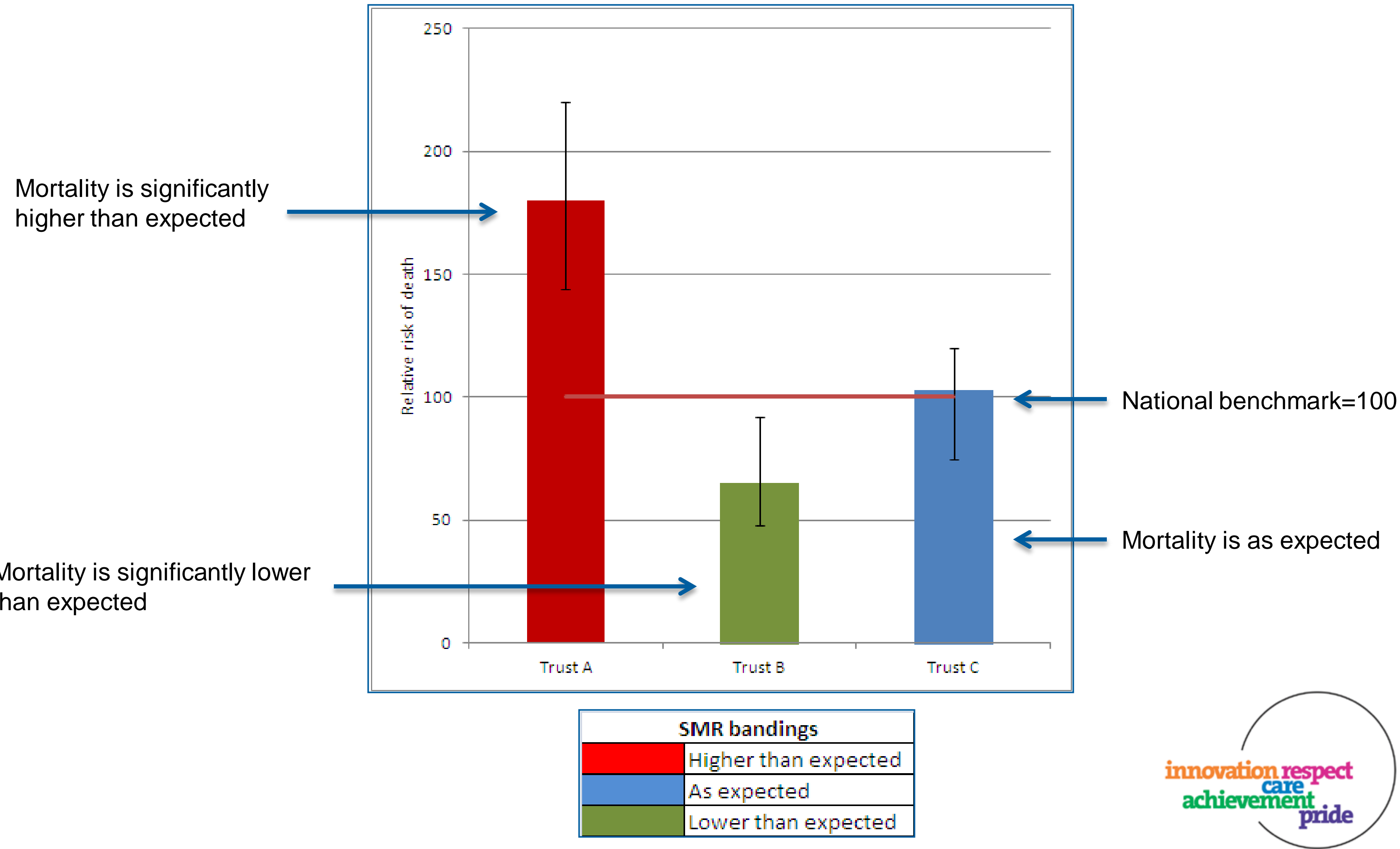
Imperial College Healthcare NHS Trust

Hospital Standardised Mortality Ratio

- The (H)SMR is a summary mortality indicator. It is based on a subset of 56 diagnosis groups that give rise to approximately 85% of in hospital deaths.
- Measuring hospital performance is complex – HSMRs are one key indicator of overall mortality.
- Logistic regression models are created for each diagnosis group.
- Adjust for casemix, taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, discharge year.
- Each patient has a 'risk' of death based on these factors. Risks are aggregated to give an expected number of deaths.
- Model is updated once each year and national benchmark re-baselined.
- Expressed in terms of a ratio:



HSMR – how to interpret results



Data Source: Dr Foster Intelligence

HSMR –Trend by month from October 2012 to September 2013

High relative risk | Low relative risk | Expected Range | Undefined | National benchmark | Confidence Intervals

Relative Risk

105 100 95 90 85 80 75 70 65 60 55 50 45

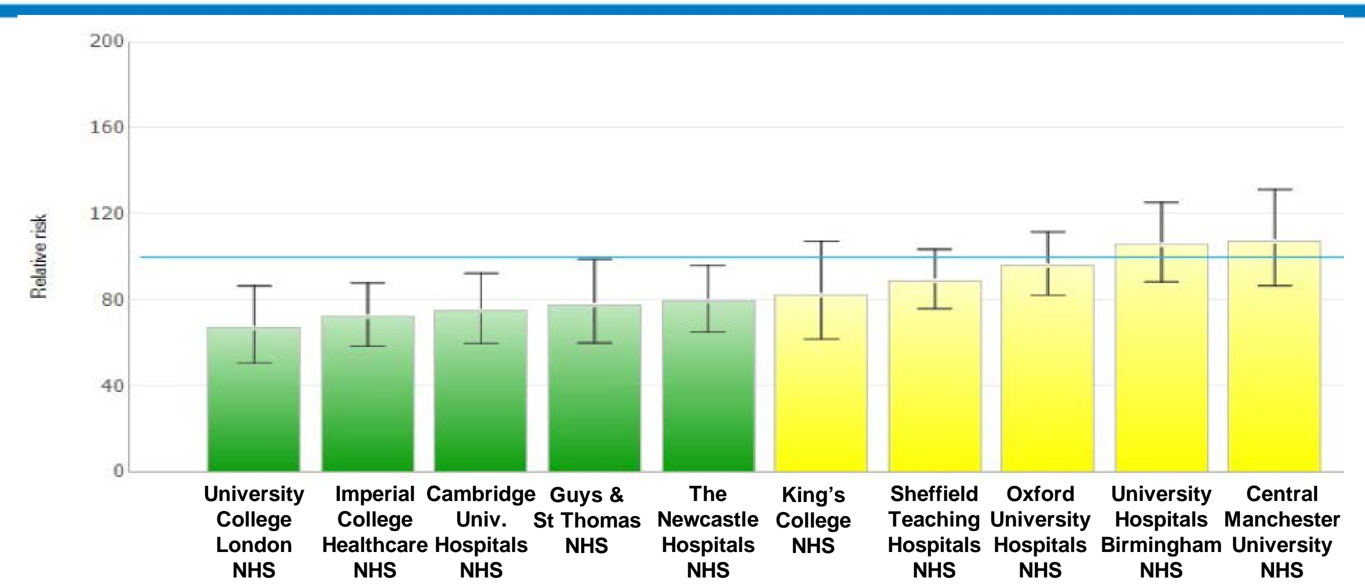
Oct-12 Nov-12 Dec-12 Jan-13 Feb-13 Mar-13 Apr-13 May-13 Jun-13 Jul-13 Aug-13 Sep-13

Imperial's HSMR for the month of September 2013 is 72; this is statistically significantly low. Imperial has maintained this significantly low mortality risk for each month in the last five months of data.

Data Period: Oct 2012 to Sep 2013

Imperial College Healthcare NHS
NHS Trust

HSMR –for Imperial and Rest of Shelford Group- for Sep 2013



Imperial has the 2nd lowest HSMR in the Shelford Group for September 2013 data. In August 2013 Imperial had the 4th lowest. This relative risk is well below the Shelford average of 86.01 for the month.

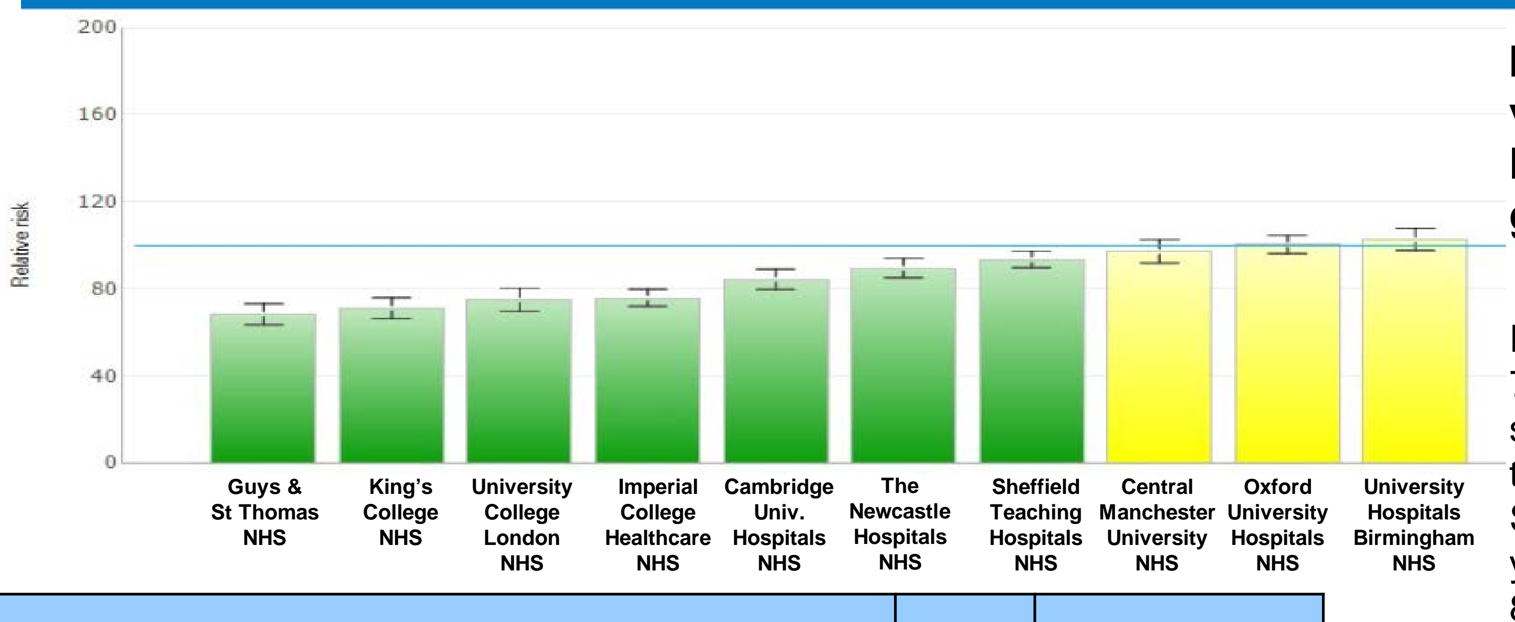
Peer	Spells	Relative Risk
ALL	38579	86.01
University College London Hospitals NHS Foundation Trust	3521	66.93
Imperial College Healthcare NHS Trust	3949	72.29
Cambridge University Hospitals NHS Foundation Trust	3718	74.89
Guy's and St Thomas' NHS Foundation Trust	2506	77.72
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	5053	79.58
King's College Hospital NHS Foundation Trust	1948	82.37
Sheffield Teaching Hospitals NHS Foundation Trust	6412	88.98
Oxford University Hospitals NHS Trust	5137	96.15
University Hospitals Birmingham NHS Foundation Trust	2968	105.72
Central Manchester University Hospitals NHS Foundation Trust	3367	107.37

SMR bandings	
(red)	Higher than expected
(yellow)	As expected
(green)	Lower than expected

Data Period: Sep 2013

Imperial College Healthcare NHS Trust

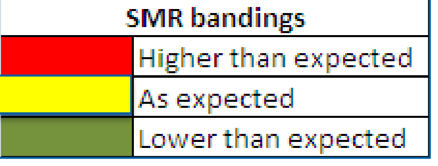
HSMR –for Imperial and Rest of Shelford Group for Oct 2012 to Sep 2013



Imperial HSMR value is 4th lowest in the group.

Imperial HSMR, at 76.01 remains significantly lower than the entire Shelford Group year average of 87.57.

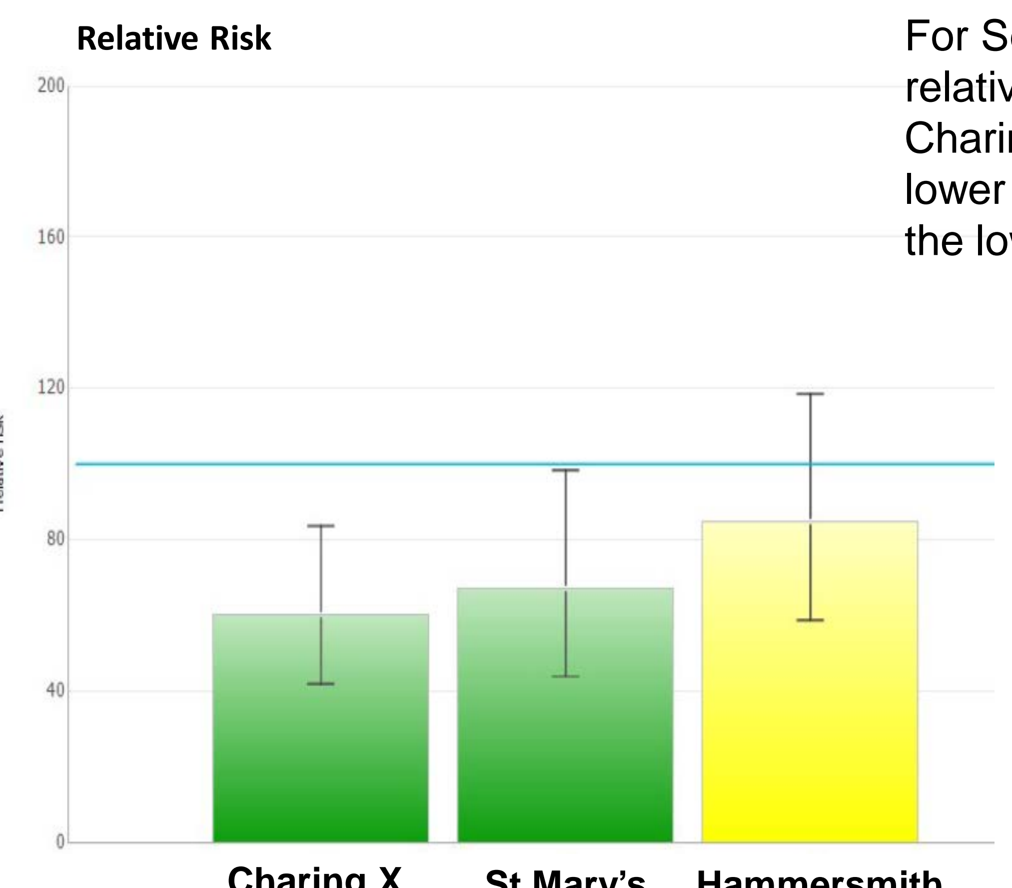
Peer	Spells	Relative Risk
ALL	487445	87.57
Guy's and St Thomas' NHS Foundation Trust	32177	68.44
King's College Hospital NHS Foundation Trust	29265	71.21
University College London Hospitals NHS Foundation Trust	42840	75.01
Imperial College Healthcare NHS Trust	49233	76.01
Cambridge University Hospitals NHS Foundation Trust	46395	84.46
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	64378	89.61
Sheffield Teaching Hospitals NHS Foundation Trust	81274	93.55
Central Manchester University Hospitals NHS Foundation Trust	41958	97.2
Oxford University Hospitals NHS Trust	63282	100.4
University Hospitals Birmingham NHS Foundation Trust	36643	102.66



Data Period: Oct 2012 to Sep 2013

HSMR –for Imperial at site level: September 2013 (site of diagnosis)

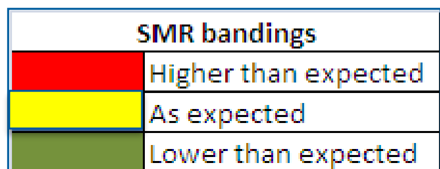
Relative Risk



For September 2013 data, Hammersmith has a relative risk for mortality within expected range. Charing Cross and St Mary's have significantly lower than expected mortality. Charing Cross has the lowest relative risk for this month of data.

Activity summary

Provider	Charing X	St Mary's	Ham Hosp
Spells	1176	1033	1730
Observed	35	26	34
Expected	58.18	38.73	40.07
Observed-Expected (Variance)	-23.18	-12.73	-6.07
Crude Rate (%)	2.98	2.52	2.32
Rel Risk	60.16	67.12	84.85



SMR bandings	
	Higher than expected
	As expected
	Lower than expected

Data Period: Sep 2013

Data Source: Dr Foster Intelligence

HSMR –for Imperial at site level: year to Sep 2013 (site of diagnosis)

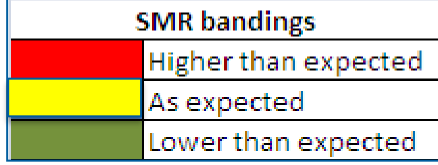
Across the past year of data, ALL sites have a lower than expected relative mortality risk. Hammersmith has both lowest HSMR and lowest crude mortality rate.

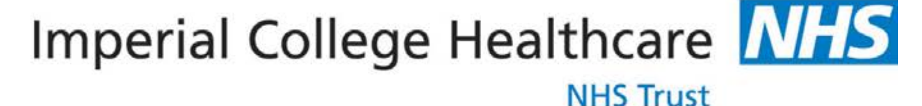
Activity summary

Provider	Ham Hosp	Charing X	St Mary's
Spells	20629	14484	14034
Observed	427	576	434
Expected	592.32	782.59	558.52
Observed-Expected (Variance)	-165.32	-205.59	-124.52
Crude Rate (%)	2.07	3.98	3.1
Rel Risk	72.09	73.60	77.71

Data Period: Oct 2012- Sep 2013

Data Source: Dr Foster Intelligence





HSMR - ten non-specialist acute providers with the lowest HSMR values in England (All Admissions) in last available year of data

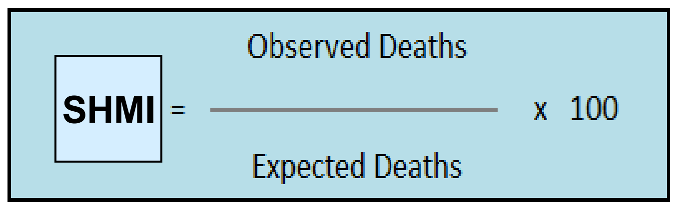
Peer (National)	RR
Guys and St Thomas NHS Foundation Trust	65.8
Kings College Hospital NHS Foundation Trust	69.5
University College London Hospitals NHS Foundation Trust	73
Royal Free London NHS Foundation Trust	74.7
Imperial College Healthcare NHS Trust	**75.5**
The Whittington Hospital NHS Trust	75.5
Ashford and St. Peters Hospitals NHS Foundation Trust	78
Salford Royal NHS Foundation Trust	78.5
Chelsea and Westminster Hospital NHS Foundation Trust	78.6
Airedale NHS Foundation Trust	79.2

This is the latest HSMR data available. HSMR data is more recent and published more regularly than SHMI data. Imperial are in the group of five hospitals with the lowest relative risk (although have exactly same relative risk as The Whittington).

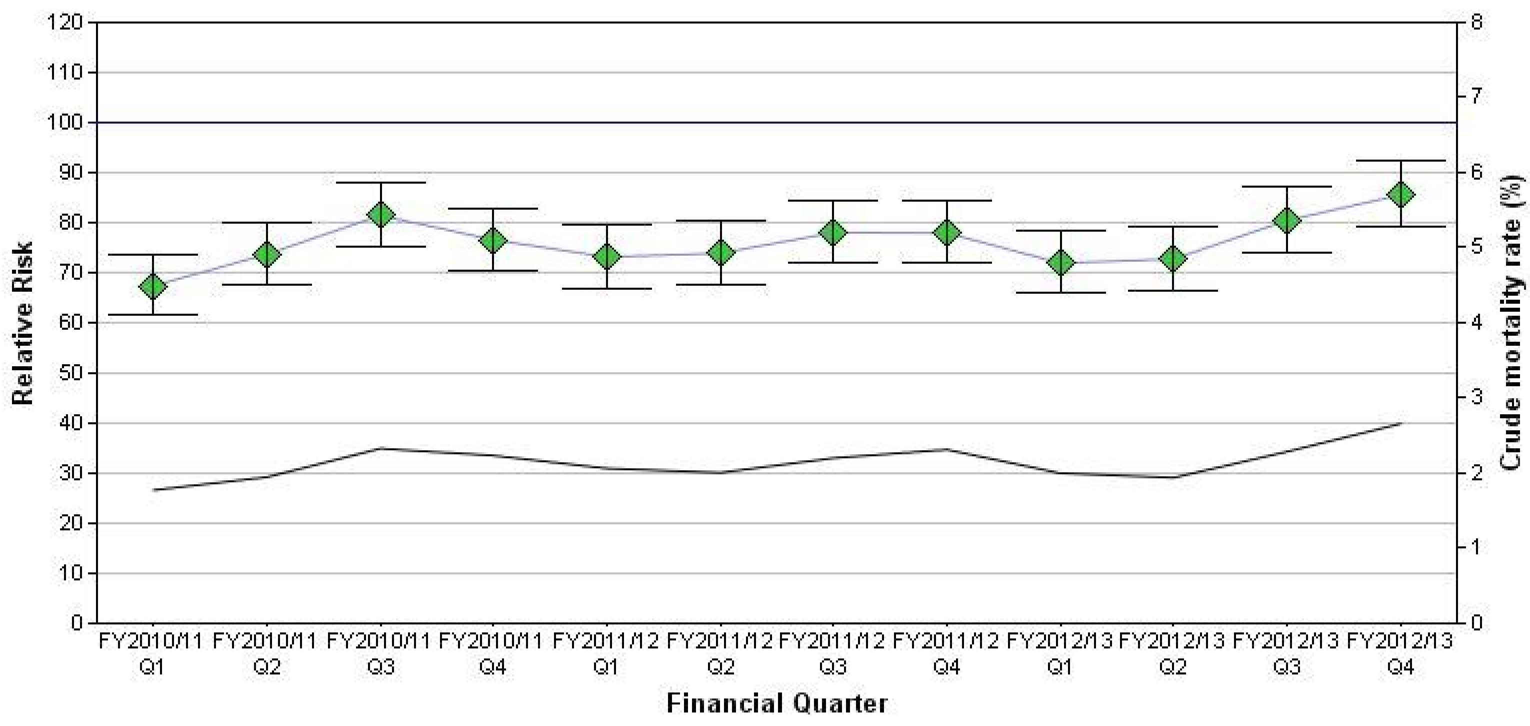
Data Period: Oct ‘12 to Sep ‘13

Summary Hospital Mortality Indicator

- SHMI is ratio of observed number to expected number of deaths for acute providers. **Covers all deaths in-hospital or within 30 days post discharge from hospital.**
- The expected number of deaths is calculated from a risk adjusted model using a patient case-mix of age, gender, admission method, comorbidity and diagnosis group.
- HSMR adjusts for more factors in risk modeling than SHMI, notably: palliative care, diagnosis sub-group, past history of admissions and month and source of admission.
- Because SHMI adjusts for deaths post discharge, there is a time lag between data submission for this and the HSMR. Whilst SHMI data is only available to March 2013, HSMR is available to Sep 2013
- SHMI is rebased quarterly using a rolling 12 month period. SHMI allocates the death to the last non-specialist provider within the patient superspell.
- As with HSMR, expressed as a ratio. As both cover different factors and patients, combined analysis allows for robust mortality reporting.



SHMI –Trend from Q1 2011/12 to Q4 2012/13



SHMI trend shows that all Imperial quarterly SHMI readings have been significantly lower than expected for the last 3 years. By way of illustration, SHMI tends to follow crude mortality rate trend almost exactly. This is the latest SHMI data made available from the HSCIC/Health & Social Care Information Centre. The current SHMI value of 85.52 is the highest in the data period.

Data Period: Apr '10- Mar '13

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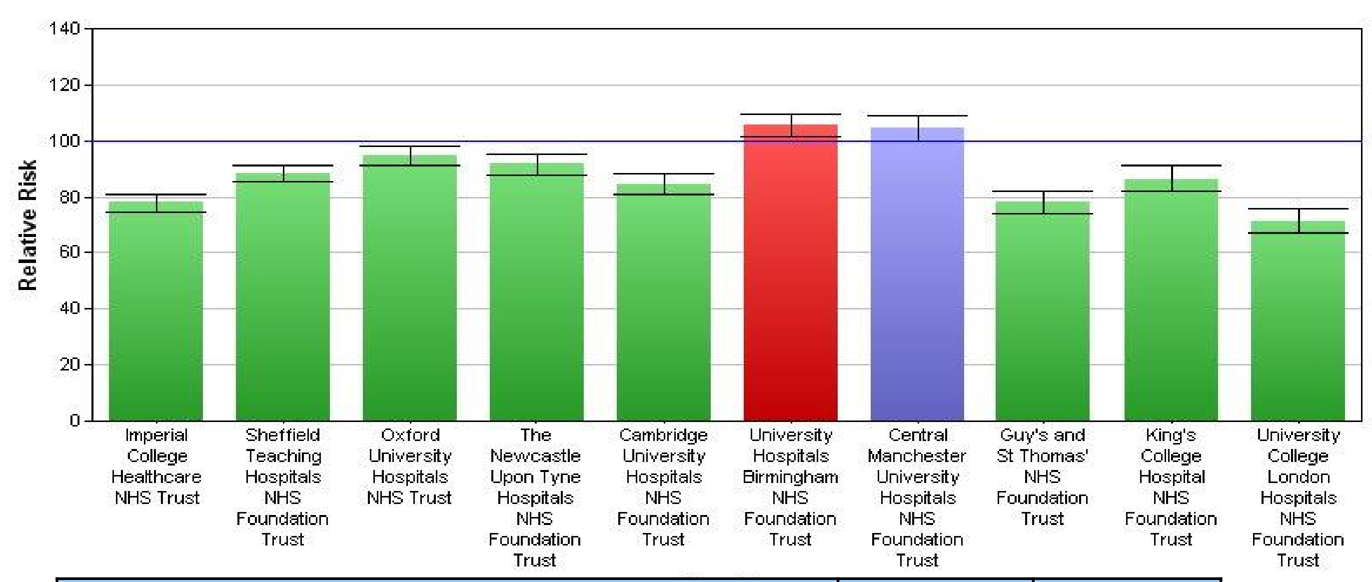
SHMI –for Imperial and rest of Shelford Group for year to March 2013

Imperial College Healthcare

NHS Trust



SHMI data is the latest made available by the Health & Social Care Information Centre (HSCIC).

Imperial have the 2nd lowest SHMI in the Shelford Group.

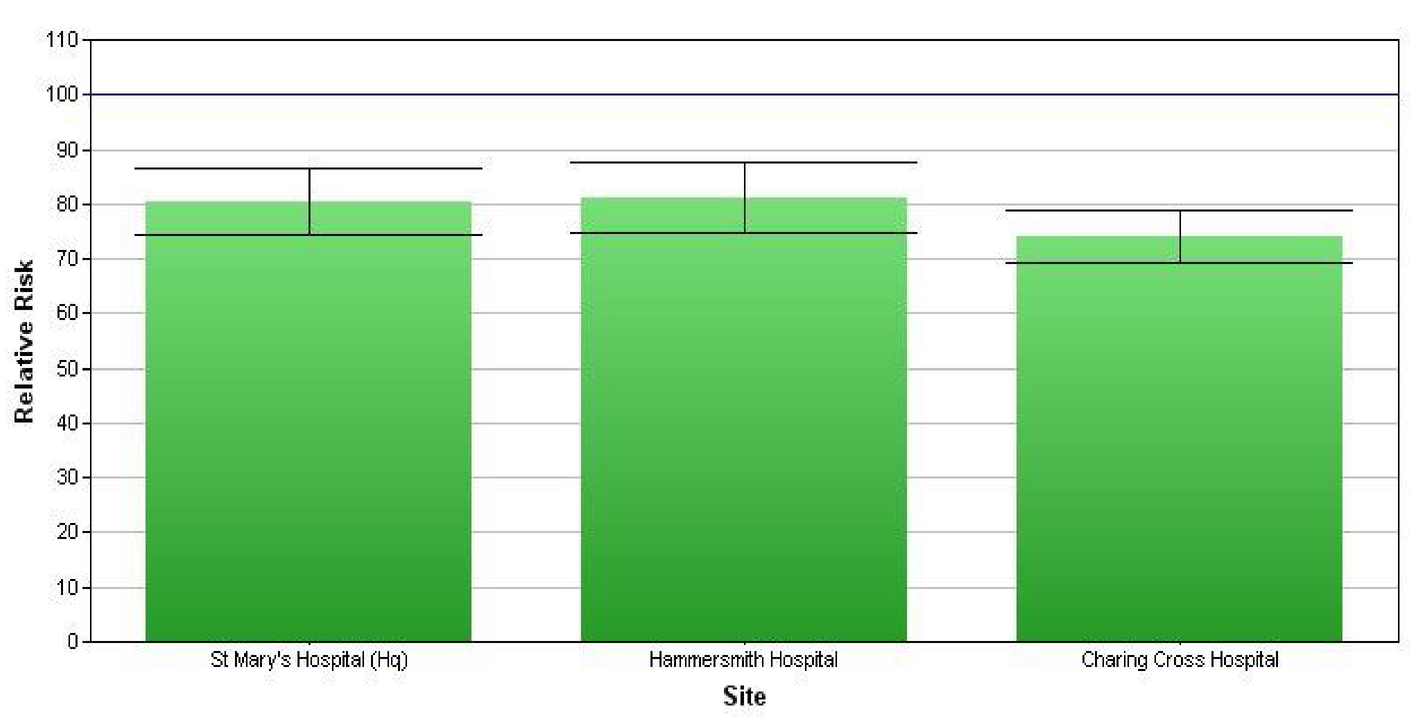
Provider	SHMI Spells	SHMI
University College London Hospitals NHS Foundation Trust	67036	71.14
Imperial College Healthcare NHS Trust	103221	77.78
Guy's and St Thomas' NHS Foundation Trust	85235	77.91
Cambridge University Hospitals NHS Foundation Trust	70167	84.49
King's College Hospital NHS Foundation Trust	68984	86.29
Sheffield Teaching Hospitals NHS Foundation Trust	105862	88.48
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	105207	91.52
Oxford University Hospitals NHS Trust	108227	94.77
Central Manchester University Hospitals NHS Foundation Trust	99940	104.55
University Hospitals Birmingham NHS Foundation Trust	57089	105.6

Data Source: Health & Social Care Information Centre (Dr Foster Intelligence)

SMR bandings	
(red)	Higher than expected
(blue)	As expected
(green)	Lower than expected

Data Period: Apr 2012 to Mar 2013

SHMI for Imperial at site level: April 2012 to March 2013



All Imperial sites have lower than expected SHMI ratios. To illustrate the differences in how HSMR and SHMI figures are derived; Hammersmith has the lowest site level HSMR but the highest site level SHMI within the trust.

Site	St Mary's	Hammersmith	Charing X
Spells	38595	32513	31690
Observed	687	646	952
Expected	856.26	796.5	1285.15
Obs- Exp (Variance)	-169.26	-150.5	-333.15
SHMI	80.23	81.11	74.08

SMR bandings	
(red)	Higher than expected
(blue)	As expected
(green)	Lower than expected

Data Period: Apr ‘12- Mar ‘13

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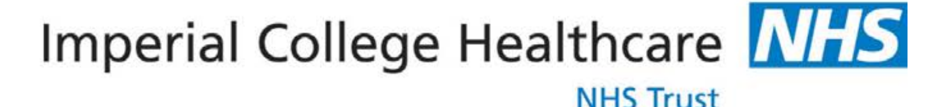
Data Source: Information Centre (Dr Foster Intelligence analysis from Health & Social Care Information Centre)



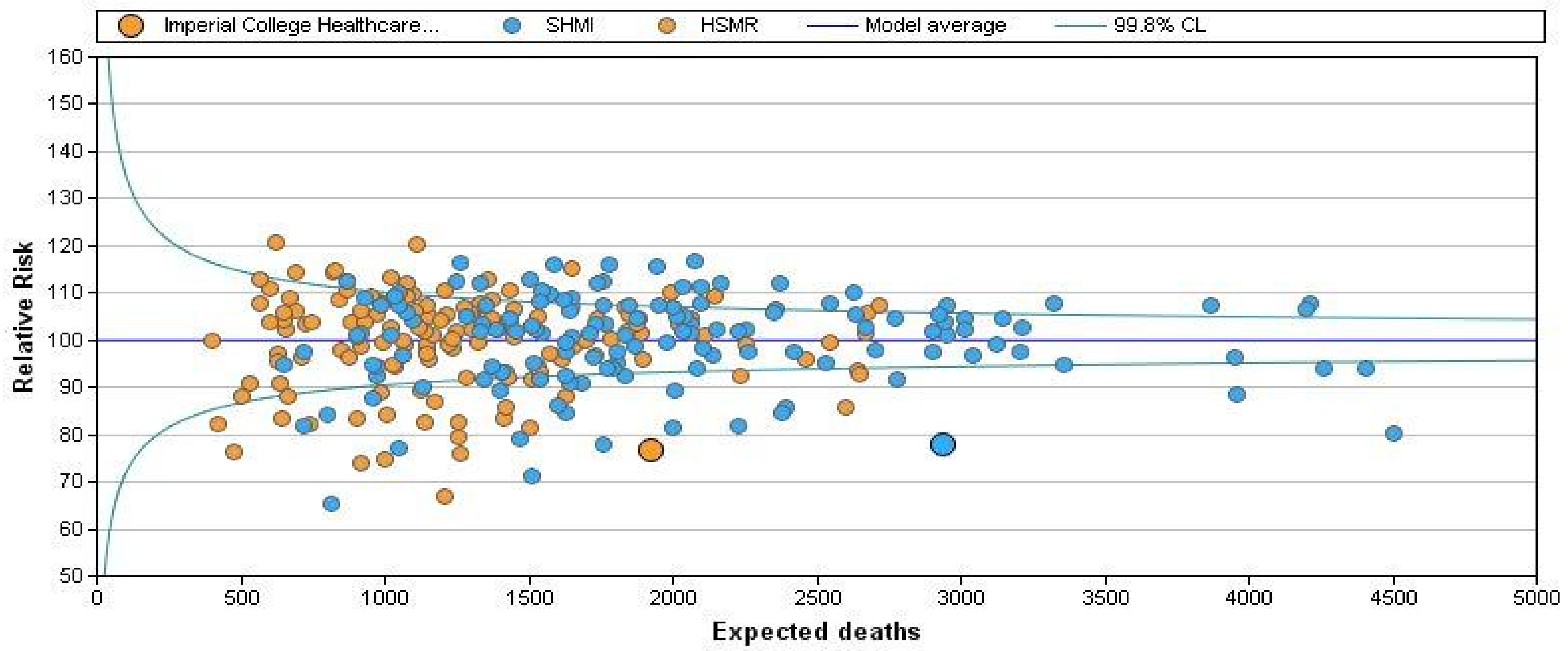
SHMI - ten non-specialist acute providers with the lowest SHMI values in England (All Admissions)

Provider	SHMI
The Whittington Hospital NHS Trust	65.23
University College London Hospitals NHS Foundation Trust	71.14
North Middlesex University Hospital NHS Trust	77.05
Imperial College Healthcare NHS Trust	77.78
Guy's and St Thomas' NHS Foundation Trust	77.91
Royal Free London NHS Foundation Trust	79.24
Barts Health NHS Trust	80.15
St George's Healthcare NHS Trust	81.34
North West London Hospitals NHS Trust	81.65
Chelsea and Westminster Hospital NHS Foundation Trust	81.81

Imperial has the 4th lowest SHMI ratio of all non-specialist providers in England. In period Jan-Dec 2012, Imperial had 3rd lowest SHMI. Imperial's SHMI has gone up slightly; from 76.49 to 77.78.

Data Period: April '12 – Mar '13

SHMI and HSMR funnel plot for all non-specialist acute providers in England



Performance funnel plot shows that for both HSMR and SHMI, Imperial have some of the lowest mortality ratios in the country (Imperial are signified by the larger dots in the plot). For consistency, data is drawn from period April '12 to March '13 (where SHMI data is most recently available. HSMR is available up to Sep 2013).

innovation respect care achievement pride

Data Period: April '12 – Mar '13

Data Source: Dr Foster Intelligence

Revalidation Support Team

Our ref: RST / 3809
6th September 2013

Dr David Mitchell
Imperial College Healthcare NHS Trust
Medical Services Directorate
Level 7 Salton House
London
W2 1NY

Dear Dr Mitchell

ORSA Comparator Report for Imperial College Healthcare NHS Trust

Thank you for submitting a response to the Organisational Readiness Self-Assessment (ORSA) exercise in April/May 2013. This report aims to provide comparative feedback on the readiness of your organisation using the information which was submitted to help in planning your next steps. It compares your organisation's submission with that of other designated bodies in England.

It is important that every designated body, irrespective of the overall RAG rating, produces an action plan to address all the development needs identified through this exercise. The action plan may need to include specific actions to improve appraisal rates, to ensure sufficient resources are available and to ensure the successful development and implementation of policies and procedures. The results of the self-assessment exercise and the resulting action plans should be presented to the board or the equivalent governance structures in non-NHS organisations.

The RST will be decommissioned in March 2014 and the on-going implementation of revalidation will be overseen by NHS England and the Department of Health. The report of the final ORSA exercise will be published in the next few weeks. Over the last three years ORSA has set clear expectations about the standards that organisational systems and processes need to meet to fulfil the requirements of revalidation. As we move through the implementation phase of revalidation, quality assurance becomes increasingly important and a management audit will be designed to provide assurance about the quality of the systems supporting the responsible officer role.

Following the first ORSA exercise, Sir Bruce Keogh highlighted the importance of the following:

- strong clinical leadership and effective local action planning
- ensuring all designated bodies have been identified
- ensuring all responsible officers have the resources to carry out their role
- providing support for responsible officers through networks

- ensuring all doctors have an annual appraisal.

It is clear that substantial progress has been made in these areas but there is still much more to be done to ensure these principles are fully implemented and embedded in all designated bodies so that the potential benefits of revalidation are realised.

If you no longer work for this organisation, or you are no longer the responsible officer, it is important that this report is immediately passed on to the new responsible officer, or to the chief executive of the organisation. If there are any changes to notify, or you have any queries, please contact the revalidation team in your region using the details below:

Your region	London
Your regional revalidation lead	Ray Field
Your regional revalidation lead contact details	revalidation.london@nhs.net

Further information on revalidation can be found on the NHS Revalidation Support Team (RST) website: www.revalidationsupport.nhs.uk

Yours sincerely

MAShelly

Dr Martin Shelly
Director of Implementation
NHS Revalidation Support Team

YOUR ORGANISATIONAL READINESS REPORT

Analysis is based on the total of 621 returns to the 2012/13 Organisational Readiness Self Assessment (ORSA) exercise for the year ending 31 March 2013, which had been received by the RST by 7 June 2013.

Name of designated body	Imperial College Healthcare NHS Trust
Region	London
Sector	Hospital Secondary Care Non-Foundation Trust
Name of responsible officer	Dr David Mitchell

Your organisation's RAG rating	Green		
Distribution of RAG ratings for organisations in the same sector	Red	Amber	Green
	0.00%	3.61%	96.39%

See appendix 1 for details of RAG rating methodology

Responses to the 2012/13 Organisational Readiness Self-Assessment exercise:

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	**Your organisation's response**	**In England: mean or % answering 'Yes'**	
		Same sector: n= 60	**All sectors: n= 621**
1.4.8 Total number of doctors with a prescribed connection	799	367.53	259.99
1.4.1 Consultants	642	259.82	70.12
1.4.2 Staff grade, associate specialist, speciality doctor	38	59.53	17.59
1.4.3 General practitioner (primary care trusts only; doctors on a medical performers list)	0	0.00	68.17
1.4.4 Trainee: doctor on national postgraduate training scheme (for LETBs only)	0	0.13	77.65
1.4.5 Doctors with practising privileges (for independent healthcare providers only)	0	0.02	2.85
1.4.6 Temporary or short-term contract holders	119	44.77	18.11
1.4.7 Other	0	3.27	5.50
2.1 RO nominated / appointed	Yes	100%	99%
2.2 Second RO nominated / appointed where required	N/A	28%	21%
2.3 Appropriate RO training undertaken	Yes	100%	97%
2.4 Local / regional support is available to the RO	Yes	100%	98%
2.5 The RO has sufficient funding / resource for the role	Yes	95%	94%
2.6.4 Total number of doctors who have had a recommendation made to GMC	0	9.78	5.36
2.6.1 Positive recommendations	0	9.35	5.03
2.6.2 Deferral requests	0	0.42	0.32
2.6.3 Notifications of non-engagement	0	0.02	0.00
2.6.5 Number of doctors who had a recommendation to GMC due but that were not completed on time	0	0.05	0.03

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	**Your organisation's response**	**In England:** **mean or % answering 'Yes'**	
		Same sector: n= 60	**All sectors: n= 621**
3.1 A medical appraisal policy is in place	Yes	97%	96%
3.2.8 Total completed appraisals	504	253.03	138.77
3.2.1 Consultants	431	196.87	52.68
3.2.2 Staff grade, associate specialist, speciality doctor	24	38.98	11.24
3.2.3 General practitioner (for primary care trusts only; doctors on a medical performers list)	0	0.00	61.58
3.2.4 Trainee: doctor on national postgraduate training scheme (for LETBs only)		0.00	0.00
3.2.5 Doctors with practising privileges (for independent healthcare providers only)	0	0.00	2.83
3.2.6 Temporary or short-term contract holders	49	16.68	7.57
3.2.7 Other	0	0.50	2.87
3.3 Audit performed for missed or incomplete appraisals	Yes	70%	67%
3.4 The number of trained appraisers is sufficient	No	92%	94%
3.4.1 Number of appraisers	152	64.12	27.37
3.4.2 Number of appraisers who are trained	135	62.48	27.37
3.5 Appraisers are supported	Yes	97%	94%
3.6 Appraisers receive feedback on their performance	Yes	82%	81%

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	**Your organisation's response**	**In England:** **mean or % answering 'Yes'**	
		Same sector: n= 60	**All sectors: n= 621**
4.1 Governance structure or strategy in place	Yes	100%	98%
4.2 Governance systems subject to review	Yes	100%	93%
4.3 System to monitor fitness to practise	Yes	98%	96%
4.4 Doctors receive feedback from patients and colleagues	Yes	100%	96%
4.5 Clinical audit activity in line with national guidance	Yes	100%	75%
4.6 Key items of information included in the appraisal	Yes	98%	94%
4.7 Information available about new doctors	Yes	97%	96%
4.8 Information available from all doctors roles	Yes	92%	93%
4.9 Process for investigation of concerns	Yes	100%	96%
4.10 Policy for re-skilling, rehabilitation, remediation and targeted support	Yes	78%	81%
4.11 RO monitors compliance with GMC undertakings	Yes	98%	97%
4.12 Support for doctors to keep knowledge and skills up to date	Yes	90%	90%
4.13 Relevant policies are non-discriminatory	Yes	98%	97%

Appendix 1: Methodology for calculating RAG ratings for the ORSA 2012/13 exercise

This table summarises the methodology for calculating the RAG ratings of designated bodies for the ORSA exercise. The methodology has been approved by the England Revalidation Implementation Board.

Section 1: Details of the designated body		
Number of doctors (and different doctor types) with whom the designated body has a prescribed connection		Number
Section 2: Responsible officer		
2.1 A responsible officer has been nominated / appointed in compliance with the regulations		Yes/No
2.3 Appropriate responsible officer training is undertaken		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Section 3: Appraisal system		
3.1 A medical appraisal policy with core content is in place		Yes/No
3.4 The number of trained medical appraisers is sufficient for the needs of the designated body		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Section 4: Organisational governance		
4.3 There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection		Yes/No
4.9 A process is established for the investigation of capability, conduct, health and fitness to practise concerns		Yes/No
4.10 A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place		Yes/No
Sectional RAG rating	3 Yes = Green 2 Yes = Amber 0 or 1 Yes = Red	Green Amber Red
Overall RAG rating		
Overall RAG rating	6 or 7 Yes = Green 4 or 5 Yes = Amber 0, 1, 2 or 3 Yes = Red Any individual section Red = Red No RO nominated/appointed = Red	Green Amber Red

Clinical Research Network

MR MARK DAVIES
CEO'S OFFICE
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
THE BAYS BUILDING
SOUTH WHARF ROAD
LONDON
W2 1NY

Fairbairn House
71-75 Clarendon Road
Leeds LS2 9PH

Telephone: 0113 343 2314
Web: crncc@nihr.ac.uk

30 August 2013

Dear Mr Davies,

Application to host the Local Clinical Research Network

Following the Selection Panel meeting on 22 July 2013, I am writing to let you know the results of your application to host the Local Clinical Research Network for the Imperial College Health Partners area.

I am delighted to inform you that the Department of Health has now accepted the Selection Panel's recommendation that Imperial College Healthcare NHS Trust be appointed as the host organisation for the NIHR Clinical Research Network Imperial College Health Partners.

We would like to be the first to congratulate you on this achievement, and to welcome you to the select group of 15 NHS Trusts and Foundation Trusts that successfully met the criteria we set for prospective hosts, and who will become our partners in driving the clinical research agenda forward over the next five years.

I am sure that you are delighted with this news, and will be keen to share it with your immediate team and others, but I must ask that you maintain strict confidentiality at this point. **Your result must remain confidential until the official public announcement has been made.** This announcement is scheduled for Tuesday 3 September.

I should also like to invite you to nominate two people from your Selection Panel team to attend a meeting on 23 September in central London (a note asking you to hold the date for this meeting was sent to you a few weeks ago). This meeting will be attended by all the successful hosts, senior representatives from the NIHR Clinical Research Network, and the Department of Health. The purpose of the meeting is to have an open discussion about forming the LCRNs, and the early actions that will need to be taken.

In the meanwhile, the members of the Selection Panel were keen to share with you some general feedback on your submission. The Panel was impressed by the clarity of the submission in relation to engaging provider organisations across the geography, to ensure

their full participation in the clinical research delivery agenda. It also noted the strength of the application with regard to clinical leadership, which will be key to making the Network a success.

Over the next few days, we need to prepare for the public announcement, so I would like to request that you:

- Email the Transition Programme Project Team on Nihrcrn.transitionprogramme@nihr.ac.uk to acknowledge your receipt of this letter, your intention to accept the invitation to become a host organisation, and confirm the names of those who will represent your organisation at the meeting on 23 September. Once your acknowledgment has been received, we will send you the timing and venue for the meeting.

- Email the NIHR CRN's communications director (louise.s.wood@nihr.ac.uk) with the name of your lead communications contact, so that we may liaise with them on the preparation of the official announcements. These announcements are subject to the approval of the Department of Health, and so will be based on an agreed wording, with an opportunity for you to add your own quote.

May I take this opportunity to thank you for the great efforts your team has made during the selection process. We very much look forward to working closely with you, as we move the Network into its next successful stage of development, and strive to bring better treatments to patients through clinical research.

Yours sincerely

Dr Jonathan Sheffield OBE FRC Path
Chief Executive Officer
NIHR Clinical Research Network

CC Professor Jonathan Weber

Trust Board Performance Report
Report Period Month 9
(to end December 2013)

Trust Board Wednesday 29th January 2014

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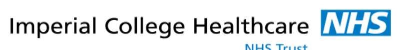
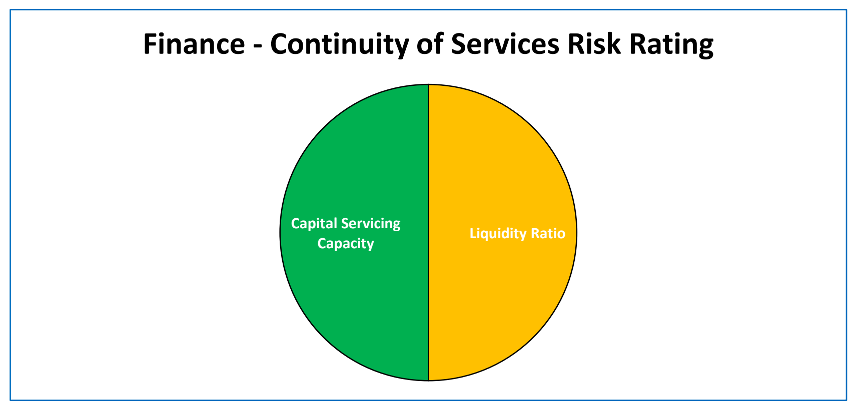
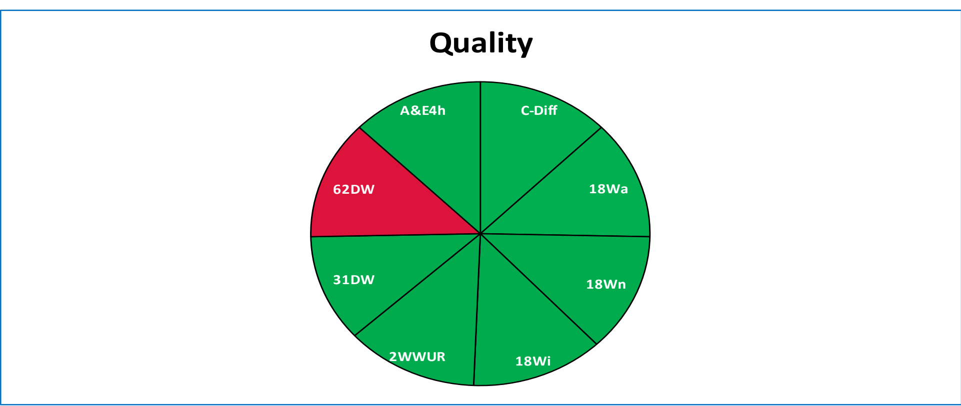


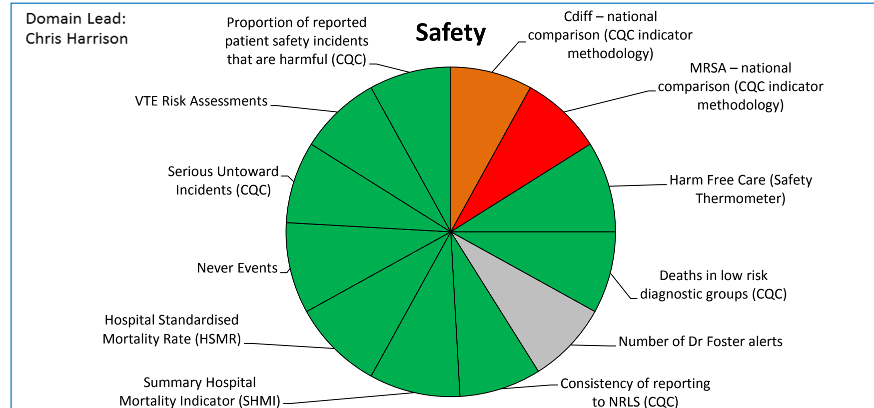
Shadow Foundation Trust Performance Framework

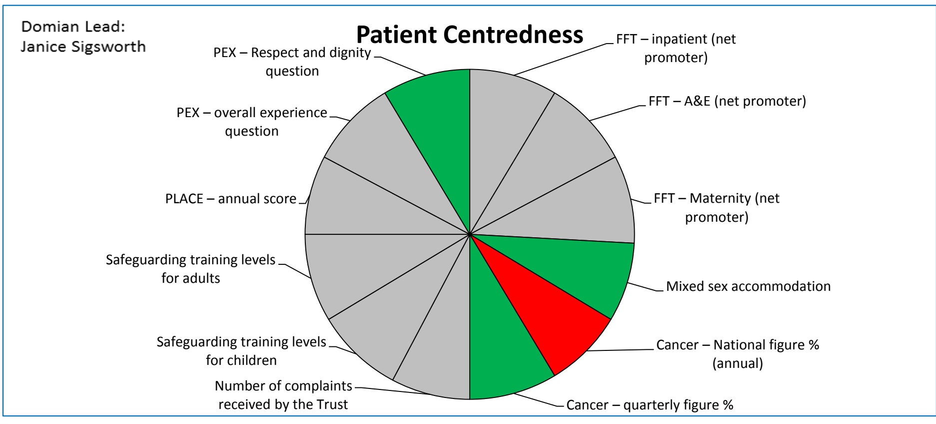


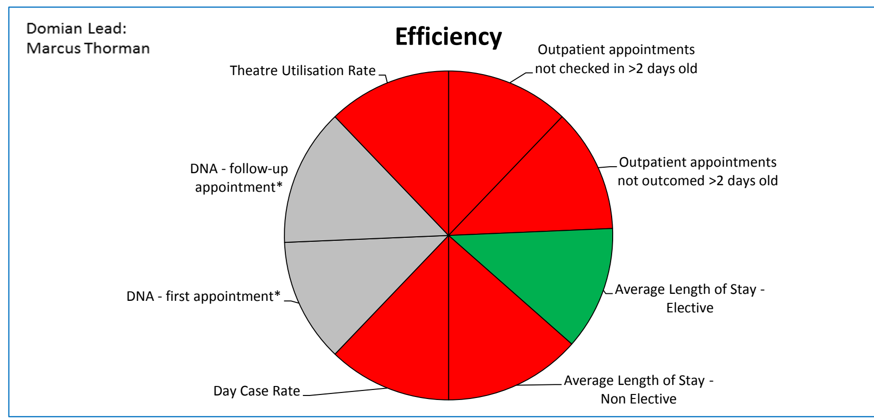


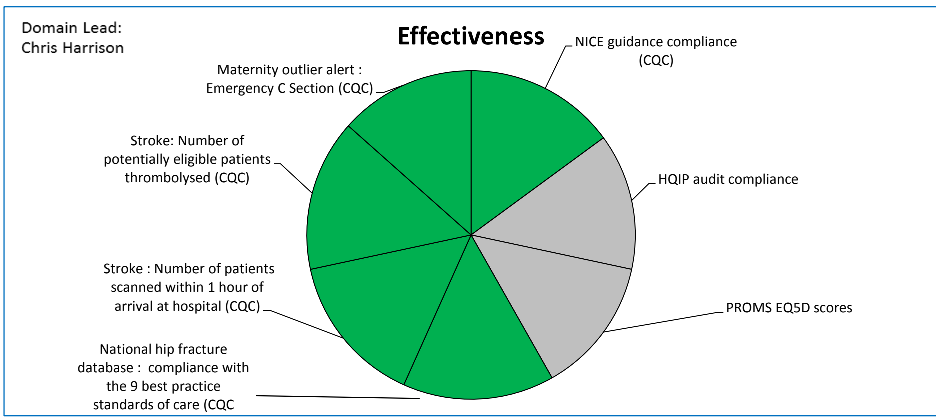
Monitor Risk Assessment Framework

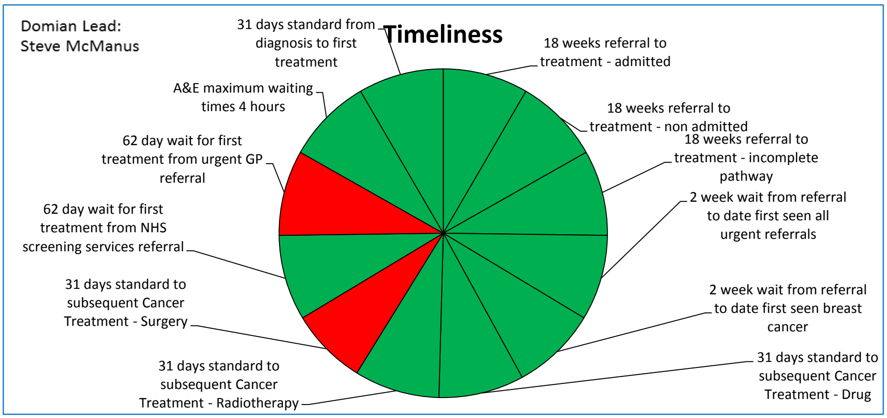
2013/14 Area	Indicator	Threshold	Performance to date 13/14 Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15
Finance	Capital Servicing Capacity		4	4	4		4		
	Liquidity Ratio		4	2	2		2		
	Continuity of Services Risk Rating		4	3	3		3		
Access	18 weeks referral to treatment - admitted	90%	92.50%	93.35%	93.18%	92.99%			
	18 weeks referral to treatment - non admitted	95%	96.85%	96.80%	95.88%	96.59%			
	18 weeks referral to treatment - incomplete pathway	92%	95.96%	95.96%	95.05%	95.73%			
	2 week wait from referral to date first seen all urgent referrals	93%	98.27%	98.37%	Qtr3 fig. not yet avail.	98.38%			
	2 week wait from referral to date first seen breast cancer	93%	97.60%	97.60%	Qtr3 fig. not yet avail.	97.50%			
	31 days standard from diagnosis to first treatment	96%	94.43%	96.89%	Qtr3 fig. not yet avail.	95.85%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%	99.47%	Qtr3 fig. not yet avail.	99.80%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.50%	98.73%	Qtr3 fig. not yet avail.	98.38%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.07%	95.47%	Qtr3 fig. not yet avail.	95.33%			
	62 day wait for first treatment from NHS Screening Services referral	90%	91.30%	95.60%	Qtr3 fig. not yet avail.	92.20%			
	62 day wait for first treatment from urgent GP referral	85%	74.27%	74.00%	Qtr3 fig. not yet avail.	75.39%			
	A&E maximum waiting times 4 hours	95%	96.24%	96.68%	95.97%	96.29%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	26	11	10	47			
	Governance Risk Rating		2	2	1	n/a	1	0	0

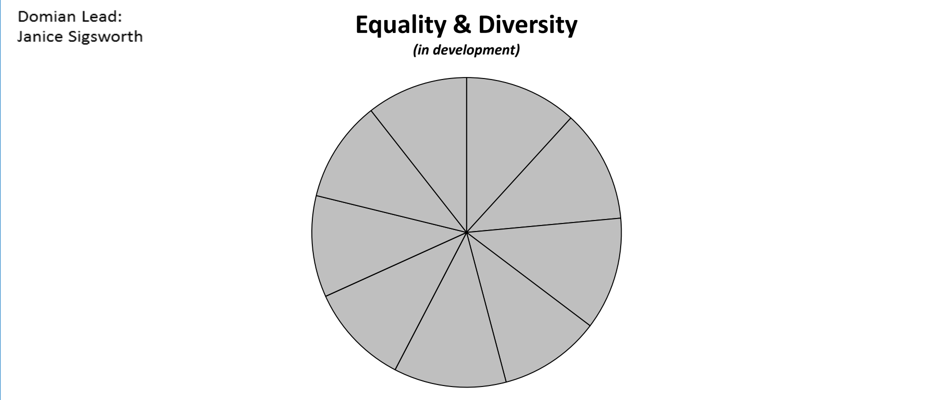

Domain Lead:
Chris Harrison
Safety
Proportion of reported patient safety incidents that are harmful (CQC)
Cdiff – national comparison (CQC indicator methodology)
MRSA – national comparison (CQC indicator methodology)
VTE Risk Assessments
Serious Untoward Incidents (CQC)
Harm Free Care (Safety Thermometer)
Never Events
Deaths in low risk diagnostic groups (CQC)
Hospital Standardised Mortality Rate (HSMR)
Number of Dr Foster alerts
Summary Hospital Mortality Indicator (SHMI)
Consistency of reporting to NRLS (CQC)


Domian Lead:
Janice Sigsworth
Patient Centredness
PEX – Respect and dignity question
FFT – inpatient (net promoter)
PEX – overall experience question
FFT – A&E (net promoter)
PLACE – annual score
FFT – Maternity (net promoter)
Safeguarding training levels for adults
Mixed sex accommodation
Safeguarding training levels for children
Cancer – National figure % (annual)
Number of complaints received by the Trust
Cancer – quarterly figure %


Domain Lead:
Marcus Thorman
Efficiency
Theatre Utilisation Rate
Outpatient appointments not checked in >2 days old
DNA - follow-up appointment*
Outpatient appointments not outcomed >2 days old
DNA - first appointment*
Average Length of Stay - Elective
Day Case Rate
Average Length of Stay - Non Elective


Domain Lead:
Chris Harrison
Effectiveness
Maternity outlier alert : Emergency C Section (CQC)
NICE guidance compliance (CQC)
Stroke: Number of potentially eligible patients thrombolysed (CQC)
HQIP audit compliance
Stroke : Number of patients scanned within 1 hour of arrival at hospital (CQC)
PROMS EQ5D scores
National hip fracture database : compliance with the 9 best practice standards of care (CQC


Domian Lead:
Steve McManus
Timeliness
31 days standard from diagnosis to first treatment
18 weeks referral to treatment - admitted
A&E maximum waiting times 4 hours
18 weeks referral to treatment - non admitted
62 day wait for first treatment from urgent GP referral
18 weeks referral to treatment - incomplete pathway
62 day wait for first treatment from NHS screening services referral
2 week wait from referral to date first seen all urgent referrals
31 days standard to subsequent Cancer Treatment - Surgery
2 week wait from referral to date first seen breast cancer
31 days standard to subsequent Cancer Treatment - Radiotherapy
31 days standard to subsequent Cancer Treatment - Drug

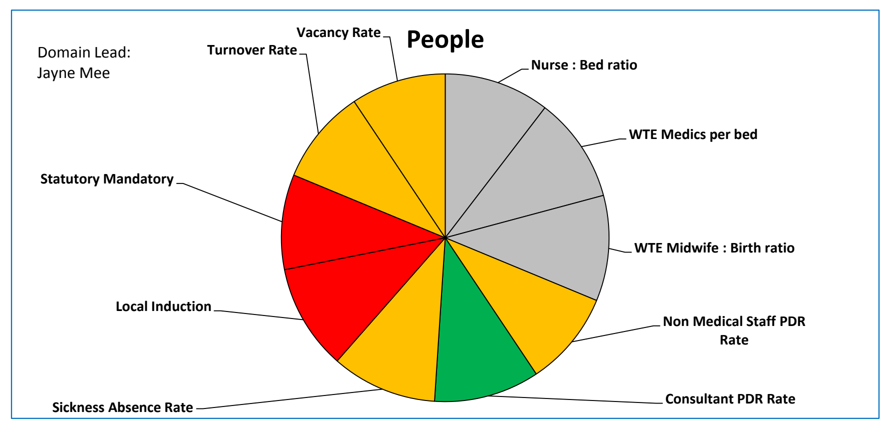

Domain Lead:
Janice Sigsworth
Equality & Diversity
(in development)

Financial Risk Rating

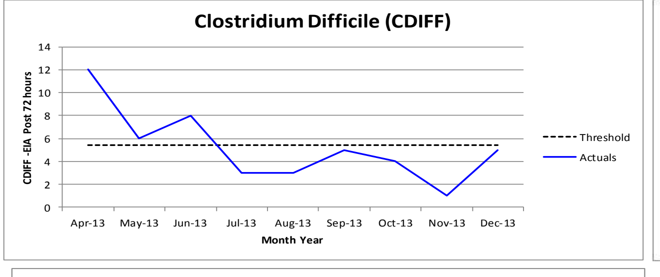
Metric	Weighting %	Metric Description	Actuals Q1	Actuals Q2	Actuals Q3	Forecast Q4
Achievement of Plan	10%	EBITDA achieved (% of Plan)	5	5	5	5
Underlying Performance	25%	EBITDA margin %	3	3	3	3
Financial Efficiency	40%	Net return after financing (%) I&E surplus margin net of dividends (%)	2	3	3	3
Liquidity	25%	Liquidity ratio (days)	4	3	3	3
Overall Financial Risk Rating			3	3	3	3

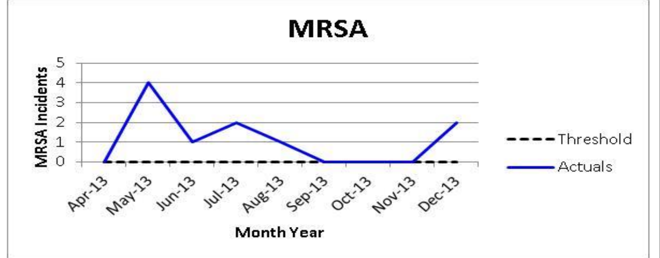
Continuity of Services Risk Rating

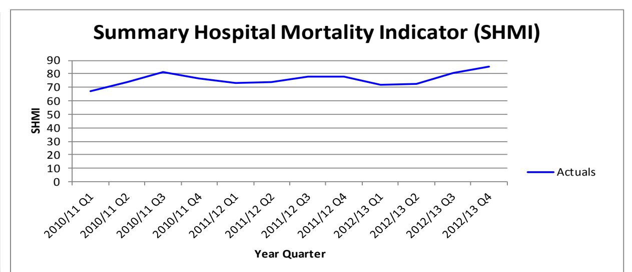
Metric	Weighting %	Metric Description	Actuals Q1	Actuals Q2	Actuals Q3	Forecast Q4
Liquidity Ratio	50%	Liquidity Ratio (days)	4	2	2	2
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	4	4	4	4
Continuity of Services Risk Rating			**4**	**3**	**3**	**3**

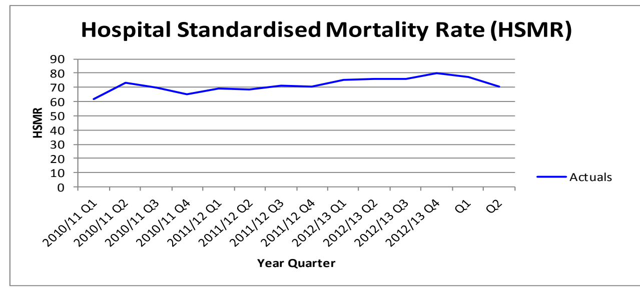


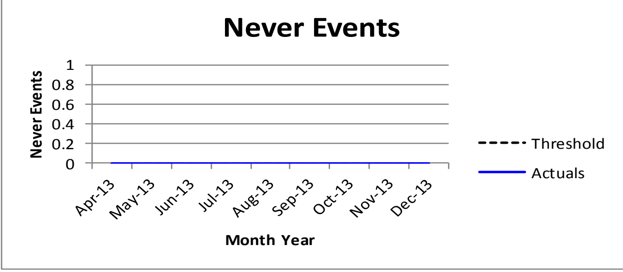
Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Infection Control														
Clostridium Difficile (C-Diff) Post 72 Hours	C-Diff	-	5 per mth	7	23	5	26	11	10	47				Mon, TDA, CQC
MRSA	MRSA	-	0	0	2	2	5	3	2	10				Mon, TDA, CQC
Mortality Indicators														
Summary Hospital Mortality Indicator (SHMI)	SHMI	-			80.4	n/a	0.0	0.0	0.0	0.0				CQC
Hospital Standardised Mortality Rate (HSMR)	HSMR	-			75.8	n/a	77.3	70.6	0.0	74.0				CQC
Incidents														
Never Events	Nev	-	0	0	1	0	0	0	0	0				TDA, CQC
Serious Untoward Incidents	SUI	-	*TBC*	4	14	9	33	40	26	99				TDA, CQC

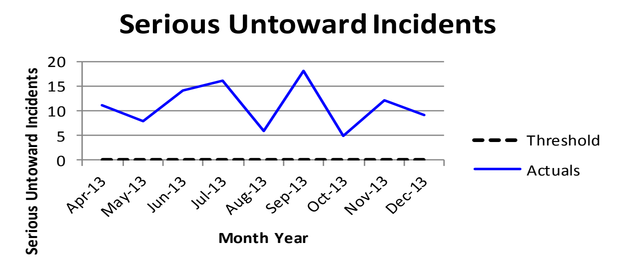






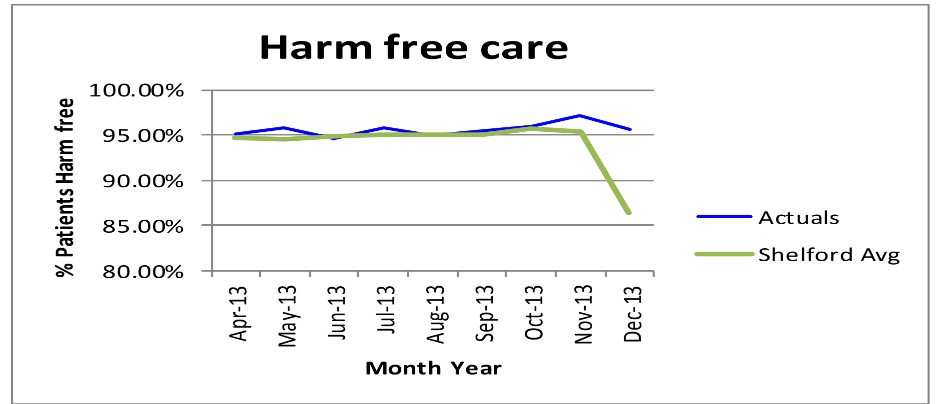


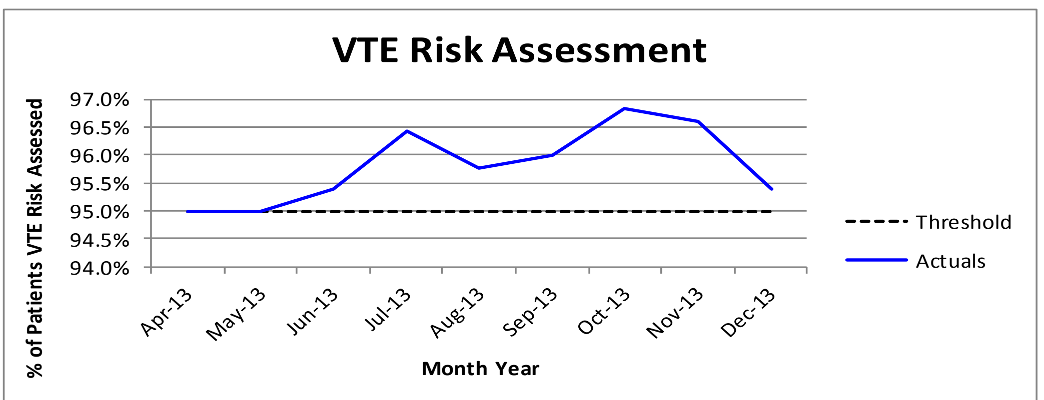




Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Performance in 2012/13 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Safety Thermometer														
Harm Free Care (Safety Thermometer)	HF	-	90%	96.00%	96.00%	95.69%	95.17%	95.40%	96.26%	95.61%				TDA, CQC
CQUIN - VTE														
CQUIN - VTE Risk Assessments	VTE	✓	95%	90%	91%	95%	95%	96%	96%	96%				CQC

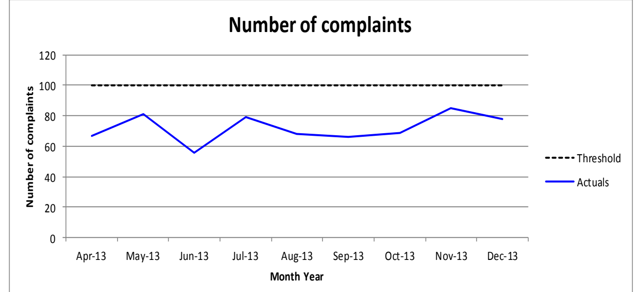
Indicators to developed
Deaths in low risk diagnostic groups
Proportion of reported harmful incidents
Consistency of reporting to NRLS
Number of Dr Foster Alerts

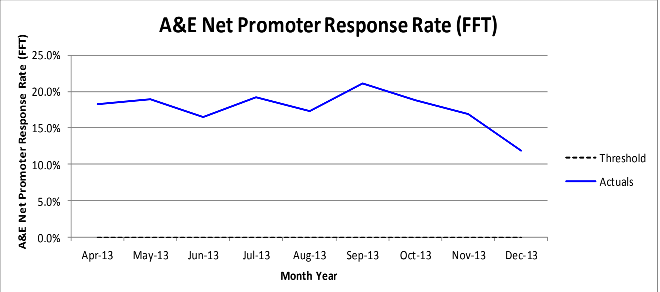


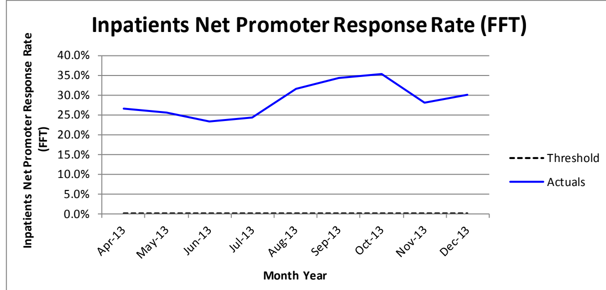


Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Complaints & Compliments														
Number of complaints received	ComRE	-	*TBC*	50	170	78	204	213	232	649				CQC
Friends & Family Test														
Inpatients Net Promoter Score (FFT)	InNet	✓	*TBC*	Not avail.	Not avail.	72	70	69	69	70				Contractual
A&E Net Promoter Score (FFT)	A&ENet	✓	*TBC*	Not avail.	Not avail.	58	49	50	56	54				Contractual
Accomodation														
Mixed Sex Accommodation	EMSA	-	0	0	0	0	0	0	0	0				TDA

Indicators to developed
Patient Exp. - Respect & Dignity
Patient Exp. - Overall experience
Patient Exp. - Cancer
Place - Annual Score
Safeguarding training levels for adults
Safeguarding training levels for children
Maternity Net Promoter Score (FFT)

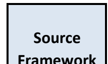






Quality Principles - Effectiveness 3.1

Indicator	Abrv.	Leading	Threshold	Performance in 2012/13		Performance Current Year To Date					Forecast			Source Framework
				Dec	Qtr3	Current Month	Q1	Q2	Q3	YTD	Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	



Indicators to developed
Nice Guidance Compliance
HQIP Audit Compliance
PROMS ESQD Scores
National Hip Fracture Database : Compliance With 9 Best Practice Standards
Stroke Care : Number of patients scanned within 1 hr of arrival at hospital
Stroke Care : Number of potentially eligible patients thrombolysed
Maternity outlier alert : Emergency C section

Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Performance in 2012/13 Qtr3	Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Productivity														
Theatre Utilisation Rate	ThUR	✓	81.00%	78.84%	80.09%	76.17%	78.80%	77.40%	76.64%	77.61%				CQC
Average Length of Stay - Elective	LOSe	✓	3.40	3.45	3.39	3.82	3.23	3.41	3.39	3.34				CQC
Average Length of Stay - Non Elective	LOSne	✓	4.49	4.41	4.29	4.45	4.78	4.27	4.34	4.46				CQC
Day Case Rate	DCR	✓	80.00%	77.90%	77.91%	77.57%	79.90%	79.63%	78.36%	79.31%				CQC
DNA - first appointment*	DNA1	✓	TBC	15.34%	14.50%	14.51%	13.82%	14.56%	14.32%	14.23%				Internal
DNA - follow-up appointment*	DNA2	✓	TBC	12.90%	12.69%	13.15%	12.80%	13.22%	13.27%	13.10%				Internal
Data Quality														
Outpatient appointments not checked in >2 days old	DQ6	✓	1%	5.02%	Not avail.	4.16%	3.67%	4.53%	3.93%	4.05%				Internal
Outpatient appointments not outcomed >2 days old	DQ7	✓	1%	5.02%	Not avail.	4.14%	5.75%	4.30%	3.86%	4.63%				Internal

Indicators to developed
*BADS Day Case Rate - Paediatric**
*Hospital Appointment Cancellations (hospital instigated)**

Theatre Utilisation Rate

Average Length of Stay - Elective

Average Length of Stay - Non Elective

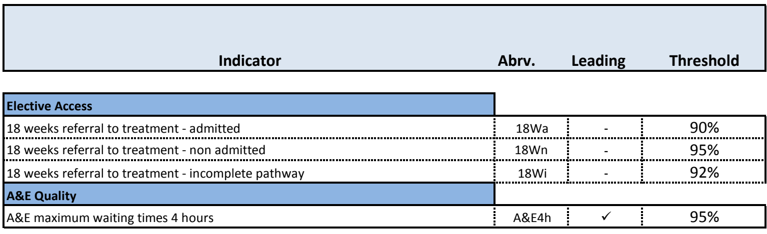
Day Case Rate

DNA - First Appointment

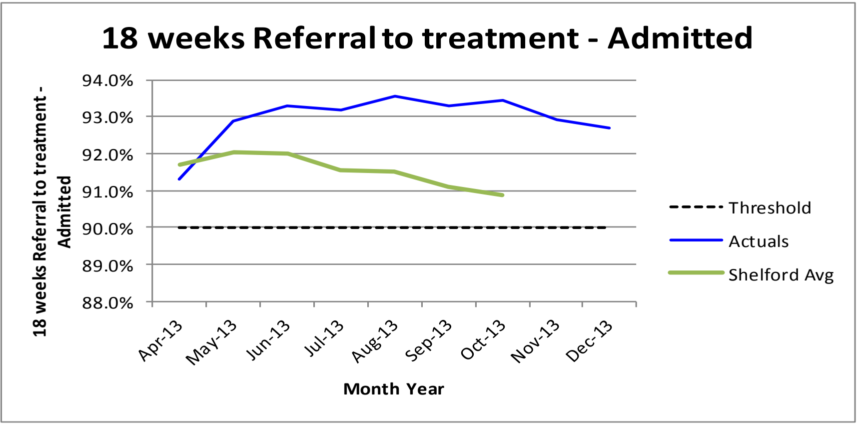
DNA - Follow-up Appointment

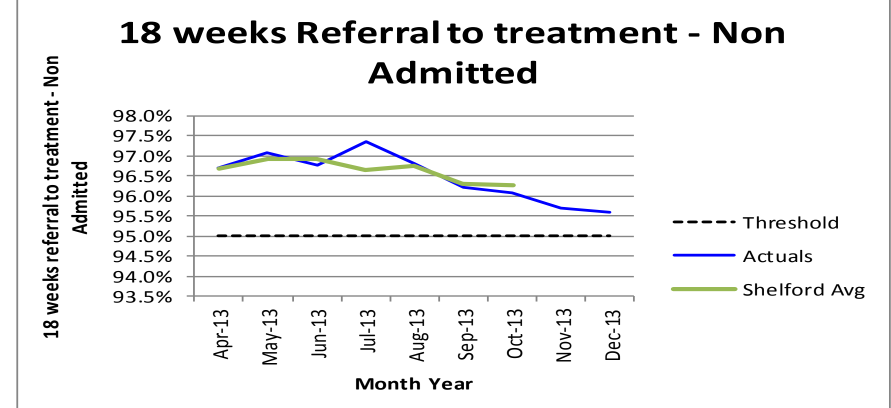
Outpatient appointments not outcomed >2 days old

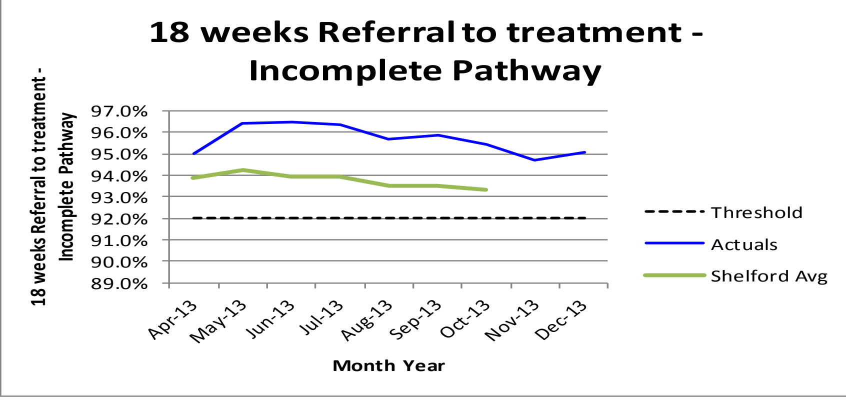
Outpatient appointments not checked in >2 days old



Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Performance in 2012/13 Qtr3	Current Month	Performance Current Year To Date Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Elective Access														
18 weeks referral to treatment - admitted	18Wa	-	90%	90.5%	89.1%	92.7%	92.5%	93.3%	93.2%	93.0%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	18Wn	-	95%	96.8%	96.6%	95.6%	96.8%	96.8%	95.8%	96.5%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	18Wi	-	92%	92.2%	92.7%	95.1%	96.0%	96.0%	95.1%	95.7%				Mon, TDA, CQC
A&E Quality														
A&E maximum waiting times 4 hours	A&E4h	✓	95%	96.8%	96.9%	95.6%	96.2%	96.7%	96.0%	96.3%				Mon, TDA, CQC







Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Performance in 2012/13 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Cancer Access Waiting Times														
2 week wait from referral to date first seen all urgent referrals	2WW	✓	93%	93.2%	93.5%	98.7%	98.3%	98.4%	98.6%	98.4%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	2WW	✓	93%	94.0%	92.6%	96.9%	97.6%	97.6%	97.1%	97.5%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	31DW	-	96%	97.5%	95.1%	96.0%	94.4%	96.9%	96.4%	95.9%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	31DT	-	98%	100.0%	99.4%	100.0%	100.0%	99.5%	100.0%	99.8%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	31DT	-	94%	100.0%	99.0%	99.1%	97.5%	98.7%	99.2%	98.4%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	31DT	-	94%	100.0%	97.8%	92.7%	96.1%	95.5%	94.0%	95.3%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	62DW	-	90%	82.6%	86.7%	90.2%	91.3%	95.6%	88.4%	92.2%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	62DW	-	85%	79.6%	78.7%	78.8%	74.3%	74.0%	79.2%	75.4%				Mon, TDA, CQC

2 week Wait from Referral to date first seen all urgent referrals

2 week wait from referral to date first seen breast Cancer

31 days standard to subsequent Cancer Treatment - Drug

31 days standard to subsequent Cancer Treatment - Radiotherapy

31 days standard to subsequent Cancer Treatment - Surgery

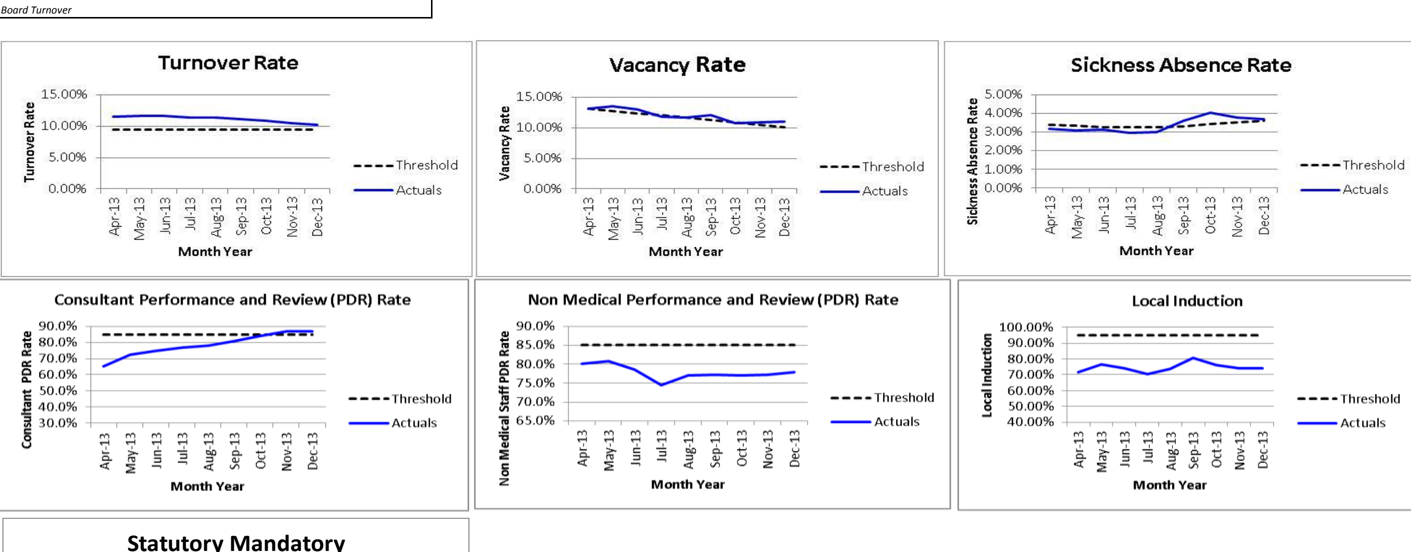
62 day wait for first treatment from NHS screening services referral

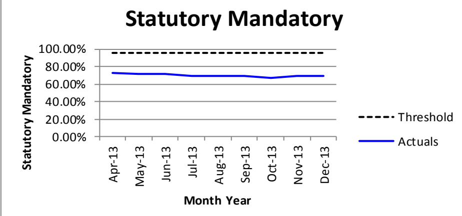
62 day wait for first treatment from urgent GP referral

31 days standard from diagnosis to first treatment

Indicator	Abrv.	Leading	Threshold	Performance in 2012/13 Dec	Performance in 2012/13 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/1	Forecast Qtr 2 14/15	Source Framework
Turnover & Vacancy Rate														
Turnover Rate	TR	✓	<9.50%*	9.55%	9.23%	10.25%	11.61%	11.27%	10.53%	11.13%				TDA
Vacancy Rate	VR	✓	<10.13%*	9.75%	9.49%	11.04%	13.19%	11.78%	10.88%	11.95%				CQC
Sickness Absence Rate	SA	✓	<3.60%	3.59%	3.77%	3.68%	3.13%	3.19%	3.83%	3.38%				CQC
Appraisal Rates														
Consultant Peformance and Development Review (PDR) Rate	CA	✓	>85.00%	65.66%	65.88%	87.00%	70.84%	78.67%	86.00%	78.50%				Define
Non Medical Staff Performance and Development Review (PDR) Rate	NMA	✓	>85.00%	63.40%	64.40%	77.92%	79.78%	76.26%	77.35%	77.80%				Define
Training Compliance														
Local Induction	LI	✓	>95.00%	68.66%	68.36%	73.92%	74.04%	74.91%	74.79%	74.58%				Define
Statutory Mandatory	SM	✓	>95.00%	77.10%	76.95%	69.15%	71.82%	69.45%	68.50%	69.92%				Define

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





POTENTIAL RISKS AND MITIGATING ACTIONS

<table>
<tr><th>Potential Risk</th><th>Threshold</th><th>Current Position</th><th>Main Controls</th><th>Mitigating Action</th><th>Target Date</th><th>Accountable Officer for Action</th></tr>
<tr><td rowspan="3">MRSA - 9 reported cases (year to date), failing the zero tolerance target, which could compromise patient safety and governance ratings</td><td rowspan="3">0</td><td rowspan="3">10</td><td rowspan="3">Infection Prevention & Control Policy
Infection Prevention Training
Clinical Rounds
Incident Reporting Monitoring</td><td>Review of procedures and practice.
Re-enforce patient safety practice and infection prevention and control on wards and clinical areas.
Checking intravenous and devices daily and their removal as soon as no longer needed.
Additional weekly MRSA screening on ward for high risk patients.
Consider universal decolonisation outside intensive care.

External experts to examine and report on safety systems for patients requiring intravenous lines and hand hygiene.</td><td>Q4</td><td>AH</td></tr>
<tr><td colspan="3">Anticipated Effect On Control</td></tr>
<tr><td colspan="3">These actions will help to avoid further cases and increase risk score, without these on-going interventions it could increase the likelihood breaching the Monitor 6 cases level.</td></tr>
<tr><td rowspan="3">62 Day Urgent GP Referral - 22 patients had treatment delayed, which included 6 inter hospital referrals referred outside day 42</td><td rowspan="3">85%</td><td rowspan="3">78.8%</td><td rowspan="3">Elective Access Policy
Cancer Standard Operating Procedures
Cancer PTL meetings
Elective Access Waiting List meeting
Cancer MDT meetings</td><td>Twice weekly meetings with Chief Operating Officer and Cancer Management Team to track patients on active pathway to ensure they are treated within target time.
Redesign of cancer pathways per tumour site which is focussing on speeding up the diagnostic part of the pathway.</td><td>Qtr4</td><td>SMcM</td></tr>
<tr><td colspan="3">Anticipated Effect On Control</td></tr>
<tr><td colspan="3">These actions will help ensure patients are treated within target time and help minimise breaches.</td></tr>
</table>

Contents

Finance Performance Report for the month ending 31st December 2013

Page	Description	Risk		Report Status
		Month 9	Month 8	
1	Statement of Comprehensive Income (SOCI)	G	G	Attached
2	Income Report	G	G	Attached
3	Expenditure Report	R	R	Attached
4	Financial Risk Rating for Divisions & Corporate Services	A	A	Attached
5	Cost Improvement Plan	A	A	Attached
6	Statement of Financial Position (Balance Sheet)	G	G	Attached
7	Capital Expenditure Report	R	R	Attached
8	Cash Flow Report	A	A	Attached
9	Financial Risk Rating for Trust	G	G	Attached
10	SLA Activity & Income Performance	G	G	Attached

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	61,341	63,720	2,379	561,825	582,810	20,985	745,934	775,660	29,726
Research & Development & Education	9,562	11,873	2,311	86,058	85,861	(197)	114,743	115,181	438
Other	6,650	6,192	(458)	59,851	58,829	(1,022)	79,799	77,696	(2,103)
TOTAL INCOME	**77,553**	**81,785**	**4,232**	**707,734**	**727,499**	**19,765**	**940,476**	**968,538**	**28,062**
Expenditure									
Pay - In post	(38,753)	(39,407)	(654)	(347,317)	(353,195)	(5,878)	(462,891)	(470,156)	(7,266)
Pay - Bank	(1,724)	(1,806)	(82)	(15,639)	(16,436)	(797)	(20,798)	(22,685)	(1,887)
Pay - Agency	(1,881)	(2,353)	(472)	(17,189)	(20,187)	(2,997)	(23,743)	(26,828)	(3,085)
Drugs & Clinical Supplies	(17,853)	(20,717)	(2,864)	(161,304)	(173,553)	(12,249)	(214,761)	(230,421)	(15,660)
General Supplies	(2,962)	(3,370)	(408)	(26,658)	(28,570)	(1,912)	(35,551)	(38,162)	(2,611)
Other	(9,397)	(10,198)	(801)	(84,666)	(80,603)	4,063	(112,879)	(110,625)	2,254
TOTAL EXPENDITURE	**(72,570)**	**(77,850)**	**(5,280)**	**(652,774)**	**(672,543)**	**(19,769)**	**(870,622)**	**(898,878)**	**(28,256)**
EBITDA	**4,983**	**3,935**	**(1,048)**	**54,960**	**54,956**	**(4)**	**69,854**	**69,660**	**(194)**
Financing Costs	(4,611)	(120,715)	(116,104)	(41,516)	(158,994)	(117,478)	(55,371)	(172,341)	(116,970)
SURPLUS / (DEFICIT) including Impairment	**372**	**(116,780)**	**(117,152)**	**13,444**	**(104,037)**	**(117,481)**	**14,483**	**(102,681)**	**(117,164)**
Impairment of Assets & Donated Asset treatment	48	117,264	117,216	391	117,762	117,371	592	117,756	117,164
SURPLUS / (DEFICIT)	**420**	**484**	**64**	**13,835**	**13,725**	**(110)**	**15,075**	**15,075**	**(0)**

Surplus / (Deficit): The Trust delivered a surplus of £484k in month, which is a favourable variance of £64k. The actual achievement of CIP YTD is £33,480k and this is behind plan by £3,046k. The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' (NCD) anticipated income and expenditure for the year. The forecast financing costs includes an impairment of assets of £117m for the devaluation of buildings.

Income: Clinical income is ahead of plan and is mainly associated with continuing over-performance on the CCGs & NHS England SLAs. R&D is ahead of plan in month but is matched with expenditure to ensure a net zero impact.

Expenditure: Pay overall is broadly consistent with the previous period. **Non Pay** this month clinical supplies includes additional spend on R&D projects which is matched by income.

Financing costs includes the impact of the recent valuation of buildings which has resulted in an impairment of £117m and the consequential saving on the PDC payment.

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

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	32,569	33,897	1,328	298,319	309,484	11,165	396,073	412,566	16,493
NHS England	23,276	23,682	406	213,185	220,685	7,500	283,046	293,247	10,201
Other NHS Organisations	1,436	2,058	622	13,157	14,189	1,032	17,469	18,375	906
Sub-Total NHS Income	**57,281**	**59,638**	**2,357**	**524,661**	**544,359**	**19,698**	**696,588**	**724,188**	**27,600**
Local Authority	784	750	(34)	7,178	7,889	711	9,529	10,485	956
Private Patients	2,699	2,626	(73)	24,701	25,346	645	32,801	34,134	1,333
Overseas Patients	149	227	78	1,370	1,619	249	1,820	2,142	322
NHS Injury Scheme	113	175	62	1,034	1,176	142	1,373	1,516	143
Non NHS Other	315	304	(11)	2,881	2,421	(460)	3,823	3,195	(628)
Total - Income from Clinical Activities	**61,341**	**63,720**	**2,379**	**561,825**	**582,810**	**20,985**	**745,934**	**775,660**	**29,726**
Other Operating Income									
Education, Research & Development	9,562	11,873	2,311	86,058	85,861	(197)	114,743	115,181	438
Non patient care activities	2,943	2,586	(357)	26,482	27,033	551	35,306	35,887	581
Income Generation	505	474	(31)	4,553	3,327	(1,226)	6,070	4,225	(1,845)
Other Income	3,202	3,133	(69)	28,816	28,468	(348)	38,423	37,583	(840)
Total - Other Operating Income	**16,212**	**18,065**	**1,853**	**145,909**	**144,689**	**(1,220)**	**194,542**	**192,877**	**(1,665)**
TOTAL INCOME	**77,553**	**81,785**	**4,232**	**707,734**	**727,499**	**19,765**	**940,476**	**968,538**	**28,062**

Income from Clinical Activities: The favourable in month variance is associated with the continuing over-performance of CCGs & NHS England SLA contracts. It is expected that the CCGs QIPP programmes will not deliver the anticipated reductions in admitted care and outpatient activity.
Education, Research & Development income for the month is greater than planned and is matched by expenditure to ensure a net zero impact on the bottom-line.

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

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	(12,417)	(12,895)	(479)	(110,143)	(114,397)	(4,254)	(150,440)	(153,107)	(2,667)
Nursing & Midwifery	(11,933)	(12,285)	(352)	(106,834)	(109,970)	(3,135)	(144,068)	(147,714)	(3,646)
Scientific, Therapeutic & Technical staff	(5,541)	(5,542)	(1)	(49,732)	(50,479)	(747)	(66,586)	(67,233)	(647)
Healthcare assistants and other support staff	(2,054)	(2,284)	(230)	(18,577)	(20,351)	(1,774)	(24,633)	(27,142)	(2,509)
Directors and Senior Managers	(2,379)	(2,549)	(170)	(22,111)	(22,319)	(208)	(28,761)	(29,310)	(549)
Administration and Estates	(4,430)	(3,852)	578	(39,920)	(35,679)	4,240	(48,403)	(45,651)	2,752
Sub-total - Pay In post	**(38,753)**	**(39,407)**	**(654)**	**(347,317)**	**(353,195)**	**(5,878)**	**(462,891)**	**(470,156)**	**(7,266)**
Pay - Bank/Agency									
Medical Staff	(614)	(1,044)	(430)	(5,675)	(7,140)	(1,466)	(8,002)	(9,514)	(1,512)
Nursing & Midwifery	(1,251)	(1,474)	(223)	(11,234)	(12,401)	(1,167)	(14,693)	(17,531)	(2,838)
Scientific, Therapeutic & Technical staff	(366)	(253)	113	(3,432)	(4,019)	(587)	(4,565)	(5,537)	(972)
Healthcare assistants and other support staff	(280)	(315)	(35)	(2,524)	(3,192)	(668)	(3,992)	(4,324)	(332)
Directors and Senior Managers	(326)	(408)	(81)	(2,938)	(1,581)	1,357	(4,010)	(1,780)	2,229
Administration and Estates	(767)	(665)	102	(7,025)	(8,290)	(1,265)	(9,278)	(10,827)	(1,548)
Sub-total - Pay Bank/Agency	**(3,605)**	**(4,159)**	**(554)**	**(32,829)**	**(36,623)**	**(3,794)**	**(44,540)**	**(49,513)**	**(4,973)**
Non Pay									
Drugs	(8,014)	(8,474)	(460)	(73,017)	(79,966)	(6,949)	(99,268)	(105,017)	(5,749)
Supplies and Services - Clinical	(9,839)	(12,243)	(2,404)	(88,287)	(93,586)	(5,300)	(115,493)	(125,404)	(9,911)
Supplies and Services - General	(2,962)	(3,370)	(408)	(26,658)	(28,570)	(1,912)	(35,551)	(38,162)	(2,611)
Consultancy Services	(1,289)	(1,804)	(515)	(11,601)	(11,711)	(110)	(15,464)	(14,805)	659
Establishment	(617)	(757)	(140)	(5,577)	(5,867)	(290)	(7,435)	(7,662)	(227)
Transport	(824)	(953)	(129)	(7,416)	(8,340)	(924)	(9,892)	(11,273)	(1,381)
Premises	(3,352)	(3,668)	(316)	(30,160)	(28,842)	1,318	(40,219)	(38,599)	1,620
Other Non Pay	(3,315)	(3,017)	298	(29,912)	(25,843)	4,069	(39,869)	(38,286)	1,583
Sub-total - Non Pay	**(30,212)**	**(34,284)**	**(4,072)**	**(272,628)**	**(282,725)**	**(10,097)**	**(363,191)**	**(379,208)**	**(16,017)**
TOTAL EXPENDITURE	**(72,570)**	**(77,850)**	**(5,280)**	**(652,774)**	**(672,543)**	**(19,769)**	**(870,622)**	**(898,878)**	**(28,256)**
Financing Costs									
Interest Receivable	24	15	(9)	215	141	(74)	287	188	(99)
Receipt of Grants for Capital Acquisitions	68	0	(68)	605	448	(157)	798	784	(14)
Interest Payable	(71)	(72)	(1)	(645)	(653)	(8)	(859)	(859)	(0)
Other Gains & Losses	0	0	0	0	(18)	(18)	0	(18)	(18)
Impairment on Assets	0	(117,142)	(117,142)	0	(117,142)	(117,142)	0	(117,142)	(117,142)
Depreciation	(2,916)	(3,069)	(153)	(26,245)	(27,593)	(1,348)	(35,001)	(36,392)	(1,391)
Public Dividend Capital	(1,716)	(446)	1,270	(15,446)	(14,177)	1,269	(20,596)	(18,902)	1,694
TOTAL - FINANCING COSTS	**(4,611)**	**(120,715)**	**(116,104)**	**(41,516)**	**(158,994)**	**(117,478)**	**(55,371)**	**(172,341)**	**(116,970)**

Pay total spend in month is broadly consistent with the previous period.

Non Pay this month clinical supplies includes additional spend on R+D projects which is matched by income.

Financing costs includes an impairment on assets of £117m as a result of the impact of the revaluation of buildings and the resultant saving on the Public Dividend Capital payment.

Statement of Comprehensive Income (SOCI)	Risk:	R

PAGE 4 - Financial Risk Rating for Clinical & Non Clinical Divisions

Medicine

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟢	🟡			
Cost Control	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Forecasting Accuracy	🔴	🔴	🔴	🔴	🔴	🟡	🟡	🟡	🟡			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

S&C

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟢	🟡			
Cost Control	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Forecasting Accuracy	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

DISCS

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🟡	🟡			
Cost Control	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Forecasting Accuracy	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

W&C

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟢	🟡			
Cost Control	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Forecasting Accuracy	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🔴			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

Corporate

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *												
Cost Control	🔴	🔴	🔴	🔴	🔴	🟡	🔴	🔴	🟡			
Forecasting Accuracy	🟡	🟡	🟡	🟡	🟡	🔴	🔴	🔴	🟡			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

TRUST

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟢	🟡			
Cost Control	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Forecasting Accuracy	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Financial Governance	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			
Working Capital & Equipment	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡			

KPI PERFORMANCE COUNT

	🔴	🟡	🟢
Medicine	28%	56%	16%
S&C	20%	52%	28%
DISCS	24%	60%	16%
W&C	28%	60%	12%
Corporate	38%	52%	10%

* Financial sustainability always uses the income figures from the previous month, due to the reporting lag around income of 1 month.

To give a more transparent view of FRR performance, the table to the left summarises the proportion of KPIs scored Red, Amber or Green for each Division and Corporate.

Improvements in timing of income reporting and the rollout of a income reporting tool to Divisions will improve transparency and engagement in maximising income receivable.

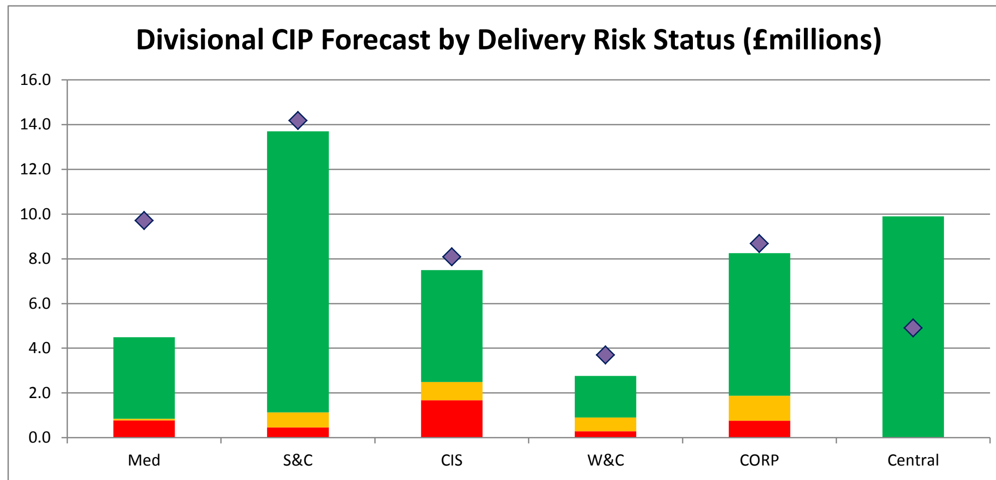
Plans to report the FRR, through a Qlikview application, at Directorate level is due to be rolled out in January 2014.

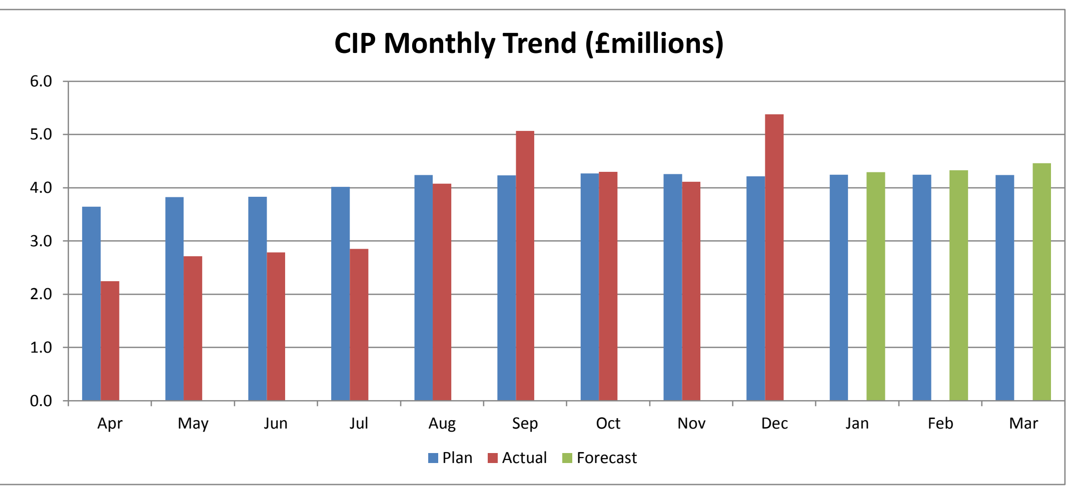
Statement of Comprehensive Income (SOCI) — **Risk: A**

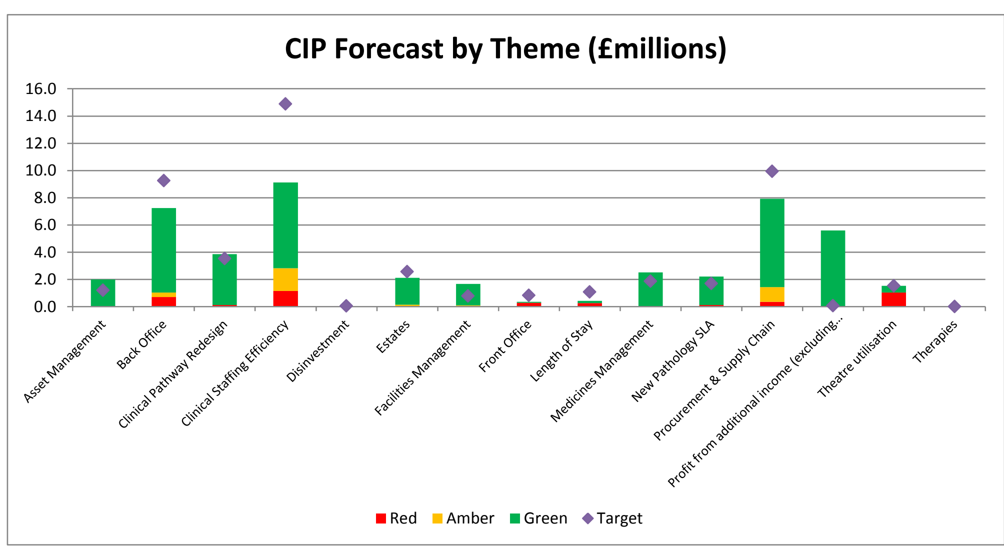
Appendix - Financial Risk Rating Detail

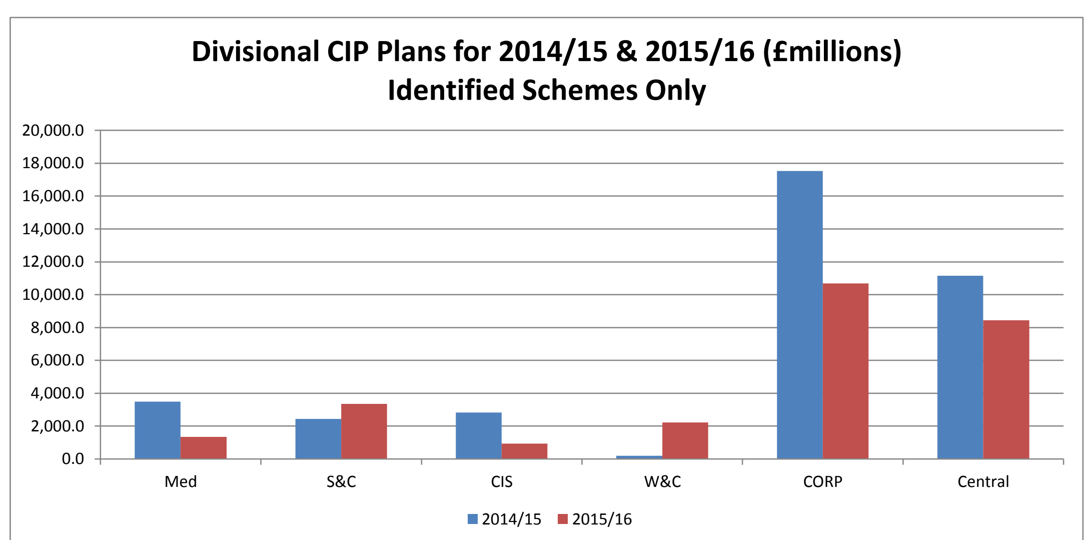
		Medicine	S&C	DISCS	W&C	Corporate
Financial Sustainability	Change in EBITDA Margin %	🔴	🔴	🔴	🔴	
	NHS Income Loss %	🟡	🟡	🟢	🟡	
	Income per Consultant Clinical PA (£)	🟡	🟡	🟡	🟡	
	NHS Clinical Income Trends	🟢	🟢	🟢	🔴	
		🟡	🟡	🟡	🟡	
Cost Control	YoY Change in Expenditure %	🔴	🟢	🟢	🔴	🔴
	Premium Pay %	🔴	🟡	🔴	🟡	🔴
	% of Total Hours related to Annual Leave, Sickness, Study & Other Leave	🟢	🟢	🟡	🟢	🟢
	Establishment Accuracy	🟡	🟡	🟡	🟡	🟡
	% Procurement Spend Covered by Catalogue	🟢	🟡	🟡	🟢	🔴
	% of Procurement Spend Covered by Contract	🟡	🟡	🟡	🟡	🟡
	Purchase Order Compliance	🟡	🔴	🟡	🟡	🔴
		🟡	🟡	🟡	🟡	🟡
Forecasting Accuracy	Monthly Forecasting Accuracy	🟢	🟢	🟡	🔴	🟡
	Quarterly Forecasting Accuracy	🟡	🟢	🟡	🟡	🟢
	Annual Planning Accuracy	🟡	🟢	🟢	🟡	🟡
	Expense Type Forecasting Accuracy	🔴	🔴	🔴	🔴	🔴
	Cost Centre Forecasting Accuracy	🔴	🔴	🔴	🔴	🔴
		🟡	🟡	🟡	🔴	🟡
Financial Governance	Planning Ownership	🟡	🟡	🟡	🟡	🟡
	Planning Integration	🟡	🟡	🟡	🟡	🟡
	Risk Management	🟡	🟡	🟡	🟡	🟡
	Training	🟡	🟡	🟡	🟡	🟡
	Attendance at Divisional Finance Review Meetings	🔴	🟢	🔴	🟢	🔴
		🟡	🟡	🟡	🟡	🟡
Working Capital & Equipment Assets	Stock Days	🟡	🟡	🟡	🟡	🟡
	Creditor Payment Terms	🔴	🔴	🔴	🔴	🔴
	Debtor Days	🟡	🟡	🟡	🟡	🟡
	Unplanned Capital Equipment Purchases	🟡	🟡	🟡	🟡	🟡
		🟡	🟡	🟡	🟡	🟡

Statement of Comprehensive Income (SOCI) — Risk: **A**









Key Issues:

- £33.5m savings delivered year to date (deficit of £3m against plan)
- £46.6m of savings forecast for current year (deficit of £2.65m against plan)
- The Trust has committed to the Trust Development Authority delivery of the full £49.25m plan. Current Divisional and Non-Clinical Directorate forecasts are £46.6m, leaving a gap of £2.65m to be mitigated.
- £26.5m of savings identified for 2014/15 by Divisions and Non-Clinical Directorates (3.7% of operating costs)
- £18.5m of savings identified for 2015/16 by Divisions and Non-Clinical Directorates (2.6% of operating costs)
- Red Clover have completed a piece of work with the Trust compiling a 3-year Quality & Efficiency Programme using programme suggestions from Chiefs of Service and General Managers.

Statement of Financial Position (SOFP)	Risk:	A

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Current Month Balance £000s	Previous Month Balance £000s	Monthly Movement £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	715,616	585,801	702,990	(117,189)	595,813
	Intangible Assets	1,681	1,380	1,413	(33)	1,225
Current Assets	Inventories (Stock)	17,652	17,874	17,501	373	15,152
	Trade & Other Receivables (Debtors)	65,462	128,044	130,007	(1,963)	68,462
	Cash	55,326	40,817	33,023	7,794	50,326
Current Liabilities	Trade & Other Payables (Creditors)	(127,930)	(141,256)	(139,218)	(2,038)	(110,511)
	Borrowings	(3,059)	(3,075)	(3,075)	0	(2,701)
	Provisions	(37,353)	(45,333)	(43,993)	(1,340)	(33,299)
Non Current Liabilities	Borrowings	(23,362)	(21,873)	(21,873)	0	(20,709)
	Provisions	0	0	0	0	0
	TOTAL ASSETS EMPLOYED	**664,033**	**562,379**	**676,775**	**(114,396)**	**563,758**

Ratio/Indicators	Risk Rating		
	Current Month	Previous Month	Forecast
Debtor Days	47	48	26
Trade Payable Days	54	57	46
Cash Liquidity Days	19	19	19

The decrease in property, plant & equipment is predominantly due to the revaluation of the Trust's property portfolio resulting in a net reduction of £114.8m.

The decrease in debtors is predominantly due to:

- Decrease in ISS payment in advance of £2.4m

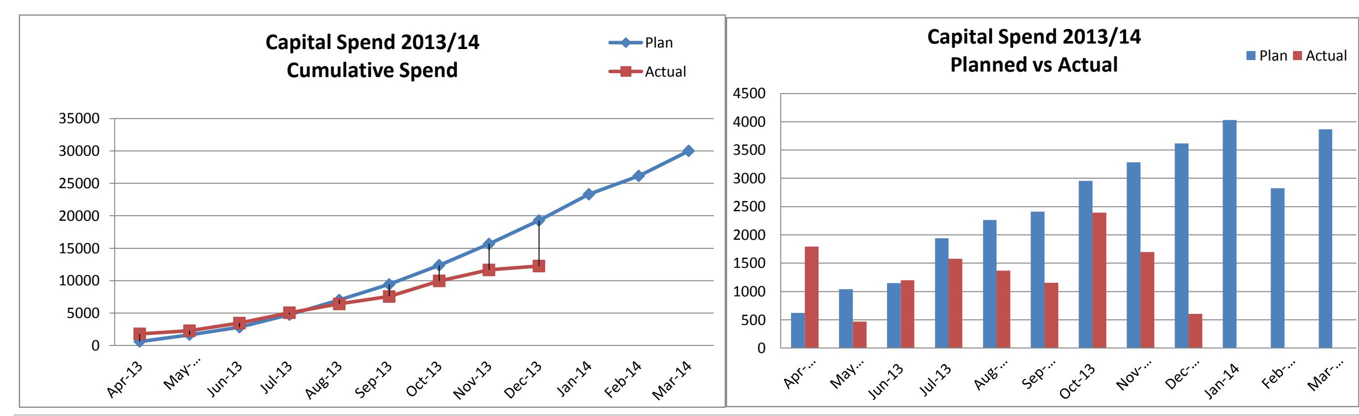
The increase in creditors is predominantly due to:

- Decrease in deferred income of £(6m), mostly due to the release of Medac income £(5.1m) and R&D MFF £(842k)
- Increase in AP creditors of £1.4m
- Non NHS accruals increased by £4m predominantly due to Lloyds Pharmacy £1.9m, POP accrual £1m and accrual for the Medtronic Cath lab contract £888k
- Increase in NHS Creditors of £1.4m, including accruals of £561k and Supply Chain invoices of £803k
- Increase in capital creditors of £0.5m

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

PAGE 7 - 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
Imaging Improvements HH	439	14	425	806	130	676	2,093	350	1,743
ICT Investment Programme	250	(952)	1,202	3,000	2,289	711	4,500	4,500	0
Endoscopy QEQM	856	489	367	4,336	2,006	2,330	5,674	5,100	574
Cardiac Relocation (EP)	87	1	86	1,123	592	531	1,708	708	1,000
Medical Equipment	500	283	217	2,450	1,629	821	4,000	4,048	(48)
Capital Maintenance CXH	100	84	16	700	707	(7)	1,000	1,000	0
Capital Maintenance HH	100	50	50	700	648	52	1,200	1,200	0
Capital Maintenance SMH	100	39	61	700	201	499	1,000	1,000	0
Access Control Upgrade	150	0	150	450	0	450	900	0	900
CCTV Development	10	0	10	20	0	20	65	65	0
Imaging Review	750	0	750	2,050	0	2,050	3,000	2,000	1,000
Theatre Upgrade	0	0	0	900	64	836	900	900	0
Pathology Equipment	0	0	0	140	0	140	140	140	0
Minor Works	75	0	75	300	0	300	500	500	0
Bathroom Upgrade HH Private Patients	0	1	(1)	250	20	230	250	50	200
Bio-Resource Centre	0	47	(47)	350	462	(112)	350	677	(327)
Aggregate Site Developments	200	170	30	1,000	1,625	(625)	1,470	2,470	(1,000)
Contingency	0	0	0	0	0	0	1,250	2,547	(1,297)
Shaping a Healthier Future Site Development	0	377	(377)	0	932	(932)	0	1,300	(1,300)
Radiotherapy Improvements	0	1	(1)	0	888	(888)	0	960	(960)
SALIX	0	0	0	0	47	(47)	0	64	(64)
New Linear Accelerators	0	2	(2)	0	15	(15)	0	450	(450)
Outpatient self-check-in kiosks	0	0	0	0	0	0	0	771	(771)
Total Capital Expenditure	**3,617**	**606**	**3,011**	**19,275**	**12,255**	**7,020**	**30,000**	**30,800**	**(800)**
Donations	**0**	**0**	**0**	**0**	**(448)**	448	**0**	**(798)**	798
Disposal Proceeds	0	0	0	0	(2)	0	0	(2)	0
Total Charge against Capital Resource Limit	**3,617**	**606**	**3,011**	**19,275**	**11,805**	**7,468**	**30,000**	**30,000**	**30,000**
Capital Resource Limit							30,000	30,064	**64**
Underspend / (Over) against CRL							**0**	**64**	**64**

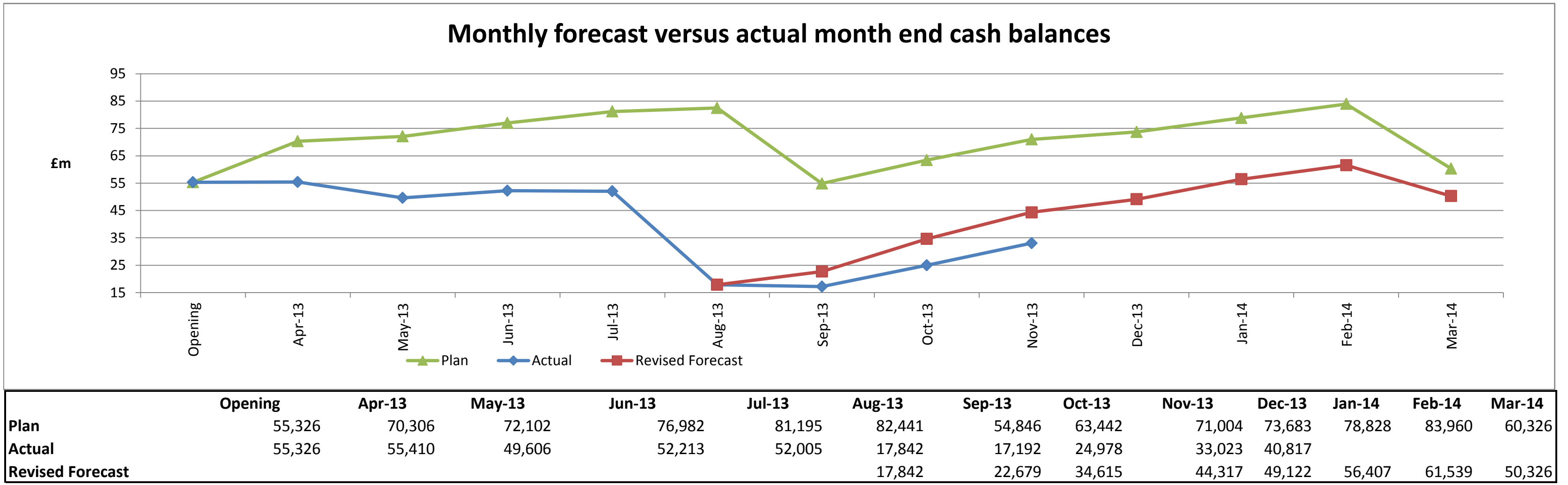


Actual spend is £13.6m versus a plan of £19.3m. The variance is largely due to previously-reported changes in Endoscopy and Imaging. A new project to roll out self-check-in kiosks in all outpatient departments was approved by Investment Committee in December and has now been included.

The contingency allowance of £2.5m remains available for any urgent requirements that may arise from winter pressures or adva ncing medical equipment purchases from next year.

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

PAGE 8 - CASH



	Opening	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Plan	55,326	70,306	72,102	76,982	81,195	82,441	54,846	63,442	71,004	73,683	78,828	83,960	60,326
Actual	55,326	55,410	49,606	52,213	52,005	17,842	17,192	24,978	33,023	40,817			
Revised Forecast						17,842	22,679	34,615	44,317	49,122	56,407	61,539	50,326

Aged Debtor Analysis

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total		Previous Month Total
NHS	£ 1,891,570	£ 17,538,626	£ 18,075,182	£ 9,677,912	£ 1,043,012	£ 304,659	**£ 48,530,961**		**£ 66,158,516**
Non-NHS	£ 1,829,306	£ 752,765	£ 3,383,356	£ 1,809,707	£ 929,181	£ 804,927	**£ 9,509,242**		**£ 10,862,804**
Overseas Visitors	£ 162,785	£ 100,852	£ 155,868	£ 303,970	£ 550,328	£ 2,214,427	**£ 3,488,229**		**£ 3,650,568**
Private Patients	£ 1,738,248	£ 1,637,857	£ 482,350	£ 2,209,453	£ 1,149,643	-£ 145,314	**£ 7,072,237**		**£ 6,582,884**
Total	**£ 5,621,909**	**£ 20,030,099**	**£ 22,096,755**	**£ 14,001,042**	**£ 3,672,164**	**£ 3,178,699**	**£ 68,600,669**		**£ 87,254,772**
% of Total Debt	**8.2%**	**29.2%**	**32.2%**	**20.4%**	**5.4%**	**4.6%**	**100.0%**		

Aged Creditor Analysis

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total		Previous Month Total
All AP Creditors	£ 5,214,546	£ 1,808,101	£ 246,223	£ 182,346	£ 157,429	£ 556,565	**£ 8,165,210**		**£ 6,683,752**
Total	**£ 5,214,546**	**£ 1,808,101**	**£ 246,223**	**£ 182,346**	**£ 157,429**	**£ 556,565**	**£ 8,165,210**		**£ 6,683,752**
% of Total Creditors	**63.9%**	**22.1%**	**3.0%**	**2.2%**	**1.9%**	**6.8%**	**100.0%**		

The level of NHS debtors reduced substantially in December as some CCGs paid invoices in relation to prior period outstanding SLAs. Overall, the Trust continues to experience delays in the receipt of NHS cash due to reorganisation and the subsequent delays in agreeing contracts with commissioners. The cash forecast was revised in August to take these delays into account as well as the 9 months advance payment to ISS.

The main elements of the variance from plan of £34m are:

- £13.4m raised to NHS England for Q1, Q2 and Q3 Project Diamond and R&D MFF funding still outstanding. Confirmation has been received for the Project Diamond funding.
- £17.8m over performance for quarters 1 and 2 remains outstanding at end of December
- £3.3m Non Contract Activity (NCA) invoiced to CCGs, NHS England and NHS Commissioning Board for months 1-7 still outstanding. Invoices for month 7 were raised in Dec 2013.
- £(3.7)m January SLA received in advance from NHS Westminster CCG

Payments when taken as a whole are £4m above plan in part due to the Trust paying an additional £5.5m in advance to ISS for the 8 months to 31st May 2014. The original plan only had a six month payment in advance.

At the end of December the balance of cash invested in the National Loan Fund scheme totalled £36m. This amount was invested for 7 days at an average rate of 0.39%. Total accumulated interest receivable at 31 December 2013 was £141k.

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

Page 9 - FINANCIAL RISK RATINGS (FRR)

Financial Risk Rating

Metric	Weighting	Metric Description	April	May	June	July	August	Sept	Oct
Achievement of Plan	10%	EBITDA achieved (% of Plan)	5	5	5	4	4	5	5
Underlying Performance	25%	EBITDA margin %	3	3	3	3	3	3	3
Financial Efficiency	40%	Net return after financing (%) I&E surplus margin net of dividends (%)	2	2	2	2	3	3	3
Liquidity	25%	Liquidity ratio (days)	4	4	4	4	4	3	3
Overall Financial Risk Rating			2	3	3	3	3	3	3

Continuity of Service Risk Rating

Metric	Weighting	Metric Description	April	May	June	July	August	Sept	Oct
Liquidity Ratio	50%	Liquidity ratio (days)	4	4	4	4	4	2	2
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	3	4	4	4	4	4	4
Overall Continuity of Service Risk Rating			**4**	**4**	**4**	**4**	**4**	**3**	**3**

The presentation of the Financial Risk Rating (FRR) has changed to a tabular format and includes the new Monitor Continuity of Service (CoS) risk rating for comparison purposes.

All risk metrics are on track for December.

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

Financial Risk Ratings

PAGE 10 - SLA Activity & Income by POD (Estimate for December 2013)

Point of Delivery	Year to Date (Activity) Plan	Year to Date (Activity) Actual	Year to Date (Activity) Variance	Year to Date (Income) Plan £000s	Year to Date (Income) Actual £000s	Year to Date (Income) Variance £000s	Forecast Plan £000s	Forecast Forecast £000s	Forecast Variance £000s
Admitted Patient Care									
- Day Cases	50,134	52,755	2,621	43,646	44,875	1,229	57,947	59,668	1,721
- Regular Day Attenders	10,647	11,536	889	4,942	5,132	190	6,561	6,827	266
- Elective	15,824	14,928	(896)	54,624	52,159	(2,465)	72,522	69,226	(3,296)
- Non Elective	62,703	64,682	1,979	119,396	124,484	5,088	157,529	165,317	7,788
Accident & Emergency	127,782	129,050	1,268	15,202	15,029	(173)	20,182	20,130	(52)
Adult Critical Care	31,079	32,572	1,493	37,675	35,791	(1,884)	50,020	47,537	(2,483)
Outpatients - New	177,732	230,282	52,550	33,926	39,508	5,582	44,087	53,547	9,460
Outpatients - Follow-up	342,311	368,973	26,662	47,969	52,232	4,263	62,972	70,623	7,651
Ward Attenders	5,319	4,369	(950)	863	714	(149)	1,146	953	(193)
PbR Exclusions	508,192	1,056,093	547,901	49,578	56,330	6,752	65,823	74,420	8,597
Direct Access	1,653,110	1,679,353	26,243	11,412	12,272	860	15,151	16,328	1,177
CQUIN	0	0	0	12,215	13,273	1,058	16,218	17,622	1,404
Others	1,782,987	1,808,274	25,287	97,831	102,131	4,300	129,798	136,107	6,309
Commissioning Business Rules	(15,412)	(17,547)	(2,135)	(14,094)	(9,677)	4,417	(18,712)	(12,825)	5,887
SLA Income	4,752,408	5,435,320	682,912	515,185	544,253	29,068	681,244	725,480	44,236
Less Non English Organisations				(10,434)	(10,923)	(489)	(13,853)	(14,492)	(639)
TDA Over performance				9,542		(9,542)	14,591		(14,591)
HTLV					968	968		1,200	1,200
Non Patient Care CCG Income				1,964	1,050	(914)	2,500	1,100	(1,400)
Performance Bond				3,919	3,919	0	5,203	5,203	0
Adjustment to TDA Plan				4,485	5,092	607	6,903	5,697	(1,206)
TOTAL	**4,752,408**	**5,435,320**	**682,912**	**524,661**	**544,359**	**19,698**	**696,588**	**724,188**	**27,600**

Income by Sector	Year to Date (Income) Plan £000s	Year to Date (Income) Actual £000s	Year to Date (Income) Variance £000s	Forecast Plan £000s	Forecast Forecast £000s	Forecast Variance £000s
North West - London	242,200	258,564	16,364	318,901	345,600	26,699
London - Others	31,177	31,115	(62)	41,311	41,333	22
Non London	15,164	14,774	(390)	20,125	19,522	(603)
NHS England	208,215	219,369	11,154	276,441	291,929	15,488
Foundation Trust	2,762	2,712	(50)	3,667	3,603	(64)
Non Contracted Activities	4,517	6,080	1,563	5,996	8,051	2,055
Out of Area Treatment	716	716	0	950	950	0
Other SLA			0			0
TDA Over performance	9,542		(9,542)	14,591		(14,591)
HTLV		968	968		1,200	1,200
Non Patient Care CCG Income	1,964	1,050	(914)	2,500	1,100	(1,400)
Performance Bond	3,919	3,919	0	5,203	5,203	0
Adjustment to TDA Plan	4,485	5,092	607	6,903	5,697	(1,206)
TOTAL	**524,661**	**544,359**	**19,698**	**696,588**	**724,188**	**27,600**

The report is an analysis of NHS SLA Income from clinical activities.
The Year to Date position is favourable variance against plan of £19.7m. The main reasons are : -
- Increase in Day case activity with the key over performing service line being Clinical Haematology £1.5m.
- Elective activity is below plan by (£2.6m). The key under performing service lines are Trauma & Orthopaedics (£1.1m), Vascul ar Surgery (£0.6m) , Head & Neck Reconstruction (£0.5m), and others (£0.4m)
- Non Elective work is above plan by £5.0m with the key over performance on Accident and Emergency £2.3m, Paediatrics £0.8m, M ajor Trauma £0.7m, General Medicine £0.7 and Urology £0.5m .
- Outpatient first appointments are above plan £5.5m reflecting the 13/14 change in the unbundled activity for imaging, cardio logy and gynaecology.
- Outpatient follow up appointments have increased against plan by £4.2m. The main variances are Cardiology £0.5m and AMD One Stop £0.7m.
- Other key over performance relates to PbR Exclusions mainly with NHSE for drugs.

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

Corporate Risk Register as at 24 January 2014

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk			Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score			Trend / Movement
				Impact	Effect	Cause					Likelihood	Consequence	Risk Score	
7	Chief Operating Officer	Risk Assessment	June 2007	**Description**: **Failure to maintain operational performance** **Cause**: • Failure of national performance targets (ED, cancer, RTT) • Failure of locally negotiated performance targets (CQUIN) • Failure of accurate reporting and poor data due to implementation of Cerner • Unexpected large-scale events impacting negatively on business continuity **Effect**: • Reduced patient experience • Increased inefficiencies • Reduced staff morale **Impact**: • Failure to gain FT Status • Loss of reputation and reduced confidence from key stakeholders • Impact on finances due to reactive and inefficient ways of working and from contractual penalties • Negative impact on patient experience and safety • Failure to meet contractual requirements • Failure to meet regulatory standards			• Weekly elective waiting list review • Cancer patient targeted list review • Daily ED Performance Reports • Local level scorecards and monitoring forums • Agreed remedial action plan with commissioners for cancer and RTT • Tri-borough urgent care board to oversee improvements in ED performance and urgent care pathway. • Patient experience programme - Itrack • Formal review re ED performance via ECIST with improvement action plan • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool • Business Continuity and Emergency Plans in place and tested regularly • Additional senior input into site operations • Introduction of Urgent Care Board And Weekly winter operational delivery group • Opening of the "winter office" to act as the interface with external agencies including data collation and submission. To be a point of contact for site issues • Funded opening of additional acute medical beds • Extended opening hours in UCC • Increased senior medical staff input into A&E • Additional trauma lists • Increased therapy support • Revised SitRep document implemented	• Adjust action in relevant action plan in line with the deteriorating performance		• 7 of the national cancer targets were met in August and September. • 3 RTT standards are at an aggregate level. • Number of treatment function codes (TFCs) achieving the standards continues to increase. In September the Trust achieved 54 out of 57 TFCs • Incomplete backlog has reduced to just over half a week's worth of activity.	5	3	15	

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
10	Director of Infection Protection Control	R A	June 2007	**Description**: **Increased levels of HealthCare Acquired Infection (HCAI).** **Cause**: Failure to maintain good infection prevention and control processes including prudent anti-infective prescribing. **Effect**: • Failure to achieve DH thresholds for *C.diffcile* and MRSA BSI's • Closure of wards • Extended length of stay • Increased waiting lists • Increased morbidity • Litigation **Impact**: • Financial penalties for cases above the DH thresholds for *C.diffcile* and MRSA BSI's • Negative media coverage resulting in loss of reputation.	• Performance monitoring system including HCAI in Trust Board Performance Report and ward level reporting • Regular executive and operational walk arounds • Trust Infection Prevention Control Committee • Comprehensive Aseptic Non-Touch Technique Training programme including competency assessment • Programme of antibiotic prescribing, monitoring and improvement in place • *Smart then Focus* campaign for appropriate prescribing of antibiotics including regular review of patients taking antibiotics • Surveillance of emerging trends in other organisms, this is dependent on adequate IT systems. • All MRSA BSI's cases have root cause analysis undertaken • All *C.difficile* cases undergo an in-depth MDT clinical review	• Weekly Trustwide HCAI taskforce to review actions that have and need to take place • Enhanced surveillance of HCAI's that have increased in incidence • With increased incidence across the organisation a review of the cases take place with the initiation of relevant policies and procedure such as outbreak management. • With an increased incidence related to a particular ward, there would be intense ward review to establish cause, a review of patient pathways to isolate source, followed by enhanced education and support, with close monitoring for impact and resolution.	Current	Between 01/04/13 – 30/11/13 the Trust reported nine 'Trust attributable MRSA BSI's', the DH target is zero. The Trust reported 42 Trust attributable cases of C.*difficile* this is within trajectory for the year. **Actions include:** • Any MRSA case is reviewed at the weekly Medical Directors meetings. • Trust wide action plans in response to increase incidence of C.*diffcile* in April and MRSA in May 2013 to ensure all learning from review of cases are implemented Trustwide. Actions are reviewed on a weekly basis in the Trustwide HCAI taskforce. • Enhanced vascular lines and device management, education and communications. Care of peripheral vascular devices policy reviewed and updated. • Appointment of a third Vascular access nurse • The Trusts Vascular access group has been redefined to form a Trustwide Vascular Access patient safety programme, that will ensure senior clinician engagement and delivery of quality improvement initiatives. • Enhanced Hand hygiene and MRSA Screening programmes • Working with peers, CCG, TDA and PHE to ensure all appropriate processes are in place. • Extension of the IPC policy on multidrug resistant organisms to address the latest advice from PHE on isolation and screening of patients at risk of carbapenem resistant organisms • Revised C. *difficile* and D&V policies to ensure isolation of patients with diarrhoea within 2 hours of onset to reduce transmission risk. • Highlighting inadequate isolation facilities as a risk to managing infection (on IP&C RR). Enhanced surveillance for MSSA and E.*coli* bacteraemias and trend analysis of risk factors.	5	4	20	↔

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
43	Chief Information Officer	Local Risk Register	July 2011	**Description**: **Failure successfully to implement the new EPR system (Cerner)** **Cause**: • Insufficient organisational engagement • Supplier fails to deliver • Failure of programme deliverables **Effect**: • Patient administrative and clinical processes are disrupted • Adverse impact on data quality **Impact**: • Harm to patients • Inability to report on activity to commissioners • Negative media coverage resulting in loss of reputation	• Cerner Programme Board is in place with Chief Operating Officer as the Senior Responsible Owner for the Programme • Clearly defined criteria that have to be met before the system is taken into live operation • Internal and external audit of business readiness prior to commencing live operation	• Delay go live until the trust and the system are fully ready • Detailed plan to provide pre and post-go live support including a familiarisation and training programme for staff, floor walkers to help end users adapt to the new system etc • A set of Key Performance Indicators to track data quality and enable management action to address any emerging problems	April 2014	• Gateway criteria have been developed against the key milestones • First two gateways have been passed successfully and the trust is on track for go live on 22nd April 2014.	3	4	12	⇔
48	Chief Financial Officer	Risk Assessment	March 2012	**Description**: **Failure to deliver Cost Improvement Programmes (CIPs)** **Cause**: • Lack of properly defined, risk assessed, achievable CIPs • Poor management and reporting of CIPs **Effect**: Reduced financial capacity **Impact**: • Failure to gain FT Status • Adverse impact on the AHSC mission.	• Transformation and CIP Board • New structure in place • Senior Finance team in place • Robust CIP identification process in place • Enhanced controls in place for appointment of staff and ordering of goods and services	• CPDs/Divisions and non-clinical directorates have earned autonomy. If they do not deliver then this will be performance managed through an escalation mechanism similar to the turnaround process in 2012/13.	Monthly	Progress on delivery of the CIP programme is reviewed monthly at the performance review meetings and the Board and bi-monthly by the Finance and Investment Committee.	3	5	15	⇩

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
49	Chief Executives	Risk Assessment	February 2012	**Description**: **Inability to achieve Shaping a Healthier Future (SaHF) activity changes due to failure to deliver associated estate change.** **Cause**: • Lack of effective working relationships with commissioners • Lack of understanding and inability to influence the commissioning agenda **Effect**: • Loss of activity/revenue • Inability to fund estate changes **Impact**: • Reduced quality of patient care • Financial loss • Operational pressures •	• Collaboration and engagement with GPs and commissioners • Revised Trust demand and capacity planning • Trust developing its own business case reflecting the changes in SaHF on the estate • PwC have been commissioned to provide a report on clinical and site strategy to include immediate next steps. Report due end of February 2014. •	• Deliver additional CIPs to account for the reduction in activity. • Review demand and capacity and close surplus capacity.	Current	Chairman and Chief Executives met with the 6 CCG leads and Daniel Elkeles to discuss commissioning needs to enable a strategy report to be commissioned.	3	4	12	↓
53	Director of Estates & Facilities	Director of Estates & Facilities	Dec 12	**Description:** **Failure to transfer patients to, from and between hospitals/wards in a safe and timely manner appropriate to their clinical need.** **Cause:** • Contractor performance declines • End-to-end planning of patient pathway takes no account of transport to and from Trust facilities • Patient transfers conducted in a manner that is not in accordance with Trust policy **Effect:** • Poor patient experience • Increased risk of serious (Datix) incidents involving patient safeguarding and complaints • Increasing numbers of patients being late for appointments • Increased level of claims made against the Trust • Potential for being subject to increased inspection regime and / or regulatory non-compliance **Impact:** • Possible harm to patients • Disruption to hospital operations due to late arrivals • Impact on finances and reputation	• Overall performance is monitored by reference to KPIs as per the DHL contract • Training records are checked periodically to ensure that drivers are appropriately trained. • Individual incidents are recorded on Datix and fully investigated. • Drivers found to cause patient safeguarding incidents through failure to follow procedures are dismissed. • Procedural flaws leading to safeguarding incidents are analysed and correct rapidly. • Where convened, Trust and contractor reps attend multi-agency safeguarding reviews. • Trust Transfer (Handover of Care) policy and monitoring of performance against KPIs	• Escalation procedures are in place within DHL and to Trust managers if necessary to handle specific incidents • Contractual penalties exist (and have been applied in the recent past) • Performance against KPIs monitored through agreed governance processes outlined in the Transfer (Handover of Care) policy		• Datix reports, complaints and PALS references have declined over the last twelve months. Datix reports comprise only 0.57% of all Trust incidents. • Some months have had zero complaints • Procedural flaws leading to a specific incident were identified, an interim fix established within 48 hours and a permanent fix within two weeks of occurrence. • Detailed analysis of journey-by-journey data is carried out independently to ensure KPIs are reported accurately and variances understood • The DHL booking centre is now located in Estates offices for close liaison when needed • Further action with Trust Divisional colleagues is needed to ensure that the end-to-end patient experience is as seamless and speedy as possible. • Newly revised Transfer (Handover of Care) policy (v3) ratified at Trust Management Board, for re-review in January 2015	3	4	12	↓

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
55	Director of Estates & Facilities	Director of Estates & Facilities	Mar 11	**Description:** **Insufficient historic and current investment in the Estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably.** **Cause** • Poor condition of much of the Estate • Large backlog of £146m (of which £3.9m is High Priority and a further £17m is Significant Priority) **Effect:** • Possible short-notice closure of facilities due to equipment failures • Hampered movement around the Trust for patients (e.g, lift unavailability) • Failure of building systems to support key clinical equipment (e.g. pathology, ICT, power) • Cosmetic work cancelled (e.g. redecorating, floor repairs • Inability to provide sufficient single rooms for HCAI patients. **Impact:** • Potential adverse impact of HCAI • Possible unavailability of clinical facilities • Adverse impact on patient experience • Possible suspension of patient services • Increased waiting list time • Breach of H&S regulations • Risk of failure of CQC Inspection	• The condition survey is to be updated to scope the issues more accurately. • PLACE (Patient-Led Assessment of the Care Environment) is run by Estates and Facilities to identify priorities from a patient point of view. • Statutory and regulatory inspections are now in place to pick up major risks to continued safe operation of the hospitals • Planned preventative maintenance schedules are largely in place now to reduce the risk of key equipment failure	• Repairs and reactive maintenance would need to increase. • Some clinical facilities may need to be closed at short notice either for extended periods to carry out repairs (e.g. as for CXH theatres in summer 2013) or permanently if repairs were judged not to be cost-effective. Risk ID 54 will influence this decisions.		• Revenue maintenance budget was increased by £2.4m per annum phase over 2012/13 and 2013/14. • A new specialist maintenance management system has gone live (1 Nov 13) to enable better tracking of maintenance checks, fault reports and identification of trends over time that can better inform prioritisation of planned works / backlog investments. • Plans for updated maintenance expenditure and backlog investment are being developed as part of the Trust business planning process for 2014/15 and beyond • Completion of work to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out. However, the cost of remedial works may turn out to be significant in some cases and may need to call on Trust contingency funds. This work is on-going.	4	4	16	
57	Divisional Director for Medicine			**Description:** **Risk to patient safety in the EU at Hammersmith Hospital as a result of insufficient/inadequate middle grade medical cover for the Department** **Cause:** • Lack of suitably qualified middle grade doctors due to poor incentive to undertake training at Hammersmith **Effect:** • Increased agency cover • Inability to fill vacant posts **Impact:** • Inconsistent levels of clinical skills • Reduced quality of care	• Continuous recruitment rounds to fill vacant posts • Use of regular, ad hoc, middle grade cover from Clinical Research Fellows • Use of long term locums where possible • Weekly review of rota by Chief of Service for Emergency Medicine • Review of the existing workforce structure to identify opportunities to reconfigure posts to make them more attractive to potential applicants	• Plans in place for reallocating duties when inadequate cover for activity. • Implementation of CCG policy for temporary reduction in service.	Current	• Hours extended in UCC to 24 hours until 31st March 2014. Planning for formal change at the EU as a result of 'Shaping healthier future' plans. • Additional recruitment of middle grades with 40% fill rate achieved. • Additional Locum consultant recruited to enhance cover during the day. • New advert for cross site rotations of middle grades about to be put out. • Emergency services at Hammersmith is planned to close end of 2015 but is likely to close later this year.	3	4	12	

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
58	Divisional Director for Women's and Children's	National recommendations	02/07/2013	**Description:** **PICU Risk to patient transmission of a multi-drug resistant infection between patients resulting in colonisation from VIM resistant Pseudomonas isolated on PICU which carries up to 75% mortality with bacteraemia** **Cause:** • Unit does not comply to Paediatric Intensive Care Society standards 2010 – bed spaces are 50% less than required standards **Effect:** • Adverse impact on infection control and patient experience **Impact:** • Breach of national standards • Possible suspension of patient services • Possible harm to patients • Negative media coverage resulting in loss of reputation	• A review of storage has taken place and controls in place to prevent accumulation of stock/equipment to assist in maintaining a clear and clutter free environment for easier cleaning and maintenance • A weekly matron cleaning audit is in place in conjunction with the ISS supervisor. Scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Hand washing and bare below the elbows audits take place and are monitored by infection control and the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • All patients are screened on admission for VIM-P • All patients are screened weekly for VIM-P • Training and adherence to the Trust's prevention of infection policy is in place • Bacterial filters are used on ventilator circuits for intubated children • There is a close partnership with the Trust's infection control team. Infection scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Remedial estate works have been carried out to replace all sinks/taps on unit have been replaced to prevent splash back • A Business Case has been compiled regarding the relocation of PICU to a larger footprint	• There is a close partnership with the Trust's infection control team in identification of trends and themes regarding infection control issues. • Review the closure of beds to mitigate risks identified	Current	UPDATE 20/11/2013 all sinks and taps replaced to conform to modern standards, all water tests on sinks clear. UPDATE 03/12/2013 a full business case to relocate PICU to a larger footprint has been compiled	4	4	16	⇔

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
59	Director of Surgery, Cancer and Cardiology			**Description:** **Lack of senior clinicians at Charing Cross to review emergency cases** **Cause:** • Reduction in Consultant Cover availability at Charing Cross • One Consultant on supervised practice restriction so cannot work independently • One Consultant on long term sick leave • Rota has been sustained by Breast and Endocrine Consultant surgeons who no longer feel skilled to undertake the GI emergency work. • Increased surgical work load at St Mary's with trauma centre work means out of hours work is intense for surgeons participating in that rota • Difficult to staff surgical rota on 3 sites to modern standards. • Recruitment difficulties of junior surgical staff at Charing Cross **Effect:** • Potential delay in review by senior clinicians **Impact:** • Detrimental impact on patient outcome • Poor patient experience • Negative media coverage resulting in loss of reputation	• Remove Breast and Endocrine Surgeons from on call rotas. • More cross site planning increasing daytime cover at Charing Cross (by moving staff across, generally from St Mary's) • Cross cover on call arrangements so Charing Cross on call rota supported by some Hammersmith Hospital Consultant surgeons • Presence of clinical pathways for patients with appropriate conditions to be transferred to St Mary's • Charing Cross Consultants no longer have on call commitments at Hammersmith site	If the Trust believed that the service was becoming unsafe despite mitigation actions it will close the acute surgery service at Charing Cross.	12 months	• All previously identified key controls are now in place or will be completed over the next week Additional work is being undertaken for additional key controls around: • Job planning review of all surgical consultants to obtain assurance of consistent senior cover on all sites. • Review of junior doctor's rotas.	3	3	9	⬌
60	Divisional Director of Investigative Science			**Description:** **The introduction of a single Radiology Information System (RIS) and Picture Archive and Communication System (PACS) has increased time to effectively undertake imaging in a timely way** **Cause:** • Contractors being unable to provide a package suitable for a multi-site organisation • Currently the system is slow, crashes and freezes **Effect:** • RIS/PACS has increased time to book an imaging appointment • Increased waiting time for appointments • Delay to patient treatment **Impact:** • Reduced productivity of radiologists • Increased administration • Backlog of appointments • Delay in diagnosis • Breach of diagnostic waiting times	• Additional administration staff employed to process imaging appointments • Additional radiographer in place • Additional radiologist sessions being undertaken • Daily monitoring and reporting of backlog • Weekly meetings with GE to address issues	• Recruit additional staff if unable to reduce the backlog	Current	Controls in place and reporting of backlog now three times a week as backlog reduced	3	4	12	⬇

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
61	Divisional Director of Women's and Children's	External Recommendations	01/01/2004	**Description:** **Consultant presence on Delivery Suite does not meet recommended benchmarks for the number of births.** **Cause:** • Unit does not comply with recommended benchmarks for the number of births (Safer Childbirth report laid out the proposed obstetric staffing targets for a unit carrying out 5000-6000 birth per year as 98 hour consultant presence by the end of 2008, 168 hours by the end of 2010 **Effect:** • A lack of 24/7consultant presence on labour ward • Reduced support and guidance for trainees **Impact:** • Breach of national standards • Possible harm to patients • Negative media coverage resulting in loss of reputation	• QCCH cap the number of bookings to 215 bookings per fortnight for out of area referrals • Risks reviewed on a regular basis by Maternity Quality and Safety Committee and W&C Quality and Safety Board • The multidisciplinary team are encouraged to report incidents on datix • All incidents reported on datix are reviewed and investigated and fed back to the team via individual and team learning, local risk meetings and the maternity newsletter "Risky Business" • Business Plan submitted to Trust Investment Committee, approval granted for 8 posts additional consultants to achieve 98 hour presence on labour ward. • Plan for recruitment in place	• On call consultant arrangements in place to mitigate risk, with the on call rota published and readily available in unit • Education and training continues for multidisciplinary team regarding the importance of escalating concerns • QCCH continue to cap the number of bookings to 215 bookings per fortnight for out of area referrals	Current	UPDATE 03/12/2013 confirmation by Divisional Director that now 6 out of 8 posts have been recruited, due to commence in post by March/April 2013	4	4	16	⇔
62	Division of Medicine	Risk Assessment	03/12/2013	**Description:** **Insufficient Level 2 beds on the Hammersmith Hospital Site.** **Cause:** • No level 2 beds established on the Hammersmith Hospital Site. • B1 ward used to deliver some aspects of level 2 care **Effect:** • Unwell patients deemed not for ITU nursed in inappropriate care environment (for example B1 ward) • Patient care undertaken in either too complex or insufficiently complex environment **Impact:** • Possible harm to patients / detrimental impact on patient outcomes	• A Trust Critical Care group is in place to discuss these issues. • To develop a clear pathway for the management of patients who are too sick to be nursed on B1 Ward. • On-going review of B1 ward nursing cover. • Early involvement of ITU for patient review.	• To explore the establishment of a Medical High Dependency Unit on the Hammersmith Site.	Current	• Trust Critical Care group is in place • Review of B1 ward nursing cover on an ongoing basis. • Change in function of B1 and C8 to centralise sick medical patients will offer opportunity to review nursing profile.	4	4	16	

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
63	Division of Medicine	External Recommendations	03/12/2013	**Description:** **Non-Compliance for NHS England Commissioner's requirements for neurosurgical services.** **Cause:** • Lack of capacity (funded beds) • Lack of 24 hour MRI service on the St. Mary's Site • Lack of designated neuro ITU beds • Lack of a designated neurosurgical theatre. • Split site neurosurgical service • Lack of neurointerventional capacity (NCEPOD report for subarachnoid haemorrhage) **Effect:** • Failure to meet commissioner requirements • Non-compliance with Royal College of Surgeons recommendations **Impact:** • Possible harm to patients • Delays in transfer to ChX from secondary care providers • Detrimental patient experience • Reputational impact of possible loss of neuro service and consequent financial impact. • Reputational damage due to poor service provision to region • Loss of critical service components to competitors	• Use of unfunded beds to meet demand. • Transfer of patients from SMH to ChX for MRI scans where appropriate • Access to four general medical ITU beds with staff that are trained in neurological conditions. • Redesignation of a trauma beds as neuro-trauma beds.	• A business case is being developed for an increase in capacity. • Meeting to be held with MRI service and ITU / Theatres to discuss requirements. • Consultant appointment at SMH • Neurosurgery level 1 capacity at SMH	Current	• Meeting held with NHS England Commissioners and it has been identified that neurosurgical services at ICHT, treating a population of 2.1million should have 30 funded beds per 1 million population. Current funded bed capacity is 19 beds. • Meeting with London Specialist commissioners confirm NCEPOD requirements for neurointervention. Progress report July 2014. • Business case for neurointerventional radiology capacity increase	3	3	9	

Board Assurance Framework

Corporate Objective Number	Corporate Objective Definition
CO1	To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
CO2	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
CO3	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
CO4	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

Column Heading	Description
Sources of Assurance	Where can the Board obtain evidence relating to the effectiveness of the controls upon which the Trust is relying?
Assurance on the Effectiveness of controls	Does the evidence demonstrate that the controls are effective?
Gaps in Control	Gaps are identified which show that adequate controls are not in place, or that they are ot sufficiently effective?
Gaps in Assurance	There is a failure to gain evidence demonstrating that the controls are effective.
Action plans for gaps in control or assurance	The Plans that are in place to address the identified gaps in control and/or assurance including appropriate timelines and indicative completion dates.

Risk Definition : 7 – Failure to maintain operational performance								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2	**Cause**: • Failure of national performance targets (ED, cancer, RTT) • Failure of locally negotiated performance targets (CQUIN) • Failure of accurate reporting and poor data due to implementation of Cerner • Unexpected large-scale events impacting negatively on business continuity **Effect**: • Reduced patient experience • Increased inefficiencies • Reduced staff morale **Impact**: • Failure to gain FT Status • Loss of reputation and reduced confidence from key stakeholders • Impact on finances due to reactive and inefficient ways of working and from contractual penalties • Negative impact on patient experience and safety • Failure to meet contractual requirements • Failure to meet regulatory standards	• Weekly elective waiting list review • Cancer patient targeted list review • Daily ED Performance Reports • Local level scorecards and monitoring forums • Agreed remedial action plan with commissioners for cancer and RTT • Tri-borough urgent care board to oversee improvements in ED performance and urgent care pathway. • Patient experience programme - Itrack • Formal review re ED performance via ECIST with improvement action plan • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool • Business Continuity and Emergency Plans in place and tested regularly • Additional senior input into site operations • Introduction of Urgent Care Board And Weekly winter operational delivery group • Opening of the “winter office” to act	Reported to Board; • Integrated performance report. • Emergency Planning annual assurance report (including business continuity) • Internal and external audit reviews of performance Reported to Board Committees • Internal and External Audit reviews of performance • Patient experience programme - I track • Emergency Planning annual assurance report (including business continuity) • Annual winter plan	• Trust Board Performance Report • Internal and external audit reviews of performance • Emergency Planning Annual Assurance report (including business continuity)	Further development of a sophisticated capacity and demand process is required to build confidence in planning assumptions and to further establish a clear evidence base for decision making	Evidence based outcomes from a sophisticated capacity and demand process to inform elective and non-elective activity planning both as part of the annual business planning process and also as part of business as usual approach to managing limited resources such as theatres, beds and staffing	Initial programme of work underway and plans to create a routine capacity and demand process as ‘business as usual’ way of working are being developed	Chief Operating Officer

		as the interface with external agencies including data collation and submission. To be a point of contact for site issues • Funded opening of additional acute medical beds • Extended opening hours in UCC • Increased senior medical staff input into A&E • Additional trauma lists • Increased therapy support • Revised SitRep document implemented						

Risk Definition: 10 - Increased levels of HealthCare Acquired Infection (HCAI)								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2	**Cause**: Failure to maintain good infection prevention and control processes. **Effect**: • Failure to achieve DH thresholds for *C.difficile* and MRSA BSI's • Closure of wards • Extended length of stay • Increased waiting lists • Increased morbidity • Litigation **Impact**: • Financial penalties for cases above the DH thresholds for *C.diffcile* and MRSA BSI's • Negative media coverage resulting in loss of reputation.	• Performance monitoring system including HCAI in Trust Board Performance Report and ward level reporting	Monthly Trust Board report Monthly IPC Scorecard Ward level IPC data ANTT compliance data HCAI taskforce minutes Hygiene code compliance Safety thermometer data	Trust Board report July, Sept, Nov 2013 Jan 2014 NMPPC July, Sept, Nov 2013 Jan 2014 Ward IPC notice boards displaying IPC data updated monthly HCAI weekly taskforce ANTT compliance at 89.5% (Dec 2013)	Lack of divisional and departmental representation.		MRSA action plan C.*difficile* action plan	Director of Infection Protection Control
		• Regular executive and operational walk arounds	Leadership walk around schedule	Monthly Leadership WA; Jan CXH, Dec QCCH, DIPC & VA walk around Jan 2014	Lack of divisional representation Delays in updates to HR system			
		• Trust Infection Prevention Control Committee (TIPCC)	TIPCC minutes TIPCC agenda TIPCC papers	TIPCC 2013 – 2014	Sustainability of 'train the trainer' programme led by divisions		Identify divisional leads and reps to attend	
		• Comprehensive Aseptic Non-Touch Technique Training programme including competency assessment	Competency assessment framework document ANTT compliance data Doctors induction schedule Vascular Access Group minutes and papers	ANTT compliance at 89.5% (Dec 2013) Team brief (Nov 2013) The Source briefings Nov 2013			Weekly discussion of progress by each division at HCAI taskforce Monthly reviews at divisional performance meetings.	
		• Programme of antibiotic prescribing, monitoring and	Pharmacy point (PPS) prevalence reports	PPS (Oct 2013) Antibiotic policy revision 2013				

		improvement in place		Antibiotic app.				
		• *Smart then Focus* campaign for appropriate prescribing of antibiotics including regular review of patients taking antibiotics	Pharmacy policy revision 2013 Antibiotic app. Update 2013	Antibiotic policy revision 2013 Antibiotic app. Update 2013	SSI program currently limited to three specialties (Ortho, Neuro and Cardiac)			
		• Surveillance of emerging trends in other organisms	Trust Board IPC report IPC scorecard	IPC policy revision			Implementation of Trustwide SSI steering group to plan and implement extension to other specialties	
		• All MRSA BSI's cases have root cause analysis undertaken • All *C.difficile* cases undergo a clinical review	ITU surveillance and BSI data SSI surveillance group RCA and PIR reports Medical Director/CEO meeting records C.difficile data C.difficile patient review forms SI panel reports Outbreak minutes MDT rounds for C.diff review	MRSA policy revision (Aug 2013) Increased screening for at risk groups identified form PIRS CQC report on CDI themes/trends/risk factors All cases are discussed at HCAI taskforce Thematic analyst and trend analyst of HCAI related SI's			Feedback at weekly HCAI taskforce of division progress on actions.	

Risk Definition: 43 - Failure successfully to implement the new EPR system (Cerner)								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2	**Cause**: • Insufficient organisational engagement • Supplier fails to deliver • Failure of programme deliverables **Effect**: • Patient administrative and clinical processes are disrupted • Adverse impact on data quality **Impact**: • Harm to patients • Inability to report on activity to commissioners • Negative media coverage resulting in loss of reputation	• Cerner Programme Board is in place with Chief Operating Officer as the Senior Responsible Owner for the Programme • Clearly defined criteria that have to be met before the system is taken into live operation Internal and external audit of business readiness prior to commencing live operation	• Regular reports to the Audit Risk and Governance Committee • Regular review of progress with the readiness criteria by the Management Board • Divisional engagement in programme via DD attendance at Cerner Programme Board and weekly meeting of Cerner Programme Team with DDOs.	• External audit by Deloitte of the Cerner Programme in the context of their VFM work • Internal Audit review of readiness criteria and their application in practice.	None identified	None identified		Chief Information Officer

Risk Definition: 48 - Failure to deliver Cost Improvement Programmes (CIPs)								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2	**Cause**: • Lack of properly defined, risk assessed, achievable CIPs • Poor management and reporting of CIPs **Effect**: Reduced financial capacity **Impact**: • Failure to gain FT Status • Adverse impact on the AHSC mission.	• Transformation and CIP Board • New structure in place • Senior Finance team in place • Robust CIP identification process in place • Enhanced controls in place for appointment of staff and ordering of goods and services	• Report to the Trust Board monthly • Report to the Finance and Investment Committee bi-monthly • Review of the Risks at Audit, Risk and Governance Committee • Report to the Management Board monthly • Report to Divisional Boards monthly	During the year there has been a marked improvement in delivery following the intervention and regular reporting at the Trust Committees	None Identified	None Identified		Chief Financial Officer

Risk Definition: 49 - Inability to achieve Shaping a Healthier Future (SaHF) activity changes due to failure to deliver associated estate change								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO2 CO4?	**Cause**: • Lack of effective working relationships with commissioners • Lack of understanding and inability to influence the commissioning agenda **Effect**: • Loss of activity/revenue • Inability to fund estate changes **Impact**: • Reduced quality of patient care • Financial loss • Operational pressures	• Collaboration and engagement with GPs and commissioners • Revised Trust demand and capacity planning • Trust developing its own business case reflecting the changes in SaHF on the estate • PwC have been commissioned to provide a report on clinical and site strategy to include immediate next steps. Report due end of February 2014. •	• PwC Report • Outputs from Commissioning Meetings		To be identified following PwC report			Chief Executives

Risk Definition: 53 - Failure to transfer patients to, from and between hospitals/wards in a safe and timely manner appropriate to their clinical need								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1	**Cause:** • Contractor performance declines • End-to-end planning of patient pathway takes no account of transport to and from Trust facilities • Patient transfers conducted in a manner that is not in accordance with Trust policy **Effect:** • Poor patient experience • Increased risk of serious (Datix) incidents involving patient safeguarding and complaints • Increasing numbers of patients being late for appointments • Increased level of claims made against the Trust • Potential for being subject to increased inspection regime and / or regulatory non-compliance **Impact:** • Possible harm to patients • Disruption to hospital operations due to late arrivals • Impact on finances and reputation •	• Overall performance is monitored by reference to KPIs as per the DHL contract • Training records are checked periodically to ensure that drivers are appropriately trained. • Individual incidents are recorded on Datix and fully investigated. • Drivers found to cause patient safeguarding incidents through failure to follow procedures are dismissed. • Procedural flaws leading to safeguarding incidents are analysed and correct rapidly. • Where convened, Trust and contractor reps attend multi-agency safeguarding reviews. • An updated effective transfer policy agreed by Management Board	• Datix reports • DHL contractor reports – summary • DHL data – detailed • DHL training records	• Detailed reports (journey-by-journey) are now regularly reviewed as part of normal contract management • Spot-checks on training records • Records are date-stamped to capture any post-event changesAll Datix reports are reviewed individually and actions checked	None identified	None Identified		Director of Estates & Facilities

Risk Definition:55 - Insufficient historic and current investment in the Estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2 CO4	**Cause** • Poor condition of much of the Estate • Large backlog of £146m (of which £3.9m is High Priority and a further £17m is Significant Priority) **Effect:** • Possible short-notice closure of facilities due to equipment failures • Hampered movement around the Trust for patients (e.g, lift unavailability) • Failure of building systems to support key clinical equipment (e.g. pathology, ICT, power) • Cosmetic work cancelled (e.g. redecorating, floor repairs • Inability to provide single rooms for HCAI patients. **Impact:** • Potential adverse impact of HCAI • Possible unavailability of clinical facilities • Adverse impact on patient experience • Possible suspension of patient services • Increased waiting list time • Breach of H&S regulations • Risk of failure of CQC Inspection	• The condition survey has recently been updated to scope the issues more accurately, and is being finalised. • PLACE (Patient-Led Assessment of the Care Environment) is run by Estates and Facilities to identify priorities from a patient point of view. • Statutory and regulatory inspections are now in place to pick up major risks to continued safe operation of the hospitals • Planned preventative maintenance schedules are largely in place now to reduce the risk of key equipment failure	• Regularly-updated condition surveys • Statutory inspection reports and follow-up actions • PLACE or ad-hoc patient concerns and incidents • Datix reports • Maintenance Computer system records showing planned maintenance actions and completion • Capital programme for maintenance repairs and investments	• Regular update son compliance and Planned Maintenance progress • Repairs performance reports to Management Board • Responses to Datix reports • PLACE Board reviews progress on dealing with issues identified	• Systematic capturing of repair investments is not in place • Inspection reports are not directly connected to remedial work plans	• The new computer system is still bedding in • Equipment asset data and condition data is incomplete • Building services are not currently prioritised systematically to according to their criticality to clinical or operational services.	• Update the condition survey • Introduce process for ensuring that remedial work is referenced to inspection reports and assets. • Identify building services that are most critical to operational continuity.	Director of Estates & Facilities

Risk Definition: 57 - Risk to patient safety in the EU at Hammersmith Hospital as a result of insufficient/inadequate middle grade medical cover for the Department								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO3	**Cause:** • Lack of suitably qualified middle grade doctors due to poor incentive to undertake training at Hammersmith **Effect:** • Increased agency cover • Inability to fill vacant posts **Impact:** • Inconsistent levels of clinical skills • Reduced quality of care	• Continuous recruitment rounds to fill vacant posts • Use of regular, ad hoc, middle grade cover from Clinical Research Fellows • Use of long term locums where possible • Weekly review of rota by Chief of Service for Emergency Medicine • Review of the existing workforce structure to identify opportunities to reconfigure posts to make them more attractive to potential applicants	Middle staff rotas drawn up in advance and gaps identified and escalated	No evenings where cover has not been found	No permanent rota in place	None Identified	Ultimately to remove the requirement for EU middle grade staff by running the UCC 24 hours a day and liaising with LAS to divert blue light cases.	Divisional Director for Medicine

Risk Definition: 58 - PICU Risk to patient transmission of a multi-drug resistant infection between patients resulting in colonisation for VIM resistant Pseudomonas isolated on PICU which carries up to 75% mortality with bacteraemia								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1	**Cause:** • Unit does not comply to Paediatric Intensive Care Society standards 2010 – bed spaces are 50% less than required standards **Effect:** • Adverse impact on infection control and patient experience **Impact:** • Breach of national standards • Possible suspension of patient services • Possible harm to patients • Negative media coverage resulting in loss of reputation	• A review of storage has taken place and controls in place to prevent accumulation of stock/equipment to assist in maintaining a clear and clutter free environment for easier cleaning and maintenance • A weekly matron cleaning audit is in place in conjunction with the ISS supervisor. Scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Hand washing and bare below the elbows audits take place and are monitored by infection control and the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • All patients are screened on admission for VIM-P	• Minutes of the Directorate Q&S meeting • Leadership walkabout by senior nurses on back to floor Friday • Minutes of the Directorate Q&S meeting and score card • Minutes of the Directorate Q&S meeting minutes • Establishment review meeting minutes • Infection control data • Directorate Q&S meeting minutes • Infection control data • Directorate Q&S meeting minutes • Education programme/data base held by practice educator • ANTT data held by infection prevention and control team	• The effectiveness of the controls is evidenced by the clutter free environment and the ordering of stock to the appropriate levels • The evidence is fed back to the directorate Q&S meeting • Audits undertaken by PICU staff and data presented in harm free care reports • The practice educator, matron and senior nurses support this process.	None Identified	None Identified		Divisional Director for Women's and Children's

		• All patients are screened weekly for VIM-P • Training and adherence to the Trust's prevention of infection policy is in place • Bacterial filters are used on ventilator circuits for intubated children • There is a close partnership with the Trust's infection control team. Infection scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Remedial estate works have been carried out to replace all sinks/taps on unit have been replaced to prevent splash back • A Business Case has been compiled regarding the relocation of PICU to a larger footprint						

Risk Definition: 59 - Lack of senior clinicians at Charing Cross to review emergency cases								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2 CO3	**Cause:** • Reduction in Consultant Cover availability at Charing Cross • One Consultant on supervised practice restriction so cannot work independently • One Consultant on long term sick leave • Rota has been sustained by Breast and Endocrine Consultant surgeons who no longer feel skilled to undertake the GI emergency work. • Increased surgical work load at St Mary's with trauma centre work means out of hours work is intense for surgeons participating in that rota • Difficult to staff surgical rota on 3 sites to modern standards. • Recruitment difficulties of junior surgical staff at Charing Cross **Effect:** • Potential delay in review by senior clinicians **Impact:** • Detrimental impact on patient outcome • Poor patient experience • Negative media coverage resulting in loss of reputation	• Remove Breast and Endocrine Surgeons from on call rotas. • More cross site planning increasing daytime cover at Charing Cross (by moving staff across, generally from St Mary's) • Cross cover on call arrangements so Charing Cross on call rota supported by some Hammersmith Hospital Consultant surgeons • Presence of clinical pathways for patients with appropriate conditions to be transferred to St Mary's • Charing Cross Consultants no longer have on call commitments at Hammersmith site	• Feedback from surgical teams providing the service • Assurance that we are filling the slots in the rota • Monitoring of datix reports • Monitoring of complaints from staff and patients.	• The new rotas have been set up for the first part of 2014 • No recent datix incidents but we are closely monitoring this and complaints going forwards	None Identified	None Identified		Director of Surgery, Cancer and Cardiology

Risk Definition: 60 - The introduction of a single Radiology Information System (RIS) and Picture Archive and Communication System (PACS) has increased time to effectively undertake imaging in a timely way								
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1 CO2 CO3? CO4?	**Cause:** • Contractors being unable to provide a package suitable for a multi-site organisation • Currently the system is slow, crashes and freezes **Effect:** • RIS/PACS has increased time to book an imaging appointment • Increased waiting time for appointments • Delay to patient treatment **Impact:** • Reduced productivity of radiologists • Increased administration • Backlog of appointments • Delay in diagnosis • Breach of diagnostic waiting times	• Additional administration staff employed to process imaging appointments • Additional radiographer in place • Additional radiologist sessions being undertaken • Daily monitoring and reporting of backlog • Weekly meetings with GE to address issues	• Diagnostic patient waiting time report • Diagnostic reporting time report • Minutes from meetings with GE • Updates to Quality board	• Diagnostic patient waiting time report • Diagnostic reporting time report • Minutes from meetings with GE • Updates to Quality board	GE solutions are not always delivering improvements promised	None identified	• Regular meetings with GE • Executive involvement through Kevin Jarrold • Updates to Quality Board	Divisional Director of Investigative Science

Risk Definition: 61 - Consultant presence on Delivery Suite does not meet recommended benchmarks for the number of births							
Corporate Objective Number	Cause Effect Impact	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in control	Gaps in Assurance	Action plans for gaps in control or assurance	Overall Risk Owner
CO1	**Cause:** • Unit does not comply with recommended benchmarks for the number of births (Safer Childbirth report laid out the proposed obstetric staffing targets for a unit carrying out 5000-6000 birth per year as 98 hour consultant presence by the end of 2008, 168 hours by the end of 2010 **Effect:** • A lack of 24/7consultant presence on labour ward • Reduced support and guidance for trainees **Impact:** • Breach of national standards • Possible harm to patients • Negative media coverage resulting in loss of reputation	• QCCH cap the number of bookings to 215 bookings per fortnight for out of area referrals • Risks reviewed on a regular basis by Maternity Quality and Safety Committee and W&C Quality and Safety Board • The multidisciplinary team are encouraged to report incidents on datix • All incidents reported on datix are reviewed and investigated and fed back to the team via individual and team learning, local risk meetings and the maternity newsletter "Risky Business" • Business Plan submitted to Trust Investment Committee, approval granted for 8 posts additional consultants to achieve 98 hour presence on labour ward Plan for recruitment in place	• Booking data and minutes of the Q&S directorate meeting • Minutes of the directorate risk meeting. Q&S meeting and divisional Q&S board • Incidents reported on datix. • Minutes of directorate risk meetings • Local team meetings • Risky business news letter circulated via email and hard copy • Minutes of: investment committee/management board/directorate of maternity and divisional Q&S board	• Booking numbers contained within the agreed capped parameters • Two risk leads undertake the risk and governance function. Open and closed incidents are monitored at the directorate risk meeting • Recruitment process partially complete with 6 new consultants starting April 2014 and the remaining 2 in May14 • Successful recruitment process	Assessment of learning is not always undertaken	• Local team meetings do not always occur • There is no confirmation that staff have read the newsletter	Staff involved in the incident must be assessed where appropriate to ensure that learning has taken place. Educational and risk leads to implement this and evidence in SI report	Divisional Director of Women's and Children's

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.

Monthly Data: October 2013 Submitted 29/11/2013.

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	Compliance Yes/ No	Comment	Executive lead
1.**Condition G4** Fit and proper persons as Governors and Directors. (also applicable to those performing equivalent or similar functions)	Yes	None	Jayne Mee, Director of People and Organisational Development.
2. Condition G5 Having regard to monitor guidance.	Yes	None	Marcus Thorman. Director of Finance.
3. Condition G7 – Registration with the Care Quality Commission.	Yes	None	Cheryl Plumridge Director of Governance.
4. Condition G8 Patient eligibility and selection criteria.	Yes	None	Steve McManus, Chief Operating Officer.
5. Condition P1 Recording of information	Yes	None	Marcus Thorman, Director of Finance.

Condition	Compliance Yes/ No	Comment	Executive lead
6. Condition P2 Provision of information.	Yes	None	Marcus Thorman, Director of Finance.
7. Condition P3 Assurance report on submissions to Monitor.	Yes	None	Marcus Thorman, Director of Finance.
Condition	**Compliance Yes/ No**	**Comment**	**Executive lead**
8. Condition P4 Compliance with the National Tariff.	Yes	None	Marcus Thorman, Director of Finance.
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	None	Marcus Thorman, Director of Finance.
10. Condition C1 The right of patients to make choices.	Yes	None	Steve McManus, Chief Operating Officer.
11. Condition C2 Competition oversight.	Yes	None	Marcus Thorman, Director of Finance.
12. Condition IC1 Provision of integrated care.	Yes	None	Claire Braithwaite, Divisional Director of Operations.

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: October 2013, Submitted 29/11/2013.

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:	Compliance Yes/ No	Comment	Executive lead
1. 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.	Yes	None	Chris Harrison, Medical Director.
2. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes	None	Janice Sigsworth, Director of Nursing.
3. The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes	None	Chris Harrison, Medical director.

For Finance, that:	Compliance Yes/ No	Comment	
4. 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.	Yes	The Trust remains a going concern as defined by the most up to date accounting standards.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	**Compliance Yes/ No**	**Comment**	
5. 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.	Yes	As part of the on-going FT application the Trust is to review its compliance with the NHS Constitution. This work to be integrated into the review of the outcome of the Francis recommendations, with the action plan monitored by the Quality Committee/Audit, Risk and Governance Committee.	Janice Sigsworth Director of Nursing.
6. 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.	Yes	The Trust has a Risk Management Strategy and a Corporate Risk Register. The CRR identifies the key risks to the organisation. The CRR accompanied the Annual Governance Statement.	Cheryl Plumridge, Director of Governance and Assurance.
7. 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.	Yes	The Annual Governance Statement identifies significant issues for the coming year. A revised Risk Management Strategy has been approved at the July Trust Board meeting.	Janice Sigsworth Director of Nursing.
8. 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	Yes	All audit committee recommendations to the Board are implemented satisfactorily. ICHT's final 2013/14 Operating Plan was approved in May 2013	Cheryl Plumridge, Director of Governance and Assurance.

by the board are implemented satisfactorily.			
9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)	Yes	The Annual Governance Statement identifies significant issues for the coming year.	Cheryl Plumridge, Director of Governance and Assurance.
10. 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.	Yes	In October 2013 the Trust achieved good performance in: Achieving seven out of the eight cancer access standards (this relates to September data as reported one month in arrears); Achieving national 18 week referral to treatment waiting time target for admitted, non-admitted patients and patients on incomplete pathways; Achieving the 95% 'all types' 4 hour Accident & Emergency standard; Maintaining zero mixed sex accommodation breaches; Achieving above target for providing national care standards for stroke and maternity patients; Achieving venous thromboembolism assessment rates; Achieving the national diagnostics waiting time Standard; Sustained good scores for patient feedback.	Steve McManus, Chief Operating Officer.

		Areas identified as underperforming are: **MRSA:** The year to date number of Trust attributed cases of MRSA is nine against a tolerance of zero. However the Trust only recognises five of these cases as three of these cases are being actively contested and one is in arbitration. An action plan is in place to further minimise the level of infection. **Cancer:** The Trust failed to meet the cancer waiting times for 62 day first standard with 27 patients having delayed treatment. The focus and scrutiny on cancer performance continues to remain a high priority. Against the Monitor Risk Assessment Framework for October, the Trust scored 2.0 as not having met the cancer 62 day standard. **C.difficile:** was over the de minimis limit and exceeded the in-year trajectory.	
11. The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes	The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
12. 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;	Yes	The Trust has a declaration of interest policy and maintains a register of interests in accordance with accepted NHS practice with an item on each Board agenda dealing with interests.	Cheryl Plumridge, Director of Governance and Assurance.

and that all board positions are filled, or plans are in place to fill any vacancies.		A review of the committee structure has been carried out, and the recommended new committee structure was approved at the July Trust Board. A Board Development programme is being undertaken during the autumn as part of the FT application process.	
13. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes	A Board development programme is being undertaken during the autumn as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
14. 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.		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.

Building world class finance

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.

Monthly Data: November 2013 Submitted 23/12/2013.

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Condition	Compliance Yes/ No	Comment	Executive lead
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2. Condition G5 Having regard to monitor guidance.	Yes	None	Marcus Thorman. Director of Finance.
3. Condition G7 – Registration with the Care Quality Commission.	Yes	None	Cheryl Plumridge Director of Governance.
4. Condition G8 Patient eligibility and selection criteria.	Yes	None	Steve McManus, Chief Operating Officer.
5. Condition P1 Recording of information	Yes	None	Marcus Thorman, Director of Finance.

Condition	**Compliance Yes/ No**	**Comment**	**Executive lead**
6. Condition P2 Provision of information.	Yes	None	Marcus Thorman, Director of Finance.
7. Condition P3 Assurance report on submissions to Monitor.	Yes	None	Marcus Thorman, Director of Finance.
8. Condition P4 Compliance with the National Tariff.	Yes	None	Marcus Thorman, Director of Finance.
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	None	Marcus Thorman, Director of Finance.
10. Condition C1 The right of patients to make choices.	Yes	None	Steve McManus, Chief Operating Officer.
11. Condition C2 Competition oversight.	Yes	None	Marcus Thorman, Director of Finance.
12. Condition IC1 Provision of integrated care.	Yes	None	Claire Braithwaite, Divisional Director of Operations.

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
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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:	Compliance Yes/ No	Comment	Executive lead
1. 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.	Yes	None	Chris Harrison, Medical Director.
2. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes	None	Cheryl Plumridge, Director of Governance.
3. The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes	None	Chris Harrison, Medical director.

For Finance, that:	Compliance Yes/ No	Comment	
4. 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.	Yes	The Trust remains a going concern as defined by the most up to date accounting standards.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	**Compliance Yes/ No**	**Comment**	
5. 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.	Yes	As part of the on-going FT application the Trust is to review its compliance with the NHS Constitution. This work to be integrated into the review of the outcome of the Francis recommendations, with the action plan monitored by the Quality Committee/Audit, Risk and Governance Committee.	Janice Sigsworth Director of Nursing.
6. 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.	Yes	The Trust has a Risk Management Strategy and a Corporate Risk Register. The CRR identifies the key risks to the organisation. The CRR accompanied the Annual Governance Statement.	Cheryl Plumridge, Director of Governance and Assurance.
7. 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.	Yes	The Annual Governance Statement identifies significant issues for the coming year. A revised Risk Management Strategy has been approved at the July Trust Board meeting.	Cheryl Plumridge, Director of Governance and Assurance.
8. 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	Yes	All audit committee recommendations to the Board are implemented satisfactorily. ICHT's final 2013/14 Operating Plan was approved in May 2013	Cheryl Plumridge, Director of Governance and Assurance.

by the board are implemented satisfactorily.			
9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)	Yes	The Annual Governance Statement identifies significant issues for the coming year.	Cheryl Plumridge, Director of Governance and Assurance.
10. 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.	Yes	In December 2013 the cancer waiting time standards for October were published showing the Trust meet six out of the eight National Standards. The Trust failed to meet the 62 day first standard, hitting 71.5% (this improves to 73.5% if you adjust for the new LCA reallocation policy) against the 85% target, and the 62 day screening target, hitting 86.5% against a 90% target. For the 62 day first standard 25 patients had their treatment delayed. Of the 25 patients delayed, eight of them were patients referred from local trusts outside the recommended Inter-Trust Referral timeline by day 42. The majority of breaches were due to delay in access and reporting of diagnostics, late ITR's, insufficient elective capacity, there were 7 unavoidable breaches relating to the patient either being medically unfit, complex pathway, DNA or patient choice. The tumour site with the largest volume of breaches (10) was within the Urology services as expected as the Trust continues to clear the	Steve McManus, Chief Operating Officer.

		backlog. Across the 17 Trusts within the LCA, ICHT is one of eight Trusts who are failing the 62 day standards. There were 3.5 patients who breached the 62 screening target and all these patient breaches related to patient choice. The focus and scrutiny on cancer performance continues to remain a high priority. The focus will remain on reducing the backlog position, turnaround time of clinic letters, rigorous PTL management and the re-engineering of cancer pathways focusing on access to diagnostic services continues. The Imaging Department are now booking where possible all cancer referrals within 3-5 days of the referral being made. Progress on the Head and Neck and the Upper GI pathways is well underway. UGI will commence a 'direct to test' pilot early in the New Year. The new pathways in Urology (prostate and haematuria) that were launched at the end of October are proving successful. The new cancer waiting times management prospective tool that was implemented in November is being rolled out and will be the focus at the Elective Access Group (EAG) weekly meetings next year. This will give the Trust a facility to prospectively manage patients and identify patients earlier in their pathway and escalate as well as give the Trust the ability for the first time to	

		predict future cancer performance. Twice weekly meetings with the Chief Operating Officer or Deputy continue with the cancer management team to review and drive improvements in the cancer performance. **MRSA** There were no cases of MRSA in November attributed to the Trust. The year to date number of Trust attributed cases of MRSA remains at nine against a tolerance of zero, however five of these cases are recognised as Trust related, as due to a new process introduced in 2013, the Trust has also been allocated cases unrelated to care at the Trust. An action plan is in place to further minimise cases. **C. difficile** The Trust reported one case of Trust attributable C. difficile in November, the year to date total is 42 against the annual threshold of 65, this means that we are on trajectory for C.difficile.	
11. The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes	The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
12. 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;	Yes	The Trust has a declaration of interest policy and maintains a register of interests in accordance with accepted NHS practice with an item on each Board agenda dealing with interests.	Cheryl Plumridge, Director of Governance and Assurance.

and that all board positions are filled, or plans are in place to fill any vacancies.		A review of the committee structure has been carried out, and the recommended new committee structure was approved at the July Trust Board. A Board Development programme is being undertaken during the autumn as part of the FT application process.	
13. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes	A Board development programme is being undertaken during the autumn as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
14. 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.		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.

Imperial College Healthcare NHS Trust

BGM Submission Document

[Insert date of BGM submission]

[Insert planned date to enter DH process as per TFA]

DRAFT

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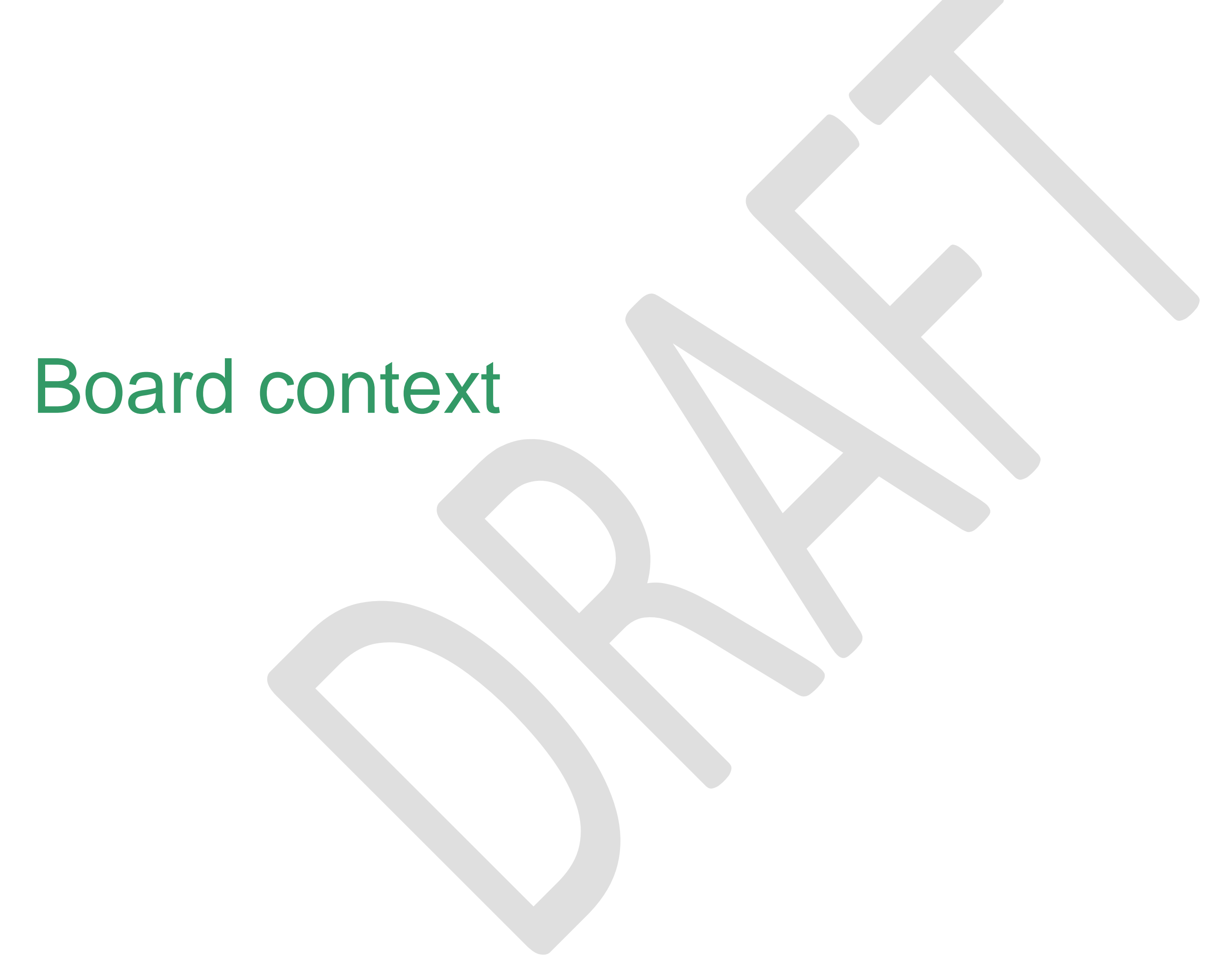
DRAFT

Board context



Board context

This section should set the overall context for the Trust and should include a brief overview of the Trust, together with a summary of the Board's key strategic objectives and how the Trust is performing against them. This overview links into section 3.3 of the Board Memorandum under good practice point 5 which covers the Board's strategic focus. It provides the Board with an opportunity to summarise what is important to the organisation, how it performs against KPIs and what patients think of the services provided.

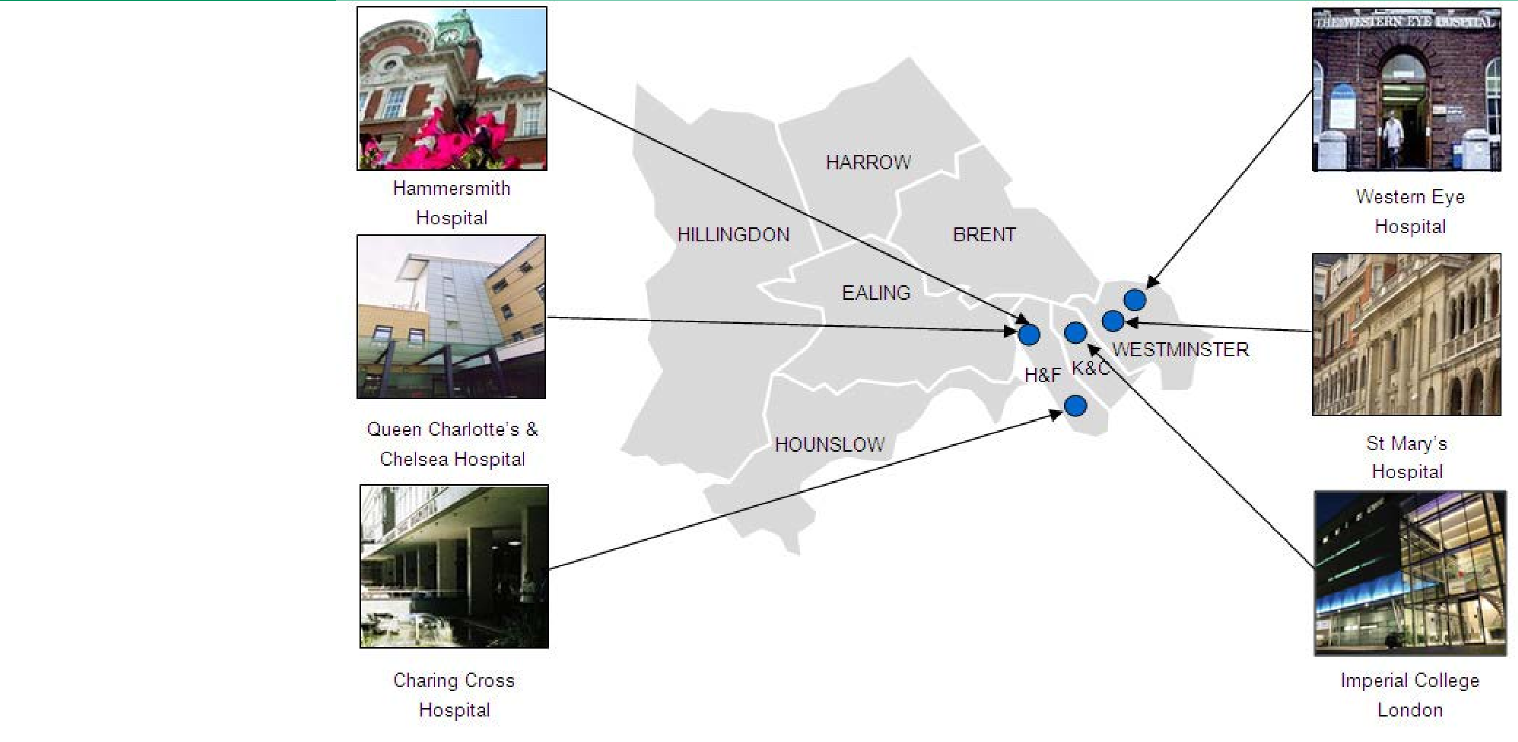
In this section please provide a brief overview of:

1. Your organisation in terms of income, staff and key services provided;
2. Your organisation's key strategic objectives;
3. Summary of the KPIs the Board uses to track performance against these objectives and how it is currently performing;
4. Summary of the Trust position with regards patient feedback

Trust Profile

Imperial College Healthcare NHS Trust is one of the largest NHS Trusts in the country, with a turnover of £971m in 2012/13. The Trust was created on 1 October 2007, by merging Hammersmith Hospitals NHS Trust and St Mary's NHS Trust. In 2013/13 the Trust provided specialist care for patients from over eighty commissioners nationwide , as well as providing a comprehensive range of services to over two million people in North West London. The Trust has consistently provided high quality care by overall UK standards, being ranked each year for the past three years to 2012 in the top three hospitals by HSMRs in England.

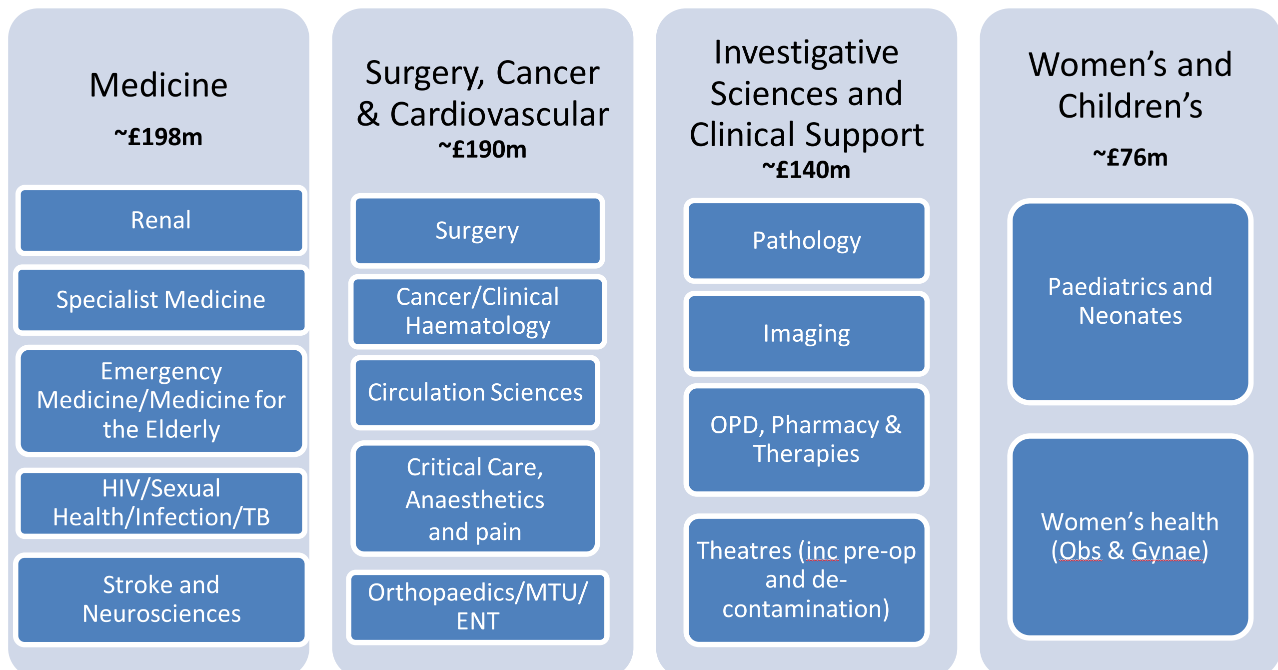
The Trust delivers services from five hospitals on three campuses at St Mary's, Hammersmith and Charing Cross. The location of these hospitals and of Imperial College within the North West London health sector is shown below :



The size and scale of the Trust is demonstrated further by the following key facts in 2012/13

- There were **1.3 million patient encounters** at our hospitals
- **811,000 outpatients** attended our hospitals
- **280,000 patients** attended our **emergency departments**
- **82,500 patients** were admitted to **emergency care**
- We undertook **65,000 day case procedures**
- **9,500 babies** were born at our maternity units
- We treated over **1,800 stroke patients**
- Over **700 head injuries** were treated in the **major trauma centre**
- More than **46,000 patients** were recruited into **clinical trials**
- More than **600 individual research projects** were active
- We employed **9,500 people**
- Our annual turnover was **£971 million**

The Clinical services that the Trust delivers are organised into four divisions, each led by a Divisional Director and supported by a Divisional Director of Operations and a Divisional Director of Nursing to ensure that the quality of care provided to our patients is led from the top. Income and services provided by the Divisions are:



Vision and Strategic Objectives

The Trust has recently reviewed and discussed its vision and strategic objectives which are:

Vision:

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 service in order to transform the experience of our patients.

Strategic objectives:

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 (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;

Performance

An integrated performance scorecard has been developed for the Trust Board to monitor key performance indicators across the main areas of quality, workforce and finance. Indicators within the quality section of the scorecard are directly linked to the Trust's Quality Strategy which defines six key themes; safety, patient centeredness, effectiveness, efficiency, timeliness and equity. Standards defined by the Care Quality Commission, Monitor and the National Trust Development Authority are all included within the scorecard. In addition, any other contractual indicators agreed nationally or in local negotiation with commissioners through CQUIN etc are included in the scorecard. In relation to the 2013/14 Monitor Risk Framework, the Trust is compliant with all mandatory indicators with the exception of the 62-day cancer waiting times standard. A detailed action plan setting out how the Trust will deliver this standard sustainably is in place and frequent updates are provided to the Board and its sub-committees. In the last two quarters of 2013/14 the Trust was rated 'green-amber' under the definitions of the Monitor risk-assessment framework

The Trust aims to provide a patient experience that matches its performance in relation to clinical outcomes. Key to achieving this is hearing the voice of patients and making sure this is listened to and acted upon. The Trust uses a number of mechanisms and routes to collect patient feedback and comments, including real-time surveys, qualitative interviews, the PALS service, NHS Choices and patient panels.

In June 2010 the Trust introduced a real-time patient feedback and monitoring system (iTrack). The Trust has invested in over 160 electronic devices, which are deployed across all services and contain surveys covering a range of metrics drawn primarily from the national surveys. From April 2013, the ability for patients to include free text comments was added.

The engagement from both patients and staff in supporting a programme of improving services using real-time feedback has been very successful. The Trust now has a much greater understanding of the key issues and areas for improvement. In the region of 10,000 responses are collected from patients each month. This feedback has informed a number of improvement initiatives for example:

- Ward contact cards to ensure that patients know who to contact
- Ward based photo boards so that patients and relatives know who is who and what they do
- Bedside information boards which include the patient's preferred name, key staff caring for them and the date they are expected to leave hospital
- A poster campaign encouraging patients to be involved in their care and encouraging them to give feedback
- "You said, we did" posters that give examples of changes that have been made as a direct result of patient feedback

In spring 2014 the Trust will launch a new patient experience strategy which is aimed at achieving patient experience improvements across a range of issues. The strategy is built around three key elements; patients, people and processes. It is recognised that getting these three things right is the best way of achieving a consistently high level of patient experience.

Whilst the trust recognises the need to continuously improve the experience of its patients, a number of indicators already demonstrate that patients rate their care highly, for example over 95% of patients would recommend inpatient services, and over 90% would recommend our A&E and maternity services. The *Friends and Family Test* scores are good when compared to the London average; inpatients = 70 (London 63) and A&E = 54 (London 49). They are essentially the same as the national average (71 and 54).

Patient experience is seen at the Trust Board through both the performance scorecards and patient stories. Ward managers and heads of department can see patient feedback in real-time using a central web based reporting system. In addition, monthly divisional and trust performance reports, which integrate qualitative feedback with the quantitative scores, are provided. This triangulated approach enables the identification of trends and themes across the trust, which in turn drives local and wider improvement plans.

Quarterly Patient Safety and Service Quality Reports evidence learning from complaints, setting out the number, type and theme of complaints and compliance against national requirements and are seen by the Trust Board. The main areas of concern this year relate to patient care/experience (52%), outpatient delays/waiting times (12%) and, communication/information to patients (8%). Additionally, a monthly joint report is presented by PALS and the central complaints team at the bi-monthly complaints forum which reviews joint themes and helps to share learning from complaints.

Last year new governance structures where established in each of our newly formed Divisions. The corporate complaints team are working closely with the Divisional complaints teams to help improve the standard of our responses and to personalise each response rather than using a one-size-fits-all template. A number of training sessions have also taken place with Trust complaints staff and the new Director of Governance & Assurance (appointed July 2013) now sees every letter of complaint and is personally involved with individual complaint handling. Benchmarking has taken place with other Trusts, in particular the Shelford group, to help refresh the KPIs used for complaint handling. These initiatives will help ensure that the feedback we receive through the complaint channel helps

to make significant change so that we can demonstrate that we are learning from complaints and concerns. The Trust is also ensuring it is linking SIs, complaints, Inquests and claims to ensure any heat spots are quickly identified and dealt with and that there is a continuum of feedback utilising all sources of feedback from patients and staff.

People Strategy

The Trust's People Strategy is predicated on the vision of providing excellent patient care services, research and education which relies on building a strong organisation. This in turn relies on developing world-class leadership and workforce. The People Strategy is focused on recruiting, retaining, developing and organising the best staff and leaders. This philosophy is at the core of all the Trust does and all that it plans to do, underpinning the overarching organisational strategy and develops the talent and culture proactively to provide a sustainable business and opportunities for advancement and development for all.

The People Strategy will be delivered through implementation of integrated plans in four key areas:

- Culture & Engagement

  - Engaging our people on the Trust's strategic aims, objectives, ways of working and values through effective organisational design, support of change management, attraction and recruitment processes, and an effective engagement programme;
  - Ensuring that our people and patients across all protected groups have an opportunity to be involved in the decisions that affect them;
  - Supporting an outstanding community of care for our patients through excellence in people management and partnership with the Trust's trade unions;
  - Embedding a culture of recognition through forging real and tangible links between performance, reward, recognition and incentives.

- Organisational Development

  - Ensuring the Trust has the leadership, talent and workforce capacity and capability, supported by the right organisational systems, culture and design to achieve its vision and strategy;
  - Creating world-class standards and practice in workforce utilisation to the benefit of our patients and our people;
  - Embedding a performance culture through forging real and tangible links between people and organisation performance,

managing performance and development, and rigorously taking action against reported KPIs;

- Maximising the performance and development of our people through the effective use of performance management and appraisal processes;
- Resourcing to attract, recruit and retain the very best workforce, and one that reflects the communities the Trust serves.

- Talent Development

  - Ensuring that the organisation meets its mandatory and statutory responsibilities as an employer in relation to the training and education of its people, as well as equipping them with the basic skills and knowledge to undertake their role safely and effectively;
  - Developing a succession planning process which allows the management of talent to ensure that the organisation has a pipeline this will deliver outstanding results and patient experience;
  - Developing world-class leadership throughout the organisation by providing emerging internal leadership development provision to ensure they are supported to develop the skills competencies and knowledge to achieve the Trust's strategic goals.

- Health and Wellbeing

  - Promoting good health for our people, our patients and their families and friends;
  - Recognising that excellent health and wellbeing is essential for optimal quality of life and productivity in our people and in the communities that the Trust serves;
  - Building on ICHT's status as a World Health Organisation Health Promoting Hospital to deliver an overarching health and wellbeing strategy that engages stakeholder populations

Education

Imperial College Healthcare NHS Trust and Imperial College London form a unique partnership and together they became the UK's first Academic Health Science Centre (AHSC) in March 2009. One of only six AHSCs in the country, it aims to improve the quality of life our patients and populations by taking scientific discoveries and translating them into new therapies and techniques and bringing them into an NHS setting in as quick a timeframe as possible. The AHSC has been successfully re-designated for a further five years from April 2014.

The Trust is a centre of excellence for biomedical research and education with a long standing and extremely successful academic

partnership with Imperial College London. It hosts the largest NIHR Biomedical Research Centre in the UK. In 2012, Imperial College Health Partners was designated an Academic Health Science Network (AHSN) representing the NHS in North West London. In addition to Imperial College Healthcare Trust and Imperial College, the partnership includes the other NHS organisations in the area from across the primary care, acute and mental health sectors. The aim of the AHSN is to act as the driving force for collaborative working across North West London, to deliver improvements in patient care and population health, generate value for the taxpayer, support and develop our staff and create wealth for the economy.

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Summary results

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Summary results

Overview of BGM sections 1 to 3 inclusive

Ref	Area	Self-Assessment rating	Any additional notes
1. Board composition and commitment			
1.1	Board positions and size	Amber/Red	
1.2	Balance and calibre of Board members	Amber/Green	
1.3	Board member commitment	Green	
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	Green	
2.2	Whole Board development programme	Amber/Green	
2.3	Board induction, succession and contingency planning	Amber/Green	
2.4	Board member appraisal and personal development	Amber/Green	
3. Board insight and foresight			
3.1	Board performance reporting	Amber/Green	
3.2	Efficiency and Productivity	Green	
3.3	Environmental and strategic focus	Amber/Green	
3.4	Quality of Board papers and timeliness of information	Amber/Green	

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Summary results

Overview of BGM sections 4 to 5 inclusive

4. Board engagement and involvement			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
4.1	External stakeholders	Green	
4.2	Internal stakeholders	Amber/Green	
4.3	Board profile and visibility	Amber/Green	
4.4	Future engagement with FT Governors	Red	

5. Board impact case studies		
Key points to highlight		
5.1	Performance issues in the areas of quality	Turnaround of RTT and Cancer Performance
5.2	Performance issues in the areas of finance	Financial Turnaround 2011 - 13
5.3	Organisational culture change	Revising the Trust's Quality Governance Structure, underpinned by the development of a Quality Structure
5.4	Organisational strategy	The Board's role in Vision and Strategy – Clinical Strategy

DRAFT

1. Board composition and commitment

DRAFT

Amber/Red

1. Board composition and commitment

1.1 Board positions and size

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The size of the Board (including voting and non-voting members of the Board) is appropriate for the requirements of the business. Board Compromises Chairman, six NEDs, one NED Designate and 5 Executive Directors. Director of People and Organisation Development and Director of Governance and Assurance attend all Board meetings with adhoc attendance of other Directors including Director of Strategy. The Director of Infection Prevention and Control attends all meetings to present her report and only attends for this item. The Dean of the Faculty of Medicine of Imperial College also attends all Board meetings. **GP2 All voting positions are substantively filed.** The Chief Executive role is currently split between two acting Chief Executives (previously the Chief Financial Officer and Medical Director) whilst arrangements are in place to recruit a permanent CEO with the Chief Financial Officer and Medical Director positions covered by deputies. **GP3 The Board has a Senior Independent Director (SID) in place.** The SID is Sir Thomas Legg. **GP4 The Board has a Foundation Trust Secretary (or equivalent) in place.** This role is undertaken by the Director of Governance & Assurance. **GP5 It is clear who on the Board is entitled to vote.** Minutes clearly show members and those in attendance. **GP6 At least half the Board of Directors, excluding the Chair, comprise NEDs determined by the Board to be independent (refer A3.2 and C2.2 in the Monitor NHS Foundation Trust Code of Governance).**		**GP2** Following the unexpected departure of the CEO in October 2013 substantive recruitment is taking place as an immediate priority and interim arrangements for the Office of the Chief Executive have been put in place with immediate effect, in consultation with the TDA. The process of recruitment is set to be concluded by 5 February 2014.

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At least half of the Board of Directors, excluding the chair, comprise NEDs determined by the Board to be independent. **GP7 Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or leave the Board within a short space of time**. Appointments are staggered.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1. The Chair and/or CEO are currently interim or the position(s) vacant. *Interim in place.* 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). ~~3. The number of people who routinely attend Board meetings is unwieldy compared to other NHS Provider Trusts~~	1. Steps are being taken as described above to recruit a permanent CEO. 2. Red flag will be removed on 1 April 2014.	1. As at 1 January 2014 the Chairman and two of the NEDs has been a member of the Board in excess of two years and from 1 April 2014 this number will increase to the Chairman and 4 of the NEDs. Following the departure of the CEO the CFO and Medical Director moved from their substantive Board roles to become the acting CEO. To cover the substantive roles of CFO and Medical Director their substantive deputies were moved into these Board roles on an acting basis. Once the appointment of the CEO has been made and affected those acting up will return to their substantive roles as appropriate. Currently only one of the Executive Directors and one of the acting CEOs has been a member of the Board in excess of two years. As from 1 April 2014, as a whole, more than 50% of the Board members will have been in post for over 2 years.

Amber/Green

1. Board composition and commitment

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the Trust over the next 5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the Trust's IBP. Due consideration has been given and a skills audit undertaken for the NEDs. The NEDs with the most appropriate skills in each area are utilised as Chairs of the Committees of the Board. The nature of the Executive's roles is clearly indicative of their area specialism. **GP2 In selecting Board members, the Chair and CEO have given due consideration to various qualities that are essential for the person to be effective in their Board role (e.g. effective at working in teams, independence of thought, well developed political/ influencing skills, sound judgement, ability to build trusting and respectful relationships, ability to listen first and then assert their view).** Due consideration has been given to the various essential qualities and there is a very clear Person Specification outlined by the TDA which has been in use and proven very helpful in particular for NEDs. For Executive Director recruitment a similar process is followed with input from recognised search firms. . The Board and Executive Development programmes are designed to build Board members self-awareness, maximise positive personal qualities and manage personal areas for development. **GP3 The Board has an appropriate blend of NEDs from the public, private and voluntary sectors.** There is appropriate representation from all three sectors. **GP4 The Board has given due consideration to the diversity of its composition in**	**GP1** A formal skills audit of the Executive Directors has not been undertaken and will be considered as part of the Executive Development Programme which is led by the Director of People and Organisation Development.	**GP4** Recruitment to comply with the Equality Act 2010 is an intrinsic part of the Trust's process both for Executive Directors directly recruited by the Trust and the criteria set down by the TDA for the appointment of NEDs. Whenever vacancies occur all appropriate encouragement will be given to enable the Trust to better represent the population that it serves but it is restricted on appointment from those who apply.

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terms of the protected characteristic groups in the Equality Act 2010. Recruitment to Board posts has been in line with the Equality Act 2010 however it recognises that it is not fully representative of the patients or population that the Trust serves. Whenever an opportunity to recruit arises, careful consideration is given to the requirements and diversity required to ensure that the Board is able to work as a unitary Board. In September 2014 Sir Thomas Legg will come to the end of his appointment and a recruitment process will be applied by the TDA that complies fully with the Equality Act 2010. **GP5 There is at least one NED with a clinical healthcare background (e.g. a doctor, nurse or allied health professional who is not conflicted).** Professor Sir Anthony Newman Taylor has a clinical background **GP6 There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.** There is an appropriate balance. **GP7 The majority of the Board are experienced Board members.** The majority of the Board are experienced Board members. **GP8 The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.** The Chairman has considerable experience including being Chairman of NHS London from December 2008 - July 2010. **GP9 The Chair of the Board has previous Non-Executive experience.** The Chairman was senior independent director, non-executive deputy chairman and chairman of the Remuneration Committee of ENRC from 2007 - June 2011 and chairman of NHS London from December 2008 to July 2010 **GP10 At least one member of the Audit Committee has recent and relevant financial experience.** Sir Gerald Acher, who is the Chair of the Audit, Risk & Governance Committee has recent and relevant financial experience.		

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Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. There are no NEDs with a recent and relevant financial background.~~ ~~2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.~~ ~~3. The majority of Board members are in their first Board position.~~ ~~4. The majority of Board members are new to the organisation (i.e. within their first 18 months).~~		

Green

1. Board composition and commitment

1.3 Board member commitment

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 Board members have a good attendance record at all formal Board and Committee meetings and at Board events (e.g. workshops; quality walks etc). Records demonstrate good attendance. At the Audit, Risk & Governance Committee consistency of attendees at committee meetings was specifically discussed in relation to proposed changes to the Terms of Reference resulting in agreement that deputies would not be nominated to attend in the absence of core committee members. **GP2 The Board has discussed the time commitment required of the FT process and Board members have committed to set aside this time.** Regular FT Updates to the Trust Board meeting demonstrate the discussion having taken place. In addition the Board has dedicated considerable time to the key aspects of the FT preparation **GP3 The Board has an explicit 'Code of Conduct' which clearly describes the behaviours expected of Board members. These behaviours are aligned to the values of the Trust and the 7 Nolan Principles of Public Life. Compliance with the code is routinely monitored by the Chair and included as part of each Board member's annual appraisal.** The Board has a Code of Conduct to which all Board members adhere and which is refreshed annually.		

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Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. There is a record of Board and Committee meetings not being quorate.~~ ~~2. There is regular non-attendance by one or more Board members at Board or Committee meetings.~~ ~~3. Attendance at one or more Committees is inconsistent (i.e. the same Board members do not consistently attend the same Committee meetings).~~ ~~4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.~~		

2. Board evaluation, development and learning

DRAFT

Green

Board evaluation, development and learning

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 Formal evaluations of the Board and Committees have been undertaken within the previous 12 months consistent with the NHS Foundation Trust Code of Governance. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken. A review of the Governance structure based upon the principles of the NHS Foundation Trust Code of Governance was undertaken during the Spring/Summer 2013 which resulted in changes to the Committee Structure and a review of Terms of Reference of all Committees which was agreed by the Board at their meeting on 24 July 2013. As part of ongoing evaluation a review will be undertaken against Monitor's Code of Governance for NHS Foundation Trusts which will be reported to the Board at their meeting on 30 July 2014. **GP2 The Board has had an independent evaluation of its effectiveness and committee structure within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.** The Board has commissioned Dr Jay Bevington of Deloitte LLP in June 2013 to assess its effectiveness and develop a programme tailored to address its development needs. The report was based on a range of sources including interviews with internal and external stakeholders, Board observations and desk based research. The evaluations focused	**GP1** The review against Monitor's Code of Governance for NHS Foundation Trusts will be led by the Director of Governance & Assurance and will report to the 30 July 2014 Board Meeting	

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equally on traditional "hard" and "soft" indicators of effectiveness, including effective chairmanship, knowledge and skills mix, effectiveness of challenge and quality of relationships. The Programme is now in place and working well. **GP3 In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners and/or patients) on whether or not they perceive the Board to be effective.** In October 2012 the Board commissioned College Hill to undertake a survey of external stakeholders' views of the organisation and its leadership. This was followed by a report detailing recommendations in August 2013 which are to be incorporated into the Board's stakeholder engagement and Board Development plans. **GP4 The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum:** **The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this;** **How effectively meetings of the Board are chaired;** **The effectiveness of challenge provided by Board members;** **Role clarity between the Chair and CEO, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees;** **Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.** **The quality of relationships between Board members, including the Chair and CEO. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.** See GP2 & GP3.		

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Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1. ~~No formal Board evaluation has been undertaken within the last 12 months.~~ 2. ~~The Board has not undertaken an independent evaluation of its effectiveness within the last 2 years.~~ 3. ~~Where the Board has undertaken an evaluation, only the perspectives of Trust Board members were considered and not those outside the Board (e.g. staff, commissioners etc).~~ 4. ~~Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).~~		

Amber/Green

Board evaluation, development and learning

2.2 Whole Board Development Programme

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding what FT status means; development specific to the Trust's FT application; and reflecting on the effectiveness of the Board and its supporting governance arrangements. The Board has commissioned Dr Jay Bevington of Deloitte LLP in June 2013 to assess its effectiveness and develop a programme tailored to address its development needs. **GP2 Understanding what FT status means - Board members have an appreciation of how they will be regulated as an NHS FT and the role of the Board and NEDs in an FT environment** The Board has received reports from the FT Programme Board which have discussed what FT status will mean. In addition developmental work forms part of the Board Development Programme referenced in GP1. **GP3 Development specific to the Trust's FT application – the Board is or has been engaged in the development of the IBP and LTFM and self-assessing the Trust's quality governance arrangements against Monitor's Quality Governance Framework.** The Board has been involved in the development of the IBP, LTFM and the governance arrangements against Monitor's Quality Governance Framework. **GP4 Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:**	**GP6** Post authorisation needs will be considered as part of the Board Development Programme in consultation with the Chairman of the FT Programme Board. The Executive lead for this will be the Director of People and Organisation Development. This will continue to be an ongoing requirement until authorisation.	

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The focus and balance of Board time;

The quality and value of the Board's contribution and added value to the AFT;

How the Board responded to any service or financial failures;

Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board;

The robustness of the Trust's risk management processes;

The reliability, validity and comprehensiveness of information received by the Board.

The Board Development Plan includes time for Board members to reflect upon the effectiveness of the Board. The Governance structure review incorporated discussion and input from members of the Board. The trustwide review of risk management processes incorporated discussion and input from members of the Board which led to a new Risk Management Strategy being approved by the Trust Board in July 2013 which sets out a clearer methodology to better articulate risk.

GP5 Time is "protected" for undertaking this programme and it is well attended.
Time is protected and the programme is well attended.

GP6 The Board has considered, at a high level, the potential development needs of the Board post authorisation as an FT.
Initial consideration has been given but this will be developed further by a programme of seminars once the current Board Development Programme is approximately half way through and will be done in conjunction with Jay Bevington from Deloitte LLP.

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. The Board does not currently have a Board development programme in place.~~ 2. ~~The Board Development Programme is not aligned to helping the Board achieve FT status~~		

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Amber/Green

Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, and the statutory duties of Board members in FTs. There is a NED induction programme framework which is tailored specifically depending on the role the NED is required to undertake. The most recent was for Dr Andreas Raffel. Executive Directors have a tailored programme depending upon their role and experience. **GP2 Induction for Board members is conducted on a timely basis.** Induction is conducted on a timely basis. **GP3 Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the Trust, the organisation's structure, Trust values and meetings with key leaders.** All new people to the Trust, including Board Members, attend the Corporate Welcome where they receive a variety of corporate information including an overview of the Trust's services, organisational structure and values. Additionally they will have a bespoke local induction programme. **GP4 Deputy positions for the Chair and CEO have been formally designated and minuted.** Deputy Chair is Sir Thomas Legg. Deputy CEO position will be addressed upon appointment of permanent CEO.	**GP5** More detailed succession plans will be developed as part of the Talent Management Programme. This work is led by the Director of People and Organisation Development.	**GP4** Although there is currently no nominated Deputy CEO the Trust currently has two interim CEOs which negates the necessity for a deputy. Upon appointment of a permanent CEO consideration will be given at that time to the appointment of a deputy.

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GP5 statement		
GP5 The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions (Executive and Non Executive) notwithstanding the requirement to market test applicants and, where appropriate, recruit externally A high level succession plan is currently in place which will be developed as part of the Trust's Talent Management Programme which is led by the Director of People and Organisation Development and which will take into account the key skills required to cover the organisation. When the decision was made to replace the Chief Executive a clear process was put in place to cover interim arrangements for that role showing a good blend of business acumen and clinical robustness to lead the Trust through what could be a challenging time. The Director roles vacated were filled by Deputies already within the Trust bringing continued stability and assurance. This clearly demonstrates that the Trust's high level plans are robust and effective.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. There is no formal induction for new members of the Board.~~ 2. Deputy Chair and Deputy CEO positions have not been formally designated and noted in Board minutes. 3. ~~NED appointment terms are not sufficiently staggered~~.		2. Deputy CEO will be appointed after completion of CEO appointment.

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Board composition and commitment

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The effectiveness of each Board member's contribution to the Board, including the Board contribution of Executive Directors, is formally evaluated on an annual basis by the Chair (in the case of Executive Directors, this appraisal may form part of a wider annual appraisal process and therefore fed back via the CEO). The evaluation process includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. 360 degree appraisal) and how they have performed against their objectives. The Chair and NEDs are appraised annually in line with TDA guidelines. The CEO is appraised annually by the Chair and Executives are appraised annually by the CEO. Performance against objectives is reviewed by the Remuneration and Appointments Committee. 360 degree appraisal is currently ongoing for the Chair but not the NEDs as this is not a requirement of the TDA process of which the Trust is obliged to follow. 360 degree evaluation has not taken place for the Executive Directors however different perspectives are taken into account before appraising. **GP2 There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the Senior Independent Director.** The Appraisal process for the Chair is currently led by the TDA. On authorisation a process of evaluation of the Chair by the SID will be agreed with the Council of Governors. **GP3 Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis by the Chair.** Each Board member has objectives specific to their Board role that are reviewed on an annual basis by the Chair. **GP4 Each Board member has a Personal Development Plan that is directly relevant to**		**GP1** The Trust recognises that 360 evaluation has not previously been undertaken but this is now taking place for the Chair. It is not taking place for NEDs (other than the chair) as this does not form part of the TDA appraisal process **GP2** Appraisal for the Chair is currently undertaken by the TDA. **GP4** All Executive Directors have PDPs as part of their formal Trust appraisal and these will include reference to their Board role where appropriate. The NEDs do not have PDPs as such. The considerable depth and breadth of the NEDs means that they have already undergone significant training and development.

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the successful delivery of their Board role. In particular, each Board member has reflected upon their personal development needs in relation to helping the Trust successfully achieve FT authorisation and, where appropriate, has included these needs within their Personal Development Plan. Executive Directors have PDPs which include, where appropriate, reference to their Board Role. All Board Members have regular Board Seminars which are developmental in approach. The NEDs do not have formal PDPs but receive adhoc development where required. In addition all of the Executive Directors have NED mentors which commenced in October 2013. All Directors have the opportunity of attending external events including Kings Fund Events. **GP5 There are processes in place to ensure the development of Executive Directors as Corporate Directors.** An Executive Development programme was established in 2013, facilitated by RHR International, designed to enhance the cohesion of the Executive team and promote a positive working culture and behavioral norms. The Executive team has participated in bi-monthly away days since September 2013. **GP6 As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level** The Board Development Programme is instrumental in supporting the development of members specifically in improving the quality of their contribution to Board meetings. Additionally the Executive Directors have been working on this as part of their Executive Development Programme which is behavioural in its approach. **GP7 The involvement of Governors in the Chair and NED appraisal process once the Trust is an FT has been considered** This will be developed working alongside the Council of Governors on authorisation as it is important for them to have ownership of the Chair and NED appraisal process.		Developmental needs are therefore addressed on an individual adhoc basis during the appraisal process and as part of the Board Development Plan. By way of example a number of the NEDs have requested individual meetings to discuss areas of the FT application with Deloittes which have been undertaken. **GP7** The Trust is keen to involve the Council of Governors in developing the appraisal process and this will be one of the first items for their first Council meeting.

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. There is not a robust performance appraisal process in place at Board level that evaluates the Board contributions of every member of the~~		

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~~Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.~~ ~~2.~~ ~~Individual Board members have not received any formal training or professional development relating to their Board role~~		

3. Board insight and foresight

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Board insight and foresight

3.1 Board Performance Reporting

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics that are relevant to the Board given the context within which it is operating and what it is trying to achieve. The Board has had the debate and a set of quality and financial metrics have been agreed in the shape of a Trust Scorecard. **GP2 The Board receives a performance report which includes:** **A fully integrated performance dashboard which enables the Board to consider the performance of the Trust against a range of metrics including quality, performance, activity and finance and enables links to be made (e.g. financial variances are linked to activity);** **Variances from plan are clearly highlighted and explained;** **Key trends and findings are outlined and commented on;** **Future performance is projected with associated risks and mitigations provided where appropriate (e.g. forecast outturn);** **Key quality information is triangulated (e.g. complaints, claims, incidents, Rule 43 issues, key HR metrics, and audit findings) so that Board members can accurately describe where problematic service lines are;** **Benchmarking of performance to comparable organisations is included where possible;**	**GP3** A written summary is not provided on key items discussed by the Committees at the present time but a summary will be developed for the March Board meeting led by the Director of Governance & Assurance.	

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Supporting performance detail is broken down by Service Line so members can understand which services are high and low performing from a financial and quality perspective.
The Chief Operating Officer is leading the development of an Integrated Performance Report (Scorecard) which will triangulate financial, operational and workforce KPIs for timely Board reporting, which will enable the Board to have greater visibility of the key drivers of performance and provide a platform for more robust scrutiny. The Board had an opportunity to discuss the format of the Integrated Performance Report at a Board Seminar on 18 December 2013 and will receive the first Integrated Performance Report at its meeting on 29 January 2014. Benchmarking of performance data with the Shelford Group has been undertaken.

GP3 The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.
The Board receives a brief verbal update from the Non-Executive Chair of each committee on key issues arising together with copies of approved minutes. Detailed discussions take place, if required. The Board does not presently receive a written summary of key items.

GP4 The Board regularly discusses the key risks facing the AFT and plans to manage or mitigate them.
The Board regularly receives FT Updates as individual papers which consider the key risks facing the Trust's FT application. It receives the minutes of the FT Programme Board and a verbal update from the Chairman of the FTPB. It also receives adhoc FT related papers eg the Consultation paper.

GP5 An action log is taken at Board meetings. Accountable individuals and challenging / demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
The Board has an action log that is updated following each formal meeting with progress against tasks actively monitored by the Corporate Governance team which is reported back to the Board via the action log. No action is removed from the log until it is closed.

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Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1~~. Significant unplanned variances in performance have occurred~~ ~~2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.~~ ~~3. Finance and Quality reports are considered in isolation from one another.~~ ~~4. The Board does not receive 12 month rolling cash flow forecast information.~~ ~~5. The Board only receives minutes of Committee meetings and does not tend to discuss them.~~ 6. ~~The Board does not have an action log.~~ ~~7. Key risks are not reported / escalated up to the Trust Board.~~		

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Board insight and foresight

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board is assured that there is a robust process for prospectively assessing the risk(s) to care quality and the potential knock-on impact on the wider health and social care community of implementing CIPs. This process requires the Medical, Nursing and Operations Directors to all sign-off each major CIP to ensure that patient safety is not compromised. There is a robust process for implementing CIPs which requires the sign off of Medical, Nursing and the Chief Operating Officer. A quarterly clinical review meeting is held between the divisional colleagues and the Medical Director and Director of Nursing to quality assure and confirm/challenge the QIA's **GP2 The Board can provide examples of CIPs that have been rejected or significantly modified due to their potential impact on patient safety.** The Board is not able to provide any examples as the CIP process is robust and appropriate which has resulted in no matters escalating up to the Board for resolution regarding a potential detrimental impact on patient safety. There are however examples of CIPs having been rejected as part of the process due to their potential detrimental impact on patient safety. **GP3 The Board receives information on all major CIPs/ QIPP plans on a regular basis, including how other organisations in the local health economy are performing against QIPP. Schemes are allocated to lead Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement of each major CIP is clearly stated and contingency measures are articulated.** Through the Finance Report, the Board receives a regular update on CIP delivery progress including an assessment of risks to delivery and contingency plans. **GP4 There is a process in place to monitor the ongoing risks to care quality for each**		

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scheme once a scheme has been implemented, including a programme of formal post implementation reviews. Change(s) to working practice(s) due to major CIPs are supported by a programme of organisation development. Post implementation reviews take place via the Investment Committee which has a post project evaluation system in place.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1~~. The Board does not receive performance information relating to progress against CIPs and QIPP targets and plans.~~ 2. ~~There is no process currently in place to prospectively assess the risk(s) to care quality presented by CIPs.~~		

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3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The CEO presents a report to every Board detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks in the health economy, PBR new tariffs etc.). The impact on strategic direction is debated and, where relevant, updates are made to the Trust's risk registers and BAF. The CEO's bi-monthly report to the Board describes important changes in the external environment and the impact this may have on the Trust. Updates to the Corporate Risk Register are made as and when required. **GP2 The Board has reviewed lessons learned from enquires and has considered the impact upon themselves. Actions arising from this exercise are captured and progress is followed up.** The Board has a track record of reviewing and overseeing implementation of the lessons learned from external reviews and enquiries eg Francis Report, Keogh Report, Hannafin Report. **GP3 The Board has conducted or updated an external stakeholder mapping exercise, market analysis and/or PESTELI analysis within the last year to inform the development of the IBP.** The Trust has developed an external stakeholder map which, together with a PESTLI and extensive market analysis, represents a key aspect of the IBP which has been drafted iteratively since May 2013. The Board reviewed working versions in July and September 2013. **GP4 In developing the IBP, the Board as a whole has explored market opportunities and threats in relation to the services it provides, discussed its appetite for risk and has considered various alternative futures (e.g. scenario planning).** See GP3 **GP5 The Board has agreed a set of corporate objectives and associated KPIs/ milestones that enable the Board to monitor progress against implementing its vision**	**GP6** The annual programme of work required is presently under review and will be taken to the March Board meeting for discussion. This is being led by the Director of Governance & Assurance. **GP7** The BAF will be presented to the 29 January 2014 Board meeting. Following that it is expected that additional work will be required and it will be represented to the March Board meeting. This is being led by the Director of Governance & Assurance.	

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and strategy for the Trust. Performance against these corporate objectives and KPIs/ milestones are reported to the Board on a quarterly basis. As part of its strategic planning activities, the Board has revised the Trust's objectives and agreed a set of KPIs and milestones against which it will monitor delivery going forward. **GP6 The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning (e.g. the risks presented by PBR, commissioning intentions and efficiency requirements). Specifically, the Board can demonstrate that it has sufficiently discussed the downside scenarios that underpin the LTFM, including key mitigation plans and trigger points for deploying these plans.** The Board does have an annual programme of work and it recognises that improvements need to be made. **GP7 Strategic risks to the Trust are actively monitored through the Board Assurance Framework (BAF).** As part of the effectiveness work the Trust Board agreed a new Risk Management Strategy and has developed a more effective manner of articulating risk. The Board Assurance Framework (BAF) is in part linked to this work and is in the process of being updated to reflect the current Objectives and the new processes. The Board recognises that further work will be required on the BAF. In addition the Board has, since the interim CEO arrangements been in place, received updates relating to the achievement of its strategy in the short, medium and longer term.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. The Board does not receive an update on developments within the external environment at each Board meeting.~~ 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning. ~~3. The Board does not formally~~		

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~~review progress towards delivering its strategy.~~		

Amber/Green

Board insight and foresight

3.4 Quality of Boards papers and timeliness of information

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Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board can demonstrate that it has actively considered the timing of Board and committee meetings and the presentation of Board and committee papers in relation to month and year end procedures and key dates (e.g. submissions to CQC) to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. The timing of Board meetings has been reviewed and not all meetings are noted to be at the most opportune moment insofar as performance data reporting is concerned. Once dates for performance reporting have been advised for the coming financial year, the timings will be carefully reviewed and amendments made if required. **GP2 A timetable for sending out papers to members is in place and adhered to.** A timetable for sending out papers to members is in place but the Trust recognises that it is not always adhered to. Additional processes have been put in place to assist with the preparation of timely reports. **GP3 Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, discussion).** Papers clearly articulate what the Board is being asked to do and are reviewed by the Corporate Governance team prior to publishing the papers. **GP4 Board members have access to in-month flash reports to demonstrate performance against key metrics and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings.** The Board members do not have access to in-month flash reports. There is a process in place to bring significant issues to the Board's attention.	**GP1** A review of the timings of Board meetings will take place once performance reporting dates have been clarified and will form part of the review of the annual programme of work which is being led by the Director of Governance and Assurance as referenced in section 3.3 GP6 **GP2** Following the introduction of additional processes to assist with the production of Board reporting the situation will be monitored over the next six months to ensure that papers are sent out in accordance with the Standing Orders and additional steps will be put in place if required. This will be led by the Director of Governance & Assurance. **GP6** As part of the review of the annual programme of work which is being led by the Director of Governance and Assurance as	**GP4** The Chief Operating Officer has been leading the development of an Integrated Performance Report. The format of the report has been commented upon by the Board during a Board Seminar on 18 December 2013 and the first iteration of the report will go to the Board at their meeting on 29 January 2014. The requirement for any further formal in month reporting to the Trust Board will be assessed once the new integrated performance scorecard has been established.

GP5 Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported, where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has already been through. Board papers outline the decisions that Executive Directors have made or propose. Business cases provided to the Board show options, rationale for choices and that they have been scrutinised. **GP6 The Board is routinely provided with data quality updates (e.g. Information Governance Toolkit scores). These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.** The Board and Audit, Risk & Governance Committee do receive some regular data quality updates and reports. However, these are not on a scheduled basis. **GP7 The Board can provide examples of where it has explored the underlying data quality of performance metrics that have been RAG rated green.** In the case of Infection Protection Control external validation of data for 2012/13 data as part of the quality accounts took place at the end of April 2013. Deloittes cross validated the Trust's *C.difficile* data and found no errors in reporting of cases to the PHE thereby indicating that the data was correctly RAG rated green.	referenced in section 3.3 GP6 and 3.4 GP1 above, data quality updates will be scheduled on a routine basis.	

Red Flags	**Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)**	**Notes/ comments**
1. ~~Reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting.~~ 2. ~~Board discussions are focused on understanding the Board papers as opposed to making decisions.~~ 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting.		

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4. Board engagement and involvement

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Board engagement and involvement

4.1 External Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has an External Stakeholder Engagement Plan that clearly describes the Trust's key existing and emerging external stakeholders, their relative priority and the tailored methods used to involve each stakeholder group (stakeholders include PCT Cluster, Clinical Commissioning Groups, Local Authorities and Wellbeing Boards). In mid-2011 it was recognised that the Trust was in a position where it operated mainly ad hoc and uncoordinated relations with political and other external stakeholders and needed to put in place specific systems and tools to improve the management of stakeholder relations. Since early 2012 the Board has had an External Stakeholder Engagement Strategy and delivery plan. The strategy emphasises the importance of the Trust's external stakeholders to its activities and the strategic need on a planned and managed basis to: inform; communicate and engage; involve; and, where appropriate, partner with them. Our objective is to communicate and engage with our stakeholders through a programme which meets their requirements for information and involvement with our activities, while demonstrating our commitment to working in partnership to deliver world-leading clinical, acute hospital, and integrated care services. The Trust understands the importance of communicating and engaging effectively with its key political stakeholders – the main local councillors and council officers along with local MPs across north west London and occasionally national politicians. The Trust's stakeholder engagement programme has continued as we seek to actively build our external relations with partners. Across the Trust's leadership team we are seeking to work with our partners in an open and constructive way which ultimately benefits the patients we care for. **GP2 A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of patients, carers, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users**	**GP3** Communication plan will be developed to enable engagement with key external stakeholders on the IBP and will be led by the Chief Financial Officer.	

with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. The Board has a Communication Strategy which sets out the methods that the Trust will use to communicate. The Trust undertook a survey of external stakeholder views in October 2012 by College Hill which has helped to develop plans for good stakeholder relations. As a matter of routine, the Trust invites patients, staff and stakeholders such as commissioners, Health Watch etc to give their views on the Quality Accounts through a series of engagement meetings. This is part of the requirements of the DoH and is valued by the Trust. These discussions support the Trust in reviewing and agreeing the new indicators for the next Quality Accounts' or something to that effect . The Trust actively participated in the CQC workshop with people with learning disabilities on their experience of NHS acute care services in March.2013 and is in the process of designing/ scoping a small in-house evaluation study to ascertain the views of people with learning disability who use our hospital services with academic support to inform our service development. The Trust has Patient User Groups for example for Brain & CNS which meets every 3 months and is made up of patients and relatives of patients. All current improvement work within the central patient experience team is conducted in a collaborative and co-deign format. The Trust seeks quantitative and qualitative views of staff and patients using the Itrack system, 1to1 interviews and group work. ICU and Paediatrics have monthly meetings/events with patients and their careers to review experience within the units with improvements being implement to support on-going improvement **GP3 The Board can evidence how key external stakeholder groups (e.g. patients, carers, commissioners and MPs) have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP.** On Monday 11 November 2013 the Trust launched its public consultation to hear from the local community, patients, the public and partner organisations what they think of the Trust's plans to become a foundation trust. The consultation is planned to run for a period of up to 12 weeks closing on Monday 10 February 2014. Details on the proposals for becoming a foundation trust are set out in the consultation document entitled 'Working in Partnership'. During the foundation trust consultation the Trust has contacted the chairs of all eight clinical commissioning groups including sending them a printed version of the consultation document 'Working in Partnership'. All local authorities in NW London have been contacted to offer attendance at health overview and scrutiny committee (HOSC) meetings, presentations, submissions and invite their responses and feedback. To date the Trust has attended HOSC meetings at Westminster and Harrow with a tri borough (Kensington and Chelsea, Hammersmith & Fulham, and Westminster) special meeting. In addition a Trust report was		

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submitted and considered by Ealing Council's HOSC. All NW London MPs have been contacted about the foundation trust application and associated issues and several face-to-face meetings have been held with key local MPs representing constituents in the boroughs of Kensington and Chelsea, Hammersmith and Fulham, and Westminster. **GP4 The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the IBP (e.g. campaigns in community vantage points, shopping centres, leisure centres; close links with academic institutions and schools; visits to 'hard to reach 'groups etc.).** The foundation trust consultation document 'Working in Partnership' sets out the Trust's emerging vision and strategic objectives together with a summary of the development of its clinical strategy for services across its hospital sites. The consultation questionnaire's first question asks: "Do you agree with our vision and strategy for the future?" As stated above the foundation trust consultation is due to close on Monday 10 February which will be followed by a post-consultation period where all feedback is considered and a consultation report is produced – planned for the end of March 2014. The period for communications and engagement on the draft IBP should logically follow on from the January Trust Board meeting and the foundation trust consultation and the outcomes would then feed into the Trust's final application for foundation trust status in Spring/Summer 2014. All the following consultation deliverables have been achieved so far: • Stakeholder database developed • Content for Website section/interactive response form • Content for Intranet section • Consultation document publication/response form • Launch introductory letter/email • Distribution of consultation materials • Three Public/Staff meeting events held • Internal staff meeting events: Open Hour/Team Brief • Programme of stakeholder meetings including MPs and local councils • News release issued • Regular internal communications via daily 'In Brief' bulletin • Regular tweets to 4,500+ followers • PowerPoint presentation: internal/external • 10,000 outpatient letters sent • Contacted eight north west London local authorities specifically regarding the issue of seats on council of governors • Final month of consultation period letter/email		

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GP5 The Trust has constructive and effective relationships with its key stakeholders, especially Lead commissioners.

The Trust has a mapping and forward planning tool of activity with the regular management mechanism of a monthly political stakeholder relations meeting involving the chief executive, director of communications and head of public affairs. This professional approach features standardised internal briefings for meetings and site visits involving stakeholders and pre-meetings to prepare with Trust representatives. The internal briefing materials highlight key messages and potential 'questions and answers' with background information on stakeholders including relevant correspondence, reports, minutes and personal profiles. Tailored briefings are provided to external stakeholders in advance of their site visits to our hospitals and in the form of reports and letters as appropriate. We are now sharing after meetings summaries and intelligence with Trust colleagues as well as ensuring action points are completed such as correspondence and the provision of further information requested.

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1. ~~The development of the IBP and LTFM has only involved the Board and a limited number of Trust staff.~~ 2. ~~The Trust has poor relationships with its commissioners.~~ 3. ~~The Trust's latest patient survey results are poor.~~ 4. ~~The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months.~~		

Amber/Green

Board engagement and involvement

4.2 Internal Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. The Trust has a number of communication channels to listen to its People. This includes a quarterly Engagement Survey and subsequent focus groups and action planning. Open Hour once a month delivered by the CEOs. Team Brief once a month delivered by the COO and also in written form. Furthermore there is the Source which Is the Imperial Intranet. Recently we have introduced the P&OD Forum where we discuss and receive feedback on specific changes which will affect our People and make their experience better. Additionally we have a bi monthly Partnership Board where we work with our Staff representatives and Trades Union colleagues. Directors also undertake walkabouts which provides the opportunity to engage with staff and receive feedback. Walkabouts are undertaken regularly by the Chairman, CEO, Director of Nursing, Director of Governance & Assurance and some of the NEDs. **GP2 The Board can evidence how staff have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP.** The IBP is currently being drafted and the Trust has not yet engaged with staff, aside from those clinical, nursing and corporate colleagues who would normally be expected to contribute to the IBP. The Trust recognises that this is an area of development and internal engagement in the IBP process is something that the Trust wishes to encourage.	**GP2** As part of the ongoing development of the IBP the Trust will look to engage with internal parties. This work is being led by the Chief Financial Officer as referenced in 4.1 GP3 & GP4 above.	

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GP3 The Board ensures that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities. The Executive Team regularly communicates the Trust's key priorities to staff and engages with them on the development of its strategy using a wide range of platforms designed to encourage open discussion and debate on individual's roles in delivery. Channels include: Monthly Open Hour and Team Brief sessions rotating around each site led by the CEO and COO for all staff; Leadership walkabouts; the Back to the Floor programme for senior nursing staff; executive webchats; the quarterly leadership forum session focusing on key priorities eg Quality Strategy; the AGM and the Annual Nursing and Midwifery Conference. **GP4 The Trust uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to patient care and the running of the Trust.** Recognition of success is a key aspect of the Trust's People Strategy and describes a range of mechanisms from local to Trust wide including the annual OSC&Rs awards and the iRecognise scheme. **GP5 The Board has communicated a clear set of values/ behaviours and how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the Trust's stated values/ behaviours.** The Trust uses a number of different communication channels to communicate with its People including its intranet, training programmes eg the Leadership development suite of programmes. Demonstration of Trust values forms a key aspect of staff annual performance and development reviews and behaviour that contradicts any values is managed under the Trust's Performance Management and/or Disciplinary policies. **GP6 There are processes in place to ensure that staff are informed about major risks that might impact on patients, staff and the Trust's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.** The Trust's intranet together with other internal communication channels is used to highlight to staff any major risks to them or their patients and provides an understanding of an individual's responsibility for managing these. **GP7 The Board can demonstrate that clinicians play a key role in management and decision-making within the Trust.** The Trust is a clinically led organisation. A number of Board Directors have clinical backgrounds. Each Clinical Division is led by a senior clinician supported by a Divisional Director of Nursing and Chiefs of Service for each clinical specialty that all play a significant role in the development of their local strategies and business plans.		

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Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
~~1. The Trust's latest staff survey results are poor.~~ ~~2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence' by the clinical community, the Trust does not have productive relationships with staff side/ trade unions etc.).~~ ~~3. There are significant unresolved quality issues.~~		

Amber/Green

Board engagement and involvement

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 There is a structured programme of events/ meetings that enable NEDs to engage with staff (e.g. quality/ leadership walks; staff awards, drop-in sessions) that is well attended by Board members and has led to improvements being made. The CEO, Chairman, Professor Sir Anthony Newman-Taylor (Chair of the Quality Committee) and Dr Andreas Raffel (NED) regularly visit wards across all three main sites. There has been adhoc attendance by other NEDs which has resulted in the development of NED visits. **GP2 There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and CEO, amongst external stakeholders.** The CEOs have regular meetings with commissioners. The Board has an Annual General Meeting in the Autumn. As part of the FT process a series of consultations on the FT application have taken place. **GP3 Board members attend and/or present at high profile events.** Executive and NEDs have a record of attendance at high profile events including the Opening of the new cath lab at Hammersmith Hospital by Sir Bruce Keogh, the Chair's press statement thanking staff following the Royal Birth, attendance at FT consultation events and Chair and CEO meetings with Senior external stakeholders eg MPs, Local Authority Leaders. **GP4 NEDs routinely meet patients and carers.** As part of the development of programme of NED visits discussed in GP1 above this will be undertaken in a more structured manner. Currently the Chair twice monthly undertakes ward visits and meets patients and carers. Adhoc visits currently take place as part of the	**GP1** Schedule of NED visits to be produced following the proposition paper that went to the Trust Board in November 2013. This is led by the Director of Governance & Assurance. **GP4** The Schedule of NED visits as referenced above in GP1 will include time to meet patients and staff. This is led by the Director of Governance & Assurance.	

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mentoring process discussed in 2.4 GP4 above and in GP1 above. **GP5 The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.** The Board ensures that its decision making is transparent. All Public Board meeting papers are on the Trust's website.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1. ~~With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.~~ 2. ~~Attendance by Board members is poor at events/ meetings that enable the Board to engage with staff (e.g. quality/ leadership walks; staff awards, drop in sessions).~~		

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Board composition and commitment

4.4 Future engagement with FT Governors

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has a plan in place to form a Council of Governors which is representative of the staff and community served by the Trust and partner organisations. The Board has considered the size of the Council of Governors to ensure it is not unwieldy and how the Council will be structured in order to discharge its statutory duties. The FTPB has received papers and discussed issues and had an input into questions raised within the Consultation. **GP2 There is a statement in place that sets out the roles and responsibilities of the Council of Governors and how these are distinct from, but complementary to, the roles and responsibilities of the Board. The statement also considers the role of specific groups of governors (e.g. staff governors) and how they will be used to best effect.** Under development. Part of the FT Programme overseen by the FTPB **GP3 There are robust plans in place to elect, induct and develop governors once the Trust is authorised.** Under development. Part of the FT Programme overseen by the FTPB. **GP4 There are robust plans in place to show how the Board will communicate with and engage governors, in particular, in the areas of strategy development, service change and quality issues.** Under development. Part of the FT Programme overseen by the FTPB. **GP5 The Board has a Membership Strategy that describes the number of members required, how that target will be reached, how the Trust will ensure that its membership is representative and how the membership will be maintained going**	**GP2, GP3 & GP4** These all form part of the FT Programme overseen by the FTPB and led by the Director of Governance & Assurance as part of the membership work to be developed and presented to the Trust Board at their May Board meeting.	

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forward. The Trust Board approved its Membership Strategy at its meeting in November 2013 **GP6 The Board has a strategy for engaging with its membership, including describing the kinds of issues it will consult with members on and how the views of hard-to-reach groups in the community will be represented.** This forms part of the Membership Strategy.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
1. The Board has not yet considered the roles and responsibilities of the Council of Governors. 2. The Board has not yet considered how best to communicate with and engage the Council of Governors. 3. The Board has not yet considered how to elect, induct and develop governors.		

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5. Board impact case studies

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5. Board impact case studies

5.1 Case Study 1

Performance Issues in the area of quality	Title: Turnaround of RTT and cancer performance
Brief description of issue	In January 2012, lack of assurance around data quality and data systems led the Trust Board to take 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. The NHS Intensive Support Team (IST) supported the Trust to implement a series of immediate actions to improve data quality and reporting for cancer recommenced in June 2012 with RTT reporting starting again in July 2012. At the point that the Trust came out of the Elective Access Reporting break it reported that; • It was failing two out of three aggregate RTT standards • It was failing 25 out of 57 RTT treatment function codes • There were 519 patients waiting over 52 weeks • It was failing 5 out of 8 national cancer targets
Outline Board's understanding of the issue and how it arrived at this	Inconsistencies in the performance data being reported within the Trust were identified as part of the Value for Money assessment carried out by Deloitte in 2011. At that point the Trust Board invited an external review from the NHS Intensive Support Team. Due to the significance, complexity and extent of the issues identified at this time the Trust Board made the decision to implement a reporting break.
Outline the challenge / scrutiny process involved	At the point of the reporting break, external reviews were commissioned by the Board and NHS London covering three core areas;

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	• The reasons why the Trust came to a point where it needed to take a reporting break (Hanifin, 2012) • Waiting list clinical review (Fryer, 2012) to provide assurance patients did not come to any clinical harm • Required actions to bring the Trust in-line with nationally defined best practice; • IST Stock Take Report, May 2012 • IST statement of assurance, October 2012 • IST statement of assurance (cancer reporting) July 2012 These reviews included full and detailed analysis of patient records and electronic data systems.
Outline how the issue was resolved	The external reviews identified 135 recommendations for implementation most of which can be grouped into the following key themes; • Clearly defined standard operating procedures with clear roles, responsibilities and accountability • Agreed data-sets provided at speciality level to support decision making • Automation and standardisation of data collection • Regular validation and audit • Robust training and education • Pathway improvements • Engagement of clinical staff . Through a series of working groups, newly established forums such as the elective access waiting list group and the implementation of a cancer performance team, to date 106 of these actions has been implemented and closed. Since reporting was resumed (in June 2012 for cancer and July 2012 for RTT) the Trust has; • Met the 6 week diagnostic target each month • Steadily improved performance against the 8 national cancer standards, from achieving just 3 of 8 in June 2012 to achieving 7 in September 2013

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	• Improved RTT performance to consistently achieving all 3 aggregate standards since November 2012 • Improved RTT performance to achieving 54 out of 57 treatment codes by September 2013 Three pieces of independent assurance demonstrate considerably improved data quality; • An Internal Audit review into waiting list data quality carried out in April 2012 and August 2013 demonstrated adequate assurance • The Deloitte Value for Money review presented to the Audit & Risk Committee in June 2013 confirmed the Trust Board had received assurance relating to data quality from the IST and that appropriate data quality assurance was in place • A targeted review of challenged specialties carried out by an external consultancy (MBI) in July 2013 recognised the improvement in RTT and also highlighted The Trust recognises that there are outstanding issues which need to be further resolved to ensure full completion and implementation of all of the initial 135 recommendations; • Elective access training • Continued auditing • Sign off of all standard operating procedures related to RTT and cancer • Validation of the outpatient waiting list • Implementation of Cerner Millennium A further baseline validation of the elective access assurances relating to data quality was commissioned by the CEO office in October 2013. This reviewed all previous external and internal reviews, outstanding actions and additional requirements to ensure the Trust maintains its focus on best practice regarding elective access data quality. The baseline validation has been shared with CCG colleagues and will continue to be reviewed through the governance structure within the Trust.

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Summarise the key learning points	The key learning points were as follows: • The required culture change needed to be driven by process and systems change; • The requirement to continually benchmark externally and seek external assurance on processes, systems and performance • Changes of this magnitude are difficult and require change management expertise and strong leadership; • The importance of consistent systems and processes that are clearly documented, communicated through adequate training, measured and monitored
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	The key improvements to the Trust's governance systems have been: • The Trust Board now receives a monthly report on data quality indicators included with the Trust's performance scorecard • The implementation of a new Trust management structure with experienced leadership, clear roles and responsibilities and defined accountability • The implementation of a new performance framework for clinical services including monthly review of integrated performance and the introduction of a new performance scorecard. Poor performance results in more detailed oversight, good performance less oversight • The establishment of a dedicated performance team to ensure sustained improvements in delivery • Strengthened participation in external quality, governance and quality forums with key stakeholders such as CCGs, CSU etc • Data quality audit is now formally part of the annual internal audit programme

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5. Board impact case studies

5.2 Case Study 2

Performance issues in the area of finance	Title: Financial turnaround 2011 -13
Brief description of issue	In 2011-12, the Trust began the year with a planned deficit of £35 million. At the end of the Q2 this estimate was revised to a £50 million deficit. The newly appointed Chief Financial Officer (CFO) was tasked with addressing this situation and by the end of the year the outturn was a £8.4 million deficit (£13 million underlying) before impairments. 2012/13 saw the need for a £50 million savings plan to achieve a planned surplus position of £7.5 million before impairment (£14.3 million underlying surplus). A similar saving is required in 2013/14 when the Trust is on track to achieve a £14.5 million surplus (£24.7 million underlying). The legacy culture in the Trust was one that gave autonomy to clinical management groups but lacked clarity around accountability for decision making and delivery with the result that expenditure decisions were taken at a local level but without any financial context, other than budget. There was a preoccupation with budgets and variance to budget, even though budgets were rolled over at year end with little review. This was a key driver of behaviour which led to “gaming” with the aim being to retain or increase the budget as much as possible and divert as much expenditure onto other budget areas as possible. Inevitably, a number of sub-optimal strategic decisions were taken which worsened the Trust’s financial position. Although the finance function was fully stretched there was insufficient business support and provision of costing and profitability information. There were many resource intensive processes in place that added little value. Financial performance management was weak and the finance function had low status.

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Outline Board's understanding of the issue and how it arrived at this	The Trust Board understood the need for decisive action in 2011-12 and supported the CFO's recommendation of establishing a turnaround team and a "command and control" approach to mitigating risks and controlling expenditure. It also recognised the need for continuous savings and fundamental change in financial management practice in the order of £50 million per annum could not be achieved without sufficient engagement of the workforce.
Outline the challenge / scrutiny process involved	The CFO established the "Building World Class Finance" programme in January 2012 and a Turnaround team in March 2012, led by an experienced turnaround director. These teams undertook a forensic review of current practices and their conclusions informed the Board's view on the definition of the problems and corrective actions.
Outline how the issue was resolved	The Board took the decision to appoint a new CFO, starting in October 2011 who would be charged with leading the turnaround agenda. It was also made clear by the Board that improving the financial position of the Trust should in no way adversely impact the quality of the services delivered. In November 2011, the CFO made it clear to the Board that addressing a possible £50 million deficit by the year end would only be possible through "command and control", which was fully supported. Strict expenditure controls were introduced. The turnaround director established a robust performance management framework with regular meetings with Clinical Programme Group (CPG) directors and managers to ensure progress was being made on cost improvement projects. There was a monthly report to the Executive team, against which those CPGs on "special measures" were held to account. There were also fortnightly meetings with all senior managers present, where project interdependencies could be identified and resolved, where progress and learning was shared and a degree of peer pressure exerted on underperforming teams. The format of finance reports to the new Finance & Investment Committee (established in June 2013 to provide detailed scrutiny and greater assurance) and the Board was improved to become a dashboard rather than narrative report to enable fuller and easier scrutiny. The forecast of £50 million deficit included a number of significant risks and the CFO and his senior team worked on implementing mitigating actions and resolved the majority of

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	the major risks. It was always recognised that this approach was only sustainable in the short term and that a more collaborative approach was needed going forward. In the following year, the approach changed to one which involved CPG teams more collaboratively in the planning and management of the financial position. The work of the turnaround director and his team in 2012 had led to the development of a more robust cost improvement programme as the team had worked with operational managers and clinical leaders to develop sustainable, credible plans to reduce expenditure. The Building World Class Finance team reviewed all financial processes, eradicating non-value adding steps, updated all the software to the latest versions and used the available technology to automate a number of processes. As a result the Trust has been able to divert resources into costing, financial planning profitability analysis, business partnering and business analysis, giving intelligent insight into operational and financial problems and providing the right level of support to front line clinical leaders and managers enabling them to control their operations and make the right investment/disinvestment decisions. The preoccupation with variance to budget was addressed through the introduction of a Financial Risk Rating (FRR). The FRR has 5 “dimensions” – sustainability, cost control, forecasting accuracy, governance and working capital control. The new Clinical Divisions and Non Clinical Divisions are assessed on the FRR score with the emphasis on improving the score rather than its absolute value. The next stage of development planned for early 2014 is to introduce self-service dashboards to enable managers and clinical leaders to drill down from their FRR score to underlying data with the intention that they identify the root cause of performance issues and take the most effective action. The approach to budgeting and forecasting has changed, eliminating rollover budgets and requiring Clinical Divisions and Non-Clinical Directorates to prepare and continually revise their own budgets and forecasts which deliver overall financial and efficiency targets. A “Collaborative Planning” tool has been implemented which is starting to allow for the instant consolidation of budgets and forecasts and also for managers to enter their own data and submit to their managers. This tool also allows managers to drill down from

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	headline financial balances right down to transactions including payslips and invoice images. The next phase of development of Collaborative Planning tool will build in the use of calculators and non-financial information to support budget managers in the development of budgets and forecasts. The development of the FRR and implementation of Collaborative Planning is designed to drive a transformation in the engagement of clinicians and managers in managing their finances. The Trust has undertaken a major training programme of finance staff and managers on the systems and the principles and will continue to develop this as the systems and processes mature. In the past two years, the cost improvement horizon has only extended for one year. This year the CFO has worked with a commercial company to develop a three year plan. It is recognised that future savings will need to be driven form clinical pathway redesigns and clinical engagement will be key. By month 7 of 2013/14, the Trust had achieved a year to date surplus of £10.9m and is forecasting an outturn surplus of £15.1m (after adjusting for impairments and donated assets). Whilst CIP delivery remains £4m behind plan, this has been offset by over-performance income on CCG contracts and utilisation of the contingency fund. Earlier this year, the Trust was awarded the prizes for HSJ Finance Team of the Year and HFMA award for best assurance, risk management and governance arrangements, both of which are a testament to the success of this programme.
Summarise the key learning points	The key learning points were as follows: • The required culture change needed to be driven by process and systems change; • Communication and training were key enablers of success and will be a continuous feature in the future as the Trust develops; • Changes of this magnitude are difficult and require change management expertise and strong leadership; • Success should not be declared too early – the Trust has had to re-emphasise its financial goals again this year after non-finance staff had begun to think that the

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	situation was fully resolved; • Continued support and encouragement from the Trust Board over a substantial period of time was effective in meeting the challenges faced.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	The key improvements to the Trust's governance systems have been: • Organisational structures, decision rights and accountabilities are being clarified and a transition to a self-service system with responsibility for planning and forecasting and cost control being in managers' hands; • Authorisation limits were amended after imposing low limits for everything to increase ability of clinical leaders to authorise clinical supplies. Run charts which can identify excessive orders or changes in average spend replaced authorisation by managers who are unable to scrutinise such orders effectively; • Performance management has moved to a balanced scorecard approach – the emphasis is not on finance or quality and safety but achievement of both is seen as essential. Managers and clinical leaders have been provided with the tools, the training and the expert support to enable them to plan and manage their services effectively in an increasingly volatile environment; • Poor performance results in more detailed oversight, good performance less oversight and better access to investments; CIP plans are developed on a three year rolling cycle and are driven by analysis and benchmarking, detailed pathway reviews rather than an arbitrary percentage target allocated across the board; • The role of finance has changed to provide technical support, insightful analysis and decision support, becoming a true business partner in the process.

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5. Board impact case studies

5.3 Case Study 3

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Organisational culture change	**Title: Revising the Trust's Quality Governance structure, underpinned by the development of a Quality Strategy**
Brief description of area of focus	Ensuring that Quality is the central focus of all that the Trust does.
Outline reasons / rationale for why the Board wanted to focus on this area	During 2011 – 2013 a number of issues related to the Quality of the services provided at ICHT had been identified. These included: • An increased number of Never events reported • Reporting break for referral to treatment targets (data quality) • Clinical reviews undertaken to assess the impact on patients who may have had lengthy waits whilst accessing ICHT's services • Patient experience performance issues in particular for cancer patients Some of these issues resulted in external reviews being undertaken with resultant action plans including an NHS London commissioned review of clinical governance systems and processes in late 2011. This in conjunction with the publication of national guidance/reviews such as the Mid-Staffordshire NHS Foundation Trust Inquiry and various quality governance best practice guidance documents published by Monitor These issues as well as the publication of national guidance/reviews such as Mid-Staffordshire NHS Foundation Trust Inquiry and Quality Governance documents from Monitor were a driver for the Board to raise concern. This was because although the Trust took action to address issues and had a number of separate strategies and action plans in place, the board was not assured that this meant that the Trust was robustly monitoring and improving quality in a systematic way. They

	felt that there was a lack of overarching strategy to ensure that our people understood what quality means and how it should be delivered at ICHT. The newly appointed Medical Director was designated as the Executive Lead to develop the Quality Strategy for ICHT drawing together the Trust's vision for quality and associated goals. The strategy is based on the six improvement principles proposed by Donald Berwick to give an integrated plan for Quality improvement. The principles are described as our quality goals which each have an Executive Lead and are under the headings of: 1. Safety 2. Efficacy 3. Patient centeredness 4. Efficiency 5. Timeliness 6. Equity To ensure delivery of the strategy there was a need to consider the effectiveness of the Trust's quality governance structures and processes to avoid duplication, demonstrate clear accountability and responsibility, avoid complex reporting structures and provide assurance. By developing a revised structure the Trust Board and its committees would be able to operate more effectively and efficiently. To this end, at a Board away day in June 2013, Board members agreed a revised committee structure. Of particular importance to note in terms of impacting on the culture related to quality are the following changes: - The Quality Committee now reports directly to the Trust Board as a sub-committee (previously this was known as the quality and safety committee and did not report to the Board) and is responsible for assurance of all elements of Quality. This has allowed strong board visibility of these key areas. - The Quality Committee is chaired by a Non-Executive Director who has a

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	clinical background. - Membership of the committee includes Divisional Directors and the Director of Infection Prevention and Control, increasing accountability to the Board. - The agenda is set under the 6 quality goals to ensure that the items being discussed align to the quality strategy. - Agenda items now include; key divisional clinical quality risks, assurance on the quality impact assessments for CIPs across the Trusts and mortality. - Each Board sub-committee is chaired by a Non-Executive whose skills and experience most align with the business of the committee e.g. Finance and Investment Committee Chair has a strong background in finance. The Governance Committee has been dissolved and is part of the Audit and Risk Committee, now known as the Audit, Risk and Governance Committee to ensure that these areas are considered alongside one another.
Outline the Board was assured that the plan/(s) in place were robust and realistic	To underpin the operational delivery of the quality strategy and business of the Trust and to separate this from assurance, the Trust has changed its approach to the Management Board whereby each week there is a specific rolling focus on; quality, strategy, operations and corporate affairs. Underneath the management board sit the quality boards based on the quality goals. For example, a patient centredness and equity board, a safety board and a timeliness board. These boards are responsible for operational delivery of the different work streams that make up the quality strategy. Each Quality goal has an Executive lead that is responsible for delivery but also reporting to the Quality Committee (board sub-committee) and the Trust Board which gives clarity.

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	The reporting structure was revised as a consequence of implementation of the strategy which reinforced the importance of Quality as the main driver of the services provided at ICHT. Progress has been reported on a regular basis to the Board as both agenda items and as part of the MD report. The strategy is ambitious however it covers all of the recommendations from the recent Berwick led report "A promise to learn, a commitment to act" as well as the five questions that CQC will now assess Trusts against. It also aligns with aspects of Monitor's Quality Governance Assurance Framework document. This has provided assurance that the strategy is robust and realistic. The strategy communication and implementation plans are detailed and provide an ongoing focus on ensuring our people are placing Quality at the centre of all that we do.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The strategy engagement plan was presented to the Board prior to and following its launch. The restructure of the Board sub-committees was approved by the Board before being implemented and a review date has been set to assess the impact of this. The agendas of all committees have been adjusted to reflect the six quality goals. Further to this, all meetings down to divisional level have been restructured to ensure that they work towards the delivery of the Quality Strategy. The Trust scorecard has also been re-set to cover the six goals. As a consequence of discussing clinical risk at the Quality Committee, there has been in depth discussion and action taken about the consultant cover arrangements for emergency surgery at the Charing Cross site. This has led to a new on-call rota being implemented with additional investment and cross site consultant working practice agreed as the solution. A Trustwide communication and engagement programme began in November, and will continue in 2014, to ensure the Quality Strategy is embedded in the Trust's culture; this includes regular news stories, intranet items, screensavers, and posters.

	Members of the quality team are presenting the strategy at meetings and events involving all different staff groups. Quality postcards requesting feedback on the strategy and asking for the opinion of staff members have been delivered across all 3 sites. The Board is aware of the communication plan, which is far ranging and ongoing and will ensure the strategy is disseminated from board to ward. Delivery of the Quality Strategy and the associated change in culture is an ongoing process. The strategy was launched in November, and evidence of cultural change will continue to be reviewed and overseen by the Board.

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5. Board impact case studies

5.4 Case Study 4

Organisational strategy	Title: The Board's role in Vision and Strategy – Clinical Strategy
Brief description of area of focus	Developing a clinical strategy for the Trust.
Outline reasons / rationale for why the Board wanted to focus on this area	The Board identified a number of issues related to the absence of a Trust-wide clinical strategy in 2013. These included: • Lack of clarity on what service development plans the Board should prioritise including capital programme and investment decisions • Lack of clarity on the priorities for development of programmes of excellence and defining services • Difficulties in identification of the 5 year cost improvement programme with no direction about service change, consolidation or expansion • Staff and patient dissatisfaction due to lack of clear direction about the future of services on each site • Lack of clarity on how the innovation and modernisation agenda was being planned in line with national and local priorities/developments • Difficulties in constructing a deliverable Integrated business plan Although the Trust had been fully engaged in the North West London reconfiguration proposal ("Shaping a Healthier Future") its purpose was not to take the place of the Trust's short and long term strategy development. The Board were concerned that while the outcome of this consultation was awaited, the Trust did not have a future strategy. Although business planning processes and improvement plans were in place,

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	these were not robust without an overall strategy. The Director of Strategy was leading the development however the scale of clinical service change that would be required to deliver a robust strategy led to the new Medical Director being designated by the Board as the Executive Lead in April 2013. The Board recognised that the Trust could not deliver a sustained improvement in performance without a clinical strategy setting direction and making clear the modernisation and innovation agenda needed.
Outline the Board was assured that the plan/(s) in place were robust and realistic	Progress on the development of the strategy has been reported and discussed at the Board regularly since April 2013. In addition a significant allocation of time has been dedicated at Board seminars to debate and agree the overall strategy and the NEDs have been heavily involved in agreeing the final plan. Input from the NEDs was also gained through 121 reviews with the Medical Director through the development process. The final strategy was presented, discussed and accepted at the Board in October 2013. The strategy describes an inter-dependent three site vision that fulfils our requirement to meet quality expectations (now and for the future), perform to NHS finance and timeliness standards and capitalise on our relationship with a world class university. The strategy has been developed using a bottom up approach with over 200 meetings and including significant consultant and senior nurse team involvement. Clinical quality and experience is at the heart of every part of the strategy development and is one of the main drivers. The strategy includes the unique roles of each of the Trust's three main sites and incorporates the role of hospital doctors in community care.

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	The strategy will ensure that the Trust continues to improve outcomes, drive up quality across the six Berwick dimensions, achieve NHS performance targets and maintain financial viability. It also will increase our national and international profile through AHSC and AHSN, grow services needed to deliver sector unique practices and profile, and respond to the need to reduce costs and provide care in new ways, in new settings. Evidence and experience from international healthcare and business have been used to ensure that it is deliverable. A detailed implementation plan is currently being confirmed and will be presented to the Trust Board in the future.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The implementation plan will not be operationalized without Board authorisation. The final strategy and implementation plan will be launched during 2014 which will detail how Board assurance will be maintained. The Board has been assured that the strategy development was on track as described above. Examples of change which have already been implemented have been reported to the Board during the development process.
Specifically explain how the NEDs were involved	The NEDs challenged the lack of strategy and progress towards the development of one. They then ensured that the strategy was clinically led by appointing the Medical Director as the Executive Lead. The NEDs have afforded significant amounts of time both at the Board and outside this through personal involvement in reviewing progress, giving direction and their experience to the strategy. The NEDs have agreed the final strategy and set targets for completion of the work required for operationalisation.

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Quality Governance Assurance Framework (QGAF)

Self-Assessment Progress Report – January 2014

1. Purpose of the report

The following report summarises the Trust's self-assessment against the Quality Governance Assurance Framework (QGAF) as part of its Foundation Trust (FT) application.

2. Terms/ acronyms used in the report.

QGAF: Quality Governance Assurance Framework
FT: Foundation Trust
FTPB: Foundation Trust Programme Board
TB: Trust Board
MB: Management Board
RR: Risk Register

3. Background

As part of the organisation's FT application process, the Trust is required to complete a self-assessment against the QGAF using 'good practice examples as defined by Monitor'. The assessment is based on the Trust's performance against 10 questions relating to strategy, capabilities and culture, processes, structure and measurement. Each question is scored using a risk rating matrix with numeric differentials between 0 – 4 (lowest being "best"). The maximum score allowed prior to FT authorisation (at the Monitor stage of the process) is 3.5 with a clear quality improvement plan of how the Trust will get to a score of zero.

The scoring methodology is outlined below.

Risk rating	Scoring	Definition	Evidence
Green	0.0	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/ Green	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and has robust action plans to address perceived short falls with proven track record of delivery
Amber/ Red	1.0	Partially meets expectations but with some concerns capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record delivery.
Red	4.0	Does not meet expectations	Major omission in Quality Governance identified. Significant volumes of action plans required and concerns on management capacity to deliver.

4. QGAF self-assessment summary

With regards to the QGAF self-assessment process, the following has been carried out to date:

- A baseline scoring meeting took place on 9th July with attendance from the Medical Director, Director of Nursing, Divisional and Corporate directorate representatives. The group risk scored the QGAF assessment as 7.5.
- Baseline scoring was presented to Management Board, FTPB and Quality Committee
- An action plan was developed and implemented to address the identified gaps
- An external supportive review was also undertaken by Deloitte in August 2013.
- A further self-assessment scoring meeting took place on 23rd October to look at the Trust's progress against the action plan and how/if this has influenced the overall score. The group determined a revised score of 3.5 recognising work is still on-going which would reduce this score further. The action plan was refreshed in light of this.
- The October QGAF assessment result and evidence used was presented at the Board development session on the 16th December 2013. The session featured good discussion and constructive challenge which led to a decision to undertake a third self-assessment.
- A third self-assessment scoring meeting took place with the Executive management team on 13th January 2014 and approved an overall score of 5.
- The third self-assessment scores were presented to the FTPB on 23rd January 2014.

The ten questions which form the QGAF self-assessment are provided below with a dashboard of the internal assessment scores from July 2013, October 2013 and January 2014.

			July 2013	October 2013	January 2014
Domain		**Question**	**Score**	**Score**	
Strategy	**1a**	Does quality drive the Trust's strategy?	0.5	0.5	0.5
	1b	Is the Board sufficiently aware of the risks to quality?	0.5	0.5	0.5
Capabilities and culture	**2a**	Does the Board have the necessary leadership skills and knowledge to ensure delivery of the quality agenda?	0.5	0	0.5
	2b	Does the Board promote a quality-focused culture throughout the Trust?	1	0.5	0.5
Process and structure	**3a**	Are there clear roles and accountabilities in relation to quality governance?	1	0.5	1
	3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	0.5	0.5	1
	3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	1	0	0.5

Measurement	4a	Is appropriate quality information being analysed and challenged	0.5	0	0
	4b	Is the Board assured of the robustness of the quality of information?	1	1	0.5
	4c	Is quality information used effectively?	1	0	0
OVERALL SCORE			**7.5**	**3.5**	**5.0**

The self-assessment scores in January 2014 have increased in four areas and reduced in one area, when compared to the scores in October 2013. This was as a direct result of challenge from Non-Executive and Executive Directors.

5. Scoring "evidence"

The following "evidence" was considered when assessing the Trust performance against each question.

Domain	Question		Rationale for scoring
Strategy	**1a**	Does quality drive the Trust's strategy?	**Evidence for scoring at 0.5** • Quality Strategy approved and launched • Clear framework for governance of all 6 elements of Quality • Operational monthly quality boards commencing Nov 2013 • Communications programme developed with launch week events which will continue throughout the year. • Strategy now discussed at Divisional Quality boards • Staff engagement – Quality email account set up for feedback • Website update in progress • Evidence of quality improvement work in divisions • Clinical strategy has been risk assessed using the 6 quality goals • Trust objectives authorised **Work needed to reach a score of 0** • Evidence of impact of Quality Strategy implementation • Trust scorecard being updated to reflect the 6 Quality goals • Strategy "crib sheets" to be written to summarise goals for staff • Opportunities to link to appraisal to be reviewed
	1b	Is the Board sufficiently aware of the risks to	**Evidence for scoring at 0.5** • Divisional top risks to quality presented to Quality Committee monthly with evidence of mitigation actions (all on Risk Register)

		quality?	• Revised risk management strategy approved July 2013 • Director of Governance & Assurance in post and TB member • Local risk register review underway but divisions confident that their registers are up to date and reviewed at appropriate meetings. • Cost Improvement Programme Quality Impact Assessment (CIP QIA) process in place with regular reporting to TB (no schemes above RR of 9) • Evidence of schemes rejected due to their risk **Work needed to reach a score of 0** • Evidence of RR review at MB and TB (planned for Nov 2013) • Ongoing monitoring of risk to quality for CIP to be further developed
Capabilities and culture	**2a**	Does the Board have the necessary leadership skills and knowledge to ensure delivery of the quality agenda?	**Evidence for scoring at 0.5** • Non-Executive Director (NED) who chairs QC is a clinician • NED roles clear • NED chairs in place for all TB committees • TB committee TOR all reviewed and re-launched • Director roles in Quality clear – particularly with the revised Quality structure agreed as part of the strategy • Site visits in progress for NED and Directors • Board development programme underway • Evidence of quality improvements impact from board level • Evidence of challenge from NED to Directors on issues related to Quality provided **Work needed to reach a score of 0** • Evidence of embeddedness
	2b	Does the Board promote a quality-focused culture throughout the Trust?	**Evidence for scoring at 0.5** • Quality strategy and governance framework approved which placed quality at the centre of ICHT • Leadership walk rounds in place with improvement action plans • NED and Director site visits in place • Quality agenda items at TB evidenced • Quality metrics in place particularly in nursing (Harm free care) and frontline staff regularly see results, influence improvements • Back to floor programme in place with quality experience focus • Engagement surveys launched to give real time feedback • Open forums in place • People and OD strategy launched

			Work needed to reach a score of 0 • Datix system upgrade with feedback module to be launched (finance agreement of business case TBC) • Communication of importance of Quality to staff will be enhanced by the QS launch – evidence of embeddedness needed
Process and structure	**3a**	Are there clear roles and accountabilities in relation to quality governance?	**Evidence for scoring at 1** • Board accountability for Quality clearly defined • NED and DD involvement evidenced • Quality goals now clearly defined in Quality Strategy • Governance framework redefined in Quality Strategy • Divisional structure in place with clear roles – evidence of meetings • QC and MB (Quality) in place • TB agenda evidence of significant discussion of Quality **Work needed to reach a score of 0** • Evidence of improvements achieved through implementation of strategy and embeddedness
	3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**Evidence for scoring at 1** • Whistleblowing policy in place but supplemented by “see something, say something” • Evidence of issues being escalated to Board level and actioned • Internal audit have undertaken work related to Quality governance • Clinical audit plans in place • Consequences for negative performance evidenced • Incentives for positive performance including OSC&R, local schemes • People and Occupational Development strategy launched • Action plans for Sis revised using SMART objectives **Work needed to reach a score of 0** • System for shared learning opportunities from issues to be implemented • Evidence of impact of audit plan to be developed • Structured audit programme to be developed to support delivery of the Quality goals in the strategy
	3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	**Evidence for scoring at 0.5** • Evidence in place – whilst recognising that improvements can be made there were no significant deficits found. • Strong examples of patient engagement available • Real time patient feedback in place with staff process • Quality account engagement undertaken • Quality strategy communication programme • Clinical Commissioning Quality group in place (monthly) with good clinical representation • CCG chairs meeting now attended by appropriate Directors

			• Evidence provided from divisions re communication structures **Work needed to reach a score of 0** • Improve the patient experience (in particular for cancer patients) through the patient centredness strategy and work plan
Measurement	**4a**	Is appropriate quality information being analysed and challenged?	**Evidence for scoring at 0** • Monthly TB scorecard includes Quality indicators • Metrics reviewed (scorecard) and rationale available – now being realigned to include the Care Quality Commission (CQC) indicators • Divisional scorecards in place supplemented where possible with ward information e.g. Harm free care • Metric development and changes can be evidenced • Weekly incident review meetings in place • Mortality monitoring now in place with outlier alerting to highlight emerging concerns - this is developing towards Consultant specific • Evidence of the use of patient experience data to recognise improvement needs • CQC indicator data prospectively reviewed
	4b	Is the Board assured of the robustness of the quality of information?	**Evidence for scoring at 0.5** • Evidence of reporting negative and positive assurance to the board. • Intensive support team reports/action plans reported to TB • Trust performs well on coding standards auditing **Work needed to reach a score of 0** • Clinical audit programme to be reviewed to specifically focus on quality performance (linked to QG15 strategy)
	4c	Is quality information used effectively?	**Evidence for scoring at 0** • Evidence of CIPs that have not been implemented due to impact on quality • Examples of system change as a result of the use of quality information available • Evidence of RAG ratings in place with benchmarking • Patient stories going to TB including complaints

6. Next steps

The self-assessment scoring summary and evidence will be submitted to the QGAF external assessors following Trust Board approval.

7. Recommendations
The Trust board is asked to:

- Approve the self-assessment score of 5 at this stage in the FT application process
- Approve the submission of this document for external review to the QGAF assessors (Grant Thornton).

Quality Governance Improvement Plan

QG15 principle	Action	Exec. Lead	Progress as at 17th January 2014	Timescale
All principles	Embed the Quality Strategy (QG15) throughout the organisation and demonstrate improvements in the quality of care as a result.	**CH**	Strategy launched in November 2013. Communication and engagement programme in place with ongoing activity planned throughout the life of the strategy. "Goal of the month" launched through the quality calendar. Quality improvement awards being developed for summer 2014 Quality boards now in place reporting to the MB with approved TOR. Agendas of quality meetings aligned to the strategy goals. Quality structures in divisions enhanced through restructure – impact assessment will be undertaken after 6/12. Quarterly improvement reports for each goal/board will commence in Q4 2013/14. Quality account to be reviewed to ensure alignment with Quality strategy.	Update 31/03/14 31/03/14

QG15 principle	Action	Exec. Lead	Progress as at 17th January 2014	Timescale
Safety	Improve HCAI performance: C.diff	**CH**	YTD (end of Dec): 47 reported cases vs. annual objective of 65. A focused action was introduced in May 2013 in response to increased incidence of C.*difficile*. The Trust is within trajectory.	31/03/14
	Improve HCAI performance: MRSA	**CH**	YTD (end of Dec): 10 cases of MRSA BSI's reported - 6 considered Trust attributable, as due to a new post infection review process, cases have been assigned to the Trust that are not related to the care received at the Trust. Allocation and arbitration process is contested in 4 cases. Currently working with external bodies to revise national process.	
			A robust MRSA action plan is in place to sustain performance in comprehensive ANTT training (5607 members are ANTT trained and have been competency assessed – 90%).	31/03/14
			Weekly HCAI taskforce continues to review all actions. Care of peripheral vascular devices policy reviewed and updated.	In place
			Enhanced communication is in place to ensure compliance with IP&C policies inc vascular device and line management, hand hygiene and MRSA screening.	In place
			A third vascular access nurse has been appointed to support on-going programme of training and development.	Completed
			The Trust's vascular access group has been redefined to form a Trustwide vascular access patient safety programme.	14/02/14
			All cases of MRSA are reviewed with the individual consultant at the weekly medical directors meeting with actions agreed and implemented.	In place
			The Trust is working with peers, the CCG, TDA and PHE to ensure all appropriate processes are in place.	27/01/14

QG15 principle	Action	Exec. Lead	Progress as at 17th January 2014	Timescale
Safety	Continue to monitor HSMR & SHMI to ensure continual improvement	CH	Monthly reporting of HSMR and SHMI now in place including alerting process at sub-specialty level. Audit process commenced to review all patients in alerting specialties reporting to safety board. Clinical audit support agreed to ensure alert review process is fully embedded within the divisions and inform improvement programme. Monthly assurance reporting to commence. Improvement programme and audit programme to be updated quarterly with results from alert review process. Divisional mortality reporting at specialty level to commence. Consultant specific mortality process to be reviewed and report on implementation to be considered by safety board.	Complete Update 31/03/14 01/02/14 01/03/14 Update 31/03/14
	Embed risk management framework to include the regular review of the corporate risk register and Board Assurance Framework (BAF).	CP	The Corporate risk register will be presented to the Management Board in January and then to the Trust Board at its meeting in January. MB will review every month and will go to the Trust Board every public board. A board development session took place in December 2013 to discuss the Board Assurance Framework. This is currently being developed and will go to the Management Board and then to the Trust Board over the coming months. The Board will then review the BAF twice a year.	Jan 2014 March 2014
	Embed the new divisional quality and safety structures and processes to ensure these are robust from Board to Ward.	SMc CH	Structures in place with recruitment in progress to fill all vacancies. Impact assessment of new structure to be completed 6/12 post implementation. Responsibility for safety transferring to the Office of the Medical Director.	June 2014 February 2014
	Implement the DATIX upgrade to facilitate the learning from incidents and complaints	CP	The business case for a complete upgrade has been approved and the implementation will commence in March 2014. A project plan is in place to manage the roll-out to include staff training.	March to Summer 2014
	Ensure the Trust meets the expectations outlined in the safe nurse staffing document published by the National Quality Board.	JS	A paper on Safe Nurse staffing will be presented to Trust Board in January. Work is currently underway to look at how the Trust can meet/is meeting the wider expectations outlined in the National Quality Board publication. In summary, the Trust is meeting the 1:8 (Patient:Nurse) and 65%:35% (RN:HCA) ratios. Further work will look at the supervisory role of the ward manager. The Board will sign off establishments for all clinical areas, every six months (no later than June 2014).	June 2014

QG15 principle	Action	Exec. Lead	Progress as at 17th January 2014	Timescale
Effectiveness	Develop 2014/15 clinical audit plan ensuring this aligns with local (QG15) and national priorities and ensure there is a robust system in place to manage this.	**CP**	Responsibility transferring to MD. Audit programme and systems to be reviewed and plan for 2014/15 to be presented to safety board in March 2014. Business case for clinical audit structure included in business plan for MD and for consideration during planning phase.	Feb 2014 01/03/14
Patient Centredness	Improve patient experience and survey results, particularly for; pain, worries and fears and meals (these areas identify the Trust as 'worse than expected' in the National Patient Survey)	**JS**	Improved patient experience and survey results will be achieved through the implementation of The Patient Centeredness Strategy and work plan. Work is underway in the following areas: care and compassion, care environment, patients leading their care and involvement and openness and transparency. Examples include; Developing welcome packs for patients during their stay, implementing strengths based recruitment for Nursing and Midwifery staff, Implementing ward based information boards and supporting staff to address patients' worries and fears.	Sustained ongoing improvement
	Improve the Cancer patient experience and survey results (the Trust is an outlier in most questions).	**JS**	Considerable work has and continues to be undertaken to address this performance at ICHT. A programme of work has been underway under the following headings; Leadership, ward and pathway changes and communications.	Sustained ongoing improvement
	Improve staff experience and survey results, particularly for; harassment from staff and public and Mandatory training (the Trust is an outlier in these areas)	**JM**	The first quarterly Engagement Survey was introduced in October which surveys a quarter of our people every quarter. The second survey takes place from Jan 20th. The current Engagement Index is 42%. Actions Plans are being developed Trust-wide. Early indications from the NHS Staff Survey suggest that harassment scores have improved, to be confirmed in Feb/March when results are in formally. Mandatory Training is slowly improving there is major focus on this across the Trust both from a completion perspective and making sure the IT systems are reporting correctly.	Sustained improvement over time from 2013-2016 as part of the People Strategy and work plan
	Reduce the number of whistleblowing alerts (the Trust has a CQC elevated risk rating for whistleblowing alerts)	**JM**	The Raising Concerns Policy has been launched and communicated and can be found on the Intranet. There is also a poster campaign across the Trust in prominent places – see something, say something. We continue to encourage our people to give us feedback through a number of communication channels.	Sustained improvement over time from 2013-2016 as part of the People Strategy and work plan

QG15 principle	Action	Exec. Lead	Progress as at 17th January 2014	Timescale
Timeliness	Improve and sustain cancer performance (the Trust has a CQC elevated risk rating for Cancer 62 day referral from GP)	**SMc**	Improvement programme in place reporting to MB and TB.	Update 01/02/14
	Improve and sustain A&E performance	**SMc**	Winter plan in place with weekly reporting and action planning through MB.	Update 01/02/14
Efficiency	Ensure that the organisation is ready and has systems assurance for Cerner implementation.	**SMc**	Cerner programme board in place with detailed implementation plan.	Update 01/02/14

Executive Lead	
CH	Chris Harrison
CP	Cheryl Plumridge
JS	Janice Sigsworth
JM	Jayne Mee
SMc	Steve McManus

Board Memorandum – Quality Governance

Purpose

Monitor require that the Board of Directors of an NHS Trust applying for Foundation Trust status confirm, by way of a Board Statement and detailed Board Memorandum, that:

- They are satisfied that the Trust has, and will keep in place, effective leadership arrangements for the purposes of monitoring and continually improving the quality of healthcare delivered to its patients;
- Due consideration has been given to the implications of future plans on quality.

This Board Memorandum has been prepared to provide the Board with assurance:

- On coverage of the four domains of quality governance (Quality Governance in the NHS – A guide for provider boards, National Quality Board, March 2011)
- That the Trust Board has appropriate quality governance arrangements in place (Guide to Applicants, Monitor, July 2010)

Executive Summary

The Trust vision and objectives were agreed by the Board and set Quality as our top priority. This is supported by the implementation of the Quality Strategy and evidenced by the Quality Account. These accounts, which are externally audited, ensure that the Trust's key annual priorities are clearly defined, robustly monitored and reported through to the Board.

Key improvements in quality governance include: development of the quality strategy, establishment of the Quality Committee, revised governance structures, refreshed Trust Board performance reports and the implementation of a robust CIP quality impact assessment process.

Imperial College Healthcare NHS Trust's vision and values

Imperial College Healthcare NHS Trust's (ICHT) vision and values reflect its position as the major provider of acute healthcare services to the residents of North West London, with a leading reputation in specialist services, academic research, medical education and training to the wider region and beyond. The Trust formed a partnership with Imperial College in 2007 and in 2009 was designated an Academic Health Science Centre (AHSC) with the objective of translating innovation into practical solutions to benefit the patients of ICHT and the wider NHS. AHSC status was re-awarded in 2013 confirming our leading position in translation of benefits in healthcare.

As one of the first wave of AHSCs in England and part of a newly designated Academic Health Science Network, ICHT's vision incorporates all elements of the tri-partite mission that cover clinical service provision, teaching and research. ICHT's vision is:

> 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 service in order to transform the experience of our patients

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The Trust's vision is founded on the recognition that, increasingly, it will need to improve the overall health of as well as provide healthcare to all its communities. This includes the diverse population of North West London, as well as those with specific health conditions where ICHT's clinicians are recognised as experts regionally, nationally and internationally. Also underpinning ICHT's vision is an understanding that the true value of clinical research in its direct impact on those requiring healthcare and that educating and training new generations of doctors and nurses must always reflect the evolving needs of our patients. Finally, the vision is founded on the adoption of new and innovative delivery models at scale to drive quality (as defined in the Quality Strategy, incorporating outcomes, patient experience and optimised operational efficiency).

In delivering this vision, ICHT will consistently put patients at the heart of what it does and continue to be guided by the five values that define what it stands for as a healthcare organisation:

- Provide the highest quality **care**;
- **Respect** our patients and colleagues;
- Encourage **innovation** in all that we do;
- Work together for the **achievement** of outstanding results;
- Take **pride** in our success.

This vision will be delivered through the achievement of the Trust's strategic objectives:

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 (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 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

These objectives were agreed at the Trust Board in September 2013 and have quality embedded in each one demonstrating the Trust's commitment to quality driving all that we do. The wording of these may change as a consequence of the FT consultation process which is currently underway.

<u>Quality Governance</u>

The four domains of quality governance which we are externally assessed against are:

- Strategy
- Capabilities and Culture
- Processes and Structure
- Measurement

Each domain has a set of key questions for which assurance is required. This memorandum outlines the Trust's performance within each domain.

1. Strategy

1a) Does quality drive the Trust's strategy?

To deliver the Trust's vision and objectives the Board identified that a Quality Strategy with improvement goals was required. This was developed during 2013.

The Quality Strategy is the Trust's plan by which we focus on the quality of clinical care at ICHT and ensure that we continuously improve our services. It sets out – under 6 headings – what we mean by quality and sets the goals for quality improvement. The strategy is ambitious and gives vision and direction to ensure quality is our number one priority and is central to all that we do.

The strategy describes how evidence and information about quality flows into and out of the four Clinical Divisions, the Office of the Medical and Nurse Director, the Quality Committee and to the Trust Board as part of a whole-system approach to improving standards and protecting the public from unacceptable standards of care.

The strategy was approved by the Board in 2013 following assurance that all recommendations from the Francis, Keogh and Berwick reports were incorporated.

To give added assurance, Quality at Imperial encompasses the six improvement principles for each quality goal advocated by Berwick, and which can be described as follows:

- **Safety:** Our patients will be as safe in our hospitals as they are in their own homes
- **Effectiveness:** Our people will minimise the use of ineffective care and maximise the use of evidence based care
- **Patient Centredness:** Our people will respect the individual patient and his/her choices, culture and specific needs
- **Equity:** We will seek to ensure that everyone we care for has the same high quality outcome, regardless of status
- **Timeliness:** We will strive to continually reduce waiting times and delays for patients and our people
- **Efficiency:** We will strive to continually reduce waste and thereby cost of care; (this includes supplies, equipment, space, capital, ideas and human spirit)

Each quality goal has a set of specific actions which will be undertaken during the three years covered by the strategy. These also align to the CQC priorities of being; safe, effective, caring, well led and responsive to people's needs.

These goals for 2013 – 2015 were developed through extensive review of literature and best practice both nationally and internationally. Consultation was carried out with all Board members in goal setting and structure alignment including presentations at Trust Board, Quality Committee and Management Board.

In addition, the quality goals for 2013/14 as set out in the Quality Account and CQUIN schemes were developed with external stakeholders, including patients, public and clinical commissioners. In all subsequent years these goals will be aligned with those in the Quality Strategy.

A communication programme is in place to ensure the strategy is widely understood and to engage with our people. This includes presentations at trustwide forums and events, use of intranet notices and screen savers and the launch of the Quality calendar. Feedback and

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engagement is being achieved through a postcard campaign and a Quality improvement "dragons den" award scheme is being developed with the Trust charity.

The quality goals are communicated formally through the Trust using the governance structure. The performance scorecards have been amended to align with the goals and these drive the agendas of all Quality meetings. Each goal has an Executive led board to ensure delivery.

1b) Is the Board sufficiently aware of the risks to quality?

The Trust Board has established effective mechanisms to ensure that they are aware of risks to quality.

Risk Management Strategy
The Risk Management Strategy provides the framework for identifying and managing all types of risk. It outlines accountabilities and responsibilities at all levels of the organisation and information flows through high level, sub, and local committees to and from the Board. In addition the strategy supports the Trust's commitment to delivering high quality services and is designed to support the development of an organisational culture whereby staff actively identify and manage risks locally. The strategy also describes the structures and processes to give assurance to the Trust Board on the effectiveness of risk management. This includes:

- A high level structure that includes the Trust Board and its sub-committees, which are all chaired by Non-Executive Directors
- The establishment of a Quality Committee, chaired by a Non-Executive Director, which reports directly to the Board, where clinical quality risks are discussed at each meeting
- The establishment of the Audit, Risk and Governance Committee, chaired by a Non-Executive Director which reports directly to the Board
- The risk management process which describes the responsibilities, mechanisms and processes used to identify, escalate and manage risk
- The Board Assurance Framework (BAF)
- The Corporate risk register which is influenced by internal and external risks and built up of Divisional risk registers depending on the risk assessment. It is reviewed by the Management Board and links to the Board Assurance Framework
- Divisional risk registers held within each division
- Departmental/Speciality risk registers are managed locally and escalated to Divisional quality and safety boards.

Examples of risks that have been addressed by intervention of the Board are:

- Referral to treatment reporting break and resultant improved access for patients
- Investment in emergency surgery provision at Charing Cross Hospital
- Clinical strategy development to address a lack of Trust direction and ability to deliver their IBP

Quality impact assessment processes
The Board has established mechanisms to ensure that quality is not adversely affected by initiatives and/or CIPs. The Risk Management Strategy is integral to this.

Productivity initiatives (including CIPs) are developed by the clinical services and are subject to a quality impact assessment (QIA). The QIAs are aligned to the six improvement

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principles outlined in our quality strategy, have been designed based on best practice and take Monitor's approach into account. The risk assessments are completed by clinical teams at specialty level before authorisation by the appropriate Divisional Directors and Divisional Directors of Nursing. Each QIA is discussed and quality assured at quarterly clinical review meetings, led by the Trust's Medical Director and Director of Nursing. This review allows schemes to be considered taking a global Trust perspective which is particularly important to identify co-dependency or impact.

The quality impact of any initiative is not only assessed before implementation but is monitored on an on-going basis. This is achieved by the monitoring of agreed key performance indicators (KPIs) which are set from the beginning of the process. The KPIs are tracked in the Divisions and are monitored in the quarterly clinical review meetings by the Medical and Nurse Directors.

Business cases are developed using the same "bottom up" approach and are supported by the Trust planning team. Risk assessment is undertaken as part of the business case development and is considered by the Medical Director and Director of Nursing at the Investment committee. Cases which have a significant risk to quality are required to be approved by the Management board before being presented to the investment committee. Examples of cases which have followed this process are:

- Re-tendering of support services contract (cleaning, catering etc)
- Centralisation of booking and administration services

An electronic system was implemented in 2013 to ensure recording and reporting processes are robust for QIAs for all CIPs. The Transformation Board is currently considering how this could be extended, which would include business cases.

The Quality Committee and Trust Board receive regular reports from the Director of Nursing to assure them that all cost improvement initiatives have been assessed for the impact to quality and that no high risk schemes have been implemented.

Aligned to this is the Trust's Transformation Board which has the following objectives:

- Performance manage the Trust's CIP, ensuring processes are in place to effectively manage any associated clinical risks;
- Executive leadership of the Trust's transformation and quality improvement programme.

The Transformation Board will shortly be renamed the "Efficiency Board" to be in line with the efficiency goal set out in the Quality Strategy.

Clinical Strategy

The Trust's Clinical Strategy has been developed during 2013/14. The final strategy was presented, discussed and accepted at the Board in October 2013.

The strategy describes an inter-dependent three site vision that fulfils our requirement to meet quality expectations (now and for the future), perform to NHS finance and timeliness standards and capitalise on our relationship with a world class university.

The strategy has been developed using a bottom up approach with over 200 meetings, and including significant consultant and senior nurse team involvement. Clinical quality and experience is at the heart of every part of the strategy development and is one of the main drivers.

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The strategy includes the unique roles of each of the Trust's three main sites and incorporates the role of hospital doctors in community care.

The strategy will ensure that the Trust continues to improve outcomes, drive up quality across the six Berwick dimensions, achieve NHS performance targets and maintain financial viability. It also will increase our national and international profile through AHSC and AHSN, grow services needed to deliver sector unique practices and profile, and respond to the need to reduce costs and provide care in new ways, in new settings.

Evidence and experience from international healthcare and business have been used to ensure that it is deliverable. This will steer the improvement/transformation programme ensuring that Quality is truly driving our future.

Performance Scorecard

Ongoing monitoring of quality impact has been strengthened by aligning the performance scorecard with the quality goals and the new CQC indicators. Variance reporting in the performance report supports the Board to track potential risks to quality by providing details on areas of underperformance, with the mitigating actions in place.

The Board set the governance structure to ensure quality performance information is reviewed from ward to Board. This includes divisional performance and establishment reviews. These reviews consider an array of metrics and the use of national standards, for example safe nurse staffing ratios. This assures the board that quality data is openly reviewed and reported.

The Trust routinely benchmarks its quality performance against its peers, through membership of the Shelford Group which gives added assurance.

The Board is also made aware of risks to quality through the findings of external visits, patient experience and staff surveys, and PALS and complaints information. Consideration of how national reviews such Mid Staffordshire and Keogh impact on the Trust are further sources of information which the Board uses to understand risks to quality and how these can be mitigated.

The Trust has mechanisms in place to capture staff concerns which include; a 'see something say something' campaign, a recently launched engagement survey, a defined Raising Concerns Policy (Whistleblowing Policy), forums such as CEO open hour and leadership walkabouts.

Mortality reporting

Hospital standardised mortality rates (HSMR) and Summary Hospital Mortality Indicators (SHMI) have historically been reported as part of the performance scorecard at hospital aggregate level. The overall results are excellent and the Trust is consistently in the top five hospitals with the lowest mortality rates across both measures.

Reporting has been strengthened during 2013 to extend to include reporting at hospital site, division and specialty level. Consultant specific mortality is now being developed. A process is now in place to undertake a case note review of all patients who die in a specialty which has a higher HSMR than expected. Results of the reviews are undertaken at divisional and operational level but report to the appropriate boards and for assurance to the Quality Committee.

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2. **Capabilities and Culture**

2a) Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

The Trust Board has changed significantly since the appointment of the current Chairman.

The Board is focused on continuous development and has assessed its capability, skills and knowledge in the form of a self-assessment. This has informed the Board Development Programme which is being led by the Director of People and Organisational Development. This programme has included sessions on quality governance.

A review of required skills and experience is carried out to assist with succession planning before Non-Executive Director terms of office are completed, or the retirement or resignation of Executive Directors

Overview of Leadership arrangements
The Trust Board comprises of five Executive Directors (Two joint Chief Executives, Chief Financial Officer, Chief Operating Officer, Medical Director and Director of Nursing) six Non-Executive Directors plus one Non-Executive Director (Designate) and the Chairman.

There are a further five Directors (Director of Communications, Director of Governance and Assurance, Chief Information Officer, Director of People and Organisation Development and Director of Strategy).

This is in line with recommended board structures.

The Board currently meets in public six times a year.

Non-Executive Directors (NEDs) chair each of the Board sub-committees (Audit, Risk and Governance Committee, Quality Committee, Finance and Investment Committee, Remuneration and Appointments Committee and Foundation Trust Programme Board).

The Board comprises a high calibre and diverse range of members with varied backgrounds and experience in public and private sectors which is aligned to their role. This is particularly evident for Non-Executive Directors, for example the Quality Committee is chaired by an internationally renowned respiratory physician, and the Chair of the Audit, Risk and Governance Committee is financially qualified with significant experience of regulation, audit and risk management.

Description of board's approach to challenging quality performance
Quality is of paramount importance to the Trust Board. As a result it considers quality first on the agenda and has re-cast its governance structure to create a Quality Committee (sub-committee of the Board), chaired by a NED with a medical background.

The roles of the executive team are clear and they report at each Board meeting on their portfolio. The Board performance scorecard and report integrates performance across all domains of Quality. KPIs are set using national standards, contractual and internal targets, and are forecast and benchmarked where available.

Debate on quality performance is encouraged and the significant time afforded to this on the agenda means there is sufficient time to do so. Patient stories, patient experience data, staff

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feedback, complaints and incidents are presented to describe the context in which care is delivered. Board members visit areas of the hospital in formal and informal walkabouts which encourage specific questioning around clinical quality. Discussions with all members of the teams are encouraged so that opinions from members of staff not routinely reporting to the Board are heard.

The CEO chairs a weekly executive team meeting and a weekly management board meeting with key members of the executive team and the Divisional Directors. A significant proportion of the agendas at both meetings involved review of issues which may or are affecting quality. A detailed and focused review of overall Quality then occurs on a monthly basis at the allocated management board. The Divisional Directors report on performance in their areas and back into the division. The CEO challenges performance and encourages open debate.

Quality boards are now in place as follows:

- Safety and Effectiveness
- Patient Centredness (including Equity)
- Timeliness
- Efficiency

These boards are chaired by an Executive Director and are responsible for implementation of the Quality strategy and delivery of the key improvement objectives. The Divisional Directors and their senior team attend these boards. Performance is reported to the Management Board, and for assurance to the Quality Committee.

The Medical Director chairs a weekly incident review meeting where all incidents categorised as moderate or above are considered. The divisional directors and their Quality team attend to present the results of their initial investigation of each incident. Decisions are made on which incidents meet the criteria for external reporting as a Serious Incident (SI) and immediate mitigating actions are agreed. Actions are agreed for all incidents and investigations debated, challenged and consensus reached on next steps. Some NEDs have attended these panels, and all gain regular updates on actions taken from the Medical Director at the Board. Representation from the junior medical staff has been sought to build on the culture of reporting and learning. The weekly review meetings ensure incidents are reviewed in a timely manner and mitigating actions can be put in place quickly to prevent incidents from repeating. Openness and transparency is encouraged to promote a learning and safety culture.

Serious incidents are investigated within the division they occurred in. The final investigation report and action plan is presented to the Executive panel chaired by the Medical Director. The scrutiny panels for pressure ulcers developed in the Trust are chaired by the Director of Nursing. Nursing and Midwifery quality indicators are reported by exception at the divisional performance reviews and the scorecard is used within divisional and directorate board meetings. Learning from the serious incidents for the organisation is achieved through the Safety and Effectiveness Board.

2b) Does the board promote a quality-focused culture throughout the trust?

The Board is engaged with quality improvement initiatives. Specific examples of the Board's impact on improving quality (and subsequent review of progress) include:

- Development of the Clinical Strategy
- Implementation of the Quality Strategy

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- Regular interaction with staff and patients through walkabout programme
- Improvement in access target performance including reporting break
- Cancer target performance improvement
- Investment in winter plan for 2013/14
- Investment in emergency surgical consultant cover

Explanation of the mechanisms used to drive quality agenda and promote an open culture

The Board approved the Quality Strategy and its leadership by the Medical Director. Each quality goal has measureable objectives and has an Executive lead making accountability and expected improvement clear. Performance will be tracked from ward to board through the revised meeting structure which ultimately reports to the management board and the new Quality Committee with assurance to the Trust Board.

The agendas of all committees have been adjusted to reflect the six quality goals to ensure their importance is recognised and constantly reinforced. Further to this, all meetings down to divisional level have been restructured to ensure that they work towards the delivery of the Quality Strategy. The cross-divisional committees have been reviewed and aligned to the most appropriate quality goal. The Trust scorecard has also been re-set to cover the six goals.

The strategy communication and implementation plans were approved by the Board and provide an ongoing focus on ensuring our people are placing Quality at the centre of all that we do and build our culture of quality. Engagement is key and examples of work in progress include:

- Quality calendar developed detailing the “goal of the month”
- Presentation programme in place
- Feedback campaign launched with 4000 postcards distributed
- Regular news stories including intranet announcements
- Quality improvement award programme “Dragons den” being developed

The Trust is clinically led with the most senior post in each Division being held by a practicing doctor. Each division also has a senior nurse holding a board position (Divisional Director of Nursing). This is to ensure that quality of care is scrutinised and maximised. These key post holders are fully supported by an operational management structure including senior management, finance and human resources. This structure was implemented in July 2013 following extensive consultation and gives clear lines of responsibility from board to ward. “Super sisters” were introduced in key areas to enhance the quality of our service for patients and our people.

External reviews have been commissioned by the Board to assure the quality of service. Actions have been taken as a result of these reviews including:

- New swab count policy clarifying who is in-charge in the theatre implemented as a consequence of a cluster of never events
- Cardiac surgery leadership enhancement and significant investment to support service transfer and improve outcomes
- Aseptic non-touch technique assessment process implemented learning from its impact in another Trust
- Sage and Thyme training programme introduced to support cancer patient experience improvements

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There are several mechanisms in place to drive an open culture within the Trust. These include; Monthly Leadership walk rounds with improvement action plans, the routine publication of quality metrics such as the harm free care report within nursing and midwifery which frontline staff regularly see, the back to floor programme, open forums with the Trust's senior leadership teams and the public display of nurse staffing levels.

Through its range of policies and procedures such as; Being Open, Serious Incident, Supporting staff, Bullying and Harassment and Raising Concerns (Whistleblowing), the Trust encourages staff to be as open as possible. The 'see something say something' campaign further strengthens this.

The Trust's Performance & Development Review process promotes a quality and value driven culture and asks staff to evidence through specific examples how they have demonstrated behaviours that are aligned to the organisation's core values.

Description of how the Trust learns from incidents and complaints
The Trust learns from incidents and complaints in a variety of ways. Examples include:

- The introduction of patient safety managers within each division to facilitate learning from complaints and incidents
- Weekly review of all incidents that are graded as 'moderate' and above, by the Medical Director and Director of Governance & Assurance to facilitate/quality assure organisational responses, resolutions and learning
- The publication of executive summaries for all serious incident investigations on the Trust intranet. This also facilitates an open culture within the organisation
- The appointment of seven registrar level patient safety officers who will work closely with the divisional governance leads on agreed projects. It is anticipated that these doctors will act as key links in ensuring feedback and learning from serious incidents is disseminated to all junior doctors
- Discussion of incidents at junior doctor 'lessons learned' forums
- Regular review of outstanding actions from serious incidents at divisional level quality boards led by divisional governance leads
- Bi-monthly complaints forums where each division present and share their learning from a selected complaint
- Capturing learning on the risk management system Datix, and producing thematic reports quarterly
- Presenting patient stories at each Trust Board meeting which can come from a complaint or incident
- The Medication Safety Review group which reviews medication incidents reported on Datix and publishes safety alerts on the intranet.

A business case for investment has been approved to introduce an updated reporting system in 2014. This will enhance the reporting culture and shows the commitment we have for continuous improvement.

The Board takes a proactive approach to improving quality through applying lessons learnt from national reviews and guidance such as the Mid-Staffordshire inquiry and the recent publication on safe nurse staffing ratios by the National Quality Board. For example, it has received detailed briefs about how these publications impact on the Trust and what we are doing in response to meet best practice/key recommendations.

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3. Processes and Structures

3a) Are there clear roles and accountabilities in relation to quality governance?

The Board is ultimately responsible for the quality of the services being provided. Therefore they have been integral in development of and implementation of the Quality Strategy and approved the complete change in governance reporting and committee structures.

Quality Performance is considered in detail each month at Trust Board, the Quality Committee, Management Board (Quality) and at the Risk Management Committee. Underpinning this are the Quality boards which report to the management board and align to the six principles outlined in the Trust's Quality Strategy.

The Governance Framework:
Trust Board
Quality is considered first on the Trust Board agendas including the Nursing and Medical Director reports. The Board receives the minutes of its sub-committees at every meeting.

Trust Board Sub Committees

- **The Quality Committee** – provides assurance to the Board that there are adequate systems, processes and controls in place to ensure high quality care is provided to the patients using the services provided by Imperial College Healthcare NHS Trust.

- **Audit, Risk and Governance Committee** – is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives and also to ensure effective internal and external audit, enabling the assessment and measurement of quality governance processes.

- **Finance and Investment Committee** – is responsible for conducting independent and objective review of financial and investment policy and financial performance issues.

- **Remuneration and Appointments Committee** – is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors and senior managers, ensuring that the Trust attracts senior staff able to develop and maintain a quality service.

Management Board
The Management Board is chaired by the CEO and consists of the senior leadership team for the Trust, including Divisional Directors and ensures the active liaison, coordination and cooperation between the clinical divisions and central directorates. It ensures clinical contribution to determine the strategic direction, proposing that direction to the Trust Board and ensuring operational delivery. The Management Board monitors the delivery of the organisation's targets, ensuring action plans are agreed where required. Each weekly meeting has a rotating focus on; quality, strategy, corporate affairs and operational performance.

Quality Boards
These boards are responsible for delivering the quality strategy at an operational level and are led by Executive Directors. They report through the executive lead to the Management Board.

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Divisional Quality Committees
Chaired by the Divisional Director to ensure quality performance is scrutinised at directorate and specialty level. These committees are responsible for implementation of the improvement objectives in the Quality Strategy.

Roles:
Chairman and Non-Executive Directors (NED)
The Chairman and Non-Executive Directors are responsible for providing oversight, governance and leadership in pursuit of the Trust's strategies to provide effective and high quality healthcare services. They scrutinise and monitor performance, so they can assure themselves with the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

Chief Executive Officer
The Chief Executive is ultimately responsible and accountable for the quality of care delivered. They ensure the appropriate resourcing, management and reporting structures are in place to deliver the quality agenda through the Trust objectives and management structure. They delegate specific roles and responsibilities to the appointed Executive Directors to ensure all quality and improvement work is co-ordinated and implemented equitably to meet the Trust objectives safely without negatively impacting on patient care.

Executive Directors
Executive Directors are accountable for the delivery of quality services in the areas within their remit whether clinical or operational and lead the delivery of the Trust’s Strategies. They ensure the quality agenda is effectively co-ordinated, resourced and implemented across the Trust in an integrated way, through being responsible for each of the six quality domains outlined in the Trust’s quality strategy. They ensure actions taken to improve the quality of service delivery are completed, measured and shared to promote learning. Executive Directors are accountable for ensuring that the potential effect on the quality of service delivery is risk assessed prior to approval of any new business proposal. They ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility is in place.

- **Medical Director** - overall responsibility for, the safety and effectiveness of care. This includes the delivery of the best possible clinical outcomes; they are also responsible for Medical Revalidation.

- **Director of Nursing** - responsibility to ensure nurses and allied professionals are focussed on quality and safety and participate in the quality programme. They are also the Executive Director responsible for the patient experience, safeguarding children and equality and diversity agendas.

- **Chief Operating Officer** - responsible for the delivery of the quality and finances of the organisation, through the line management of the Divisional Directors and Divisions. They have specific responsibility for the leadership and delivery of the Health and Safety agenda and Estates Strategy.

- **Chief Financial Officer** - responsible for ensuring adequate resourcing to deliver quality services.

Divisions and Corporate Departments
Each division and corporate department has inclusive systems in place to ensure that all

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aspects of their work are subject to regular review across all specialties and teams. This will be identified within their documented governance structure and reflect the Trust requirement for specified outcomes for each aspect of service provision.

Divisional Directors, Divisional Managers and other Managers with an operational role

All Senior Managers ensure systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust's priorities. They identify risks within the division, ensure appropriate actions are taken to mitigate these, and comply with the reporting and governance requirements to ensure learning is shared across the organisation. They monitor their staff and service compliance against identified standards and safe systems of work whether set nationally or locally and facilitate and act upon regular patient feedback.

3b) Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?

The Trust has well defined and effective processes for escalating issues and managing performance, coupled with robust performance and governance frameworks.

Issues can be escalated within the Trust through three main routes:

Performance Framework

The Trust has recently reviewed its performance management arrangements to align with best practice. This has led to an integrated approach to ensure that the inter-dependencies of patient care, the use of resources and the delivery of regulatory standards are explored and tested by the senior leadership team with the teams accountable for the operational/clinical delivery units across the organisation. The Trust's framework is summarised below:

- Performance reviews take place quarterly involving full executive/senior director team including CEO
- Additional performance reviews take place as required dependant on Divisional performance metrics
- Agenda is driven by Divisional performance metrics via a Divisional Integrated Performance Scorecard. This is bespoke to Divisions as required but follows the format of the newly developed Trust Integrated Performance Scorecard. The first part of the agenda focuses on quality.

Risk management process

The Trust's risk management strategy sets out the framework for identifying, escalating and managing all types of risk/issues. Risks and issues are escalated as follows:

- Departmental/Speciality risk registers are managed locally and escalated to Divisional quality and safety boards
- Depending on the risk assessment, risks are escalated onto the divisional risk register
- Depending on the risk assessment, risks are then escalated onto the trust-wide/corporate risk register which is influenced by internal and external risks and built up of the Divisional risks
- The Corporate risk register is reviewed by the Management Board
- The Board Assurance Framework (BAF) is reviewed twice yearly by the Board.

Governance structure

The governance structure is used to ensure that risks and issues are identified and

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escalated from ward to board including:

- Divisional performance reviews which consider the Division's risk register at each meeting and other performance issues
- Review of the corporate risk register at Management Board and the Audit, Governance and Risk Committee
- Review of Divisional risks relating to quality at the Quality Committee
- Review of the minutes for the Quality Committee and the Audit, Governance and Risk Committee by the Trust Board.

There are further mechanisms through which issues can be identified and are escalated. These include the weekly incident review meeting, complaints, claims, inspections and national reviews. The Trust also has escalation policies such as managing pressure within A&E and ensuring safe nurse staffing which gives additional "smoke signals".

The Trust has recently introduced a quarterly engagement staff survey designed to obtain feedback on a more regular basis than the national annual staff survey. The results from this have been categorised into three areas; action, watch and celebrate.

Staff can also raise concerns and issues through the Raising Concerns Policy (Whistleblowing policy). An open and honest approach is encouraged at the communication forums in place e.g. Open Hour where opinion and comment is invited. Examples of changes which have been implemented as a consequence include a medical trainee induction review and action taken to ensure the critical care escalation plan is adhered to.

Where concerns have been identified, the Trust Board has initiated, led and monitored delivery of robust action plans to improve performance e.g. 18 week reporting, cancer waiting time performance and cancer patient experience.

There is a fast track email process in place to escalate urgent matters to the Board immediately rather than complete reliance on the formal board meetings.

Divisions have structures and processes in place for escalation of concerns to their senior management team. These include the use of division and departmental scorecards, regular reviews of safety and experience data and regular engagement surveys with staff across all areas. Clinical leadership is in place to specialty level with the appointment of "Heads of Specialty" who have the delivery of quality as one of their key performance indicators. This coupled with the introduction of the "super sister" in 2013 has strengthened the leadership in patient facing services and clear lines of escalation and accountability are clear.

The Trust is registered without condition by the CQC which shows external assurance of the quality of our care.

The Trust has methods in place to recognise and reward performance, including the staff awards process (OSC&R) which recognise individuals and teams who display dedication and commitment and embody the five Trust values.

External & Internal Audit

The clinical audit team develops the annual plan in conjunction with Divisional clinical leads. Audit plans include five local clinical audit projects, including at least one re-audit and at least one project based on a priority derived from a risk-related issue. The plans are also informed by national priority clinical audits that are on the Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit and Patient Outcomes Programme and the

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Department of Health's Quality Account list.

As the Trust has recently revised its governance structure, progress against plans are monitored within divisions and at the Safety and Effectiveness Board which reports to the Management Board.

Clinical audit information is used to drive quality through the following mechanisms:

- Back to the floor Friday meetings for nurses and midwives
- Clinical audit afternoons for Doctors
- Divisional and departmental Clinical Governance meetings
- Regular nursing and midwifery quality audits are validated through a mechanism peer review audit, quality rounds and 'spot checks'.

The internal audit plan is developed by the Executive Directors in conjunction with the Trust's internal auditor and is approved by the Audit, Risk and Governance Committee. It is driven by the following; risks and incidents identified through the governance and assurance framework, cases of fraud, benchmarking with similar organisations, the implementation of new systems or processes to proactively challenge and improve them to ensure they are effective and other priority areas for the Trust.

The 2012/13 plan covers quality governance topics such as; Clinical Governance/Clinical Audit, CQC Assurance, Quality Accounts, Patient Experience, Safeguarding Adults/ Children, Complaints and Clinical Coding/Data Quality. Looking ahead, the Trust will align its internal audit plan with the quality strategy and its QG15 goals.

The organisation receives feedback from a variety of sources including; staff, patients and the public and external organisations such as Healthwatch.

Staff Survey

The 2012 staff survey action plans are in place however they will be reviewed and refreshed in light of the engagement survey results and areas under the 'action' category will be included. Local action plans which address the themes are in place but will be further developed and owned by the divisions. The management board will monitor and review actions going forward to ensure these are delivered and acted upon.

In addition to the National Survey, the Trust implemented a quarterly local Engagement Survey in October 2013. This survey will provide us with more timely feedback from our people and will enable us to review results at ward and departmental level. The first survey was carried out in October 2013 and results were fed back across the Trust in December 2013. With a response rate of 27th, the results showed that we had an initial Engagement Score of 42% i.e. 42% of our people rated the questions positively, 36% were neutral and 22% rated the questions negatively. The priority areas from, Survey 1 include:

- Improving staff health and wellbeing
- Empowering and inspiring our people
- Making opinions count

The Divisions and Directorates are developing local action plans in response to their own results.

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The roll out of this Engagement Survey enables us to easily implement the new Department of Health (DoH) requirement from April 2014, to ask the "Friends and Family" test questions to all our people on a regular basis. These questions are already included in our survey and we will be able to adapt this to meet with new DoH requirements once finalised. The two Friends and Family questions which will be required are:

1) "If a friend or relative needed treatment I would be happy with the standard of care provided by this Trust "
2) "I would recommend my ward/ team as a great place to work "

We have received the initial results from the 2013 Staff Survey. This year the survey was conducted online for the first time and we have a response rate which was marginally above average at 49.4%. Our results were stable compared with previous years, with an improvement in responses in 3 questions and deterioration in 3 questions. Significant improvement has been seen in the following areas:

- Number of staff having equality and diversity training: This follows the launch of a new E & D e-learning module as a result of the poor results in last year's survey
- Harassment, bullying or abuse from patients/service users, their relatives or members of the public following a campaign of work as a result of poor results in previous surveys.

The action plans which were developed by Directorates and Divisions have resulted in a wide range of tangible actions and improvements at local level, and we await the further full results from the survey to assess impact.

Joint work is underway with MacMillan to begin to match patient and staff experience feedback. This will inform the actions we need to take to ensure our people are engaged and content and so deliver a more positive patient experience.

Feedback from Patients & Public

Feedback from patients and the public is received in a variety of ways including; real time patient trackers, the friends and family test, national surveys, complaints, patient stories and patient involvement events. All relevant staff have access to real-time patient experience feedback using the Trust's patient experience reporting system (PERSy) which displays responses, performance scores and free text comments at a ward and Divisional level.

At Divisional performance meetings, directors receive regular patient experience performance information in quantitative and qualitative formats. From these reports local and divisional improvement plans are developed to demonstrate how the feedback is being used and how they are meeting specific patient experience performance metrics. Patient experience is also captured on the Trust-wide integrated performance scorecard. Examples of acting on feedback received include; renovating ward environments, providing training (confidence and techniques) for staff who undertake difficult conversations, introducing patient bed boards, refurbishing the discharge lounge and reviewing and improving the patient food menu. The Trust's 'you said we did' campaign clearly demonstrates to patients and the public through the display of posters on notice boards, about areas patients have fed back on and what we have done as a result.

The PALS team coordinate early intervention relating to patient concerns with an aim to resolving them in a timely manner without the need for a formal process. The PALS team is supported by the complaints team which is responsible for coordinating and ensuring

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Divisions respond appropriately to concerns raised formally in a timely way.

Complaints are investigated locally and management actions identified to prevent recurrence. The Board has received reports on 'hearing what patients say' detailing the specific actions taken in relation to resolving complaints and acting on the learning form these.

Analysis of complaints includes identification of themes, by type, division and department and taking deep dives into key areas where appropriate. Examples of actions which have been implemented as a result of this feedback include:

- Implementing a new Consultant led ward round on the post natal ward
- Additional teaching sessions for clinical staff within a specific area
- Introducing a ward based Consultant on an Oncology ward to undertake daily ward rounds and to review patients' care plans and symptoms

Complaints relating to particular areas of practice may be reviewed in specialist multi-disciplinary forums. For example, the themes from complaints relating to end of life care are reviewed on a quarterly basis in the End of Life Care working group, which reports to the Patient Centredness Board. The Director of Nursing sits on this group. Outputs from this group include initiatives to further improve end of life care as a result of feedback from complaints, such as commissioning a feasibility study for a bereavement service and a review of Trust wide care planning in response to the withdrawal of the Liverpool Care Pathway.

External organisations such as Healthwatch are encouraged by the Trust to undertake regular 'enter and view' visits designed to provide an independent review of our services. Feedback from these visits is shared internally through the Trust's governance structure and action plans developed and managed as a result.

3c) Does the board actively engage patients, staff and other key stakeholders on quality?

The Trust has made considerable improvements in engaging with our stakeholders. The Quality Strategy has a well-defined communications plan designed to communicate key messages on quality, from ward to board. Some of the mechanisms used include; internal and external stakeholder events, briefings on the Trust's intranet and website, presentations at key meetings such as at the leadership forum, Nursing and Midwifery annual conference and divisional meetings.

The Trust's Patient Centeredness and People and Organisational Development strategies set out the mechanisms the Trust uses to engage with patients and its people. The work plan to deliver the patient centredness strategy coupled with its communications plan includes key actions to engage stakeholders, such as briefing events and the quarterly engagement survey.

All current improvement work within the central patient experience team is conducted using a collaborative and co-design approach. We seek quantitative and qualitative views of staff and patients using the Itrack system, one to one interviews and group work. Below are some examples of how this has been used:

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- Improvement by co-design: A working group was formed which consisted of staff and patients to design the content of the information boards for the Inpatient wards.
- Values Based standard: we work with staff, patients and carers to co-design improvements at ward level in our cancer services. A survey has been designed to measure the success of these improvements that focus on behaviours. The results have shown a high level of success where the values based standard has been implemented.
- Co-design by experience pathways: we are in the process of initiating a project in cancer services that will focus on an agreed pathway where patients and staff will co-design steps in the pathway that cause the most emotional distress. This will also improve the processes we work to.
- ICU and Paediatrics: These teams have monthly meetings/events with patients and their carers to review experience within these units. As a consequence, improvements are implemented where required.

Mechanisms to engage patients and the public in setting the quality agenda include the development of the Quality Account and the annual assessment of the Equality Delivery System. Members from Healthwatch, and other organisations the Trust works with, are actively involved in both of these areas.

The Board engages with external stakeholders such as commissioners through regular attendance at the Clinical Quality Group (CQG) and the CCG Chairs meeting. It discusses quality at each of these meetings and works in partnership to set the agenda for the CQG meeting to ensure that appropriate quality issues are discussed. Members of the Board also engage with overview and scrutiny committees and with members of parliament through local government.

The Membership Strategy sets out how the Trust will use the views of its members, patients and carers to shape and improve the services it provides. For example, members will have the opportunity to influence the Trust's strategic direction and service developments through invitations to meetings, focus groups and members' forums on relevant health topics.

The Board also engages with patients, staff and stakeholders by:
- Listening to patient stories at each public meeting
- The Chairman's monthly walkabout
- Non-Executive and Executive Director Walkabouts
- Briefing and engagement forums with staff led by the Chief Executives and other Directors
- Attending complaint resolution meetings

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4. **Measurement**

4a) Is appropriate quality information being analysed and challenged?

The Trust has undertaken a review of its integrated performance scorecard and has revised it to align with the six quality goals, best practice and recent national reviews/indicators such as the new CQC indicators. The information includes both qualitative and quantitative measures and this is presented in chart format to provide trend and comparison data and include target performance, ensuring that issues can be readily identified, with parameters clearly defined and aligned to relevant requirements.

The information has been selected by the Board based on those that are relevant to the delivery of the Trust's strategic objectives. They reflect external contexts within which we operate and national, regional or local priorities.

Quality information is analysed in order to examine and learn from the past together with predicting through early warning and as a result prevent inadequate care to our patients.

The Board reviews monthly KPIs through the integrated performance scorecard as described earlier. The Trust's governance structure to include Board sub-committees and the divisional performance review structure, facilitate reviewing more granular quality performance information. Examples include:

- **Quality:** Mortality, Patient Experience, Infection Prevention and Control, Eliminating Mixed Sex Accommodation (EMSA), Stroke Care, Research and development, Safety Thermometer.

  Detailed information relating to incidents and infection prevention and control is discussed at the Safety and Effectiveness board which is also underpinned by weekly incident review meetings held with the Medical Director. Mortality monitoring is in place with outlier alerting to ensure early investigation takes place. Patient experience information such as that relating to cancer services is discussed at the Patient Centredness board and also at the cancer recovery meeting. The 'harm free care report' monitors ward level nurse sensitive indicators and translates organisational KPIs to local department level. These are reviewed at ward and divisional level in detail, at the nursing and midwifery professional practice committee and by exception in divisional performance reviews.

- **Operations:** Accident & Emergency - 4 Hour maximum waiting time, Accident & Emergency - Clinical Quality Indicators, Cancer Waiting times, Elective Access - Referral to Treatment, Diagnostic Waiting times, Maternity, Delayed Transfer of Care, Quality, Innovation, Productivity and Prevention, Data quality.

  Granular operational performance information is considered at divisional performance reviews and also at management board.

- **Workforce:** Vacancy rate, Bank and Agency Spend, Pay Expenditure, Turnover, Appraisals, Statutory Mandatory Training and Local Induction, Sickness Absence

  Granular workforce indicators are considered at divisional performance reviews, establishment reviews and also at management board.

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As part of the governance structure, committees and divisions review quality information through scorecards which are relevant to the delivery of their portfolio/business plan. This information aligns with the same parameters set at Board level to ensure integration from ward to Board.

A six monthly review of each of the scorecards will take place to ensure the continued relevance of the metrics.

Quality performance information is available alongside financial and workforce performance information via the Trust's business intelligence portal. This is available to all Trust staff and allows for all aspects of performance to be considered.

4b) Is the board assured of the robustness of the quality information?

The Trust has a range of policies and standard operating procedures in place to assure data quality as well as a defined governance structure. Data quality is discussed at the Operational Data Standards Committee which looks at internal performance as well as benchmarking against other similar Trusts.

The Trust uses the Cymbio data quality framework which focuses on the provision of the right data quality intelligence to the right individuals in the organisation and links data quality problems back to the operational procedures which have not been followed. This provides the feedback loop back to the operational areas that are responsible for the specific problem, and the tools to both prevent and correct it. Operational managers are then able to drive ownership for data quality back into the areas of the Trust that are responsible for the initial data entry. Eight areas from the framework relating to data quality are discussed at divisional performance reviews and also reported at Trust board level through the integrated performance scorecard.

Data quality is also assured through external audits and assessments. For example, the Trust was subject to the Payment by Results data quality audit by the Audit Commission during 2012/13. The results indicate that the Trust is performing above the national average in most of the areas audited.

The clinical coding team regularly engages with clinical colleagues to ensure understanding of coding and the resolution of issues that may arise. Representatives from clinical coding, the information department and clinicians have jointly undertaken coding audits to assure the robustness of the data. The highest level – level three - was reached for clinical coding quality under the national Information Governance assessment report in 2012/13.

The Trust has a comprehensive clinical audit programme in place which measures clinical quality against agreed standards.

The current internal audit plan includes audits on coding and data quality with a scope to look at SUS reconciliation, information provision analytical review and other data quality controls evaluation and data validation. The audits will also select a system to review and data will be extracted and tests performed using Computer Assisted Audit Techniques to determine the completeness of data fields and whether those fields conform to certain queries set by management. Findings are followed up through the governance structure and through the audit, risk and governance committee. Coding accuracy is audited annually by both Internal Audit and External Audit. Audit Recommendations are reported to and tracked by the Trust's Operational Data Standards Committee, part of the Trust's Information Governance Framework.

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'.

4c) Is quality information being used effectively?

Information in quality reports and the Trust's integrated scorecard is displayed clearly and consistently with the inclusion of targets, RAG ratings and trends showing in month performance as well as year to date.

Quality information is available as near to real time as possible through the Trust's Business Intelligence Portal which allows users to access 'on demand' data. Please refer to sections 4a and 4b for further information.

Examples of how quality information has led to improvements in quality include:

- Cancer MDT review undertaken to address cancer performance issues at specialty level
- Closure of the vascular HDU and improvement programme implemented
- Quarterly review of data quality of "degree of harm" in incidents
- Nursing and midwifery:
    - Harm Free Care > 95% since this measure was mandated as a national CQUIN in 2012 (no national target, but national average (90 to 93.5% over the same period)
    - Falls with harm – ICHT continue to remain significantly below the national average for this indicator

Factual accuracy

The Board is satisfied to the best of its knowledge that the content of this Board Quality Governance Memorandum is factually accurate.

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