

TRUST BOARD AGENDA – PUBLIC

29 March 2017

11.30 – 13.00

Clarence Wing Boardroom

Agenda Number		Presenter	Timing	Paper
1	Administrative Matters			
1.1	Chairman's opening remarks & apologies	Chairman	11.30	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 25 January 2017	Chairman		1
1.4	Record of items discussed at Part II of board meetings held on 25 January 2017	Chairman		2
1.5	Action Log and matters arising	Chairman		3
2	Operational items			
2.1	Patient story	Director of nursing	11.35	4
2.2	Chief Executive's report	Chief executive		5
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		6
2.4	Month 11 2016/17 Finance report	Chief finance officer		7
3	Items for decision or approval			
3.1	Board assurance framework	Trust company secretary	12.15	8
4	Items for discussion			
4.1	Infection Control report	Director of infection prevention and control	12.20	9
4.2	Charity name & volunteer update	Chief executive, Imperial Charity		10
4.3	Hospital pharmacy transformation	Chief pharmacist		11
4.4	CQC quarter 3 update	Director of nursing		12
5	Items for information			
5.1	NHS Mandate	Chief executive	12.45	13
5.2	Summary of STP Joint health and care transformation group	Chief executive		14
5.3	Sustainability and Transformation Plans update	Chief executive		15
6	Board committee reports			
6.1	Finance and investment committee	Committee chair	12.50	16
6.2	Redevelopment committee	Committee chair		17
6.3	Quality committee	Committee chair		18
6.4	Audit, risk & governance committee	Committee chair		19
6.5	Remuneration committee	Committee chair		20
7	Any other business			
8	Questions from the Public relating to agenda items			
			12.55	
9	Date of next meeting			
	Public Trust board: Wednesday 24 May 2017, W12 Hammersmith Hospital			

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 25 January 2017
 11.45 – 13.00
 New Boardroom, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Acher	Non-executive director
Dr Rodney Eastwood	Non-executive director
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Andy Bush	Non-executive director
Nick Ross	Designate non-executive director
Victoria Russell	Designate non-executive director
Dr Tracey Batten	Chief executive
Prof Janice Sigsworth	Director of nursing
Dr Julian Redhead	Medical Director
Richard Alexander	Chief financial officer
In attendance:	
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Michelle Dixon	Director of communications
Prof Tim Orchard	Divisional director, medicine & integrated care
Prof Jamil Mayet	Divisional director, surgery, cancer & cardiovascular
Prof TG Teoh	Divisional director, women's, children's & clinical sciences
Prof Jonathan Weber	Director of research
Jan Aps	Trust company secretary (minutes)

1	Administrative Matters	Action
1.1	Chairman's opening remarks and apologies The Chairman extended thanks to all staff for providing safe and effective care to patients during a period of tremendously high patient demand, with extremely high bed occupancy; he commented that the Trust board should be proud of the staff for this real achievement. Dr Julian Redhead thanked the Chairman and said he would ensure that these comments were passed to the staff.	
1.2	Board member's declarations of interests There were no declarations of interest made at the meeting.	
1.3	Minutes of the meeting held on 30 November 2016 The minutes were accepted as an accurate record of the meeting.	
1.4	Record of items discussed at Part II of board meetings held on 23/30 November 2016 The Trust board noted the report.	
1.5	Action Log and matters arising The Trust board noted the report, particularly the update on the FFT scores in maternity, which had started to see some improvement.	
2	Operational items	
2.1	Patient Story Prof Janice Sigsworth introduced the item, commenting that the BBC Hospital documentary had provided a rich selection of patient stories. The story for this occasion was a further	

	<p>new approach, a video of a patient complaint interview held with a patient.</p> <p>Mrs P had experienced a long waiting time for her appointment which had then been cancelled at only two weeks' notice, with a further long wait for the rearranged appointment – this had all been distressing. She felt that the complaints department had been helpful and taken her concerns seriously, and had been able to shorten the further wait. The cause of the short-notice cancellation was under investigation (<i>post meeting note: the cancellation had been due to the surgeon requiring urgent surgery</i>). She had then had a long wait for her operation, and the pain was affecting her quality of life and her ability to work; it had been possible to shorten the wait by transferring to another surgeon's list.</p> <p>Prof Mayet acknowledged that the waiting times were, unfortunately, not isolated, and commented that there was no complacency in seeking improvement. Recent increased capacity in outpatients, and the re-opening of the Riverside theatres would help reduce overall waits, and the introduction of pooled referrals was also ensuring no patient waited longer than necessary. Alternative ways of increasing capacity (including outsourcing) continued to be considered; most trusts across London were reporting a similar position. Responding to a query from Nick Ross, Prof Mayet confirmed that a minimum of six weeks' notice of cancellation was the aim, but at times it was not possible to achieve this.</p> <p>The comprehensive outpatient improvement programme was delivering more efficient administrative systems, and verbal feedback from CQC had recognised an improvement in the departments, but Prof Teoh acknowledged there was much yet to do to ensure that all outpatients received a good experience.</p> <p>With current systems, it was not possible to identify patients as they passed the target 18 week waiting time, and work was currently focused on those patients who had waited in excess of 40 weeks. Responding to a query from the Chairman, the Trust board noted that whilst some GPs followed up individual patients, it was by no means comprehensive, and the patience of patients was recognised and appreciated, but not taken for granted.</p> <p>The Trust board noted the report, and asked to be kept informed of improvement in patient waiting times.</p>	
2.2	<p>Chief Executive's report</p> <p>Highlighting several of the items in her report, Dr Tracey Batten echoed the Chairman's opening comments, complimenting the staff on the amazing job they were doing in providing patient care during the particularly busy winter period. She noted that it was pleasing to see financial performance on track with plan. Commenting on the positive and widespread viewing feedback received on the BBC documentary, she reflected on the amazing stories that happened every day across the hospitals. Dr Batten also outlined the major building development works which had been recently completed or were underway, many of them funded by the welcome support of Imperial College Healthcare Charity. She also reported that the planning application for the outpatients' building, the first phase of St Mary's redevelopment, had been submitted, and that the first stage of the business case had been approved by NHS Improvement.</p> <p>The Trust board noted the chief executive's report.</p>	
2.3	<p>Integrated performance report</p> <p>SAFE/ EFFECTIVE: In commenting on the safety and effectiveness indicators, Dr Julian Redhead particularly noted: that overall the safety record remained good; there had been a slight increase in incidents causing harm reflecting a change in practice to review all deaths, which was considered good practice as it provided a further opportunity to learn; the continuing delivery of the Health Education NWL quality visit action plan and improved position in the national training survey; and the return to threshold trajectory of C difficile cases.</p> <p>The Chairman requested a full infection prevention and control report at the March board meeting, to include a focus on gram negative infections.</p> <p>CARING: Prof Janice Sigsworth noted that the friends and family response and satisfaction rates were showing slow improvement in outpatients and maternity services. Dr Eastwood commented that it was pleasing to see that the emergency department satisfaction rates had not fallen in response to the operational pressures. Prof Sigsworth noted that there had been some particularly positive comments on care in the emergency departments on the NHS Choices website. She also noted that the transport waiting times, whilst improving</p>	JR/AH

<p>slowly, were receiving further attention, and the continuing challenge of ensuring no mixed sex breaches once patients were ready for discharge from the ICU (the guidance was being reviewed to ensure the Trust was not over-reporting). Prof Sigsworth reported a focus on improving the response time of the estates maintenance teams, and, in response to non-executive directors identifying areas where the contractor could improve, commented that the contractor had underestimated the scale of the problem when they took the contract, but along with the Trust, this was being addressed.</p> <p>WELL-LED: David Wells reported that there had been an increase in the vacancy rate in December but that actions being taken were expected to improve the position. Individual recruitment plans were in place for each ward and department; there had been a significant improvement in the timeliness of recruitment processes (David Wells would provide an update in the next performance report). He also noted that: voluntary turnover remained relatively low; sickness remained on target; and agency usage, whilst challenging during the winter period, remained on trajectory to achieve the NHSI target.</p> <p>RESPONSIVE: Prof Tim Orchard reiterated the pressure under which the emergency departments had been working, and recognised the amazing job done by staff across the entire pathway of care to ensure that patients received the treatment they need. Overall, there had been a 10% increase in patient attendees (this had been more marked towards the end of the year), and a 6% increase in admissions. Various elements in capacity management had helped with managing the increase; there had been a 20% increase in patients attending the ambulatory unit, and dedicated admissions units, both medical and surgical, were now in place. Prof Orchard noted that the Trust had reported that it could only achieve the planned 2016/17 performance trajectory if activity did not continue at 10% growth and the urgent care centre (UCC) delivered on its targets; neither of these had been delivered, and the impact was clear. The Trust had six work programmes looking at improving patient pathways through the hospital; the plans put in place to address the winter pressures had clearly improved patient flow. Responding to queries from non-executive directors, Prof Orchard:</p> <ul style="list-style-type: none"> • confirmed that most people attending the emergency department had required the care provided there; this was even more so given the situation that the UCC took much of the primary care type activity away from the department. He noted, though, that many patients admitted needed only short stays to stabilise conditions rather than longer periods of hospital care, and the difficulty in discharging patients in a timely manner with the appropriate care, created additional pressures. • reported that the Trust performance was similar to other trauma centres, and at a median position compared with other London trusts; those that had higher performance tended to have a higher percentage of beds to admissions. • commented that good practice from other sites continued to be reviewed and adopted where appropriate, as part of the wider review of patient pathway improvement. Each of the new work streams was led by a clinician and managerially supported by one of the general managers, and each was preparing a number of SMART objectives for the work stream; where further resources were needed, these would be provided. <p>Prof Jamil Mayet reported that he expected the referral to treatment (RTT) position to start to improve, and that whilst the emergency operational pressures were having an impact, this should be offset by the re-opening of the Riverside theatres at Charing Cross Hospital. The Trust was focusing on operating on those patients who had experienced waits of over 52 weeks, although there were some capacity issues in orthopaedics and reconstructive plastic surgery. Gender reassignment surgery, now part of the wider RTT reporting, was ahead of trajectory, but patients were experiencing long waits. The 62 day cancer target had not been met, mainly due to late referrals from other trusts; this was expected to change once the revised reporting requirements were in place from April 2017. Responding to a query from Peter Goldsbrough, Prof Mayet outlined the demand analysis review underway which would support improved planning in the future, internally and also in discussion with the CCGs.</p> <p>Prof TG Teoh reported that few patients now waited in excess of six weeks for diagnostic investigations, and that whilst outpatient waits had increased slightly, he expected this position to improve shortly.</p> <p>The Trust board noted the integrated performance report.</p>	<p>DW</p>
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2.4	<p>Month 9 2016/17 Finance report</p> <p>Richard Alexander presented the month 9 financial report noting that the Trust was meeting its plan in-month and was £0.4m favourable to plan year to date, at a deficit of £38.4m before Sustainability and Transformation Funding. This position was being achieved by an increase in both activity and income; whilst the Trust was slightly behind its efficiency programme, significant focus was being given to improving this position.</p> <p>The Trust board noted the finance report.</p>	
3	<p>Items for decision or approval</p>	
3.1	<p>Investment and capital approvals update</p> <p>Richard Alexander presented the paper which outlined the changes in NHS Improvement capital regime guidance and thresholds; the main change was the increase in the Trust's delegated approval threshold to £15m. Reflecting this increase, the Trust board was requested to increase the delegated approval threshold of the chief executive for capital investment to £5m. A summary of investments approved in this manner would be presented to the finance and investment committee. The paper also proposed a stronger executive overview of investment cases between £5m and £15m, including independent review where appropriate. This would be undertaken prior to submission to the finance and investment committee and Trust board for approval. Sarika Patel noted that the Trust had previously had an investment committee, which had been absorbed into the main executive committee.</p> <p>The Trust board:</p> <ul style="list-style-type: none"> • noted the contents of the NHS Improvement capital regime guidance; • approved an increase to the delegated approval threshold of the chief executive to £5m; • approved the creation of an internal investment review panel chaired by the chief executive or chief finance officer to consider investments valued between £5m and £15m, prior to their submission to the finance and investment committee and Trust board for approval; • approved the investment appraisal framework; and • approved the revisions being reflected in the schedule of delegated financial authorities. 	
3.2	<p>LINACs replacement</p> <p>Prof Mayet presented the paper which reported the Trust's plan to bid for funding for two LINACs from the NHS England radiotherapy modernisation fund. A full business case was in preparation for replacement of two of the four LINACs at Charing Cross Hospital, and had been, in principle supported by the executive committee and finance and investment committee. Both LINACs were in excess of ten years old and declared 'obsolete' by the NHS England definition. Of the total required capital investment, it was expected that up to £5m could be available from the modernisation fund, and the remaining requirement would need to be funded from the Trust's capital, phased over two years. The business case would need to be submitted prior to the March Trust board, and the paper requested that approval to submit be delegated to the chief finance officer.</p> <p>The Trust board supported the bid for funding and agreed to delegate approval to the chief finance officer.</p>	
4	<p>Items for discussion</p>	
4.1	<p>Research report</p> <p>Prof Jonathan Weber presented a summary of recent progress with respect to the various research initiatives being undertaken within the Imperial Academic Health Science Centre (ASHC), including the outcome of the recent NIHR Imperial Biomedical Research Centre (BRC) re-application, clinical impacts from the BRC 2015/16 annual report, and update of the Trust recruitment activity for NWL Clinical Research Network portfolio studies, a brief description of our plans to grow commercially-sponsored research income, and an update of the NIHR/ Wellcome Trust Clinical Research Facility.</p> <p>The BRC was awarded a total value of £90m over the five years 2017/18 to 2021/22, a reduction on the £112m over the previous five years; the financial impact of the BRC proposal has been reviewed by the deputy chief finance officer. The women's and</p>	

	<p>children’s theme had not been funded in this round of awards, as it had not been seen to be competitive – this demonstrated the need to review, re-focus, and change this position prior to the next round of bidding.</p> <p>Prof Weber considered that the reduction in funding was a result of a failure to recruit to a number of key senior lecturer posts – this was being addressed in the new BRC, and would be overseen by the AHSC. Whilst there was a strong research performance, he felt it needed to be further strengthened; there was a more compelling case in all areas where there was a particularly strong academic presence. There were a number of further funding bids to be submitted over the next few months.</p> <p>The Chairman thanked Prof Weber for his leadership of the research function, and recognised that the Trust and College needed to do even more to ensure that funding was maximised to enable the very highest levels of research.</p> <p>The Trust board noted the research report.</p>	
4.2	<p>Corporate risk register</p> <p>Prof Janice Sigsworth presented the bi-annual Trust board review of the risk register, noting the many of the key risks had been discussed throughout the course of the meeting. There a total of 17 corporate risks, of which eleven were considered to be operational and six to be strategic in nature.</p> <p>Responding to a query from Sarika Patel as to whether the antibiotic strategy should be added to the Corporate risk register, Dr Redhead commented that risks relating to antibiotic usage and efficacy were reviewed closely, and that compliance with the antibiotic policy was carefully scrutinised by both the Executive and Quality Committees. He agreed to further review risk 88 to ensure that all potential elements were appropriately covered.</p> <p>Sir Gerry Acher commented that, as chair of the Audit, Risk and Governance Committee (ARG), he was pleased with the way that the risk register had developed; it was clearly a ‘live’ document, and subject to robust executive overview, and review at ARG. Prof Sigsworth noted that, following a recent internal audit, a couple of amendments would be introduced. The next phase would be to ensure the Trust is operationalising risk management through Datix, and ensure that effective risk registers were in place at directorate level.</p> <p>The Trust board noted the risk register and recent changes to it, and took assurance from the overall risk management approach.</p>	JR
5	Items for information	
5.1	<p>Summary of STP Joint health and care transformation group</p> <p>Dr Batten introduced the summary report from the STP joint health and care transformation group, noting that this would be a regular report to the Trust board. She noted that the group was fairly new in bringing together such a breadth of parties, but that good relationships were being built. A number of schemes had been submitted for central funding, the outcome of which would be reported at the next meeting.</p> <p>The Trust board noted the report.</p>	
6	Board committee reports	
6.1	<p>Finance and investment committee</p> <p>The Trust board noted the report, particularly the approvals outlined elsewhere in the minutes.</p>	
6.2	<p>Redevelopment committee</p> <p>The Trust board noted the report, particularly that the Trust continued to have reservations about the safety of the proposed access to the hospital; this had been made clear to the appropriate planning officials.</p>	
6.3	<p>Quality committee (January 2017)</p> <p>The Trust board noted the report, particularly that safety standards were not seen to be slipping under the increased operational pressures.</p>	
6.4	<p>Audit, risk & governance committee (December 2016) and minutes of October 2016</p> <p>The Trust board noted the report and minutes.</p>	

7	Any other business	
	There was no other business.	
8	<p>Questions from the Public relating to agenda items</p> <p>In responding to questions from the public, the following key points were made by Trust board members:</p> <ul style="list-style-type: none"> • That any shortfall or withdrawal of central STF funding would have no immediate effect on the Trust's ability to run the hospital, pay staff, or pay suppliers. It would have a more strategic impact in that if performance was deemed unacceptable, NHS Improvement would reduce the autonomy of the Trust board and, in extremis, appoint additional members to the board. • It was again confirmed that, over the five year life of the STP, there were no plans for major change to the service reconfiguration at the Trust – this clearly included the emergency department at Charing Cross Hospital. • In response to a comment from the public that STP data, obtained through an FoI, indicated a plan to reduce staffing across NW London health and care bodies over five years by 8,000 individuals, Dr Batten commented that the changes in demand since the initial planning of the STP were recognised across the health economy and would be subject to further review by the CCGs, providers and councils. She further iterated the commitment in the STP that there would be no changes to acute services at the Trust until/ unless there was demonstrable evidence that demand was being diverted and so was decreasing at the emergency departments. • The good working relationships and similar approaches to discharge across the Tri-borough area were recognised; outside this area, work continued to smooth the support arrangements for patient discharge. It was noted that the Trust had some of the shortest waits for ambulance transfers, with almost no waits over an hour. • It was acknowledged that the operational performance of the CCGs urgent care centre contract with Vocare had, at times, impacted the Trust's emergency department; the Trust continued to support the provider to ensure the impact on patient care was minimised. • It was noted that, notwithstanding the PwC led financial improvement programme, the Trust's cost improvement programme was slightly behind plan (although the Trust was on plan overall). In response to concerns as to how savings were being identified without impacting patient care, it was noted that, for example, the 10% increase in patient attendances in the emergency department had seen both additional medical and nursing staff appointed; the additional income from these patients making this possible. Recognising the investment in PwC, it was considered that they had helped bring structure to planning and processes, and helped ensure the sustainability of saving plans. 	
9	Date of next meeting	
	Public Trust board, Wednesday 29 March 2017, Clarence Wing Boardroom, St Mary's Hospital	

Report to:	Date of meeting
Trust board - public	25 January 2016

Record of items discussed at the confidential Trust board meetings on 25 January 2016

Executive summary:

Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board held in public.

Issues of note and decisions taken at the Trust board's confidential meetings held on 25 January 2017:

Shared electronic patient system with Chelsea & Westminster NHS FT

The Trust board ratified approval of the revised Cerner contract, highlighting the benefits which would derive from a shared system, both for patients and the trusts alike.

Business plan 2017/19

The Trust board noted both the plan that had been submitted on 23 December and that a further revised plan, taking account of commissioning amendments, was being prepared for submission by the end of March 2017.

Potential NW London corporate services consolidation

The Trust board approved the Trust's participation in the feasibility study to review the opportunities from consolidation of NW London corporate services, contingent on full funding of the study and implementation costs from NHS Improvement and approval by all trusts.

Global digital excellence award

The Trust had been informed that it had been awarded a global digital excellence award, the object of which was to enable organisations who had demonstrated a track record of delivery to go further faster by the provision of additional resources. The Trust board noted the progress being made, and noted that a financial analysis of the plan, including match funding and capital / revenue split would be reviewed by the finance and investment committee.

Review of the organisational restructure implemented in April 2016

The Trust board welcome the results of the review, which had been positive in terms of implementation, delivery and impact. The Trust board noted that delivery of outstanding items would be monitored by the executive committee.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellence leadership, efficient use of resources, and effective governance.

Author	Responsible executive director
Jan Aps, Trust company secretary	Tracey Batten, Chief executive

TRUST BOARD MEETING IN PUBLIC
ACTION LOG

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
Recruitment processes: to provide the Trust board with an update on timeliness of recruitment processes in the next Performance report	January 2017 2.3	David Wells	In progress	The time to hire in the September ARG report was exceeding 100 days. Since then the process has been redesigned and the time to hire is now meeting the London Streamlining target of 40 days. We are continually improving the process and our aim is enhance this further.
IPC risks: to review risk 88 on the corporate register to ensure appropriate cover of antibiotic strategy and associated infections	January 2017 4.2	Julian Redhead / Alison Holmes	Completed	Reviewed and updated.
Volunteers: to provide an update on the involvement of volunteers following the move to the Charity	November 2016 2.1	Michelle Dixon / Ian Lush	Completed	On agenda
Trust strategy document: a summary document would be prepared and presented to the Trust board for publication on the Trust website	November 2016 3.2	Michelle Dixon	In progress	Document in preparation.

MATTERS ARISING

Minute Number	Action /issue	Responsible	January 2017 Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Report to:	Date of meeting
Trust board - public	29 March 2017

Patient Story

Executive summary:

Patient stories are seen as a powerful method of bringing the experience of patients to the Board. Their purpose is to support the framing of patient experience as an integral component of quality alongside clinical effectiveness and safety.

This month's patient story highlights how our people 'live the values' and how this has a positive impact for our patients. Mrs A will tell her story about the specialist care she received when she was being treated for a rare cancer by one of our specialist teams; miles from her home.

Quality impact:

The board will hear how staff can have a positive impact on patients' experience; through expert knowledge and empathy, patients can be supported through difficult situations.

This activity is relevant to the safe and caring CQC domains.

Financial impact:

Has no financial impact.

Risk impact:

None

Recommendation to the Trust board:

The Trust board is asked to note this paper and the patient story

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.

Author	Responsible executive director	Date submitted
Stephanie Harrison-White Guy Young	Janice Sigsworth	22 March 2017

Patient Story

1. Background

The use of patient stories at board and committee level is increasingly seen as positive way of reducing the “ward to board” gap, by regularly connecting the organisation’s core business with its most senior leaders. There is an expectation from both commissioners and the Trust Development Authority that ICHT will use this approach.

The perceived benefits of patient stories are:

- To raise awareness of the patient experience to support Board decision making
- To triangulate patient experience with other forms of reported data
- To support safety improvements
- To provide assurance in relation to the quality of care being provided (most stories will feature positive as well as negative experiences) and that the organisation is capable of learning from poor experiences
- To illustrate the personal and emotional sequelae of a failure to deliver quality services, for example following a serious incident

The Board has previously approved the patient and public involvement strategy, a key part of which is engagement with users of our services and increasing the number of patients who are actively involved.

2. Mrs A

The Trust has one of two specialist centre centres in England, located at Charing Cross Hospital that provides treatment and follow-up surveillance for women who have experienced a molar pregnancy leading to malignant trophoblastic disease.

Our internationally renowned Gestational trophoblastic disease (GTD) team are world leaders in the investigation and treatment of these rare conditions, registering around 1,200 women and treating around 120 women. We have a 100 per cent cure rate for patients identified through our registration and screening facility. Our service has the largest database of GTD patients in the world, holding records of over 35,000 women with the condition. This provides excellent data for research and audit, leading to excellent outcomes, improved treatment and better services for patients.

Mrs A was referred to these services in September 2016 from her local hospital in South Wales. Mrs A was initially distressed, due to the distance from home and the uncertainty about her condition. At this time, Mrs A did not have a confirmed diagnosis and treatment plan in place.

Following a number of tests and scans, Mrs A was quickly diagnosed with malignant trophoblastic disease, a rare form of cancer, caused by a molar pregnancy. This diagnosis came as a shock to Mrs A, who was understandably frightened and alarmed by the news.

The care that she received from the clinical team had such a positive impact on Mrs A. Dr Sarwar (Mrs A’s consultant) carefully explained the disease in an understandable way, demonstrating empathy whilst conveying all the information she needed. The GTD team, notably Linda Dayal (clinical nurse specialist) team were kind and caring, answering all Mrs A’s questions and providing her with support.

Mrs A was cared for on 6 South ward where she experienced excellent care. She was especially impressed by the cleanliness of the ward; the medicines management and the caring nature of the staff. Both Mrs A and her husband felt supported and cared for.

As a result of her patient experience, Mrs A took the time to write to the Trust to share her feedback and to ensure that the staff who had made such a difference to her, were recognised. This has been shared with the relevant staff and teams.

Mrs A wanted to share her story in recognition of the excellent care she has received and to convey the impact that our people have had upon her patient experience.

Report to:	Date of meeting
Trust Board - public	29 March 2017

Chief Executive's Report

Executive summary:

This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover:

Key strategic priorities:

- 1) Financial performance
- 2) The Trust's financial improvement programme
- 3) Operational performance
- 4) Stakeholder engagement
- 5) BBC2 documentary, 'Hospital', series 2
- 6) Update on major building improvements
- 7) Unannounced Care Quality Commission inspection
- 8) NHS national staff survey results
- 9) Budget 2017

Key strategic issues:

- 10) St Mary's Hospital redevelopment plans
- 11) North West London Pathology

Quality impact:

N/A

Financial impact:

No direct financial impact

Risk impact:

N/A

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.

To educate and engage skilled and diverse people committed to continual learning and improvements.

As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.

To pioneer integrated models of care with our partners to improve the health of the communities we serve.

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Tracey Batten	Tracey Batten, Chief Executive	22 March 2017

Chief Executive's report

Key Strategic Priorities

1. Financial performance

For February 2017, the Trust reported an in-month deficit of £6.3million before sustainability and transformation funding (STF), which was £0.25m over plan for the month. Year-to-date (i.e. up to the end of February 2017), the Trust reported a deficit of £46.4million, before STF, £0.6million better than plan.

The Trust is forecasting to be £0.25million better than plan at the end of the year (i.e. up to the end of March 2017) with a deficit of £40.7million before STF. STF funding is forecast to be £0.25m under plan, due to forecast underachievement in RTT, bringing the Trust in balance to plan overall including STF. The STF available to the Trust in the 2016/17 financial year is £24.1million.

2. Financial improvement programme

The Trust has established a Project Support Office (PSO) which is driving efficiencies in the long-term and improving cost management across the organisation. PwC has completed their handover to the PSO ensuring that the financial improvement programme is sustainable now that the majority of the PwC support has ended. PwC continues to support the cost improvement programme in a limited number of areas.

You will note that the Chief Financial Officer's report on the February Trust board agenda states that the cost improvement plan programme is forecast to be behind plan by £4.5million at the end of the year (i.e. up to the end of March 2017). The Trust is working to close this gap as part of meeting its overall control total, while also maintaining its continued focus on the safety and quality of clinical services and sustainable planning for 2017/18 and beyond.

3. Operational Performance

Cancer: In January 2017 the Trust achieved five of the eight national cancer standards. The Trust underperformed against the 2WW GP referral to 1st appointment standard, the 62-day GP referral to 1st treatment (all cancers) standard and the 62-day GP referral to screening standard. The Trust had higher than normal patient choice delays over the Christmas period for 2 week waits. Clinic planning issues also reduced capacity below the level expected for bank holiday period. In January the Trust received late referrals of patients on shared pathways from other NW London sites, and also saw internal pathway delays. The Trust is continuing to work with linked hospitals and CCGs to improve shared patient pathways to recover performance. None of the breaches for the screening standard were Trust attributable.

Accident and Emergency: Performance against the four hour access standard for patients attending Accident and Emergency was 87.9% in February 2017, which did not meet the performance trajectory target of 92.2% for the month. The Trust delivered improved performance in January 2017 and February 2017 and continues to implement a programme to expand capacity, improve patient flow, reduce potentially unavoidable admissions and reduce waits.

In view of the continuing pressures that the NHS is experiencing in meeting the accident and emergency target nationally, NHS Improvement (NHSI)/NHS England (NHSE) have issued a letter outlining the action required to get performance back on track. The letter identifies three themes requiring concrete changes to ensure performance improves:

- difficulties in discharging inpatients when they are ready to go home
- rising demand at A&E departments, with the fragmented nature of out-of hospital

services unable to offer patients adequate alternatives

- complex oversight arrangements between trusts, clinical commissioning groups (CCGs) and councils.

For 2017/18, NHSI/NHSE intend to focus the whole of the 30 % performance element of providers' sustainability and transformation fund allocations on A&E performance (this year it is also allocated on referral to treatment [RTT] and cancer wait performance).

Referral to treatment (RTT): At end February, 82.4% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%. This was an improvement on the January position of 82.0% and achieved the Trust's trajectory of 81.7% for the month.

The Trust continues the work on its waiting list improvement, with external expert advice and support, to ensure we return to delivering the RTT standard sustainably. As part of this, the on-going data clean-up of the waiting lists has identified a significant number of patients waiting over 52 weeks for treatment. At the end of February, 316 patients were waiting over 52 weeks; this was an improvement on January's reported position (383 patients) but did not achieve the trajectory of 152 patients. Reducing the number of patients waiting over 52 weeks is a key priority over the coming months, and work continues to support the directorates in their efforts to rapidly improve this position.

Diagnostic waiting times: In February 2017, 0.18% of patients were waiting over six weeks against a tolerance of 1%, therefore achieving the standard.

4. Stakeholder engagement

We have continued our regular programme of stakeholder engagement meetings. In February, I met Cllr Heather Acton Westminster City Council's recently appointed Cabinet Member for Adult Social Services and Public Health. I also met with Westminster City Council's Leader of the Opposition Cllr Adam Hug and the Labour Group's Health Spokesperson Cllr Barrie Taylor. In March, I met with the new chair of Westminster City Council's health scrutiny committee Cllr Jonathan Glanz who also visited the St Mary's Hospital A&E department and major trauma ward. For the London Borough of Hammersmith & Fulham, I met with their Cabinet Member for Health and Adult Social Care Cllr Vivienne Lukey and Mike Boyle, Director of Adult Social Care Commissioning.

On 29 March we are attending Westminster City Council's health scrutiny committee to discuss A&E service performance at St Mary's Hospital.

We were delighted to host a visit to Hammersmith Hospital's heart assessment centre for the Duchess of York earlier this month. The visit was organised by consultant cardiologist Dr Ramzi Khamis in partnership with the British Heart Foundation.

The Trust's strategic lay forum held a development session at the beginning of March to support patient and public involvement in the implementation of our strategies, programmes and projects.

In addition, the Trust's three bi-monthly electronic newsletters for stakeholders, GPs and trust members were published in February.

5. Second series of BBC Two Documentary

Filming for the second series of the BBC Two documentary series Hospital started on Monday 20 March and will run until Sunday 23 April across all Trust sites. The four-part series is expected to air in June 2017.

The Trust was asked by production company Label 1 to film a second series following the success of series one which saw around 2.5 million viewers per episode. For the Trust, the benefits of series one have included greater public engagement through our website and

social media channels, a significant rise in job applications and a boost to staff morale.

Series two will again show how the Trust is responding to our everyday challenges and opportunities. The production team are keen to showcase activities and services that did not feature prominently in the first series including providing an insight into how the work of the Trust sits within the wider community, particularly in relation to social care and mental health.

As with series one, only individuals who wish to be involved will be filmed. It is being made absolutely clear to our patients that their decision to be involved or not will have no impact on their care or waiting time. We will be using the detailed consent and filming protocol we have in place from series one to ensure that patient safety, care and experience continue to always come first.

6. Update on other major building improvements

Refurbishment of Main Outpatients and the new Central Booking Office: Work continues to refurbish the Outpatients' departments at both at Charing Cross and Hammersmith Hospitals; the ENT area re-opened in December 2016, and Audiology and Ophthalmology clinic areas will be completed next. Work to the main Outpatients area at Charing Cross is scheduled for later this year. In addition, the new Central Booking Office on the Charing Cross site, which opened in December 2016, will help streamline patient administration across the Trust. Work is also now underway to refurbish the main and renal outpatients at Hammersmith Hospital.

The whole refurbishment programme for Outpatients and the Central Booking Office has been funded by Imperial College Healthcare Charity.

St Mary's Hospital Emergency Department and Paediatric Emergency Department Refurbishment: As part of the Emergency Department improvements, and completing the expansion linked to Ealing Hospital service changes, the remodelling of the resuscitation and paediatric areas has reached its final phase of works. These include creating a new clinical decision unit within the paediatric emergency department, refurbishment and expansion of resuscitation from four to six beds, and creating a new combined assessment space for ambulance and self-presenting patients. The works are due to complete by the end of May 2017.

The whole refurbishment programme has been funded by Imperial College Healthcare Charity.

Co-locating acute emergency care on the ground floor at Charing Cross: Works have been completed to support improvements to urgent and emergency care pathways:

- New south green acute assessment unit with 13 bays as part of works to improve and co-locate all emergency acute medicine services on the ground floor, close to the emergency department and imaging;
- Creating the 36-bed Marjory Warren acute medical unit for people who may need further assessment and a short stay - bringing together services that were on ward 5 west and ward 5 south;
- related works to transfer the Lady Skinner rehabilitation unit from the ground floor to ward 5 west.

Riverside theatres at Charing Cross Hospital: Full refurbishment of theatres 1, 2 & 3 and upgrade of recovery rooms, including a new air handling unit to the theatres, as part of the Theatres improvements /maintenance programme, was completed in January 2017 and part funded by Imperial College Healthcare Charity.

Paediatric intensive care unit (PICU) at St Mary's Hospital: Works continue to support the

expansion of, and improvements to, PICU. Phase 1 is underway to prepare new space in Cambridge Wing to allow relocation of the paediatric research unit which, in turn, will allow expansion space for PICU in the QEQM building. The redeveloped unit will have 15 beds, almost doubling the current number, plus new equipment, a dedicated parents' room and a private room.

The project is funded through both Trust capital and Charity funding.

Two new SPECT CTs at Hammersmith Hospital: Work is currently underway for the full refurbishment of the old endoscopy and current nuclear medicine area in A block, to facilitate two new SPECT CT scanners, control rooms and recovery areas. Works include new plant, power and infrastructure installation to support new services.

The project is being funded via Trust capital with the enabling works due to be complete in April 2017 ready for delivery of the SPECT CTs at the end of April 2017.

Backlog works including Lifts replacement across Charing Cross and St Mary's: As part of the continued works under back log maintenance, there is a major lift replacement programme currently underway on the seven main lifts at St Mary's QEQM building, and the seven main tower lifts at Charing Cross Hospital.

So far, three new lifts have been fitted on each site; the remaining lifts are being designed and will be replaced as the others are brought back into use. The replacement programme will continue throughout 2017/18 and is due to complete in May 2018.

7. Unannounced Care Quality Commission (CQC) Inspection

Inspections took place, in maternity at St Mary's Hospital, and of the medical care at St Mary's, Charing Cross and Hammersmith Hospitals, earlier this month. CQC inspectors have finished the on-site part of the inspection, but may return over the coming weeks with further unannounced visits to ensure they have all the information they need to make their judgements on these services. The inspectors will now produce their inspection reports, which we don't expect to receive for at least a few months.

I'd like to say a huge thank you to everyone involved in the CQC unannounced inspections. In their turn, the Inspectors wanted to pass on their thanks for the warm welcome from staff during the visit.

The Trust is still waiting for formal feedback from the CQC on their re-inspection of our Outpatient and Diagnostic Imaging services undertaken in November 2016.

8. NHS national staff survey results

I'm pleased to say that the Trust's overall engagement score with our staff has risen to 3.8 out of 5, moving us up two categories from 'bottom 20%' to 'average' for all trusts of a similar type.

We achieved some very positive scores:

- percentage of staff appraised in the past 12 months;
- staff satisfaction with the quality of work and care they are able to deliver;
- quality of non-mandatory training, learning or development.

Our lowest scores were for the:

- percentage of staff experiencing physical violence in the last 12 months;
- percentage of staff experiencing discrimination at work in the last 12 months.

We will now be looking to build in additional actions to existing engagement action plans to address the findings of the national survey, and sharing updates and good practice over the coming weeks. It is very clear that a top priority as a Trust must be the well-being of our

staff, and we are paying particular attention to what our staff have said about their experiences of violence and discrimination at work.

9. Budget 2017

The Government's budget for 2017 was published earlier this month, with a number of important announcements in health and social care. The key highlights include:

- Accident and Emergency capital investment of £100million in 2017/18;
- Sustainability and transformation plan (STP) capital investment of £325million over the next 3 years to STP's that 'have demonstrated the most progress to date';
- An additional £2billion for adult social care by 2020, £1billion of which is to be made available in 2017/18;
- A London devolution deal, which will include further agreements on health and social care.

Our Trust is now working through the implications of these budget announcements and working with our partners in the North West London STP to support these initiatives.

Key Strategic Issues

10. St Mary's Hospital redevelopment plans

Phase One Outpatients' building planning application update: The determination of the application is ongoing and a number of consultee responses have been received. We expect the application to be heard at the May committee of Westminster City Council.

Phase One Outpatients' building Strategic Outline Case and Outline Business Case: The trust has been advised that the Strategic Outline Business Case has been approved by the Department of Health. We are now commencing preparation of the Outline Business Case.

Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital still to be addressed: Despite lobbying from both the trust and London Ambulance Service the Mayor of London on the 6th February 2017 granted stage 2 permission for the Paddington Quarter 'Cube' planning application. The Mayor of London has acknowledged our serious concerns about the safety of the scheme's proposed new road access for St Mary's Hospital. While the Mayor decided not to use his powers to take over the Paddington Cube planning application, he states in his letter to Westminster City Council, that he is "mindful of the road safety concerns raised to date by Imperial College Healthcare NHS Trust and the London Ambulance Service." The Mayor has instructed Transport for London (TfL) "to ensure that outstanding issues relating to these safety concerns are resolved... prior to them signing the section 106 legal agreement" (the legal agreement between Westminster City Council and the developer about the measures they must take to make their scheme acceptable. Formal response from TfL is awaited and we continue to work hard with TfL and the Mayor's Office to ensure our safety concerns are addressed.

11. North West London Pathology (NWLP)

Further to updates in the November 2016 and January 2017 Chief Executive reports, NWLP will go live on 1 April 2017 as planned. It is an NHS owned joint venture between Hillingdon Hospitals NHS Foundation Trust, Chelsea and Westminster Hospital NHS Foundation Trust and our Trust which will provide pathology services across north west London through a new 'hub and spoke' model. Imperial will be the host provider for NWLP with the hub based at Charing Cross Hospital.

This is a significant achievement and an exciting opportunity as NWLP will deliver 30 million tests per year and is estimated to be about 5-6% of the total pathology service in England.

Report to:	Date
Trust board - public	29 March 2017

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of March 2016 (month 11).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author

Terence Lacey (Performance Support Business Partner)

Julie O'Dea (Head of Performance Support)

Responsible executive director

Julian Redhead (Medical Director)

Janice Sigsworth (Director of Nursing)

David Wells (Director of People and Organisational Development)

Jamil Mayet (Divisional Director)

Tim Orchard (Divisional Director)

Tg Teoh (Divisional Director)

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1. Scorecard summary

ICHT Integrated Performance Scorecard - Responsive

Month 11 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Feb-17	-	12	
Incidents causing severe harm (number)	Julian Redhead	Feb-17	-	1	
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Feb-17	-	0.11%	
Incidents causing extreme harm (number)	Julian Redhead	Feb-17	-	1	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Feb-17	-	0.06%	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Feb-17	44.0	43.5	
Never events (number)	Julian Redhead	Feb-17	0	0	
MRSA (number)	Julian Redhead	Feb-17	0	0	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Feb-17	56	57	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Feb-17	95.0%	95.1%	
CAS alerts outstanding (number)	Janice Sigsworth	Feb-17	0	0	
Avoidable pressure ulcers (number)	Janice Sigsworth	Feb-17	-	1	
Staffing fill rates (%)	Janice Sigsworth	Feb-17	tbc	98.0%	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Feb-17	2.80%	2.4%	
Core training - excluding doctors in training / trust grades (%)	David Wells	Feb-17	90.0%	85.0%	
Core training - doctors in training / trust grades (%)	David Wells	Feb-17	90.0%	85.0%	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Feb-17	0	2	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Oct-16	100	59.2	
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Qtr 3 16/17	90.0%	85.1%	
Unplanned readmission rates (28 days) for over 15s (%)	Tim Orchard	Aug-16	-	6.99%	
Unplanned readmission rates (28 days) for under 15s (%)	Tg Teoh	Aug-16	-	4.95%	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Caring					
Friends and Family Test: Inpatient service % patients recommended	Janice Sigsworth	Feb-17	95.0%	96.5%	
Friends and Family Test: A&E service % recommended	Janice Sigsworth	Feb-17	85.0%	94.2%	
Friends and Family Test: Maternity service % recommended	Janice Sigsworth	Feb-17	95.0%	93.0%	
Friends and Family Test: Outpatient service % recommended	Janice Sigsworth	Feb-17	94.0%	90.6%	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Feb-17	-	84.7%	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Feb-17	0	12	
Well Led					
Vacancy rate (%)	David Wells	Feb-17	10.0%	11.3%	
Voluntary turnover rate (%) 12-month rolling	David Wells	Feb-17	10.0%	10.5%	
Sickness absence (%)	David Wells	Feb-17	3.1%	3.0%	
Bank and agency spend (%)	David Wells	Feb-17	9.2%	11.9%	
Personal development reviews (%)	David Wells	Sep-16	95.0%	n/a	
Doctor Appraisal Rate (%)	Julian Redhead	Feb-17	95.0%	89.0%	
Staff FFT (% recommended as a place to work)	David Wells	Q2	-	65.0%	
Staff FFT (% recommended as a place for treatment)	David Wells	Q2	-	83.0%	
Education open actions (number)	Julian Redhead	Feb-17	-	24	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Feb-17	98%	45.6%	
Responsive					
RTT: 18 Weeks Incomplete (%)	Jamil Mayet	Feb-17	92.0%	82.2%	
RTT: Patients waiting over 18 weeks for treatment (number)	Jamil Mayet	Feb-17	-	11090	
RTT: Patients waiting 52 weeks or more for treatment (number)	Jamil Mayet	Feb-17	0	316	
Cancer: 2-week GP referral to 1st outpatient - cancer (%)	Jamil Mayet	Jan-17	93.0%	87.2%	
Cancer: Two week GP referral to 1st outpatient – breast symptoms (%)	Jamil Mayet	Jan-17	93.0%	93.4%	
Cancer: 31 day wait from diagnosis to first treatment (%)	Jamil Mayet	Jan-17	96.0%	96.0%	
Cancer: 31 day second or subsequent treatment (surgery) (%)	Jamil Mayet	Jan-17	94.0%	96.4%	
Cancer: 31 day second or subsequent treatment (drug) (%)	Jamil Mayet	Jan-17	98.0%	98.4%	
Cancer: 31 day second or subsequent treatment (radiotherapy) (%)	Jamil Mayet	Jan-17	94.0%	98.8%	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Jamil Mayet	Jan-17	85.0%	76.2%	
Cancer: 62 day urgent GP referral to treatment from screening (%)	Jamil Mayet	Jan-17	90.0%	80.4%	
Cancelled operations (as % of total elective activity)	Jamil Mayet	Dec-16	0.8%	0.7%	
28 day rebooking breaches (% of cancellations)	Jamil Mayet	Dec-16	5.0%	10.4%	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Feb-17	95.0%	69.7%	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Feb-17	95.0%	87.8%	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Feb-17	1.0%	0.2%	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Feb-17	11.0%	11.6%	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Feb-17	8.5%	8.0%	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Feb-17	95.0%	78.9%	
Antenatal booking 12 weeks and 6 days excluding late referrals (%)	Tg Teoh	Feb-17	95.0%	95.2%	
Complaints: Total number received from our patients	Janice Sigsworth	Feb-17	100	82	
Complaints: % responded to within timeframe	Janice Sigsworth	Feb-17	95.0%	98.9%	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Feb-17		0.00	
YTD variance to plan (£m)	Richard Alexander	Feb-17		0.39	
Annual forecast variance to plan (£m)	Richard Alexander	Feb-17		0.00	
Agency staffing (% YTD)	Richard Alexander	Feb-17		5.5%	
YTD NHS income performance variance to plan (£m)	Richard Alexander	Feb-17		13.03	
CIP % delivery YTD	Richard Alexander	Feb-17		96.6%	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Twelve serious incidents were reported in February 2017. These are currently under investigation.

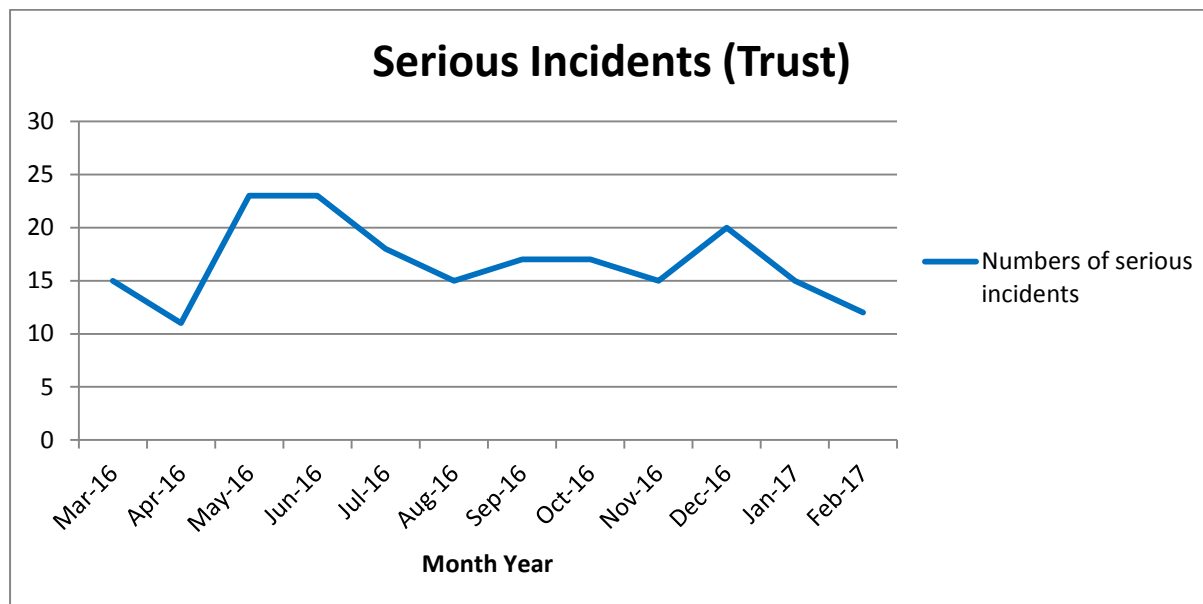


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period March 2016 – February 2017

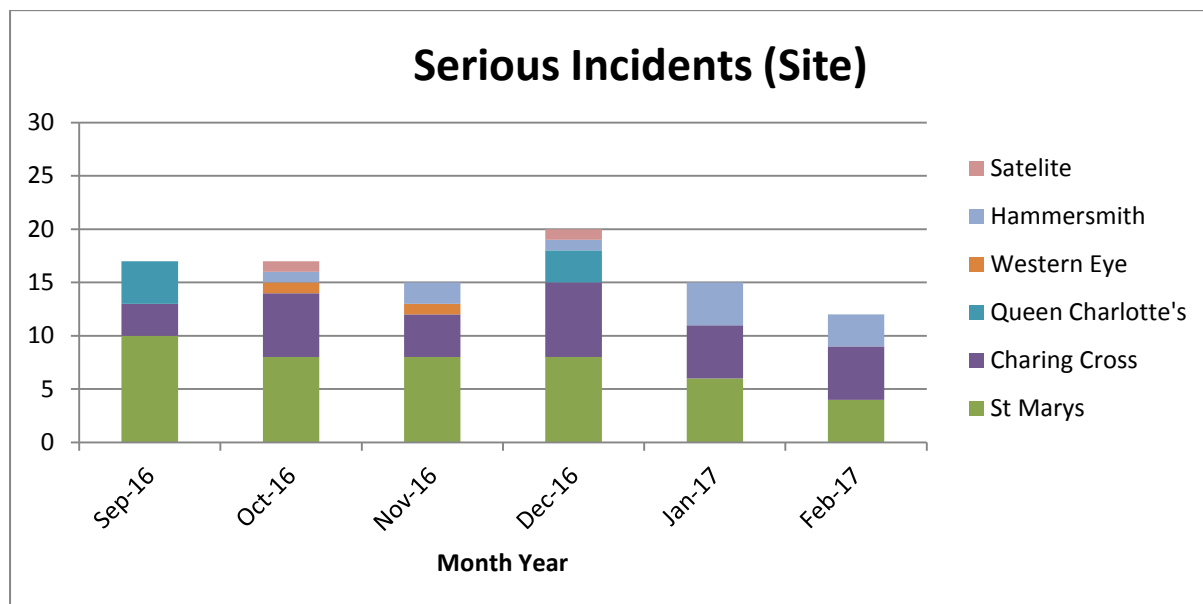


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period September 2016 – February 2017

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported one major/severe harm incident and one extreme harm/death incident in February 2017.

The percentage of incidents causing these levels of harm reported by the Trust since April 2016 remains below national average when compared to data published by the National Reporting and Learning System (NRLS) in September 2016.

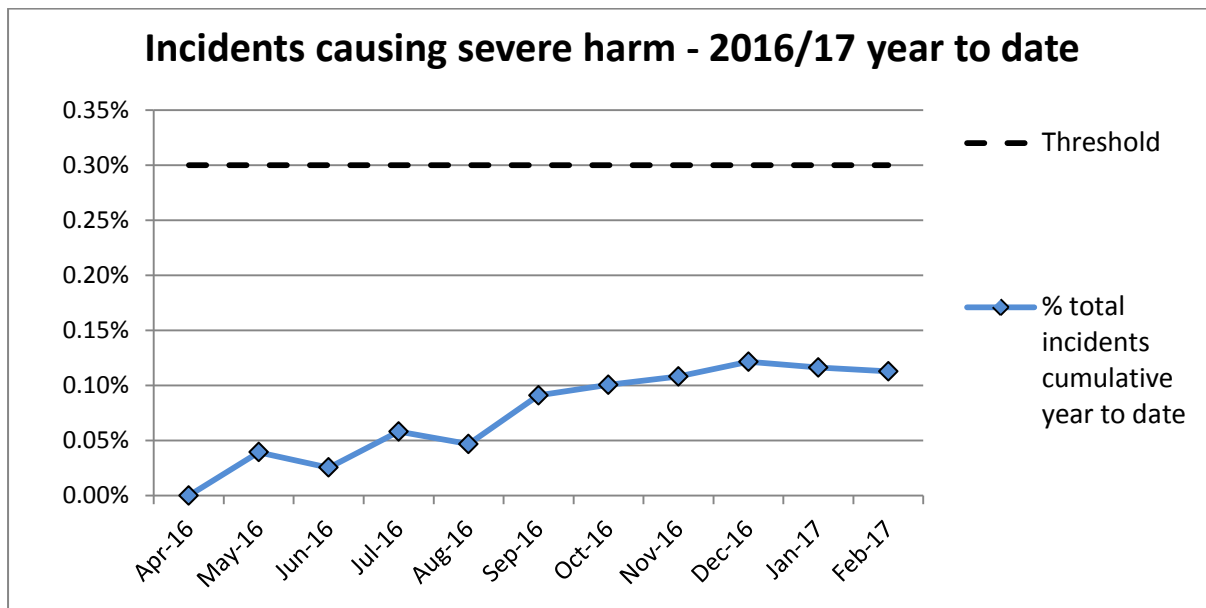


Figure 3 – Incidents causing severe harm by month from the period April 2016 – February 2017 (% of total patient safety incidents YTD)

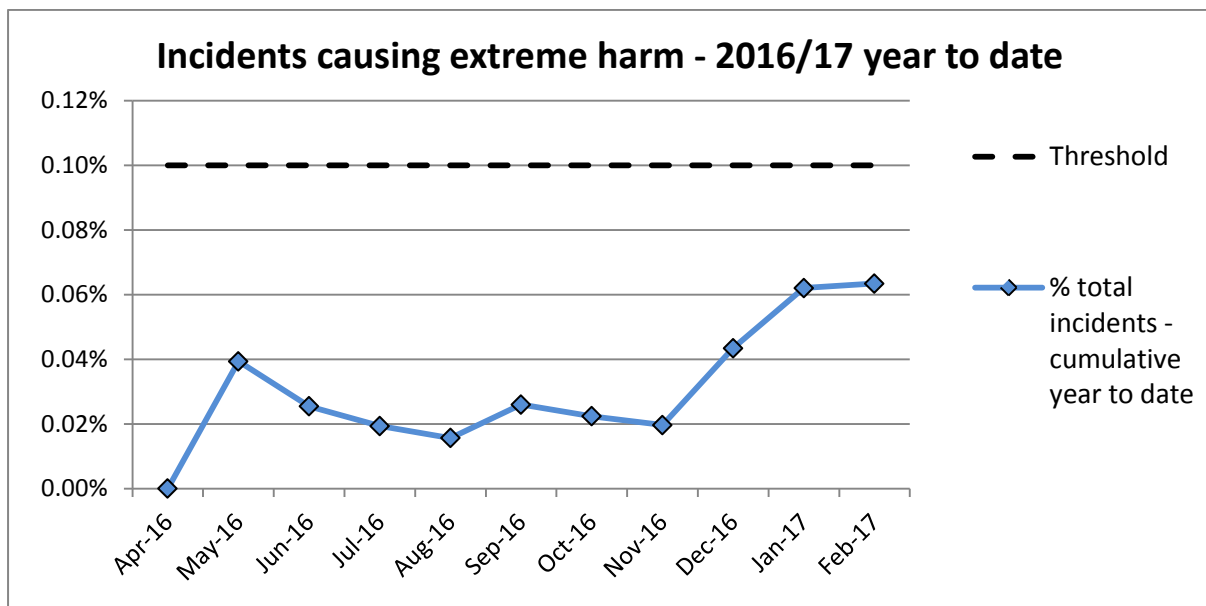


Figure 4 – Incidents causing extreme harm by month from the period April 2016 – February 2017 (% of total patient safety incidents YTD)

Patient safety incident reporting rate

The Trust's incident reporting rate for February 2017 is 43.50 per 1,000 bed days. This places the organisation just outside the highest 25 per cent of reporters nationally.

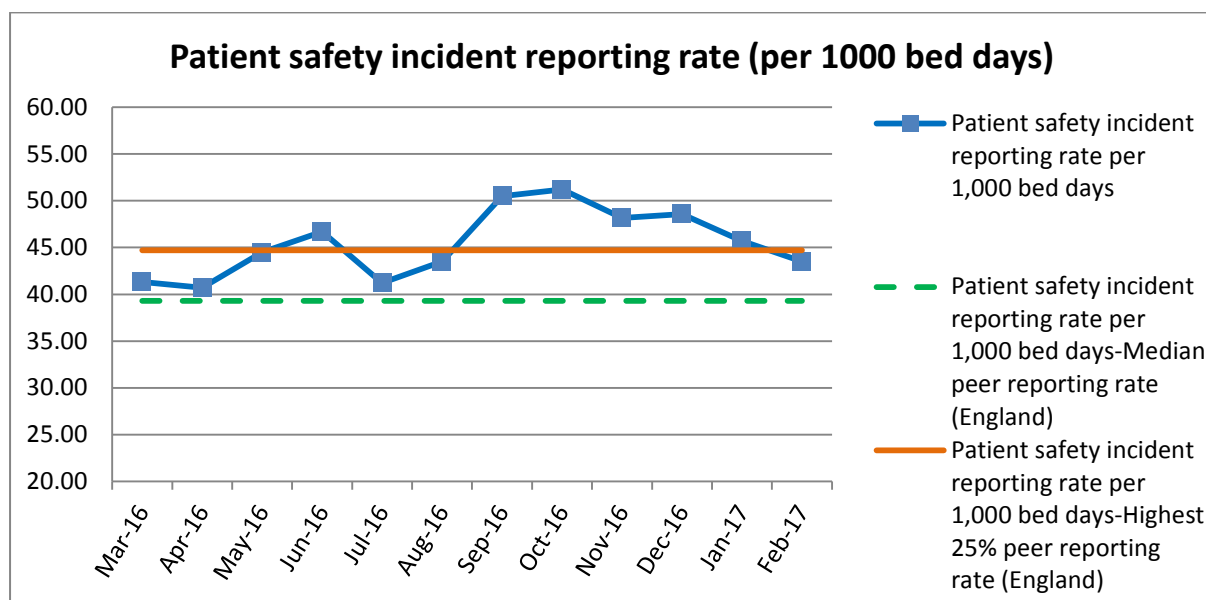


Figure 5 – Trust incident reporting rate by month for the period March 2016 – February 2017

- (1) Median reporting rate for Acute non specialist organisations (NRLS 01/10/2015 to 01/03/2016)
- (2) Highest 25% of incident reporters among all Acute non specialist organisations (NRLS 01/04/2015 to 30/09/2015)

Never Events

No never events were reported in February 2017.

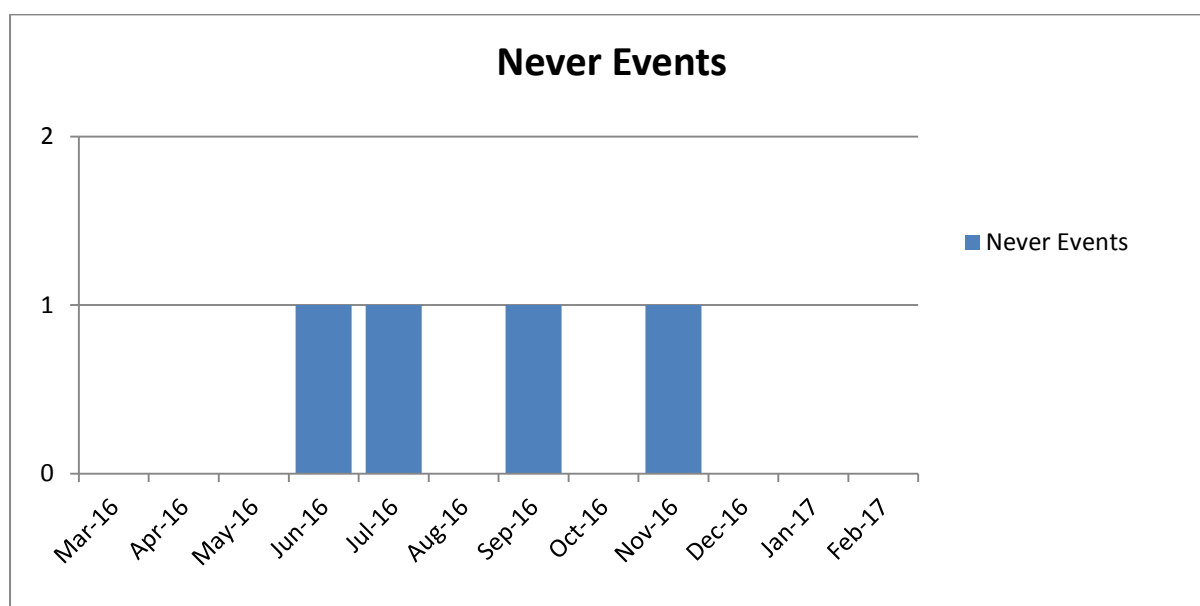


Figure 6 – Trust Never Events by month for the period March 2016 – February 2017

2.1.3 Safe: Meticillin - resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

Nine cases of MRSA BSI have been identified at the Trust between April 2016 and February 2017; three of these have been allocated to the Trust, one in May 2016, one in October 2016 and one in November 2016. Each case is reviewed by a multi-disciplinary team. Actions arising from these meetings are reviewed regularly to identify themes. Contributory factors are addressed with the divisions via the weekly Taskforce group meetings.

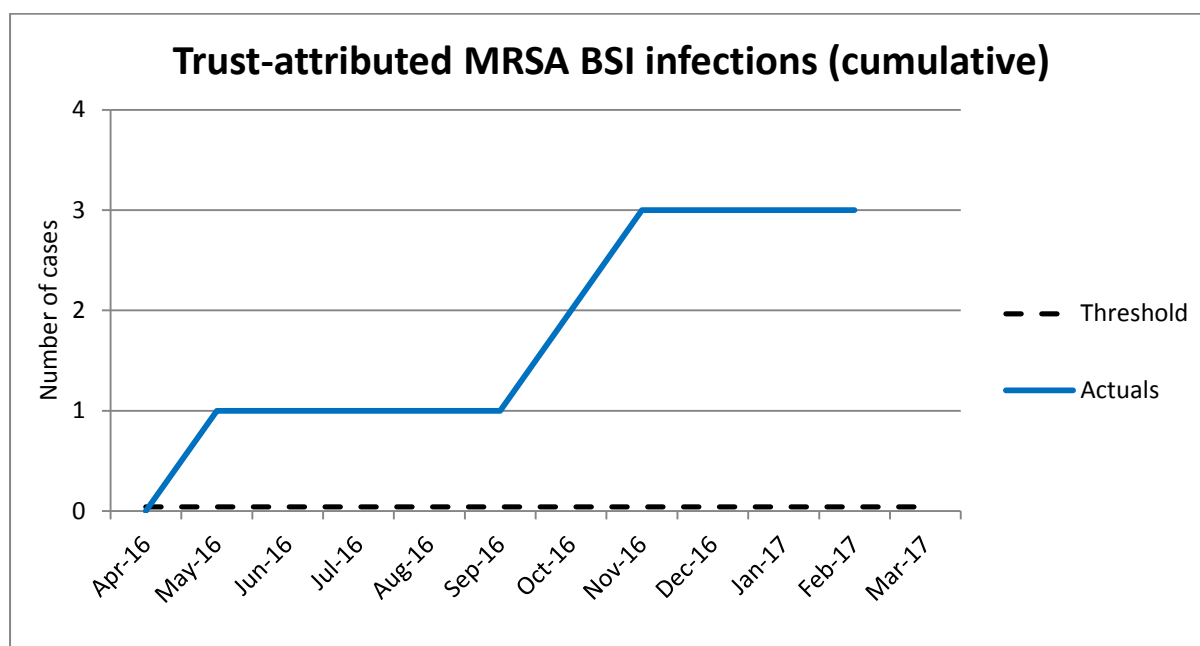


Figure 7 – Cumulative number of MRSA BSI infections for the period April 2016 – February 2017

2.1.4 Safe: *Clostridium difficile*

Two cases of *Clostridium difficile* were allocated to the Trust for February 2017, none of which have been identified as a lapse in care.

A total of 57 cases have been allocated to the Trust between April 2016 and February 2017; the annual target is 69 cases.

Each case is reviewed by a multi-disciplinary team to examine whether any lapses in care occurred.

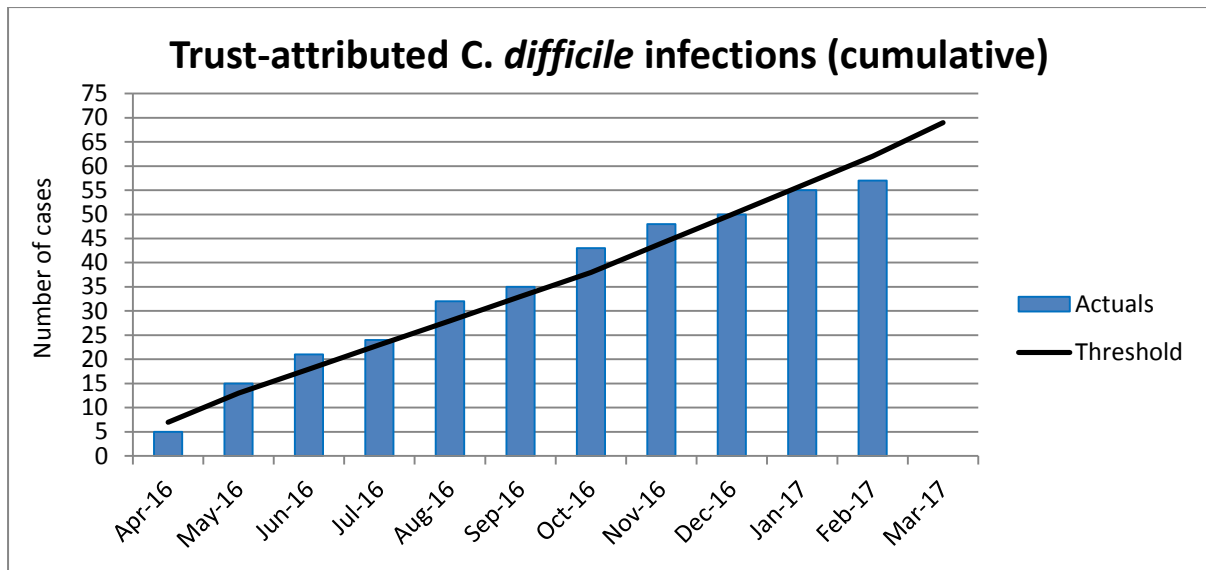


Figure 8 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2016 – February 2017

2.1.5 Safe: Venous thromboembolism (VTE) risk assessment

The VTE risk assessment performance for February 2017 was 95.1 per cent of adult inpatients (including day cases) assessed for venous thromboembolism (VTE) within 24 hours of admission, against the national quality target of 95 per cent or more. The dip in performance reported in December and 2016 January 2017 coincided with pilots testing the use of the Cerner discharge process.

A new process for the recording of VTE assessment on CERNER was rolled out on 22nd March. This mandates assessment at the point of prescription. An action plan is in place to ensure the new process is embedded and performance against the target sustained. Weekly reporting of data to the divisions is planned to allow immediate response to any areas of reduced compliance.

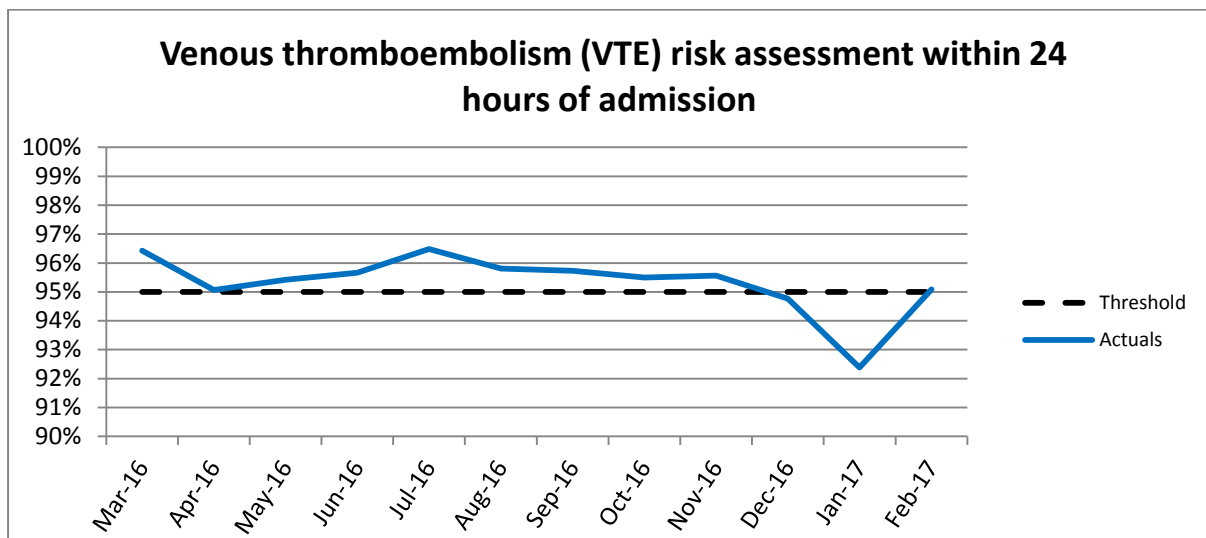


Figure 9 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period March 2016 – February 2017

2.1.6 Safe: Avoidable pressure ulcers

One confirmed unstageable pressure ulcer was reported in February 2017 bringing the total to 26 for the 2016/17 year to date. The Trust target was to achieve no more than 22 for the whole of 2016/17. While this ambitious target has not been achieved the Trust remains a high performing outlier with comparatively very low incidence of avoidable pressure ulcers. The trust has not reported a category 4 trust acquired pressure ulcer since March 2013.

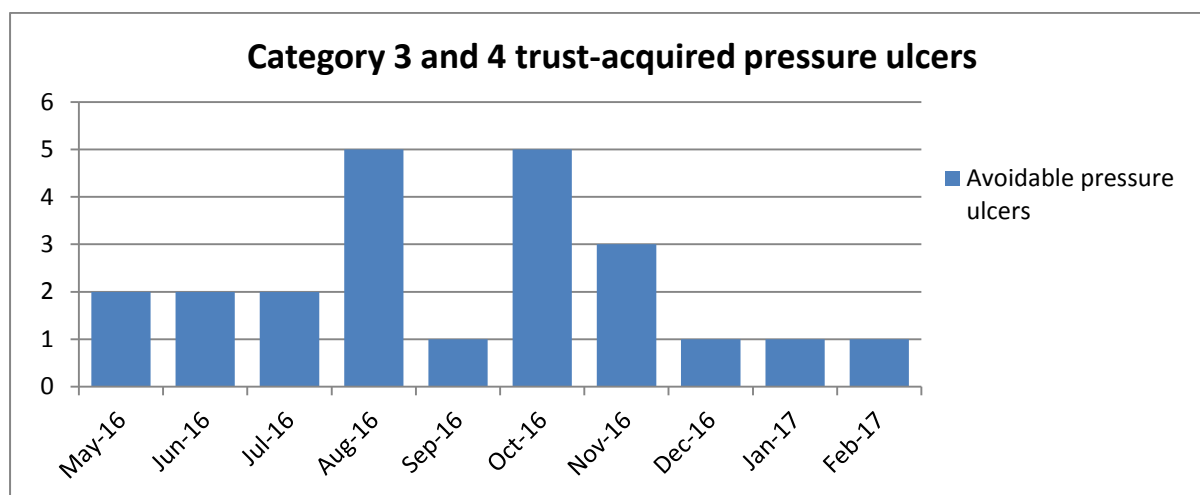


Figure 10 – Number of category 3 and category 4 (including unstageable) trust-acquired pressure ulcers by month for the period April 2016 – February 2017

2.1.7 Safe: Safe staffing levels for registered nurses, midwives and care staff

The Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff. The percentage of shifts meeting planned safe staffing levels by hospital site are as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	95.16%	89.78%	97.73%	95.90%
Hammersmith	96.99%	90.83%	99.05%	96.83%
Queen Charlotte's	97.14%	91.61%	98.27%	93.78%
St. Mary's	96.60%	92.07%	98.25%	98.94%

See appendix 1 for ward level narrative detail of the fill rate below threshold.

In order to maintain standards of care the Trust's Divisional Directors of Nursing and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Using the workforce flexibly across floors and clinical areas and in some circumstances between the three hospital sites.

- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In order to respond to the continued challenge of filling shifts for health care staff from the nurse bank, plans are being established to improve the uptake of these shifts to reduce future staffing gaps. There is also renewed focus on recruitment and retention of staff across bands 2-6 and a strategic response to the challenge is being developed.

The Nursing Associate pilot will commence in April and 21 new trainees will be employed across our partner organisations, 13 of which will be based at ICHT.

The development of the apprentice nurse pathway in the coming months will also offer an opportunity to bolster up the workforce whilst new recruits train towards registration over a four year period, whilst being employed as apprentices. The divisions will consider increasing numbers of trainees in the coming months.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in February 2017 were safe and appropriate for the clinical case mix.

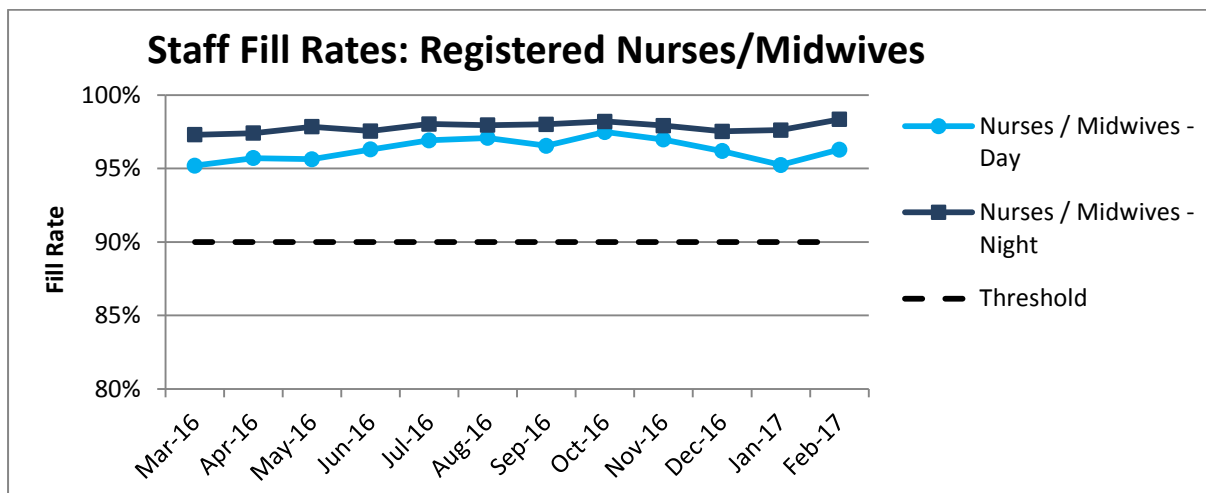


Figure 11 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period March 2016 – February 2017

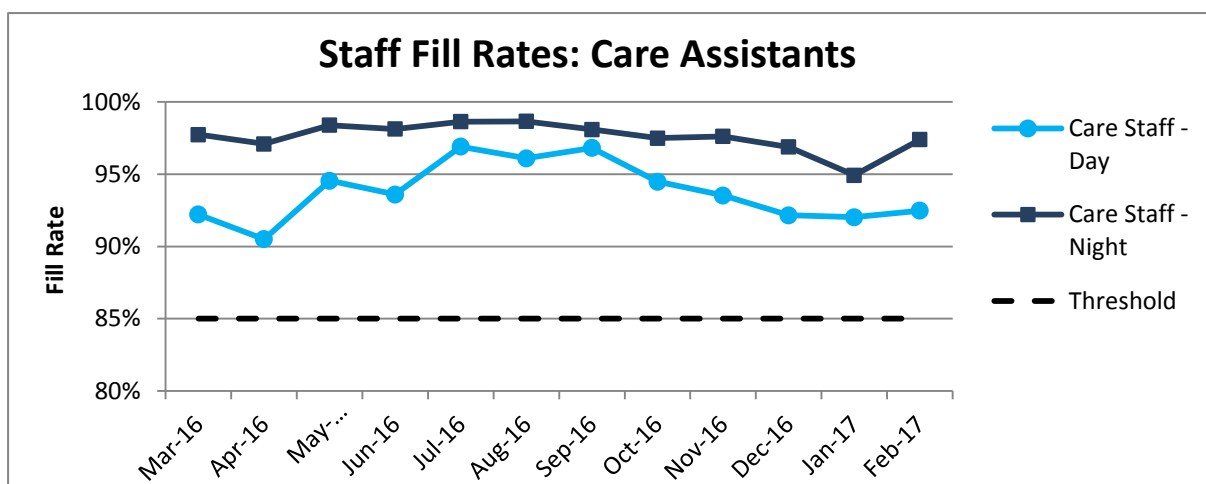


Figure 12 - Monthly staff fill rates (Care Assistants) by month for the period March 2016 – February 2017

2.1.8 Safe: Postpartum haemorrhage

In February 2.4 per cent of women who gave birth at the Trust had a postpartum haemorrhage (PPH), involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby. This met the Trust target of 2.8 per cent or less.

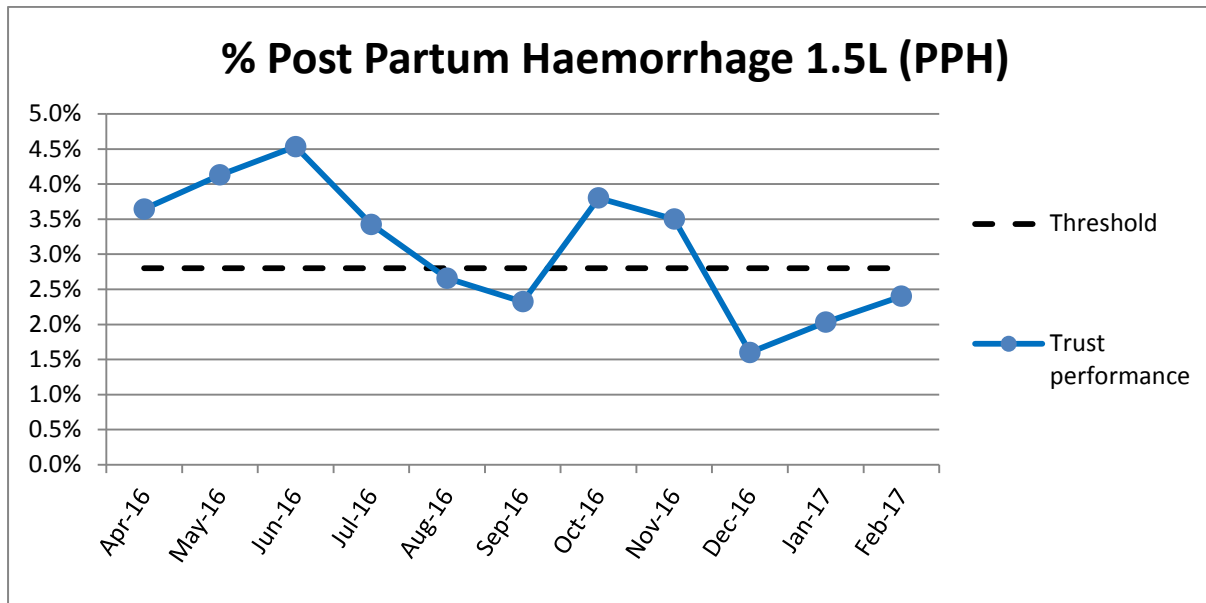


Figure 13 – Postpartum haemorrhage (PPH) for the period April 2016 – February 2017

2.1.9 Safe: Statutory and mandatory training

Core skills - excluding doctors in training / trust grade

Overall compliance was 84.7 per cent against a target of 90 per cent.

Core Skills for doctors in training / trust grade

Overall compliance was 70.8 per cent against a target of 90 per cent, compliance for Junior Doctors continues to improve.

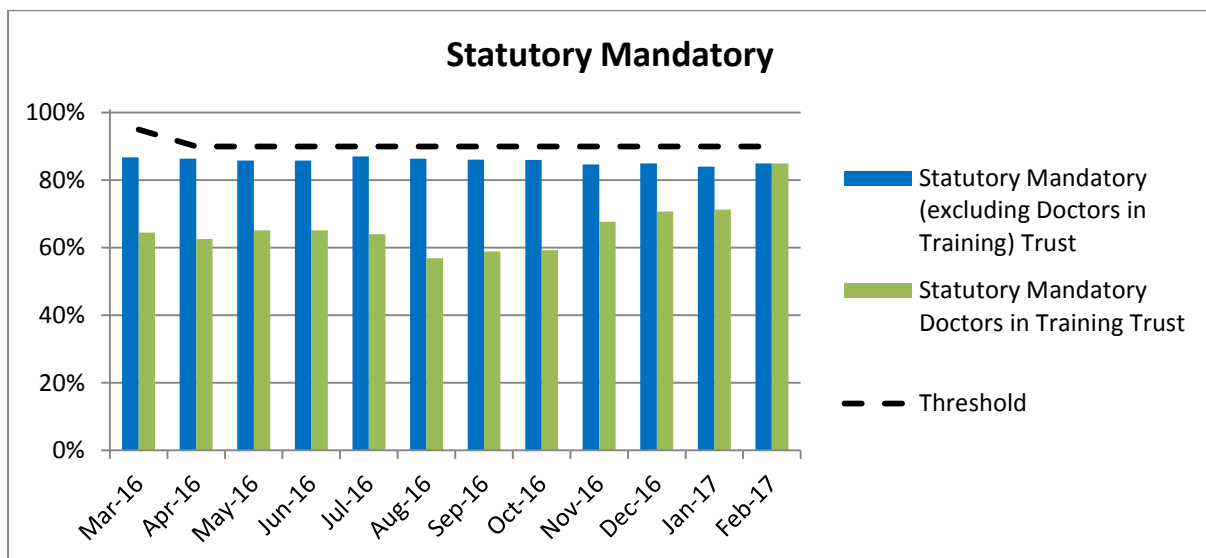


Figure 14 - Statutory and mandatory training for the period March 2016 – February 2017

2.1.10 Safe: Work-related reportable accidents and incidents

There were two RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in February 2017.

- The first incident involved a member of staff who was exposed accidentally to a biological agent. The incident was reportable to the Health and Safety Executive as a Dangerous Occurrence.
- The second incident involved a catastrophic failure of a small carbon dioxide cylinder, resulting in a gas leak. The incident was reportable to the HSE as a Dangerous Occurrence.

In the 12 months to end February 2017, there have been 37 RIDDOR reportable incidents of which 12 were slips, trips and falls. The Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

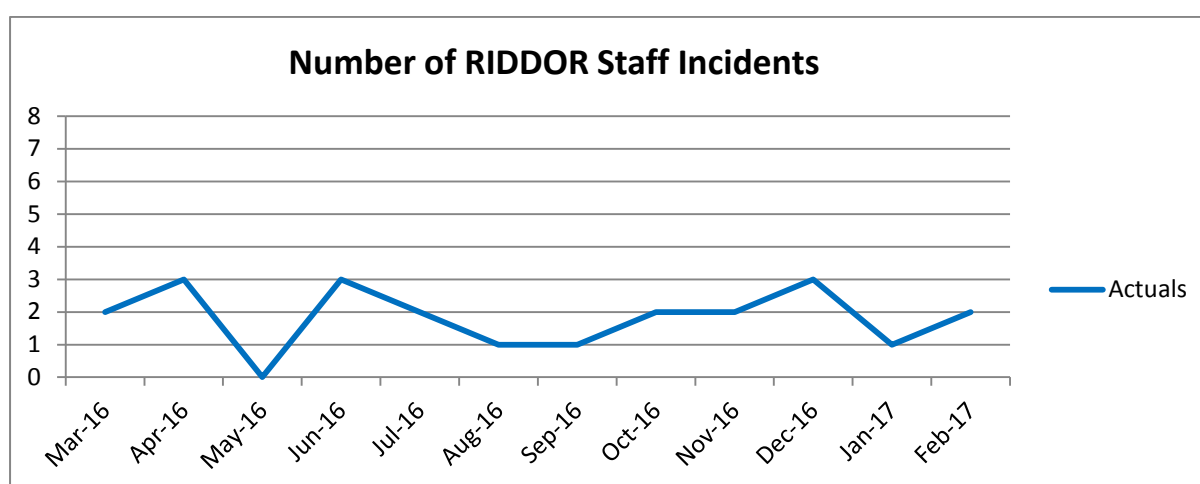


Figure 15 – RIDDOR Staff Incidents for the period March 2016 – February 2017

2.2 Effective

2.2.1 Effective: National Clinical Audits

Thirty four national clinical audit reports have been published since April 2016 in which the Trust participated. Fourteen have been reviewed by the divisions, with actions plans developed in response to recommendations and areas for improvement.

Twenty national clinical audit reports are still under review. The divisions have been asked to review all outstanding audit reports by 31 March.

2.2.2 Effective: Mortality data

The Trust target for mortality rates in 2016/17 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI).

The most recent HSMR is 59.18 (October 2016). Over the previous 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust has the fourth lowest SHMI of all non-specialist providers in England for July 2015 to June 2016.

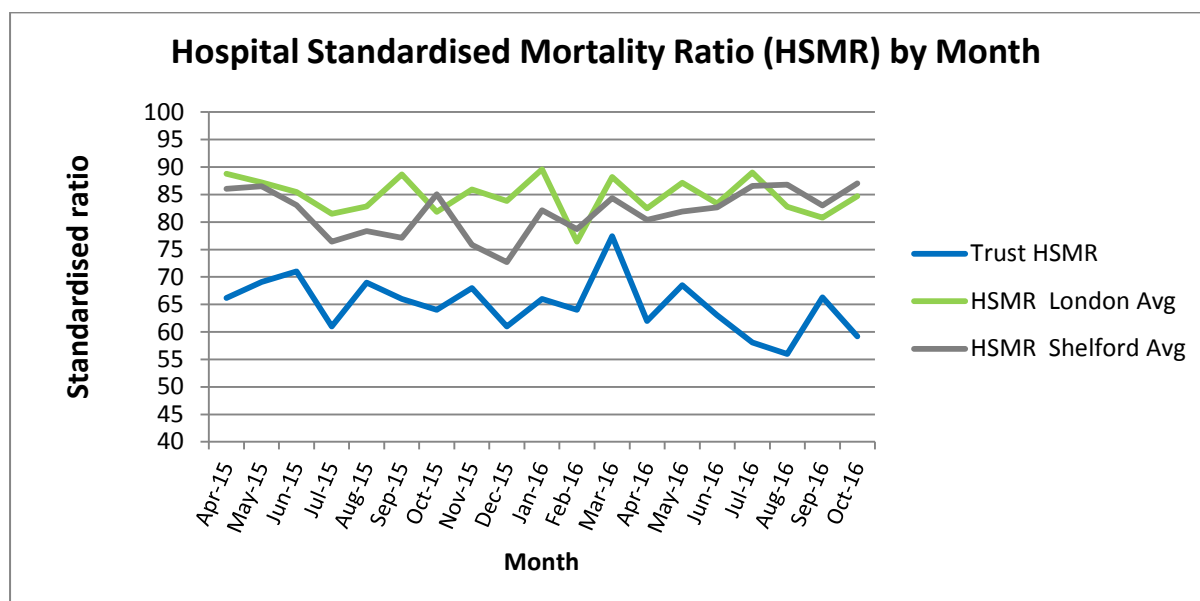


Figure 16 - Hospital Standardised Mortality Ratios for the period April 2015 – October 2016

2.2.3 Effective: Mortality reviews completed

Since the online mortality review system went live in February 2016, five avoidable deaths have been confirmed. These have all been investigated as serious incidents. An additional five cases of potential avoidable death currently remain under review.

Seventy three per cent of deaths occurring in the Trust between February-December 2016 have been reviewed by the divisions as part of this process. Plans are in place within the divisions to review outstanding cases. This data is reported quarterly and will next be updated in May 2017.

2.2.4 Effective: Recruitment of patients into interventional studies

The Trust did not achieve its target of 90 per cent of clinical trials recruiting their first patient within 70 days of a valid research application in quarter two and three 2016/17.

The most recent results reflect the impact of the full implementation of the new Health Research Authority (HRA) approvals process. The main reason for longer approval times in the new system is that the full duration of contract negotiation must now be included within the strictly-defined study initiation window of 70 days. The contracts team only receives legal agreements for review on the date when the HRA clock starts; no initial review or assessment can take place prior to that date (which was the practice previously). The average approval times have increased nationally as well as locally in the last two quarters, according to the NIHR reports. ICHT are reviewing processes for contractual review and negotiation, to identify ways of

shortening these approval times and coming back within our target metric. This is likely to take another two quarters to achieve given the inherent lag involved in the clinical trials submission and set-up process.

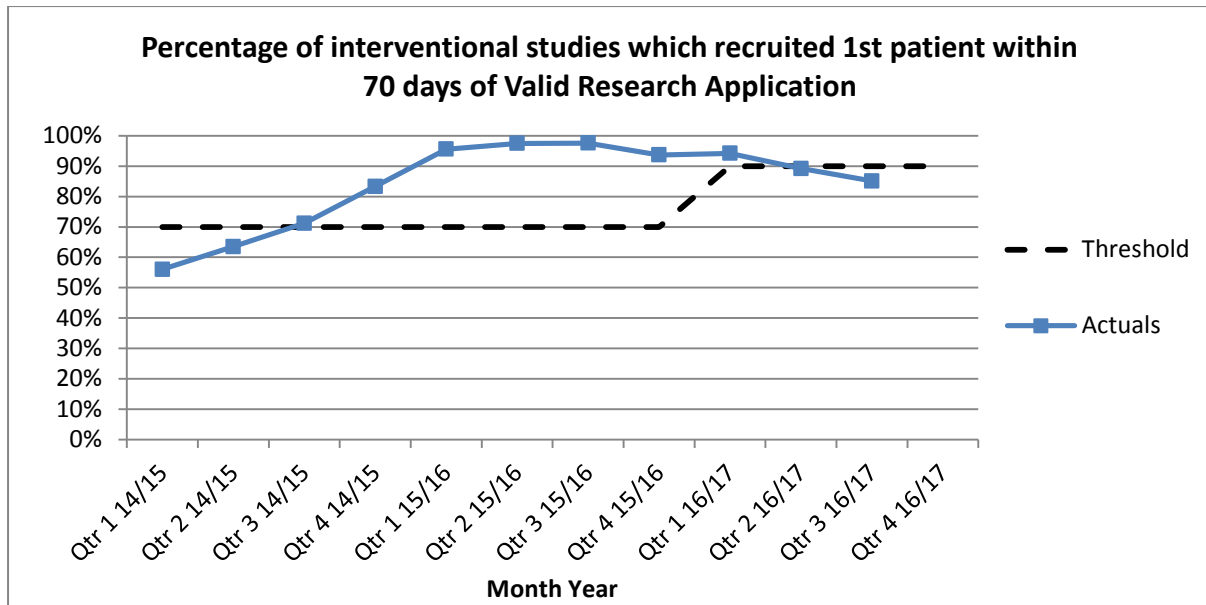


Figure 17 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q3 2016/17

2.2.5 Effective: Readmission rates

The most recent monthly figure is for August 2016 where the Trust’s readmission rates were lower in both age groups than the Shelford and National rates.

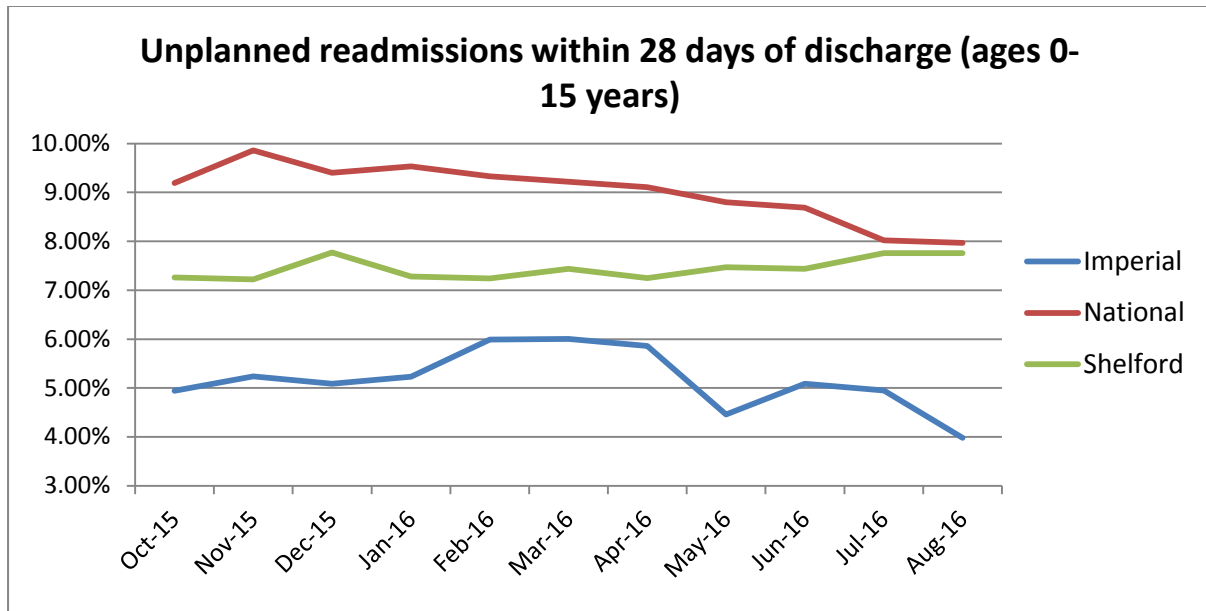


Figure 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – August 2016

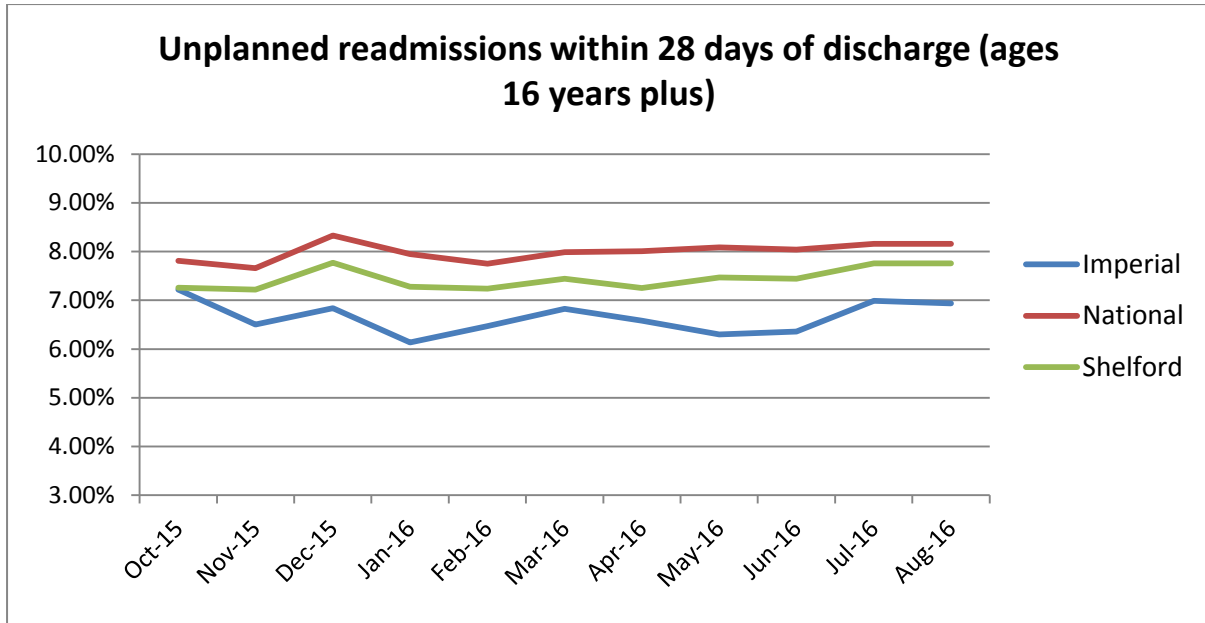


Figure 19 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – August 2016

2.2.6 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust system (CERNER) and then checked-out after their appointment so that it is clear what is going to happen next. The improving performance reflects new Trust-wide targets and escalation processes to clear appointments on the system in a timely manner.

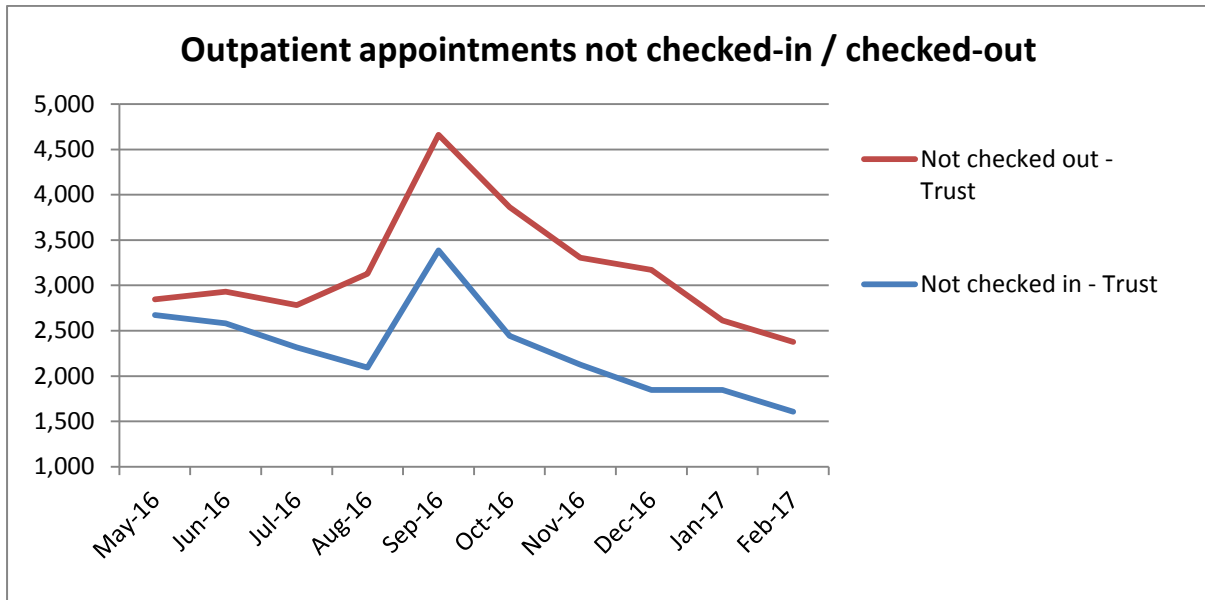


Figure 20 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days)/ checked-in and not checked-out for the period May 2016 – February 2017

2.3 Caring

2.3.1 Caring: Friends and Family Test

The inpatient response rate improved in February bringing it back up above the required threshold. The A&E response rate has stabilised after two months of falling. The outpatient willingness to recommend score exceeded 90 per cent for the first time in 8 months (since the introduction of the new mode of collection) and appears to be on a steady upward trajectory.

Service	Metric Name	Jan-17	Feb-17
Inpatients	Response Rate (target 30%)	28%	35%
	Recommend %	95%	97%
	Not Recommend %	1%	1%
A&E	Response Rate (target 20%)	12%	13%
	Recommend %	94%	94%
	Not Recommend %	3%	3%
Maternity	Response Rate (target 15%)	36%	32%
	Recommend %	95%	93%
	Not Recommend %	2%	3%
Outpatients	Response Rate (target 6%)	11%	12%
	Recommend %	91%	91%
	Not Recommend %	5%	5%

Friends and Family test: January 2017 and February 2017 results

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

The performance in non-emergency patient transport for patients leaving the hospital continues to improve.

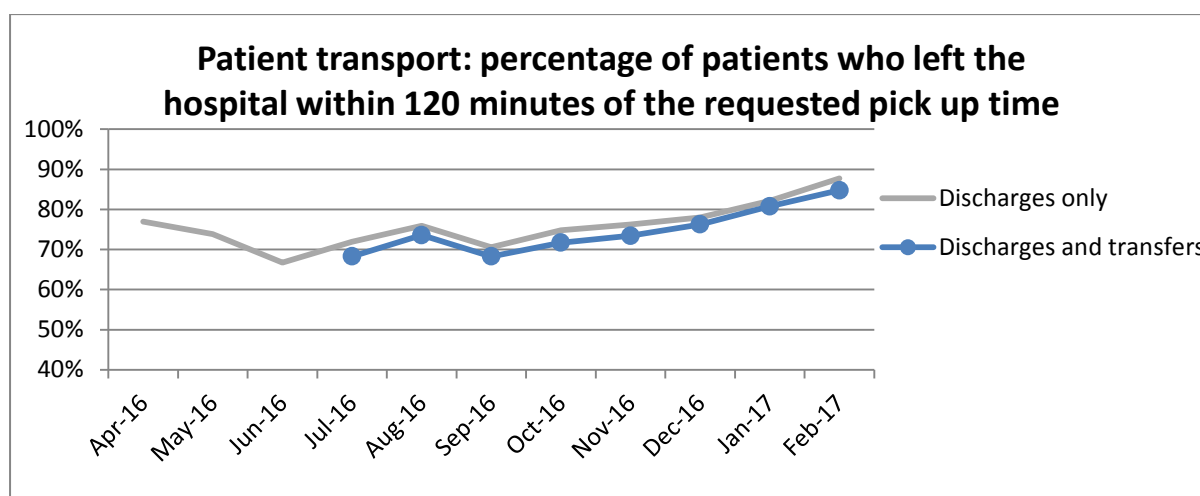


Figure 21 - Percentage of patients who left the hospital (discharges and transfers) as part of the patient transport scheme within 120 minutes of their requested pick up time between April 2016 and February 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 12 mixed-sex accommodation (MSA) breaches in February 2017. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed.

Patients who are waiting for discharge from ICU to the appropriate ward are counted as MSA breaches if they are still in the ICU at midnight. Patients are usually identified for discharge at 9am.

The Trust previously used side rooms to move patients awaiting discharge to prevent MSA breaches. However this practice has stopped because it presents a safety risk for these patients and there have been concerns about infection control and the need to minimise patient moves following a recent VRE outbreak.

The key issues for February performance are as follows:

- Increased demand for critical care with many patients requiring side rooms on clinical grounds e.g. suspected flu or potential norovirus which requires isolation for clinical areas cases. This has further restricted their use for patients awaiting discharge.
- A rising trend in patients waiting longer in critical care to be discharged.

A new discharge process is in place and the impact on performance continues to be closely monitored.

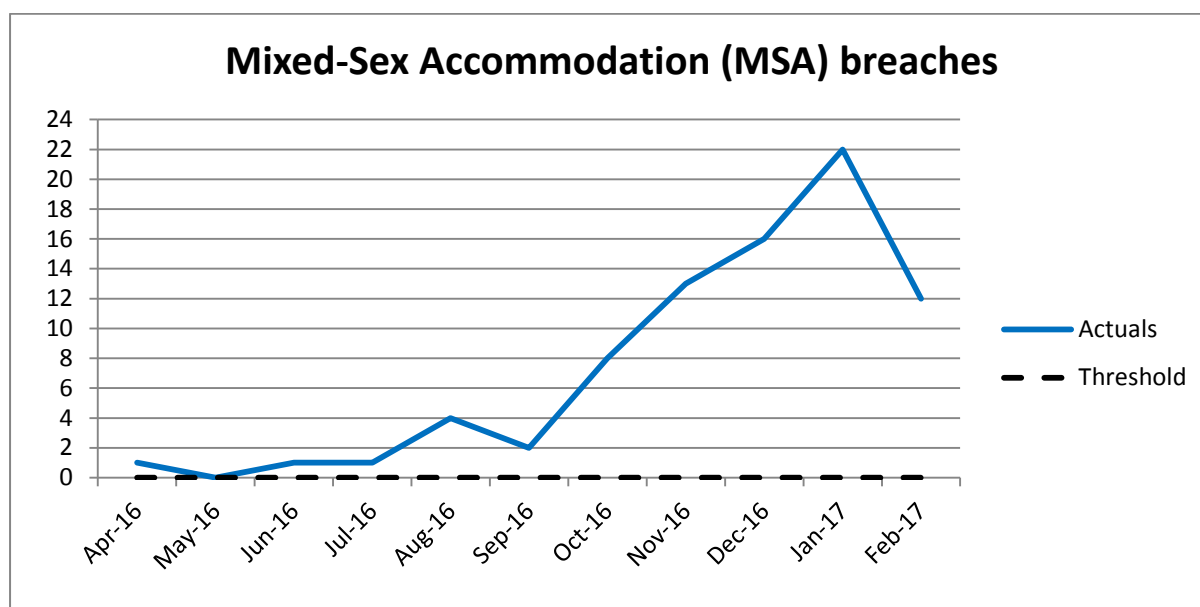


Figure 22 – Number of mixed-sex accommodation breaches reported for the period April 2016 – February 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

The contractual vacancy rate was 11.3 per cent against the target of 10 per cent (January vacancy rate was 11.1 per cent). The average vacancy rate for all London Trusts is 14.0 per cent.

Actions include:

- Bespoke campaigns across specialties;
- Open days, Recruitment Fairs, social media, print advertising and recruitment databases;
- The medical recruitment process is under review;
- The Trust microsite and brand is under review;
- A social media campaign to maximise publicity from the BBC documentary; &
- Assessment and selection tool to ensure consistent decision-making to support retention and engagement.

All Nursing & Midwifery Roles

The contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 14.2 per cent with 699 WTE vacancies; the average across London is 15 per cent. The vacancy rate band 2 – 6 roles was at 16.7 per cent.

The Trust is working with other London Acute Teaching Trusts to benchmark and share information to support a reduction in vacancies.

A range of activities and actions are being taken including:

- Open days, social media and marketing including new videos / brochures (currently planned for Haematology, children's services, and care for the elderly);
- Capital Nurse Rotation Programme;
- Nurse Associate Pilot commencing April 2017;
- Attracting additional student nurses over and above our trainees;
- - An automatic conditional offer letter will be sent out to all of our student nurses who graduate in August – depending on obtaining their qualification; &
- Scoping of new International recruitment campaign.

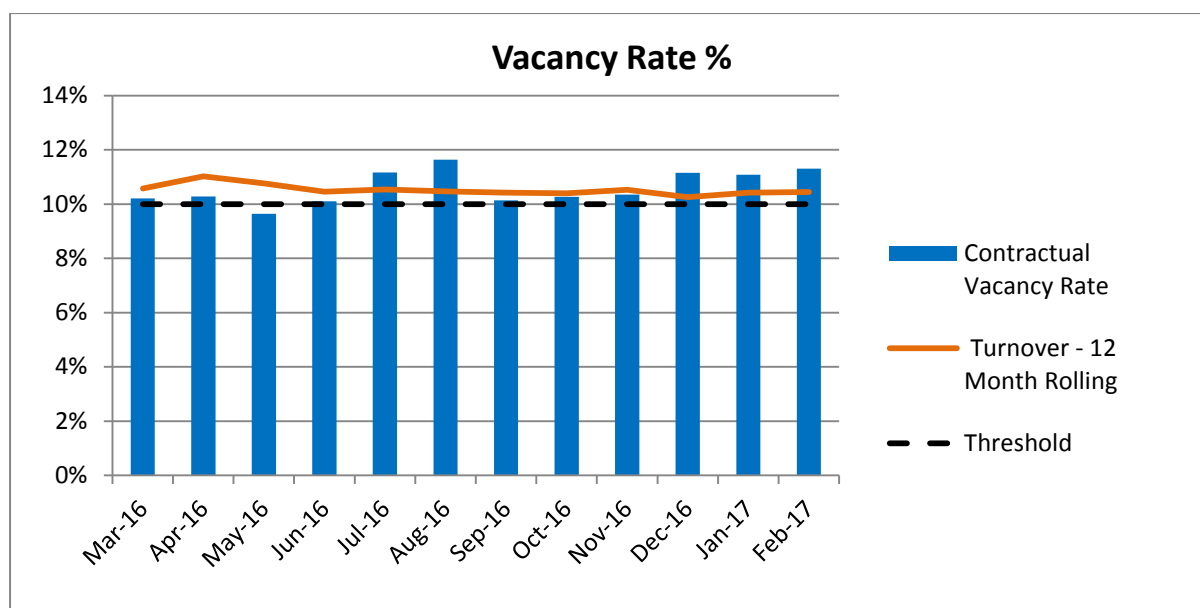


Figure 23 - Vacancy rates for the period March 2016 – February 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence fell from 3.8 per cent in January to 3.0 per cent in February. This brings the Trusts rolling 12 month sickness position to 3.04 per cent against the year-end target of 3.10 per cent or lower.

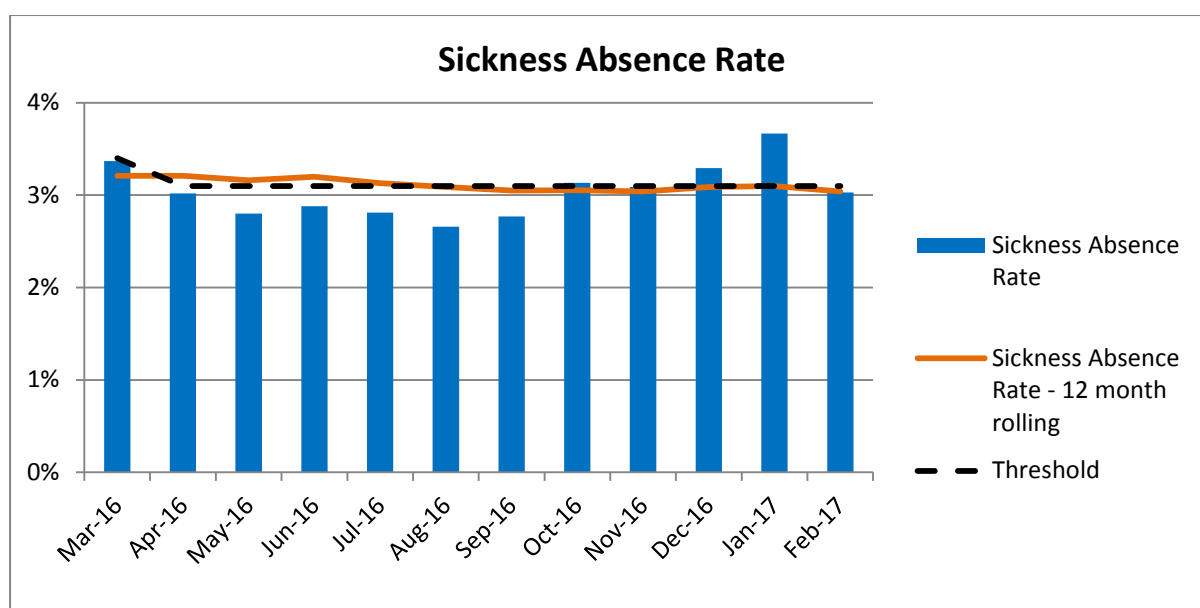


Figure 24 - Sickness absence rates for the period March 2016 – February 2017

2.4.3 Well-Led: Performance development reviews

The Trust achieved an 86 per cent compliance rate for completed Performance Development Reviews (PDR) for our non-medical staff. The new PDR cycle for 2017/18 will begin on 1st April 2017 and will run up until September 2017.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates decreased from 91 per cent in January to 89 per cent in February. The Trust remains above the national average of 86.6 per cent.

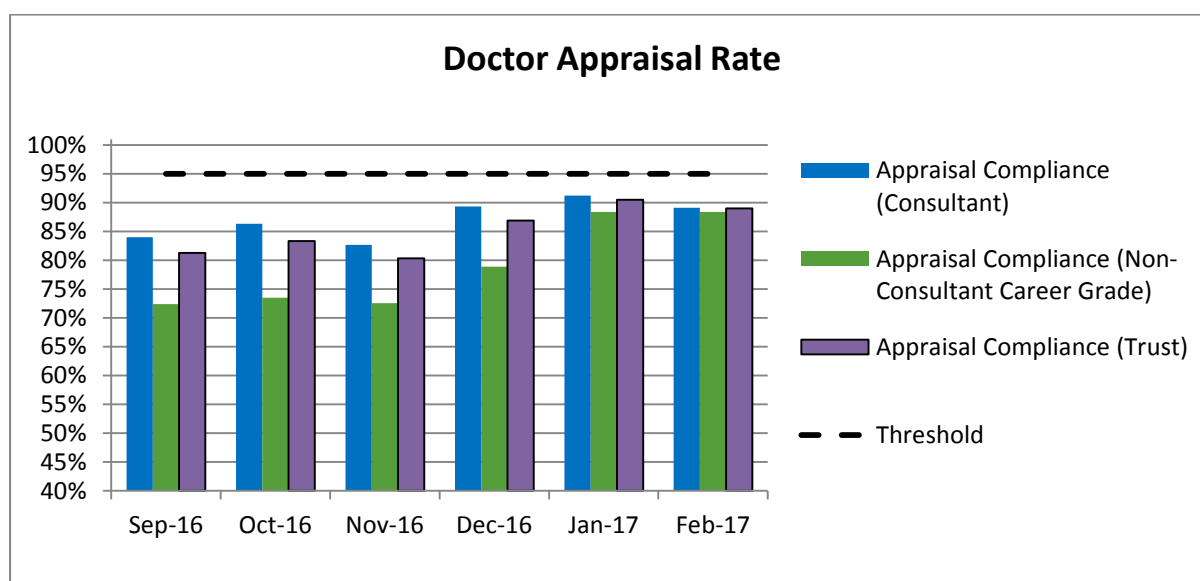


Figure 25 - Doctor Appraisal Rates for the period September 2016 to February 2017

2.4.5 Well-Led: General Medical Council - National Training Survey Actions

Health Education North West London (HENWL) quality visit

Twenty four actions remain open from the Health Education North West London quality visit; progress with the open actions was submitted in January 2017 and a response from HENWL is awaited.

2015/16 General Medical Council National Training Survey

An updated action plan in response to the GMC NTS red flags was submitted to Health Education England in January 2017 and a response is awaited.

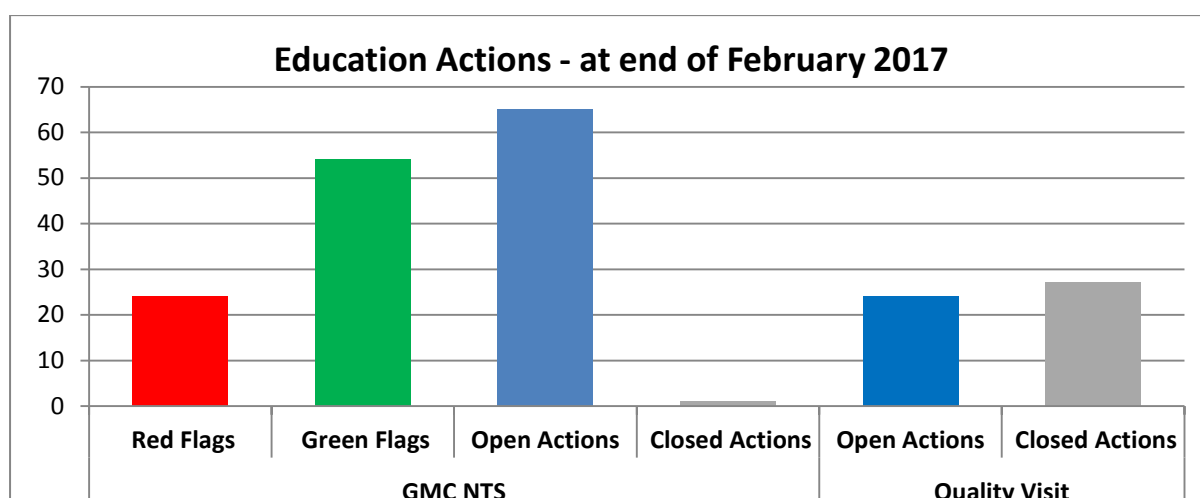


Figure 26 – General Medical Council - National Training Survey action tracker, updated at end February 2017

2.4.6 Well Led: Estates – maintenance tasks completed on time

The percentage of estates maintenance tasks completed on time fell during February. The main underlying causes were annual leave and sickness absence and this is being closely monitored by the Estates team.

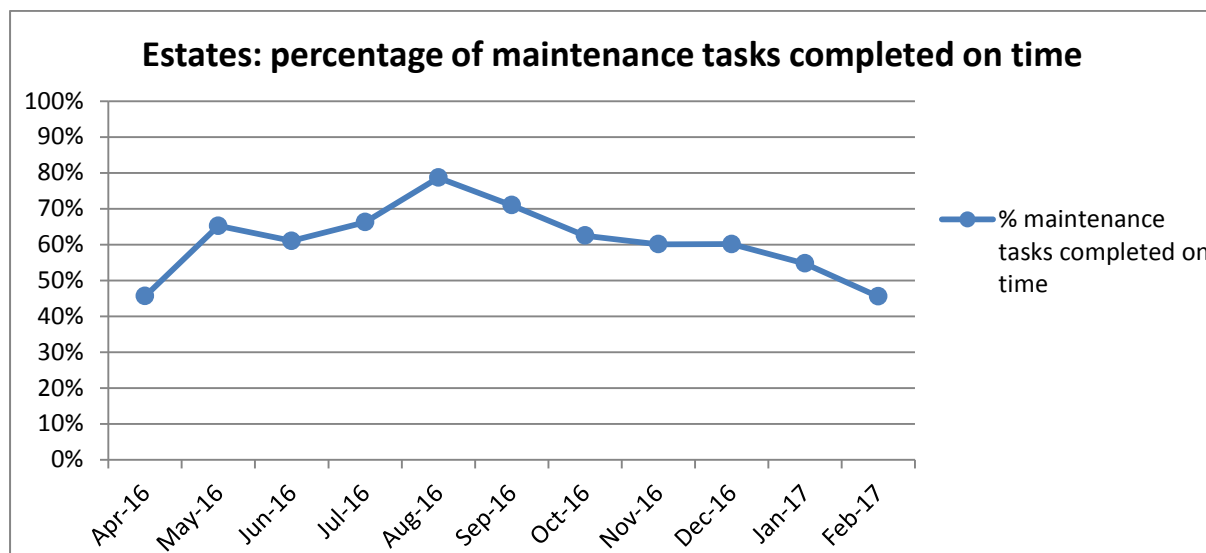


Figure 27 – Estates: percentage of maintenance tasks completed on time for the period April 2016 – February 2017

2.5 Responsive

2.5.3 Consultant-led Referral to Treatment waiting times

At the end of the February, 82.24 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment. The numbers of patients waiting over 18 weeks was 11,090. This achieved the Trust's Sustainability and Transformation Fund (STF) RTT incomplete trajectory of 81.74 per cent, and was an improvement from the reported position of 81.98 per cent at the end January.

The Trust continues the work of its waiting list improvement programme (WLIP) and action plan to address RTT challenges and return to delivering the RTT standard sustainably. The WLIP also oversees the management of the existing clinical review process which provides assurance that patients who wait over 52 weeks are not coming to harm.

Significant progress has been made on all of the aspects of the programme, including the data clean-up of the waiting lists, the roll out of a new Clinical Outcome form across the Trust, the establishment of right first time processes, additional clinical activity and theatre capacity and performance recovery trajectories for 18 week and long waiters. The project continues into 2017/18.

Performance is expected to continue to improve over the coming months; however there is a risk to delivery of the March trajectory as target performance is 1 per cent higher than February and there are on-going capacity pressures in many services. Elective capacity modelling has now been completed and actions are underway to

support improvements. Additional capacity is also being delivered for outpatients and work is on-going to quantify the capacity and demand gap to inform future planning.

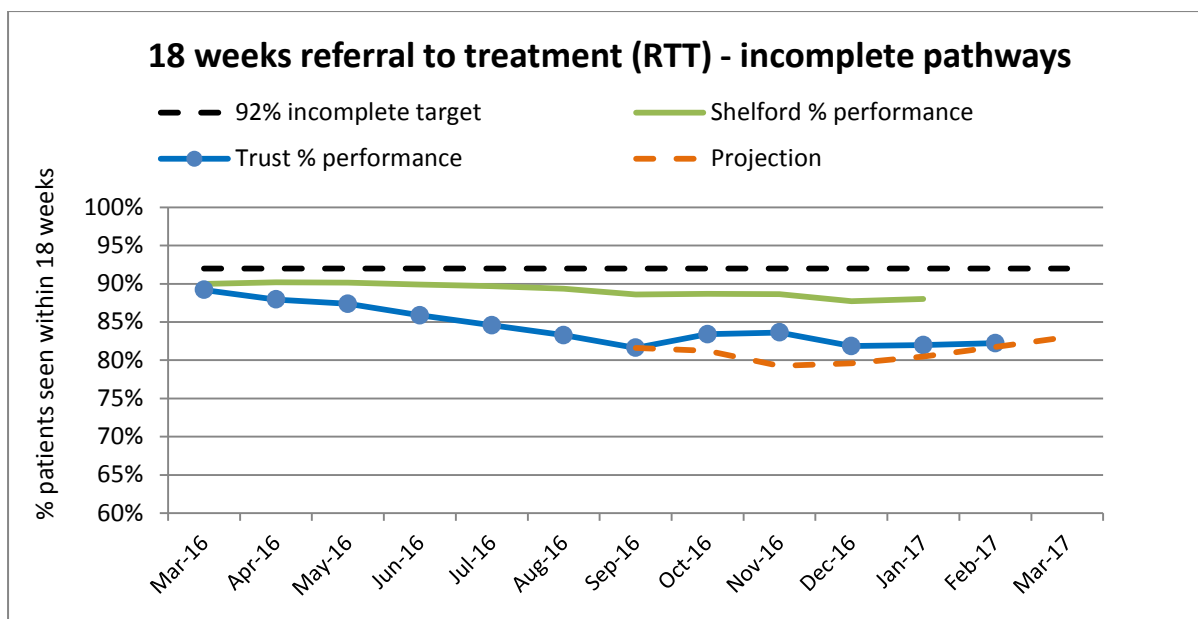


Figure 28 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period March 2016 – February 2017

52 weeks

The on-going data clean-up of the inpatient and outpatient waiting lists has resulted in a large number of patients whom we had not been tracking consistently in specific specialities. This is because RTT rules were applied incorrectly at an earlier stage of the patient's treatment pathway.

The Trust reported 316 patients waiting over 52 weeks at the end of February; this was an improvement on January's reported position (383 patients) but did not achieve the STF trajectory of 152 patients. This is primarily due to continued high levels of patients being reported from the data clean-up work streams, on-going capacity challenges in orthopaedics, plastics and ENT, and the continued impact of winter pressures.

The priority for all long waiters is to agree a date for treatment for each patient as soon as possible. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment.

Performance is expected to continue to improve over the coming months, however it is not expected that the STF trajectory for March for 52 weeks will be achieved.

Reducing the number of patients waiting over 52 weeks is a priority work stream for the programme over the coming months, and work is currently on going to support the directorates in their efforts to rapidly improve this position.

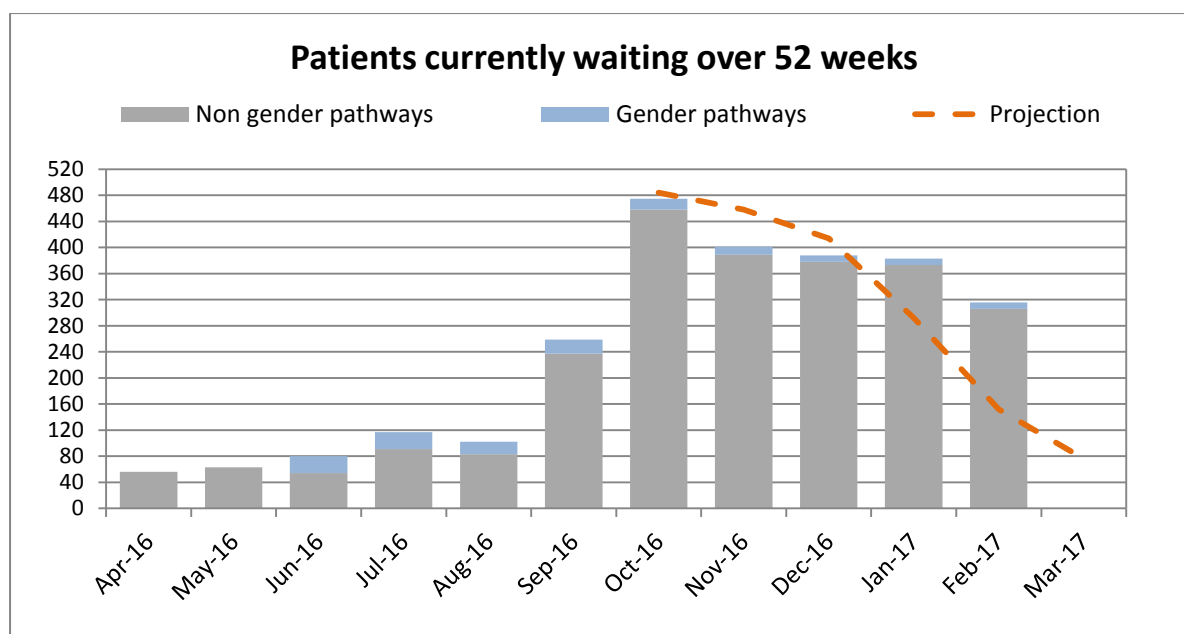


Figure 29 - Number of patients waiting over 52 weeks split by gender pathways and non-gender pathways, for the period April 2016 – February 2016

2.5.4 Responsive: Cancer

In March 2017, performance is reported for Cancer Waiting Times standards for January 2017.

In January 2017 the Trust achieved five of the eight national cancer standards. The Trust underperformed against the two week GP referral to 1st appointment (delivering 87.2% against a 93% standard), the GP referral to treatment for all cancers (delivering 76.2% against a 85% target), and the 62-day GP referral to treatment from screening (delivering 80.4% against a 90 per cent target).

The 2WW target standard failed through a combination of three issues. Firstly, larger than normal patient choice delays as a result of the Christmas period, with many patients opting to be seen after the New Year. Secondly, some services did not adequately provide capacity over the back end of December meaning capacity was reduced below what would have already been expected for the bank holidays. The third problem related specifically to dermatology after the department cancelled four 2WW clinics with patients booked into them at very short notice and not all patients could be accommodated into alternative clinics within what remained of their 2WW clocks.

Our cancer team are working with the new dermatology lead to start to address the clinic planning issues in that service. Their performance has been poor for a number of months but we are now making some headway with better planning across the three sites. We have also started demand and capacity modelling for breast, urology, colorectal and ENT, and we will work through the remainder of the specialties by order of priority. This will also feed into the RTT programme and the service planning that is being undertaken as part of that.

The 62-day GP referral to treatment standard (all cancers) failed principally because of late referrals of patients on shared pathway who we share the breach for on the current allocation rules. However, this month we also failed if only our internal pathways are considered. This was principally related to the low numbers of cancers diagnosed this month leading to a low denominator. We are continuing to work with our linked hospitals and CCGs to improve shared patient pathways.

The screening standard was missed partly through a low denominator making the standard more susceptible to big swings in performance. There were only 22 treatments against the standard in January. None of the breaches were the fault of ICHT. Two were genuinely complex pathways with multiple repeated diagnostics as malignancy could not be confirmed, two breaches were the result of patients refusing to attend their first appointments (for which there is no adjustment available) and one breach occurred at the local treating hospital after they were repatriated by the ICHT screening service.

Indicator	Standard	Jan-16
Two week GP referral to 1st outpatient – all urgent referrals (%)	93.0%	87.2%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.4%
31 day wait from diagnosis to first treatment (%)	96.0%	96.0%
31 day second or subsequent treatment (drug treatments) (%)	98.0%	98.4%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	98.8%
31 day second or subsequent treatment (surgery) (%)	94.0%	96.4%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	76.2%
62 day urgent GP referral to treatment from screening (%)	90.0%	80.4%

Performance against national cancer standards for January 2017

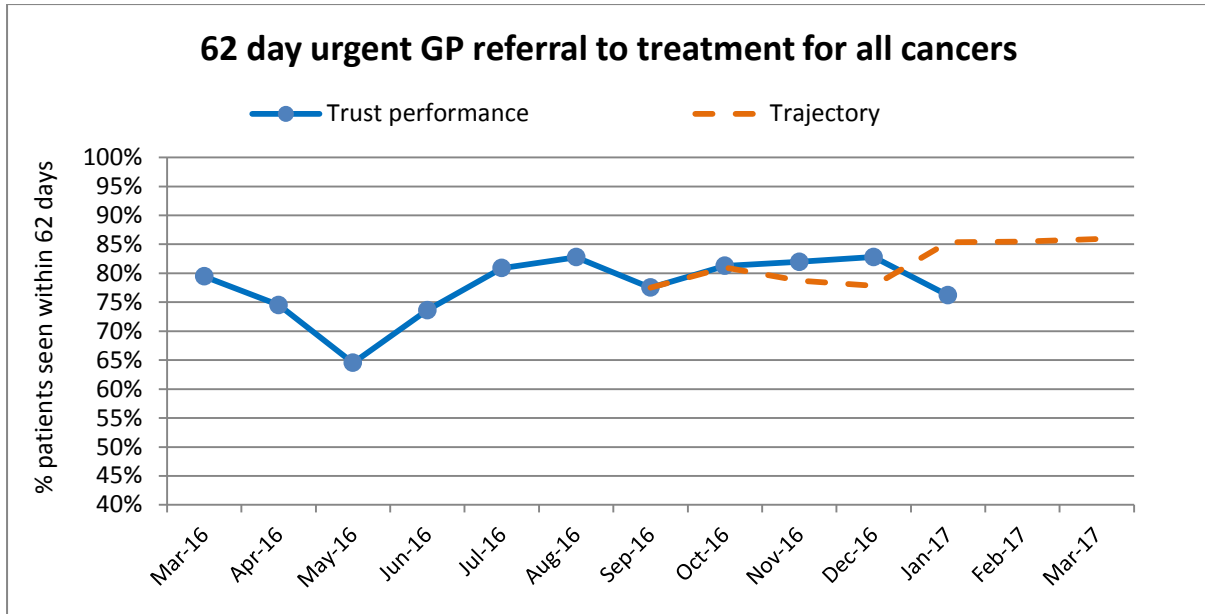


Figure 30 – Cancer 62 day GP referral to treatment performance for the period March 2016 – January 2017

2.5.5 Responsive: Elective operations cancelled on the day for non-clinical reasons

The non-clinical cancelled operations performance is submitted quarterly. In quarter three, 0.7 per cent of operations (195 cancellations) were cancelled on the day as a percentage of total elective activity. Breaches of the 28-day rebooking guarantee remain high at the Trust (26 breaches reported in quarter 3).

A full update has been scheduled for presentation to the Clinical Quality Group meeting on 22 April 2017. This paper will cover: Trend data of cancellations incl. repeat cancellations and cancer pathways; actions in place to reduce cancellations and ensure compliance with the 28-day rebooking guarantee; management of clinical risks; and patient experience.

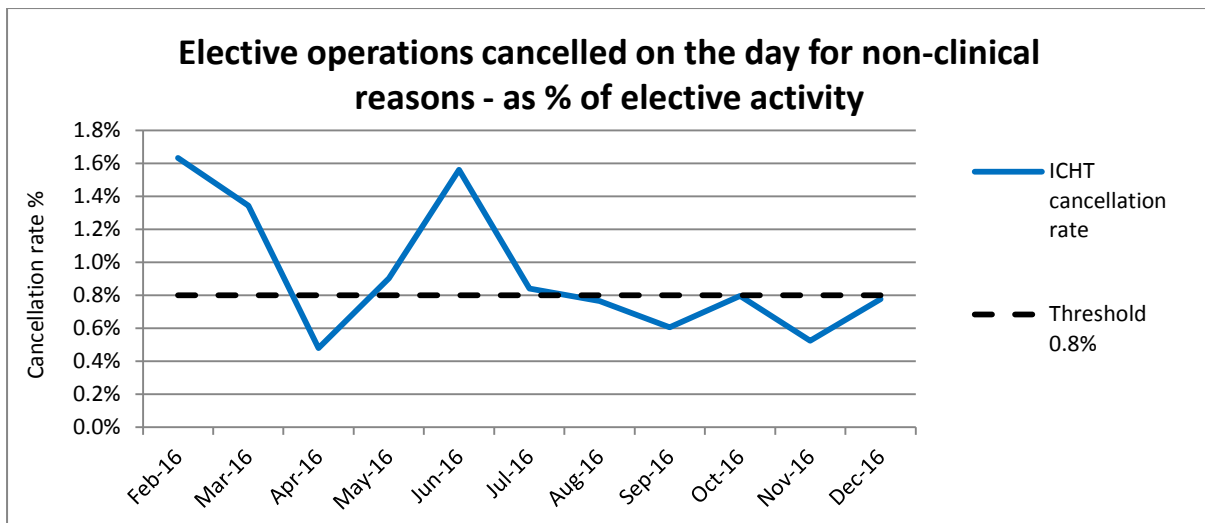


Figure 31 – Non-clinical cancellations as a % of total elective admissions for the period February 2016 – December 2016

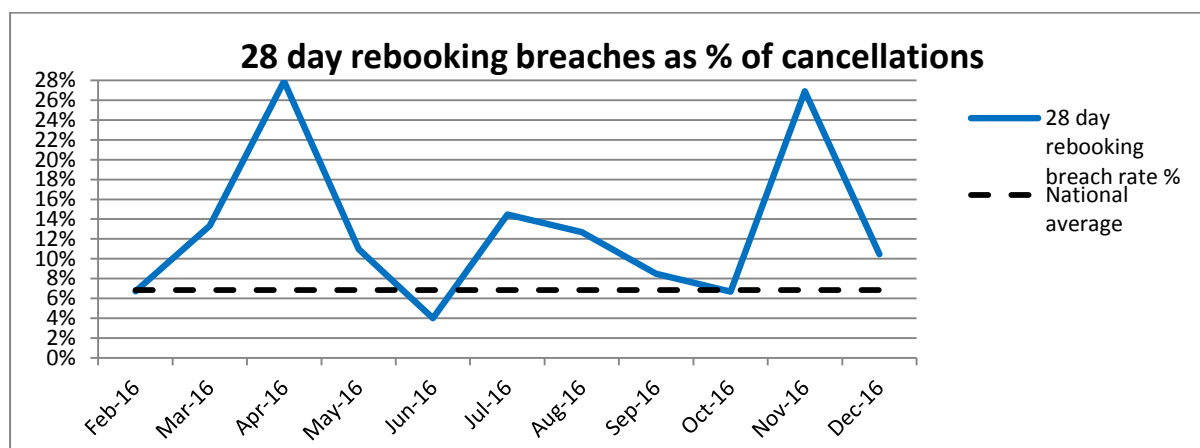


Figure 32 - Patients not treated within 28 days of their cancellation as a % of cancellations for the period February 2016 – December 2016

2.5.6 Responsive: Accident and Emergency

Performance against the four hour access standard for patients attending Accident and Emergency continued to improve in February 2017. Overall performance was 87.83 per cent (January performance was 86.30 per cent). This was against the performance trajectory target of 93.22 per cent for the month which was not achieved.

The improved performance follows expansion in capacity for emergency admissions with the opening of a new acute assessment unit at CXH and a new surgical assessment unit at SMH. The Trust is also extending operational hours for ambulatory emergency care services to help avoid unnecessary hospital admissions.

The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare UCC to the Emergency Department;
- Increased demand and acuity;
- High levels of bed occupancy;
- High numbers of bed days lost through delayed transfers of care from the hospital; & delays for mental health beds.

The Trust continues to implement its on-going programme of improvements and interventions to reduce waits, improve flow and capacity and manage demand.

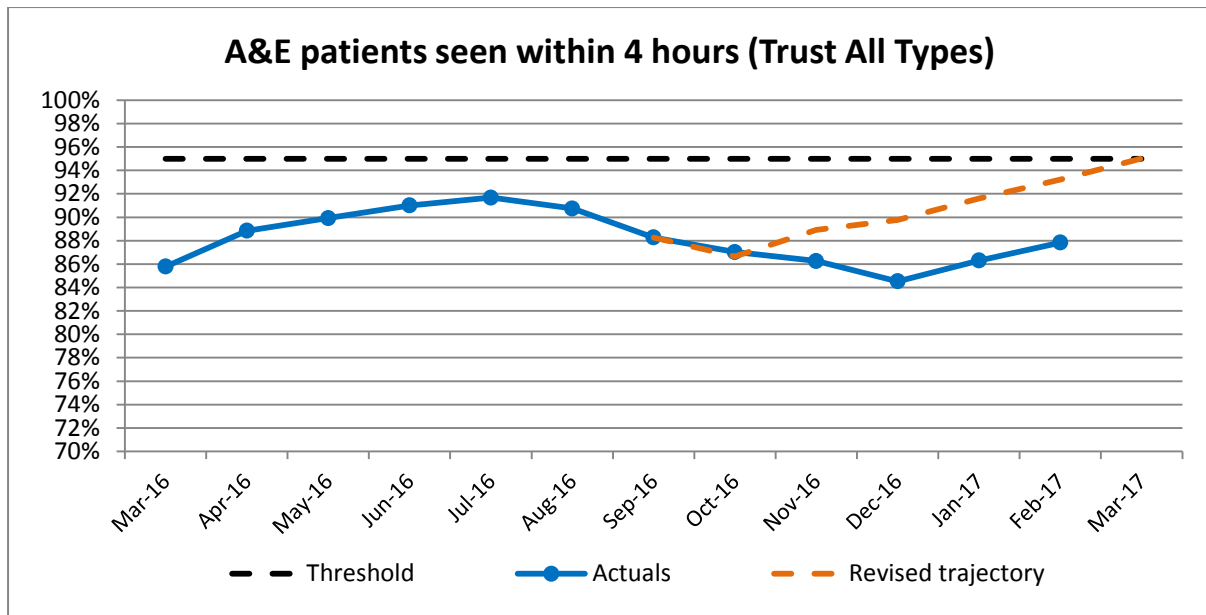


Figure 33 – A&E Maximum waiting times 4 hours (Trust All Types) for the period March 2016 – February 2017

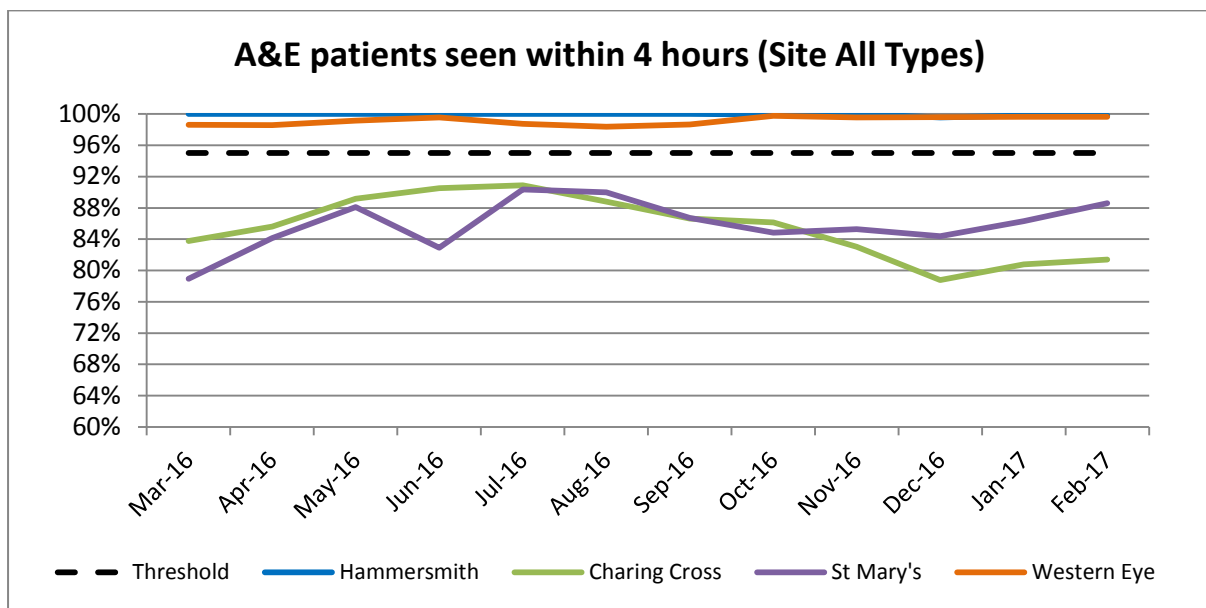


Figure 34 – A&E Maximum waiting times (Site All Types) 4 hours for the period March 2016 – February 2017

2.5.7 Responsive: Diagnostics

In February the Trust met the monthly 6 week diagnostic waiting time standard with 0.18 per cent of patients waiting over six weeks against a tolerance of 1 per cent.

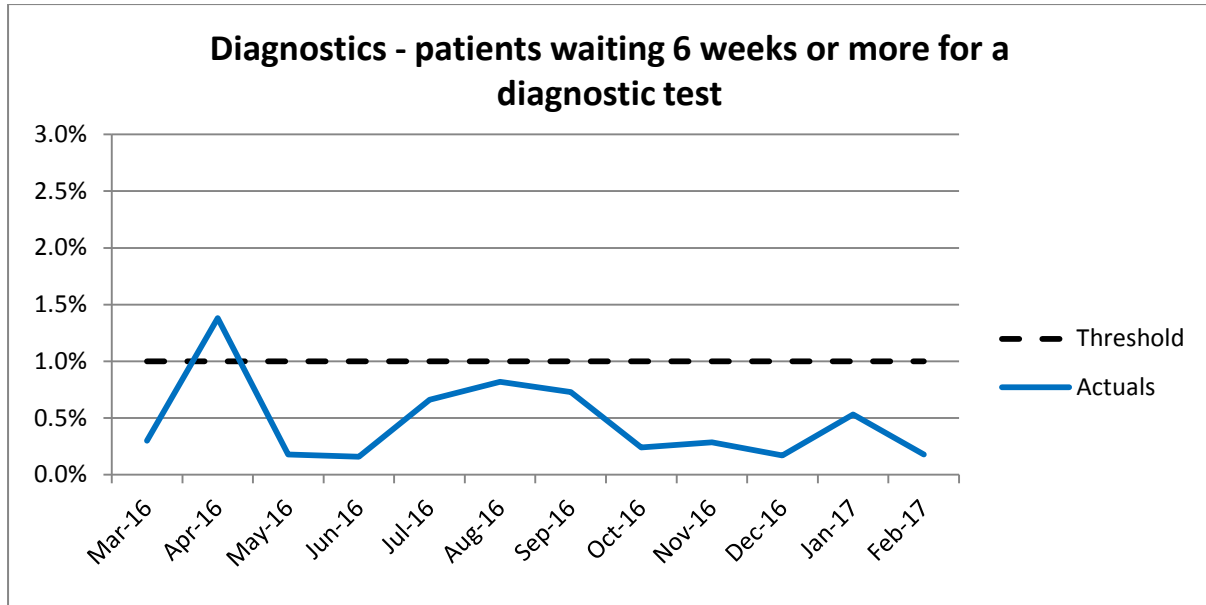


Figure 35 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period March 2016 – February 2017

2.5.8 Responsive: Patient attendance rates at outpatient appointments

The overall DNA (first and follow up) rate was 11.6 per cent (9,611 appointments) and has come down by 0.7 per cent from the previous month (January performance was 12.3 per cent). The DNA rate for new appointments was 12.5 per cent and for Follow-up appointments it was 11.2 per cent.

The outpatient improvement programme is carrying a detailed review of the data to ascertain the underlying trends, establish contributing factors and identify steps that can be taken to improve attendance at outpatient appointments further.

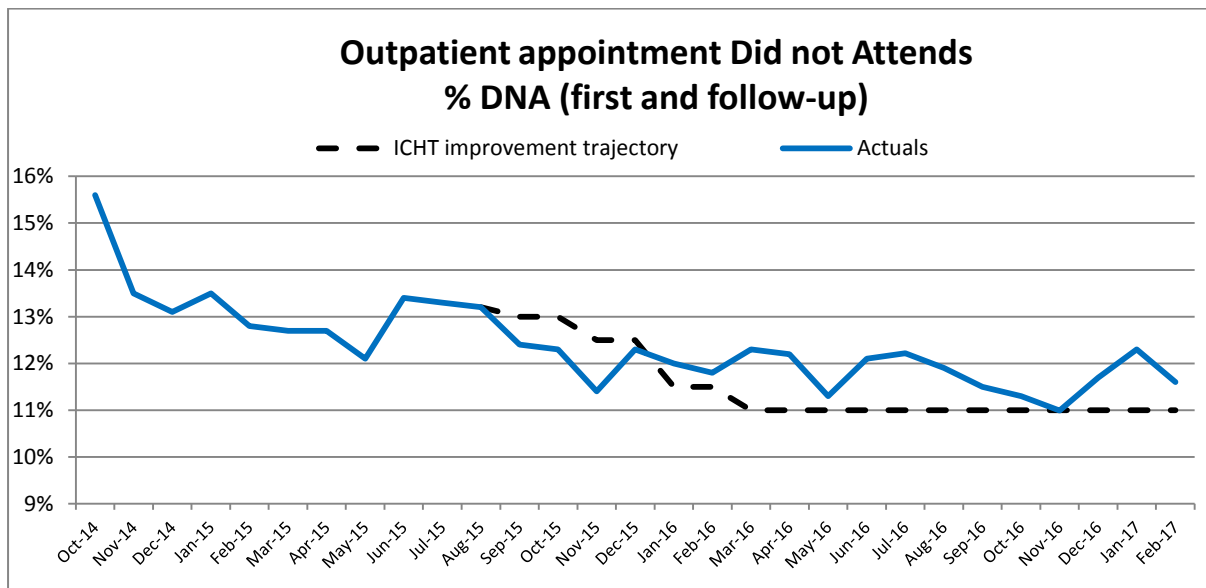


Figure 36 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period October 2014 – February 2017

2.5.9 Responsive: Outpatient appointments cancelled by the Trust

In January, 8.0 per cent (9,193) of outpatient appointments were cancelled by the hospital with less than 6 weeks’ notice. This is a slight increase on the January performance of 7.5 per cent but still within the target threshold of 8.5 per cent for the month.

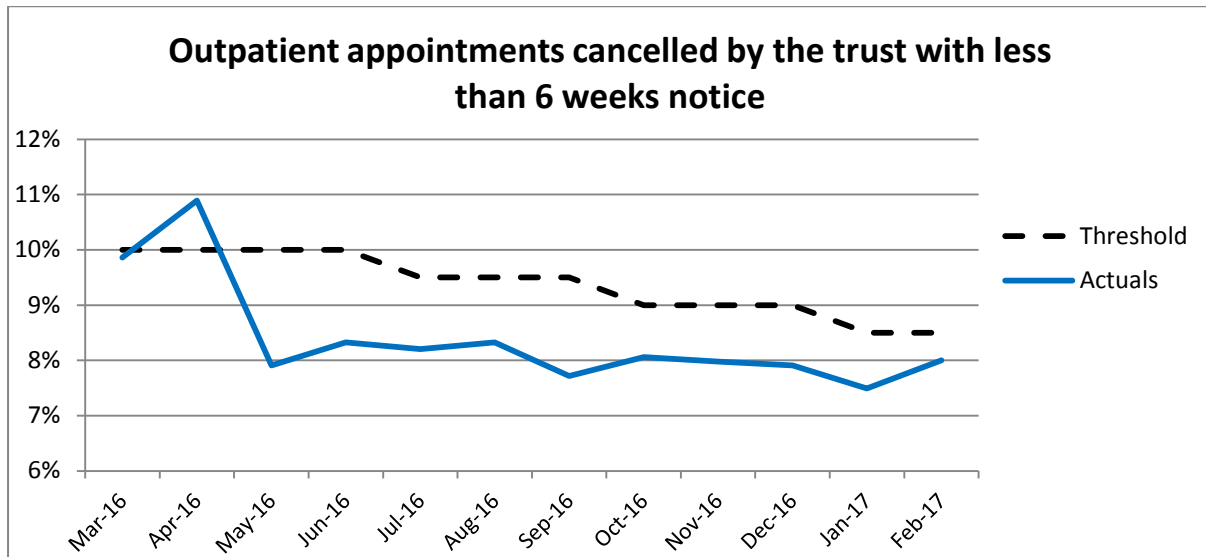


Figure 37 – Outpatient appointments cancelled by the Trust with less than 6 weeks’ notice for the period March 2016 – February 2017

2.5.10 Responsive: Outpatient appointments made within 5 days of receipt

The Trust’s quality strategy target is for 95 per cent of routine outpatient appointments to be made within 5 working days of receipt of referral. In February, 78.9 per cent of routine appointments were made within 5 days. This reflects continued focus on new ways of working though the Patient Service Centre for centralised services, such as improved tracking and performance monitoring, increased responsiveness to outliers using huddle boards, and increased resourcing allocation and improved call handling.

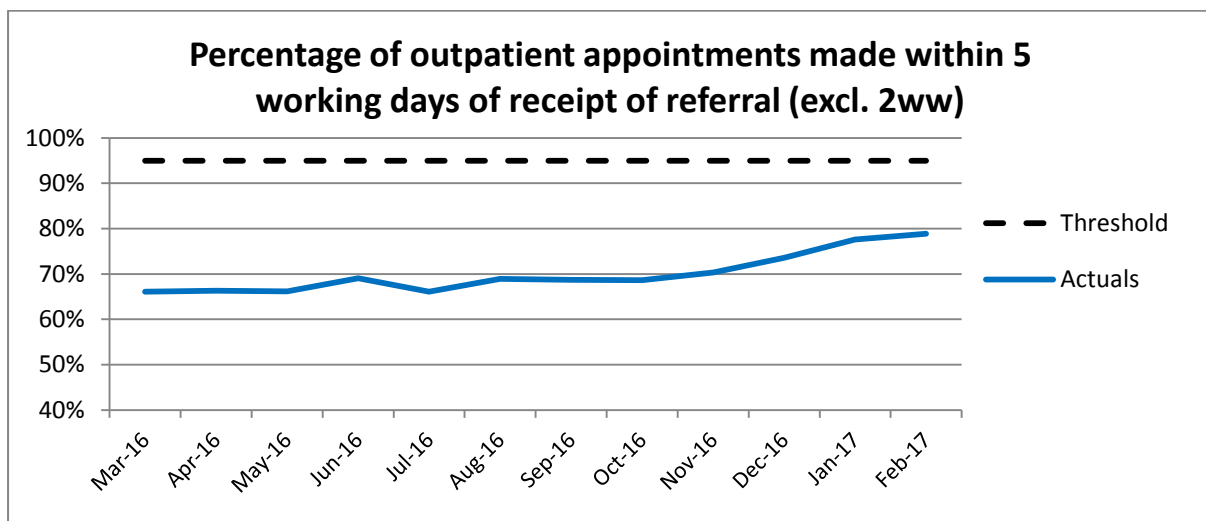


Figure 38 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period March 2016 – February 2017

2.5.11 Responsive: Access to antenatal care – booking appointment

In February 96.0 per cent of pregnant women accessing antenatal care services completed their booking appointment by 12 weeks and 6 days (excluding late referrals), meeting the target of 95 per cent or more.

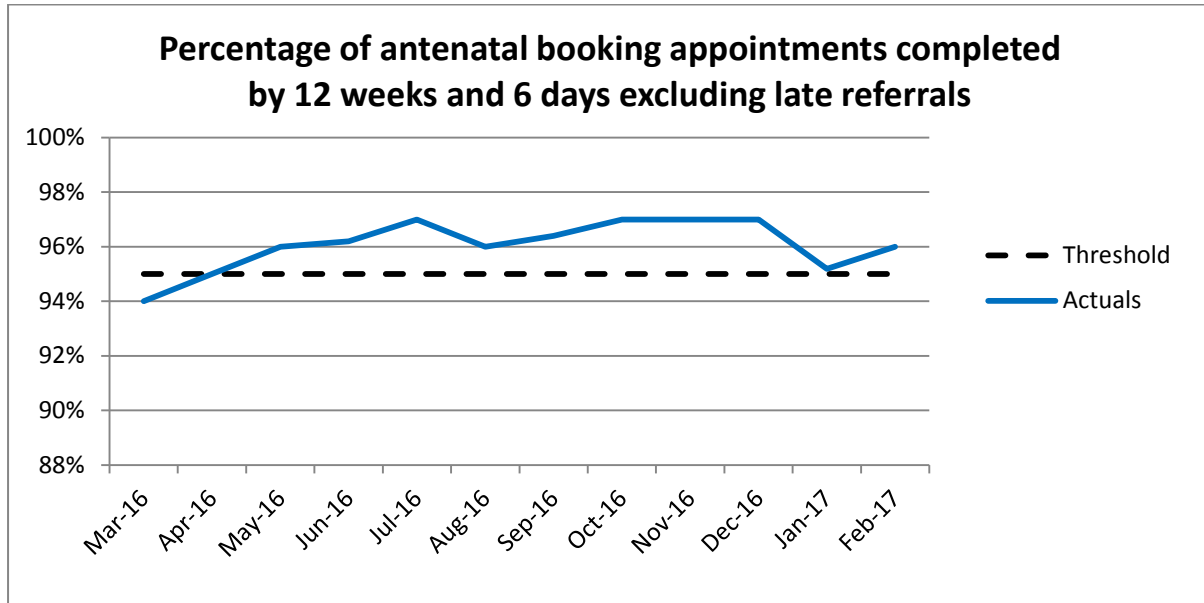


Figure 39 – Percentage of antenatal booking appointments completed by 12 weeks and 6 days excluding late referrals for the period March 2016 – February 2017

2.5.12 Responsive: Complaints

The number of complaints in February was consistent with previous months (excluding December). In February all complaints received were acknowledged within 3 days. Ninety-nine per cent of complaints were responded to within the time agreed with the complainant, with the average time to respond falling to 21 days, the lowest yet recorded.

In quarter 3 the Parliamentary Health Service Ombudsman (PHSO) investigated seven complaints where the complainants had been unhappy with the outcome from the ICHT complaints process. The PHSO did not uphold any of these, suggesting that the quality of ICHT complaints investigations and responses is good.

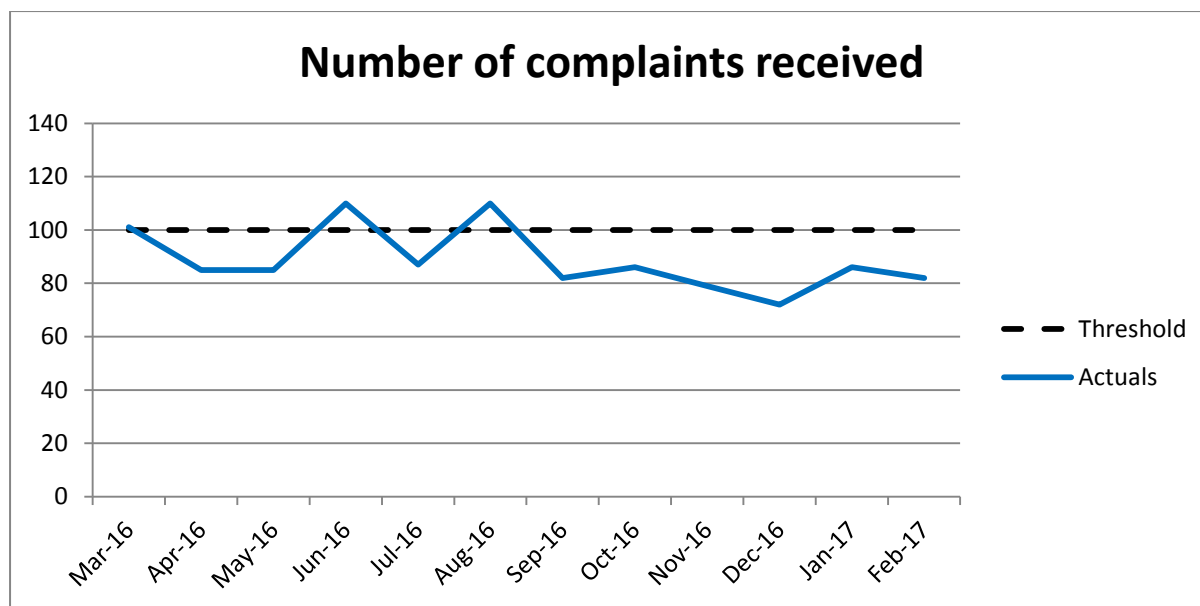


Figure 40 – Number of complaints received for the period March 2016 – February 2017

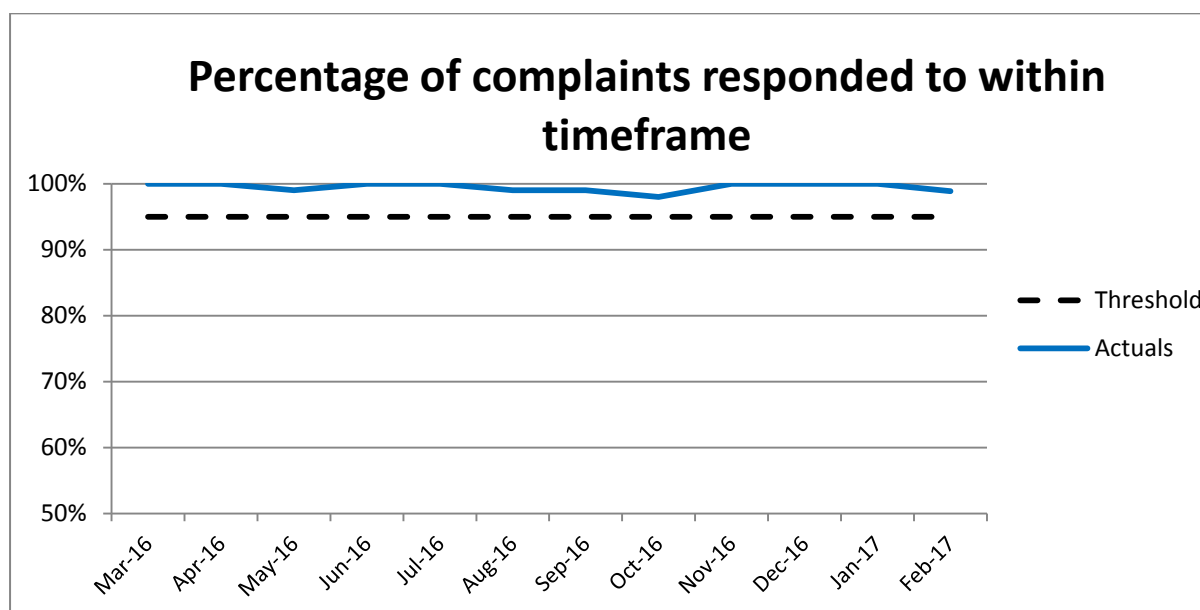


Figure 41 – Response times to complaints for the period March 2016 – February 2017

3. Finance

Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

Appendix 1 Safe staffing levels below target by ward (additional detail for section 2.1.7)

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in the following wards:

- 10 North (neurology) had a day fill rate of 52.38 per cent during the day for care staff. Although the report shows a staffing gap there was a much smaller gap than reported as the roster had not been updated to reflect the actual staffing levels that had altered due to fluctuations in staffing requirements.
- 11 South (neurosurgery) had a day fill rate of 64.44 per cent during the day for care staff. Although the report shows a staffing gap there was a much smaller gap than reported as the roster had not been updated to reflect the actual staffing levels that had altered due to fluctuations in staffing requirements. In both areas (10 North and 11 South), registered nurses covered the actual gaps .
- 9 West (neuro rehabilitation) had a day fill rate of 85.51 per cent for registered nurse staff, which resulted from unfilled RMN cover and enhanced care requirements . There was also a night fill rate of 88.26 per cent for registered nurse staff. This equated to 6 shifts unfilled. These shifts were covered by the Nurse in Charge and other registered nurses to ensure patient needs were met. The overall day fill rate was 89.09 per cent. The overall night fill rate was 92.73 per cent.
- DAAU HDU had a day fill rate of 88.90 per cent for registered nurses, and a night fill rate of 89.54 per cent. As there is no establishment for care staff, these requests are entered onto the RN line of the roster template, but do not reflect actual shortages in RN staff. The unfilled care staff shifts were requested for the enhanced care of patients and these needs were covered by the registered staff.
- Handfield Jones had a day fill rate of 75.61 per cent for care staff. This equated to 20 shifts unfilled. The care requirements of patients were met by the Ward Matron and other registered nurses .
- John Humphrey Ward had a day fill rate of 84.07 per cent for care staff. This equated to 3 shifts unfilled. Care staff from across the floor were utilised to cover any staffing gaps that arose from these shifts being unfilled.
- A7 (cardiology) had a day fill rate of 83.39 per cent for care staff. This equated to 5 shifts unfilled for enhanced care. Shifts were covered by the Ward Manager. The overall day fill rate was 94.90 per cent.
- A8 had a night fill rate of 74.73 per cent for care staff. This equated to 4 shifts unfilled for enhanced care. A8 does not have care staff overnight, registered nurse provided enhanced care. The overall night fill rate was 94.92 per cent.

- 6 South had a night fill rate of 84.62 per cent for registered nurses. This equated to 9 shifts unfilled. Staffing across days and nights was flexed to cover unfilled gaps. The overall night fill rate was 87.76 per cent.
- ISIC Surgical Assessment Unit had a day fill rate of 88.79 per cent for registered nurses, this equated to 2 shifts, and a 50.00 per cent fill rate for care staff, this equated to 1 shift. Registered nurse shifts were covered by the Ward Manager. The care staff shift was covered by movement of staff. These gaps reflect the need for a reconciliation in the establishment template that is set up for 12 beds, when only five were open during the month of February. This is a new area and as more beds are open the staffing levels will be flexed up to meet the established levels required for a 12 bedded unit as it becomes necessary.
- Paterson ward had a day fill rate of 84.38 per cent for care staff. This equated to 5 shifts unfilled for enhanced care. The gap in staffing reflects increased activity over the month of January for medical patients who needed enhanced care. Staff were used flexibly across the unit. The overall day fill rate was 93.68 per cent.

Report to:	Date of meeting
Trust board - public	29 March 2017

Finance Report for the eleven months to end February 2017

Executive summary:

This paper presents the highlights for the eleven months to February 2017, including income, pay, non pay performance, and the summary divisional performance.

Overall, the Trust is on plan in month, £0.4m favourable year to date, and is forecasting to overachieve the planned deficit by £0.5m. In month the Trust has recognised the risk to achievement of the RTT STF trajectory and reduced the forecast for the income by £0.5m. Operational performance has been forecast to be £0.5m better than plan to offset this, and can be delivered through non-recurrent stretch.

Quality impact:

No direct quality impact.

Financial impact:

No direct financial impact.

Risk impact:

Risks are highlighted in the summary pages.

Recommendation to the Trust board:

The Trust board is asked to note the paper.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author	Responsible executive director	Date submitted
Janice Stephens, Deputy CFO Michelle Openibo, Associate Director: Business Partnering	Richard Alexander, CFO	23 March 2017

IMPERIAL COLLEGE HEALTHCARE NHS TRUST**FINANCE REPORT – 11 MONTHS ENDED 28th FEBRUARY 2017****1. Introduction**

This report provides a brief summary of the Trust's financial results for the 11 months ended 28th February 2017. The Trust Board is asked to note this paper.

2. Summary

The Trust is reporting a deficit of £46.4m before Sustainability and Transformation Funding (STF); a favourable variance to plan of £0.6m. The table below provides a summary of the income and expenditure position.

	In Month			Year To Date (Cumulative)		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	81.90	84.54	2.64	939.00	959.63	20.63
Pay	(50.08)	(51.21)	(1.13)	(549.42)	(545.98)	3.45
Non Pay	(33.95)	(35.53)	(1.59)	(385.42)	(410.62)	(25.20)
Reserves	(0.20)	(0.20)	(0.00)	(6.68)	(6.68)	0.00
EBITDA	(2.32)	(2.40)	(0.07)	(2.53)	(3.65)	(1.12)
Financing Costs	(3.94)	(3.30)	0.64	(33.79)	(36.34)	(2.55)
SURPLUS / (DEFICIT) including donated asset	(6.27)	(5.70)	0.57	(36.32)	(39.99)	(3.67)
Donated Asset treatment	(0.23)	(0.55)	(0.32)	(10.73)	(6.42)	4.31
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT)	(6.50)	(6.25)	0.25	(47.05)	(46.41)	0.64
STF Income	2.01	1.76	(0.25)	22.09	21.84	(0.25)
SURPLUS / (DEFICIT) after STF income	(4.49)	(4.49)	(0.00)	(24.96)	(24.57)	0.39

In month the Trust reduced the amount of STF funding expected by £0.25m to reflect the potential underachievement of the Referral To Treatment (RTT) trajectory for February. The Trust was able to increase the operational forecast by £0.25m to compensate bringing the overall Trust position on plan in month and £0.4m better than plan year to date.

Income is £20.6m ahead of plan; £13.0m is due to activity based commissioning income and £4.5m relates to pass through drugs and devices. Pay costs are £3.5m favourable to plan, following below plan spend earlier in the year, largely in Women and Children's, Corporate and Medicine and Integrated Care. Pay costs have increased throughout the financial year as posts have been filled and NWL Pathology staff have transferred into the Trust. Non pay is £25.2m adverse to plan, £4.5m of which relates to pass through drugs and devices. Key drivers for the variances to plan are the additional costs of activity, unidentified CIPs and overspend on facilities and estates contracts.

2.1 NHS Activity and Income

The summary table shows the position by division.

	Year To Date Activity			Year To Date Income (£m)		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine and Integrated care	696,905	726,446	29,541	218.90	222.88	3.99
Division of Surgery, Cancer and Cardiovascular	536,289	531,897	(4,391)	249.30	252.21	2.92
Division of Women, Children and Clinical Support	282,057	283,572	1,516	121.20	123.06	1.86
Central Income	-	-	-	118.53	127.20	8.65
Pathology	1,880,401	1,922,180	41,780	11.56	11.65	0.09
Clinical Commissioning Income	3,395,651	3,464,096	68,445	719.49	737.00	17.51

NHS Clinical Income continues to over perform plan, however February was a low income month, mainly due to the reduced number of working days. Income within Medicine and Integrated Care is over performing in Stroke and Neurosciences which is £2.8m over plan YTD. There is also significant over performance in Integrated care. Surgery, Cancer and Cardiovascular is over performing in Major Trauma by £1.4m year to date. There has also been over performance in surgical specialties where work is being undertaken to meet referral to treatment times. Within Women and Children and Clinical Support Division Children's services has continued to over perform and is £1.9m over plan YTD. This is somewhat offset by underperformance in Maternity of £1.4m

2.2 Clinical Divisions

The devolved financial position for clinical divisions is set out in the table below.

	In Month			YTD		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	19.58	20.53	0.95	234.08	238.20	4.12
Expenditure	(16.70)	(17.38)	(0.68)	(187.99)	(192.61)	(4.61)
Medicine and Integrated Care	2.88	3.15	0.27	46.08	45.59	(0.49)
Income	21.46	22.02	0.56	253.11	257.49	4.38
Expenditure	(20.03)	(22.43)	(2.40)	(224.16)	(233.83)	(9.67)
Surgery, Cancer and Cardiovascular	1.43	(0.41)	(1.84)	28.95	23.66	(5.29)
Income	11.61	12.15	0.54	135.09	136.58	1.49
Expenditure	(12.02)	(12.26)	(0.25)	(132.28)	(133.17)	(0.89)
Women, Children & Clinical Support	(0.40)	(0.11)	0.29	2.81	3.41	0.59
Income	2.96	3.09	0.13	32.88	32.01	(0.87)
Expenditure	(5.29)	(5.27)	0.02	(57.23)	(57.16)	0.07
Pathology	(2.32)	(2.18)	0.15	(24.35)	(25.16)	(0.80)
Imperial Private Healthcare	0.96	0.78	(0.17)	11.13	10.65	(0.48)
Total Clinical Division	2.54	1.24	(1.30)	64.62	58.15	(6.47)

Medicine and Integrated Care is £0.5m adverse to plan YTD, mainly due to non-pay overspends on costs for activity above the plan and unmet CIP plans. Surgery, Cancer and Cardiovascular is £5.3m behind plan there have been additional costs for the waiting list improvement programme and to cover additional theatre sessions. Women, Children and Clinical Support is favourable to plan by £0.6m, the Division has over performed on income and underspent on pay but has unmet CIPs offsetting some favourable variance. Pathology is underperforming by £0.8m year to date mainly due to under achievement on income contracts with other providers. Private Health is adverse to plan year to date by £0.5m, costs are below plan but not enough to offset the income underperformance.

2.3 Private Care income

Private care income was £0.5m behind plan in month and £3.1m behind plan year to date. There have been delays to income generation schemes and capacity constraints at Hammersmith and Charing Cross Hospitals which have reduced private activity below plan. The Private Patients Division is working with Clinical Divisions to set a challenging but achievable private care income target for 2017/18.

3. **Efficiency programme**

£48.3m of CIP efficiencies have been delivered year to date, adverse to plan by £2.9m. The largest areas of underperformance are in Medicine and Integrated Care and Women, Children's, and Clinical Support Divisions which are behind plan due to unidentified CIPs and delays to income generation schemes. Pathology is also underperforming against plan due to unavoidable delays in executing a new managed equipment service. The Trust is working with the Project Support Office to identify additional CIPs to improve the position especially where this has robust benefits toward meeting the 2017/18 CIP target.

4. **Cash**

The cash balance at the end of the month was £41.4m. Overall the Trust is continuously demonstrating effective cash handling which is minimising the need to drawdown further against our working capital facility.

5. **Conclusion**

The Trust is favourable to plan year to date by £0.4m.

The size of NHS income over performance is a risk to the Trust's financial position as it may cause an affordability issue for commissioners. The forecast over performance is in line with North West London Clinical Commissioning Group (NWL CCG) forecast and the joint work that has been undertaken between the Trust and NWL CCG continues to mitigate risks for both organisations.

There is a risk that if the Trust is unable to achieve all the performance targets set when agreeing the STF and does not win appeals against underperformance then there will be further reductions in the income received.

The Executive continues to work internally to reduce costs while safeguarding quality and with the commissioners and NHSI to ensure fair remuneration for activity carried out.

The Trust Board is requested to note this report.

Appendix

Statement of Comprehensive Income – 11 months to 28th February 2017

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	63.8	66.8	3.0	737.2	763.1	25.9
Private Patients	4.1	3.5	(0.5)	44.7	41.6	(3.1)
Research & Development & Education	9.1	8.7	(0.4)	99.6	100.0	0.5
Other	4.9	5.5	0.5	57.5	54.9	(2.7)
TOTAL INCOME	81.9	84.5	2.6	939.0	959.6	20.6
Expenditure						
Pay - In post	(48.9)	(45.4)	3.5	(535.7)	(481.0)	54.7
Pay - Bank	(0.7)	(3.0)	(2.4)	(7.2)	(34.6)	(27.4)
Pay - Agency	(0.5)	(2.8)	(2.3)	(6.6)	(30.4)	(23.9)
Drugs & Clinical Supplies	(23.5)	(22.8)	0.7	(258.4)	(264.0)	(5.6)
General Supplies	(2.8)	(3.1)	(0.2)	(31.2)	(33.2)	(2.0)
Other	(7.6)	(9.7)	(2.1)	(95.9)	(113.4)	(17.5)
TOTAL EXPENDITURE	(84.0)	(86.7)	(2.7)	(934.8)	(956.6)	(21.7)
Reserves	(0.2)	(0.2)	(0.0)	(6.7)	(6.7)	0.0
Earnings Before Interest, Tax, Depreciation & Amortisation	(2.3)	(2.4)	(0.1)	(2.5)	(3.6)	(1.1)
Financing Costs	(3.9)	(3.3)	0.6	(33.8)	(36.3)	(2.6)
SURPLUS / (DEFICIT) including financing costs	(6.3)	(5.7)	0.6	(36.3)	(40.0)	(3.7)
Donated Asset treatment	(0.2)	(0.6)	(0.3)	(10.7)	(6.4)	4.3
SURPLUS / (DEFICIT) including donated asset treatment	(6.5)	(6.3)	0.2	(47.0)	(46.4)	0.6
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	(6.5)	(6.3)	0.2	(47.0)	(46.4)	0.6
STF	2.0	1.8	(0.3)	22.1	21.8	(0.3)
SURPLUS / (DEFICIT)	(4.5)	(4.5)	(0.0)	(25.0)	(24.6)	0.4

Report to:	Date of meeting
Trust board - public	29 March 2017

Board assurance framework

Executive summary:

Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the executive team with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Trust board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

The Trust board approved the new approach to the assurance framework in July 2016, and work continues to strengthen both the main document and associated documents (for example the structure of management and governance committees across the Trust). The latest version of the board assurance framework, as attached, is intrinsically similar to the version presented last year; the main changes are:

- Generally –
 - sources of assurance have been strengthened and are more comprehensive than on the previous document;
 - all risk register references have been reviewed;
 - TDA references have been amended to NHS Improvement;
- Areas of activity – where possible these have been given a ‘group’ heading along with the specific, such that subsets of the framework can be reviewed separately should this be relevant;
- Patient safety - Infection control - now specifically relates to CPE, to align with the risk register;
- ICT - Data quality – now reflects the increased attention being paid to this area, including the strengthened programme of internal audit and the new Data Quality Steering Group;
- Management of estates – strengthened in relation to backlog maintenance and site redevelopment;
- Health & safety – specific mention of occupational health role in protecting staff;
- New area of activity added – Development of ACP arrangements – also refers to the STP developments;
- Financial performance – specific mention of control total and STF;
- ICT – programmes – specific mention of NHSE Global digital excellence as a form of external assurance;
- ICT – information security – extended to include cyber crime, and link to corporate risk 90. Residual risk increased from low to medium as a result;
- CQC compliance – removed as a separate area and embedded in appropriate areas of activity within assurance framework.

Quality impact:

Ensuring that we seek to continuing improve various areas of our corporate governance will

demonstrate that the Trust strives to be a well-led organisation.

Financial impact:

The framework has no direct financial impact.

Risk impact:

Each of the work streams within corporate governance are regularly reviewed for risk impact, and risk register entries developed, including controls and mitigations as appropriate.

Recommendation to the Trust board:

The Trust board is asked to:

- Approve the proposed board assurance framework.
-

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author

Jan Aps, Trust company secretary

Responsible executive director

Tracey Batten, Chief executive

Board Assurance Framework

Revised March 2017 (v2.2)

Corporate objectives

1. To achieve excellent patient experience and outcomes delivered with care and compassion
2. To educate and engage skilled and diverse people committed to continual learning and improvement
3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care
4. To pioneer integrated models of care with our partners to improve the health of the communities we serve
5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

CQC domain	Areas of activity	Corporate objective	Lead	Area of risk	Corporate risk register reference	Sources of Assurance			Principal Assurance Committee(s)	Timetable of assurance reporting	Board reporting		Risk classification (see guidance)	
						1st line Reporting	2nd line Internal assurance	3rd line External assurance			What	When	Inherent risk	Residual risk
Safe	Patient safety: Infection control	1	DIPC	Risk of spread of CPE	88	Reports on outbreaks reports against key metrics	Quarterly report to quality committee	CQC inspection	Quality Committee	Quarterly	Quality committee report to the board	Bi-monthly	Medium	Low
Safe	Patient safety: Medicine management	5	Medical director / chief pharmacist	Failure to: <ul style="list-style-type: none"> - adopt best practice may lead to sub-optimal treatment - control medicines usage may lead to unnecessary costs - control drugs may lead to improper use / theft of medicines 	Held on relevant dept RR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	MRHA annual submission and review CQC inspection	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe	Patient safety: Staff: Fire	1	Director of estates & facilities	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems	Held on relevant dept RR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	Review and on-going oversight by London Fire Brigade	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	High	Medium
Safe Effective	Patient safety: Clinical governance	5	Medical director	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory /contractual obligations	81 /71	Divisional governance leads review directorate and divisional arrangements	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly. Internal audit	Commissioner Quality Group have oversight CQC inspections	Quality Committee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe Caring Effective	Patient care	1	Medical dir / dir of nursing/ divisional directors	Failure to safe and effective care affects CQC rating / incurs penalties/ impacts support for Trust strategic plans	81	Incidents raised on Datix Complaints Whistleblowing Service line self-assessments	Board member visits Core service reviews Deep dive reviews Internal audit support to core service reviews	CQC inspections PLACE audits	Quality Committee Ad-hoc risk reports are reported to the ARG Comm)	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium
Safe Effective Well-led	Risk management	5	Chief executive	Failure to mitigate any risk may affect patient care and/or financial position	48 / 71	Local risk registers Datix reporting	Executive Committee responsible for the management of risk Corporate risk register reported to the executive monthly Internal audit of risk management & BAF	Internal auditors audited BAF / and risk management in March 2016 - recommendations are being implemented	ARG Committee reviews the risk management policy F&I Committee and Quality Committee consider risks within their sphere	Quarterly or bi-monthly depending	Corporate risk register and board assurance framework reviewed at board	Six-monthly	Medium	Low
Safe Caring Well-led	Patient safety: Safeguarding	1	Director of nursing	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	71	Incidents raised on Datix	Six monthly report to the executive committee	Serious case review outcomes Ofsted reports	Quality Committee	Six-monthly report	Update on safeguarding cases and position	Six-monthly	Medium	Low
Safe Caring Well-led	Staff: recruitment and retention	2	Dir P&OD	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care Inability to deliver a workforce that enables the required changes for the clinical model	83	Vacancy rates Time to recruit	Executive committee monitoring programme looks at the efficiency and effectiveness of the recruitment process Internal audit	Safe staffing reported to Commissioners and NHSI at Commissioners Quality Group	Quality Committee receives report on safer staffing and by exception on other risks associated with shortage of appropriate staff	Bi-monthly	Safer staffing figures published monthly Update by exception through the quality committee report	Bi-monthly	High	Medium
Safe Responsive Well-led	ICT: Data quality	5	CIO, CFO, Divisional directors, Dir P&OD	Poor quality of patient information may undermine patient care Poor data quality of Trust information may undermine strategic and contractual decisions	Held of relevant dept RR	Standardised business and reporting rules that are aligned to national policy with standard definitions and robust change control processes	Snap-shot audits via carried out at team and individual level Monthly audit of backing data at patient level and cross checking against clinical systems Programme of internal audit DQ Steering Group newly in place	The external auditors provide a limited audit of information reported as part of their work on annual report and accounts	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Quarterly	High	Medium
Safe Responsive Well-led	Patient safety: Availability of necessary equipment	1	Dir of estates & facilities Divisional directors	Failure to provide safe equipment impacts patient and staff safety Equipment failure reduces ability to achieve operational targets	55	Incidents raised on Datix	Capital steering group oversees prioritisation of critical equipment spend Exception reports to executive & board committee if required	No relevant body	Quality committee Finance & investment committee	Bi-monthly	Update by exception through the committee reports	Bi-monthly	High	Medium
Safe Well-led	Patient safety: Staff safety: Management of estates	5	Director of estates & facilities	Failure to: <ul style="list-style-type: none"> - provide safe estate impacts patient and staff safety - provide an appropriate environment impacting patient experience and outcomes - manage property portfolio impacts on financial position - secure redevelopment approval and funding 	55	Incidents raised on Datix Trust's outsourced hard FM have clear procedures for responding to priorities issues	Capital programme reports to executive committee External review of backlog maintenance identified £1.3bn of which £130m of high risk; programme in place to continually monitor priorities as issues are addressed	NHSI aware of external review outcome, and Trust's approach to managing the risk	Finance and investment committee Redevelopment Committee progressing St Mary' site strategy	Bi-monthly capital report to F&I Comm	Update by exception through the report of the F&I Comm, the report of the Redevelopment Comm Specific report on Backlog maintenance	Bi-monthly	High	High
Safe Well-led	Staff: Health & safety	5	Dir P&OD	Failure to ensure: <ul style="list-style-type: none"> - appropriate arrangements in place to protect staff - that staff are immunised fully against biological agents to which they may be exposed 	92 /72	Incidents raised on Datix Incidents reported by Occ Health	Bimonthly report to the executive committee	HSE inspections CQC inspections Internal audits	Quality committee	Bi monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low

Effective	Research	3	Medical director	Failure to: - secure development of NIHR biomedical research centre - ensure research embedded in divisions - to develop AHSC to potential	Held on relevant dept RR	Research lead in each division reporting through management reporting structure	Research and AHSC reports to executive committee	National research oversight bodies	Quality committee	Six monthly research report	Overview of AHSC and other research activity	Annual Six monthly	Medium	Low
Effective Caring	Patient pathway: Development of ACP arrangements	4,1	Chief executive	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care and the STP	73	Clear governance arrangements across STP, with H&FGPF, and within Trust	Regular reports to Executive Committee	NHSI have oversight of the STP plans, and engaged in development of ACP arrangements	Audit, risk & governance committee	Propose an annual review of governance arrangements	Annual seminar on integrated care developments; regular updates in CE report	Annual Bi-monthly	Medium	Medium
Effective Well-led	Staff: Education and training (including mandatory training)	2,3	Medical director / Dir POD / Dir of nursing	Failure to: - adequately train staff poses risk to quality of patient care - achieve benchmark levels of medical education performance	65 POD RR	On-line register for all staff	Monthly reporting to the executive committee Internal audits of the systems and processes	Various Royal College and and GMC inspections and visits	Quality committee	Annual report of validation; performance report	Annual seminar on educational activities; mandatory elements in performance report; revalidation report	Annual Bi-monthly Annual	Medium	Low
Well-led	Corporate governance	5	Chief executive	Failures of corporate governance may lead to non-compliance with statutory / contractual failures	Held on relevant dept RR	Process in place to ensure that all board directors comply with Fit & Proper persons test Director self-assessment compliance statements	Review of board assurance statement Review of annual governance statement - (also reviewed by Audit Committee Executive self-assessment compliance statements Internal audit of BAF & AGS	External review of board governance (2014) to be repeated every three/four years	Audit, Risk & Governance Committee	Bi-monthly	Board and committee self-assessment External governance review report Review of compliance statements AGS	Annual 3 yearly Six monthly Annual	Medium	Low
Well-led	Finance: Financial performance	5	Chief financial officer	Failure to maintain financial sustainability	48	Divisional reporting Review financial review meetings for each division	The F&I scrutinise the financial position of the Trust The Exec Comm monitor delivery of achievement against savings plans, and performance against NHSI targets	External audit review during annual accounts preparation NHSI oversight, particularly in relation to control total and the STP	Finance and investment committee	Bi-monthly	Monthly finance report circulated Full reporting every other month in Finance report F&I Committee reports every other month	Monthly Bimonthly	High	High
Well-led	Finance: Financial control	5	Chief financial officer	Failures of financial control risk leads to unanticipated budget overspends	48	Standing financial instructions; scheme of delegated authorities; discretionary spend controls	SFIs; SoDFA reviewed annually at executive and relevant board committee	Internal audit opinion External audit opinion CQUIN achievement	Audit, Risk & Governance Committee	Quarterly, and annual	Audit opinions reported as part of the annual accounts	Annual April/May	High	Medium
Well-led	Finance: Annual Report and Accounts	5	Chief financial officer	Failure to comply with statutory duty to file annual report and accounts in prescribed format	81	Adherence to DH reporting manual and NHSI guidance	Executive and board committee review of report, AGS and accounts Internal audit	External audit of accounts and of the reports to ensure statutory requirements are met	Audit, Risk & Governance Committee	Annual	Consideration of the draft prior to sign off	Annual April/May	Low	Low
Well-led	Counter fraud	5	Chief financial officer	Poor systems and processes put the Trust at risk of financial loss	48	Cases raised Cases pursued	Internal	LCFS reports National benchmarking Home Office feedback	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Bimonthly	Medium	Medium
Well-led	Clinical governance: Quality account	5 1	Medical director	Failure to comply with statutory duty to file quality report in prescribed format Reputational risk of not achieving agreed quality targets	81	Adherence to DH reporting manual and NHSI guidance	Executive and board committee review of proposed objectives and draft and final report	External audit provide assurance in respect of data quality of the information provided and to ensure that it meets statutory requirements	Quality Committee Audit, Risk & Governance Committee	Annual	Report on potential quality indicators Review of final quality account	Annual April/May	Low	Low
Well-led	ICT: Programmes & systems	5 1	Chief information officer	Failure to: - deliver against the ICT programme may lead to failure to deliver clinical models (inc new) - maintain control may lead to overspend on major investments Potential distraction of shared ICO	ICT RR	Clear governance arrangements within ICT and between Imperial and C&W to ensure planned progress achieved, and manage risk of 'shared ICO'	Dedicated Executive Digital Strategy Strategy Committee will monitor delivery against key ICT projects, and ensure engagement Business cases and post-implementation reports are presented to the F&I Committee	NHS England - Global Digital Excellence oversight	Finance and investment committee / ARG Committee	Bi-monthly	Reports of the F&I Committee to each Trust board	Bi-monthly	Medium	Low
Well-led	ICT: Information security and cyber crime	5	Chief information officer / SIRO	Breaches indicate a detriment to patients or staff. Serious breaches may incur financial penalties Ransomware challenges	90	Process in place for reporting breaches Clear awareness and actions in place to minimise the impact of cyber crime	Annual report on performance in the Annual governance statement Exception reports on serious breaches IG annual return Internal audit	DH Information Governance return NHSIC have overview of all cyber crime issues	Audit, risk & governance committee	Quarterly	Annual performance in the Annual governance statement Exception reports on serious breaches IG annual return	Annual	Medium	Medium
Well-led Responsive	Operational performance	5 1	Divisional directors	Failure to deliver: - to plan affects the future development of the Trust - against NHSI targets (particular ED performance & emergency flow & RTT & elective performance)	87	Divisional review / ICT reporting Senior level committees in place addressing ED / emergency flow, RTT/elective activity, and outpatient improvement	Executive committee reviews performance each month, including reports from committees	NHSI and commissioners - monthly reporting	Executive committee	Bi-monthly	Operations performance report reported to Trust board	Monthly	High	High
Well-led Responsive	Finance: Commissioning environment	5	Chief financial officer	Failure to secure contracts impacts on the financial security of the Trust and may adversely affect quality of service	48	Clear direction and guidance in place within commissioning team	Executive and F&I Comm receive regular updates on contract position Review as part of the Business Planning process	Monthly NHSI oversight, and review of contracts agreed with Commissioners	Finance and investment committee	Bi-monthly	Exception reporting through Committee report Considered as part of business planning	Bi-monthly Annual	High	Medium

Report to:	Date of meeting
Trust board - public	29 March 2017

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q3 2016/17

Executive summary:

IPC-related activity and surveillance updates for Q3 2016/17 are reported. Points to highlight include:

- The number of *C. difficile* cases is on trajectory to meet the annual ceiling; only one lapse in care has occurred in Q3.
- There have been three Trust-attributed MRSA bloodstream infections (BSIs) (compared with six at the end of Q3 in the last financial year).
- There is now an increasing focus on Gram-negative BSIs, which will inform targeted strategies to minimise these infections where possible, including the appropriate use of antibiotics and monitoring antibiotic resistance trends.
- There has been only one central line-associated bloodstream infection (CLABSI) in the adult ICUs during Q3.
- Strategies to protect and reduce the usage of key Gram-negative antibiotics (including carbapenem and piperacillin/ tazobactam) are in place and will be developed further.

Quality impact:

IPC and careful management of antimicrobials is critical to the quality of care received by patients at ICHT, crossing all CQC domains.

Financial impact:

No direct financial impact.

Risk impact:

The report highlights key risks related to IPC, and how they are being managed.

Recommendation(s) to the Committee:

To note.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Alison Holmes, DIPC Jon Otter, IPC Interim Head of Ops	Julian Redhead	23 March 2017

1 Healthcare-associated infection (HCAI)

1.1 HCAI mandatory reporting summary

Table 1 provides a summary of PHE HCAI mandatory reporting, showing the number of cases by month and against the trajectory for *C. difficile*. 'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital.

	Apr-16		May-16		Jun-16		Jul-16		Aug-16		Sep-16		Oct-16		Nov-16		Dec-16		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	YTD (ceiling)
Trust MRSA BSI	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	3	0
Trust <i>C.difficile</i>	5	7	10	6	6	5	3	5	8	5	3	5	8	5	5	6	2	6	50	50
Trust <i>E.coli</i> BSI	9	-	5	-	8	-	13	-	13	-	7	-	12	-	9	-	5	-	81	-
Trust MSSA BSI	3	-	3	-	2	-	0	-	3	-	1	-	3	-	5	-	3	-	23	-

Table 1: HCAI mandatory reporting summary. For MRSA, MSSA, and *E. coli* BSI Trust cases are those that are identified after two days of hospitalisation; for *C. difficile*, Trust cases are those that are identified after three days of hospitalisation.

1.2 *C. difficile*

There have been 50 Trust-attributed cases to date this financial year (FY), against a ceiling of 50 cases to meet an annual ceiling of 69 cases for FY 2016/17 (Figure 1). The Trust has a comprehensive strategy in place to reduce the transmission of *C. difficile*, which was outlined in the Q2 report, including multidisciplinary clinical review of all cases, and rapid feedback of lapses in care to prompt ward-level learning. To continue our drive to reduce avoidable infection, the use of hydrogen peroxide vapour (HPV) for all transfers and discharges of patients who have had *C. difficile* infection is being discussed with Clinical Divisions.

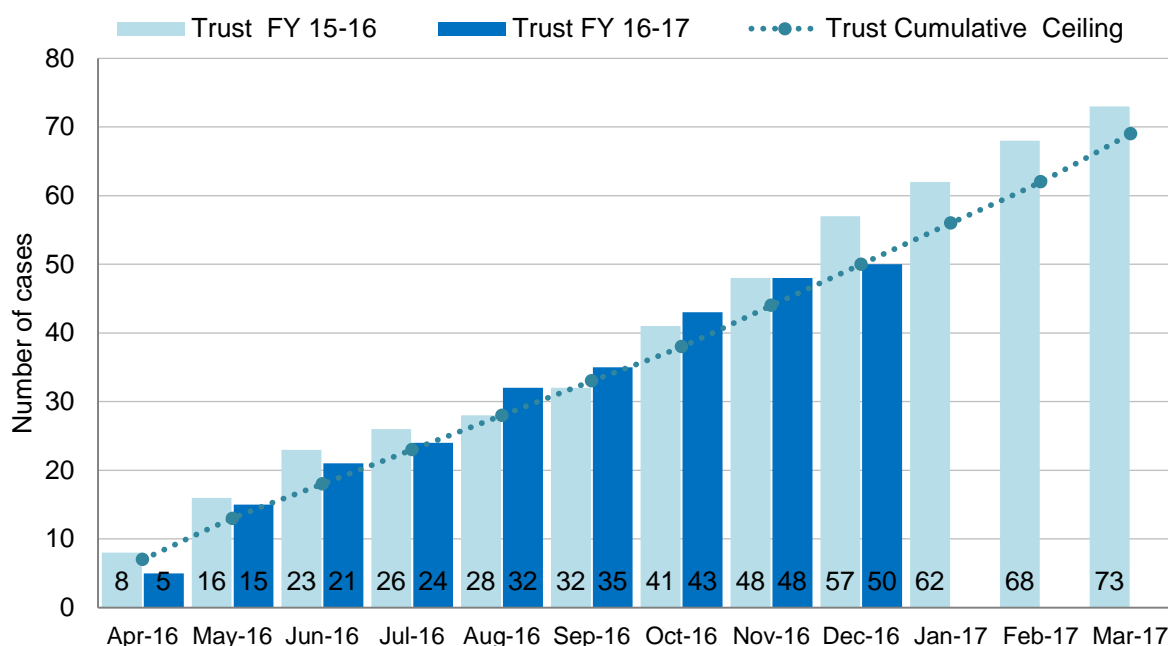


Figure 1: Cumulative monthly FY 16-17 Trust-attributed *C. difficile* (PCR+/EIA+) (dark blue bars) compared with FY 15-16 (light blue bars)

1.2.1 *C. difficile*: lapses in care

8 of 50 (16%) of the cases of *C. difficile* reported have had a lapse in care relating to pathway crossover (3), antibiotic exposures (4) and 1 relating to both pathway crossover + antibiotic exposure (Table 2). Only one of these lapses in care occurred during Q3. Lapses in care are reported to the relevant ward and Divisional teams to address any poor practice identified.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total number of toxin positive cases 16/17	5	10	6	3	8	3	8	5	2
Specimens sent for <i>C. difficile</i>	592	579	716	626	658	596	628	662	589
Antibiotics									
No exposure	1	2	0	0	0	0	0	1	0
Prescribed as per policy	4	4	6	3	8	3	8	3	2
Outside of policy and action taken	0	4	0	0	0	0	0	1	0
Transmission									
No contact with other patients with <i>C. difficile</i>	2	7	3	3	3	1	5	3	0
Had contact with other patients with <i>C. difficile</i>	3	3	3	0	5	2	3	2	2
Lapse in care	0	4	1	0	2	0	0	1	0

The definition of a lapse in care associated with toxin positive *C. difficile* disease is non-compliance with the ICHT antibiotic policy, or potential transmission. Potential transmission is identified if, following a review of the patient's journey prior to the positive test, there is a point at which the patient shared a ward with a patient who was symptomatic with *C. difficile* positive diarrhoea of the same ribotype.

Table 2: Summary of lapses in care related to *C. difficile*.

1.2.2 *C. difficile*: time to isolation

The Trust has a policy in place to isolate patients who develop diarrhoea within 2 hours of the start of their symptoms (Figure 2). To address lack of policy awareness and the lack of documentation of patient isolation, the importance of isolating patients with diarrhoea and documenting when a patient with diarrhoea is moved to a single room has been raised via the HCAI Taskforce call. Policy awareness and documentation is improving, whereas lack of available side rooms remains challenging.

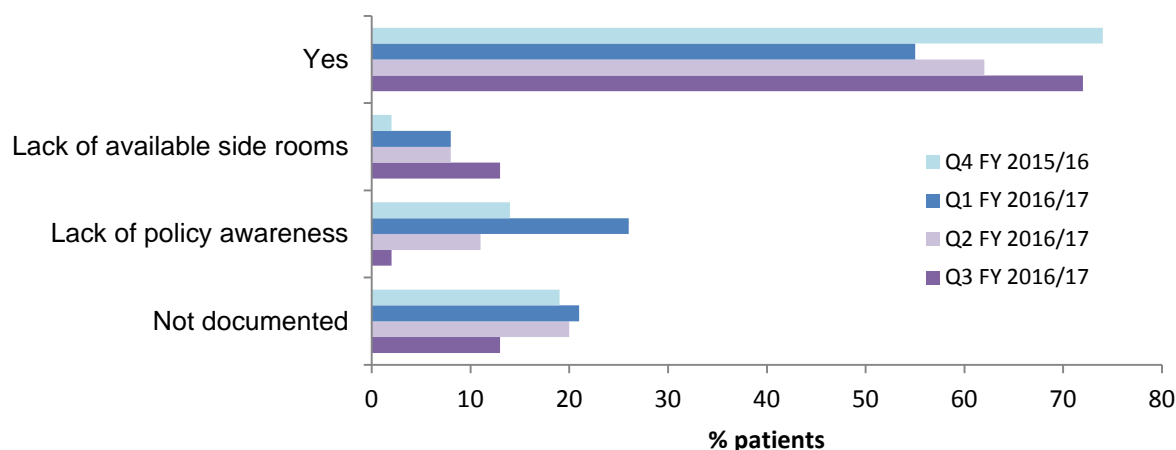


Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with *C. difficile* diarrhoea.

1.2.3 C. difficile: comparison with the Shelford group

Imperial has the 3rd highest rate in the Shelford group of hospitals for the rate of Trust-attributed *C. difficile* in the FY to date, compared with the 2nd highest rate in the 15/16 FY (Figure 3). The rate of specimens tested for *C. difficile* in the other Trusts is unknown.

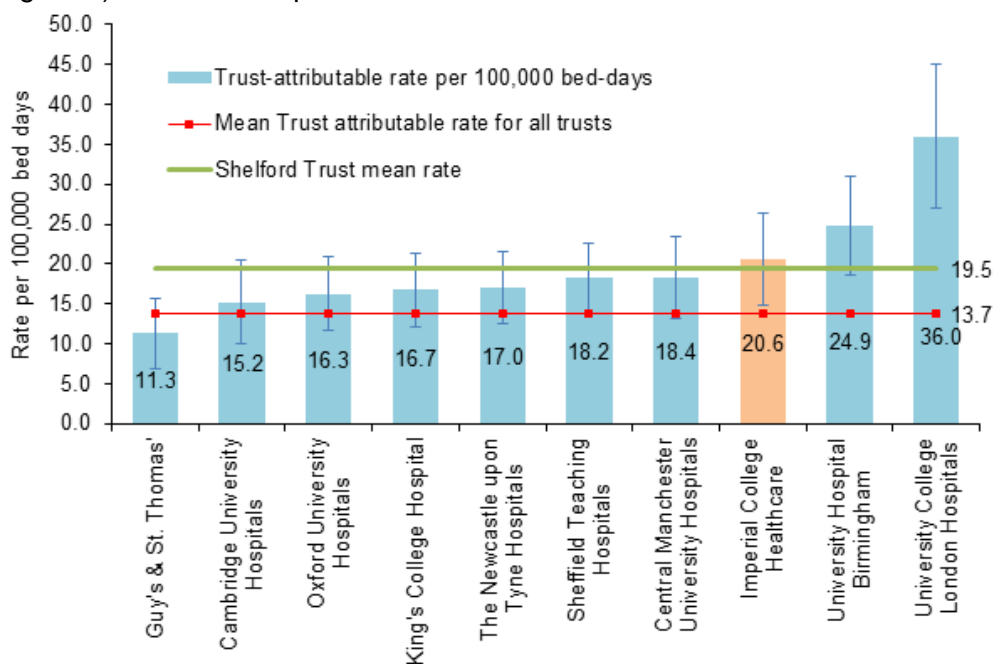


Figure 3: *C. difficile* Shelford Group comparison, FY to date.

1.3 MRSA bloodstream infection

24,293 blood cultures were tested during Q1, Q2 and Q3 FY 16/17. There have been eight cases of MRSA BSI identified at the Trust in Q1, Q2 and Q3 FY16/17, three of which have been Trust-attributed, compared with six Trust-attributed cases this time last year. Two Trust-attributed cases have occurred in Q3. Potential sources of infection in these complex cases included biliary (May 2016), metalwork following emergency spinal surgery (October), and skin lesions (November 2016). Figure 4 shows the cumulative number of Trust cases identified. None of the cases were related to vascular access devices or blood culture contamination. All MRSA cases are reviewed in detail by a multidisciplinary team, and learning is fed back on a ward and divisional level.

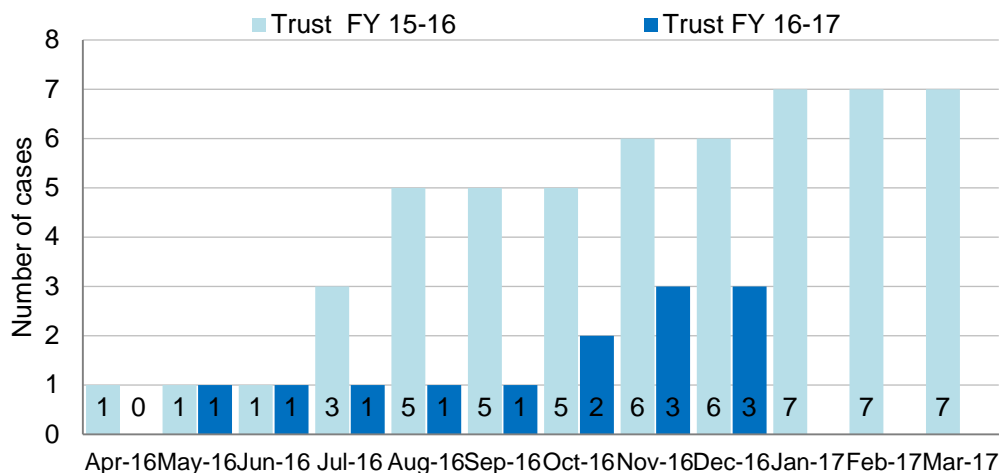


Figure 4: Cumulative monthly FY 16-17 Trust-attributed MRSA BSI (dark blue bars) compared to FY 15-16 (light blue bars).

1.3.1 MRSA BSI: comparison with the Shelford group

Imperial has the 6th highest rate in the Shelford group of hospitals for Trust-attributed MRSA BSI based on three Trust cases this FY, compared with the 2nd highest rate in the 15/16 FY (Figure 5). The rate of blood samples tested for MRSA in the other Trusts is unknown.

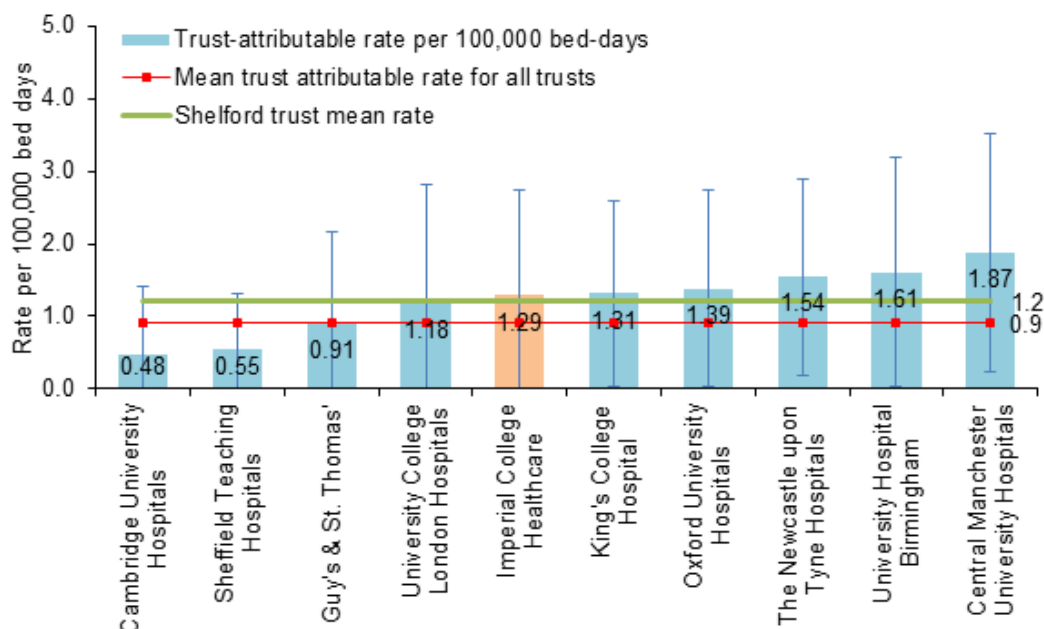


Figure 5: MRSA Shelford Group comparisons, FY to date.

1.4 MSSA BSI

There have been 23 cases of MSSA BSI in Q1, Q2 and Q3 FY16/17, compared with 19 cases in Q1, Q2 and Q3 FY15/16. There is no threshold for MSSA BSI at present. Cases of MSSA BSI are reviewed monthly to identify any potential clustering on individual wards. There were 11 cases of MSSA BSI in Q3. No potential clusters were identified. Only two cases were associated with vascular access devices, which has led to ward-level feedback and learning.

1.5 E. coli BSI

There have been 81 cases of *E. coli* BSI in Q1, Q2 and Q3 FY16/17, compared with 67 cases in Q1, Q2 and Q3 FY 15/16 (Figure 6). There is no threshold for *E. coli* BSI at present. The national rise in *E. coli* BSIs is now a national focus. Cases of *E. coli* BSI are reviewed monthly to identify any potential clustering on individual wards. Three cases in the same calendar month were identified on a neonatal ward, representing vertical transmission from a mother and one horizontal transmission event. Two cases of neutropenic sepsis in the same calendar month were identified on a haematology ward and there was no evidence of transmission. No other potential clusters were noted.

Of the 25 cases of *E. coli* BSIs for Q3, the following sources were identified; eight urinary (including one catheter associated UTI), six neutropenic sepsis, four late onset sepsis in extremely premature newborns (three siblings as above), two in patients with cirrhotic liver disease, one superficial SSI, one chorioamnionitis, one abdominal source (post tumour debulking), one biliary sepsis, and one in which the source was not investigated (palliative patient).

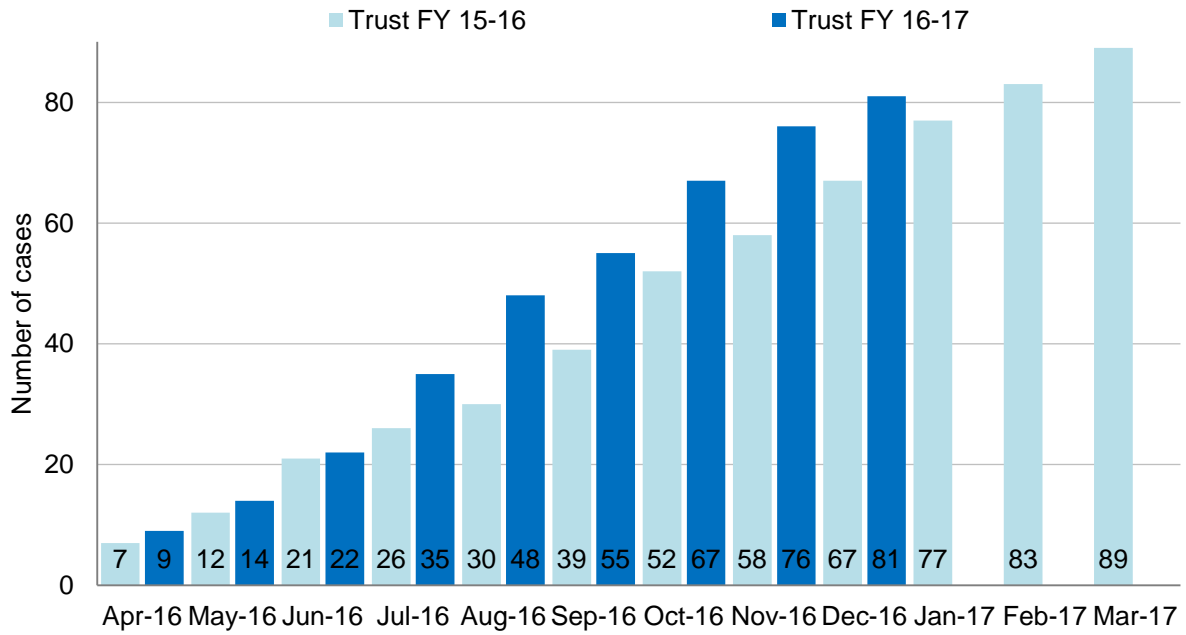


Figure 6: Cumulative monthly FY 16-17 Trust-attributed *E. coli* BSI (dark blue bars) compared to FY 15-16 (light blue bars).

1.5.1 *E.coli* BSI: comparison with the Shelford group

Imperial ranks 4th in the Shelford group of hospitals for the combined rate of Trust and non-Trust-attributed *E. coli* this FY (Figure 7).

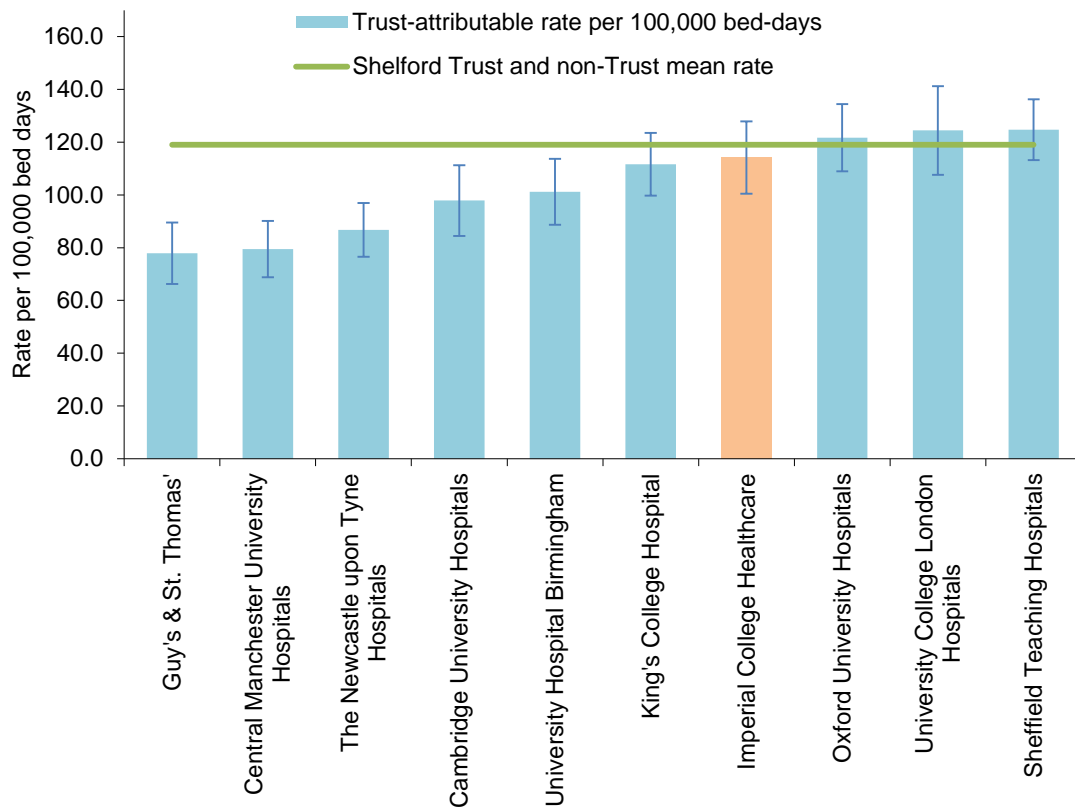


Figure 7: *E.coli* BSI Shelford Group comparisons, FY to date.

1.6 BSI summary

The trend in BSIs by organism / organism-group since Apr-16 is presented in Figure 8.

Gram-negative bacteria predominate, with *E. coli*, accounting for approximately 38 BSI per month (median 38, range 23 to 47), and for 19.3% of all positive blood cultures.

MRSA accounted for <0.03% of all blood cultures taken, and <0.5% of BSIs that grew micro-organisms. Blood cultures associated with bacteria usually associated with patients skin and not representing infection ('contaminated blood cultures') accounted for a substantial proportion of all positive cultures (2.4% of 25, 210 blood cultures taken during this period), which is below our local benchmark of 3%¹.

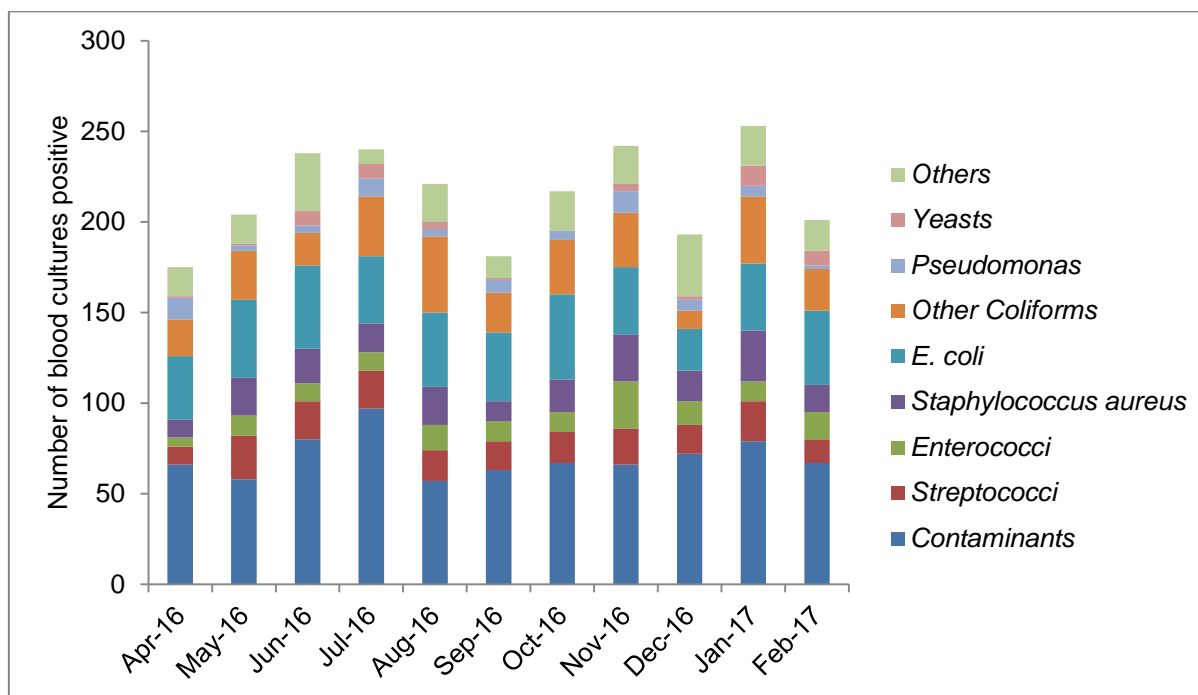


Figure 8: Blood cultures by species / species-group FY2016-17.

1.6.1 Antibiotic resistance in Gram-negative BSI

The antibiotic resistance patterns for the Enterobacteriaceae is shown in Figure 9. High rates of resistance were reported to Tazocin (12%) and Gentamicin (14%). Low rates of resistance were reported to Amikacin, Meropenem, Ertapenem, Temocillin, and Tigecycline were 3%. These rates of resistance are in line with national trends. A particular concern was the frequency of resistance patterns consistent with the production of ESBL (16%) and AmpC enzymes (11%) were common, which is in line with international increases in these bacterial groups. Increases in resistance to these key antibiotics drives the usage of carbapenems which, in turn, drives the emergence of CPE. However, carbapenem-resistance was rare, with only 8 isolates phenotypically resistant, of which four were carbapenemase-producing Enterobacteriaceae (CPE).

¹ Benchmark set based on published literature, which suggest 3%: Self et al. *Acad Emerg Med* 2013;20:89-97.

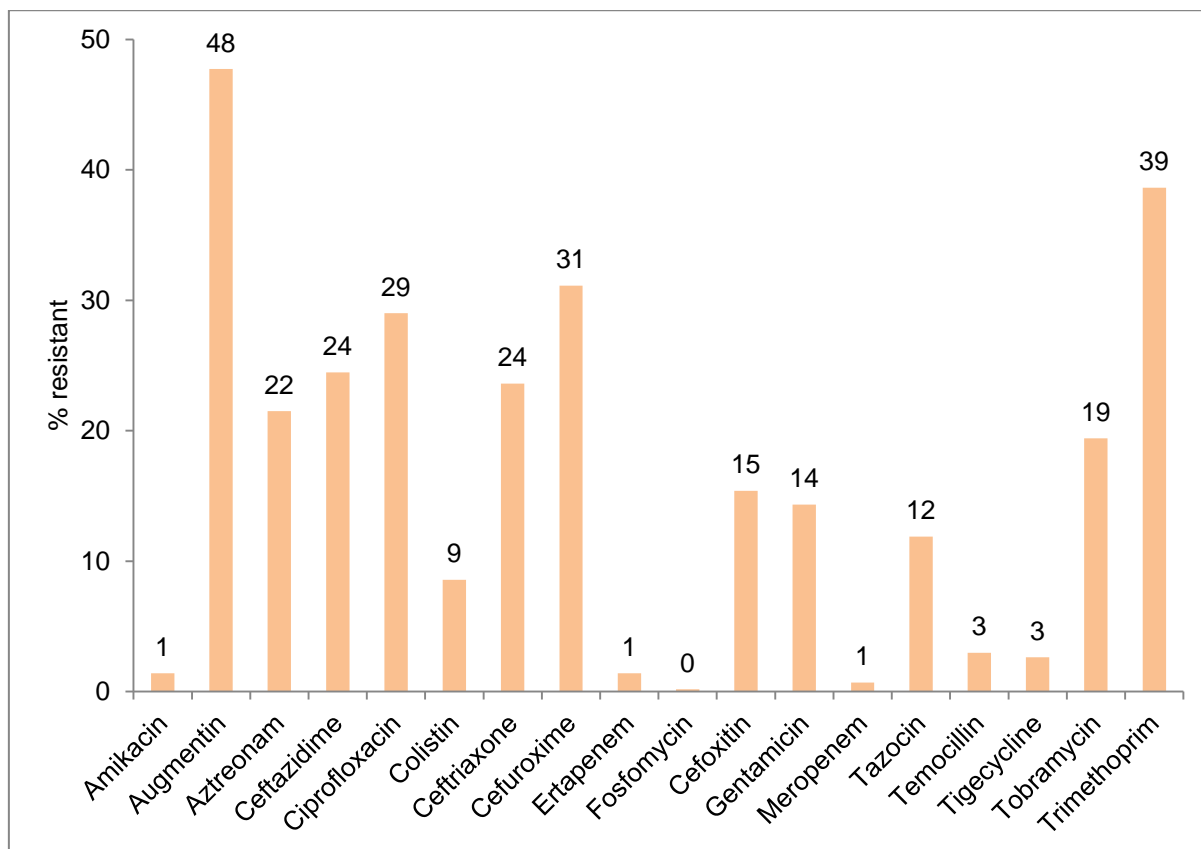


Figure 9: Resistance to antibiotics of Enterobacteriaceae BSI isolates FY 2016/17 Q1-3.

Pseudomonas aeruginosa BSI rates are variable each month, accounting for an average of 2% of all positive blood cultures (range 0 to 7%). Rates of resistance in *Pseudomonas aeruginosa* bacteraemia isolates were low, with all antibiotics tested having resistance rates of less than 10%. There were no multidrug resistant isolates that were not sensitive to aminoglycosides.

1.6.2 Blood Stream Infection (BSI) surveillance in ICUs

1.6.2.1 BSI summary in Trust ICUs

Adult ICUs: The catheter line-associated BSI (CLABSI) rate over the past 12 months is 1.4 per 1000 catheter line-days, which is below the benchmark of 3.0 per 1000 catheter-line days (Figure 10) (ECDC benchmark). Split by site, over the past 12 months (Jan to Dec-16), the CLABSI rate (per 1000 catheter line days) is 0.9 for Charing Cross hospital, 2.2 for Hammersmith, 1.2 for St. Mary's hospital. There has only been one CLABSI during Q3 on the three ICUs combined.

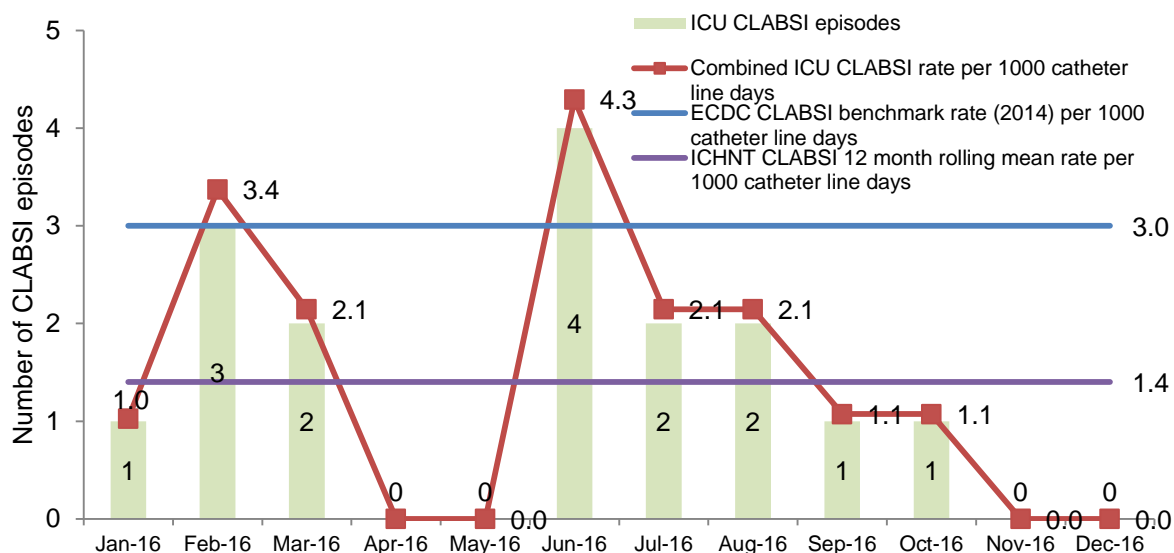


Figure 10: CLABSI episodes on the adult ICUs against the benchmark rate.

Paediatric ICU (PICU): In the 12 month period, Jan to Dec-16, PICU have seen two CLABSI episodes of 1889 catheter-line days (in Feb-16 and Oct-16), which is a rate of 1.1 per 1000 catheter-line days, below the ECDC European benchmark of 3.0 per 1000 catheter line days.

Neonatal ICU (NICU): The 12 month (Jan – Dec 16) CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined is 9.5 per 1000 catheter line days. The [National Neonatal Audit Programme \(NNAP\)](#) benchmark 3.0 per 1000 line days. The 12 month (Jan – Dec 16) CLABSI rate in Very Low Birth Weight Babies (VLBW) in the NICU was 10.7 per 1000 catheter line days, higher than the [NEO-KISS nosocomial infections surveillance project benchmark](#) figure of 8.6 per 1000 catheter line days. This is due to a transient increase in VLBW CLABSI rate (19.3 per 1000 line days) in the Jul to Sep 16 quarter. This increase involved one set of twins and one set of triplets who were particularly premature and had complex risk factors in Jul-16. This has been investigated together with Public Health England and a robust action plan has been developed with the Divisional and clinical governance teams as part of the SI process, in parallel with the Quality Surveillance Meeting process. The latest data suggests a downward trend in VLBW CLABSI rate.

1.7 Respiratory viruses (including influenza)

The trends in respiratory viruses detected in the Trust are presented in Figure 11. There has been the expected seasonal increases in respiratory viruses.

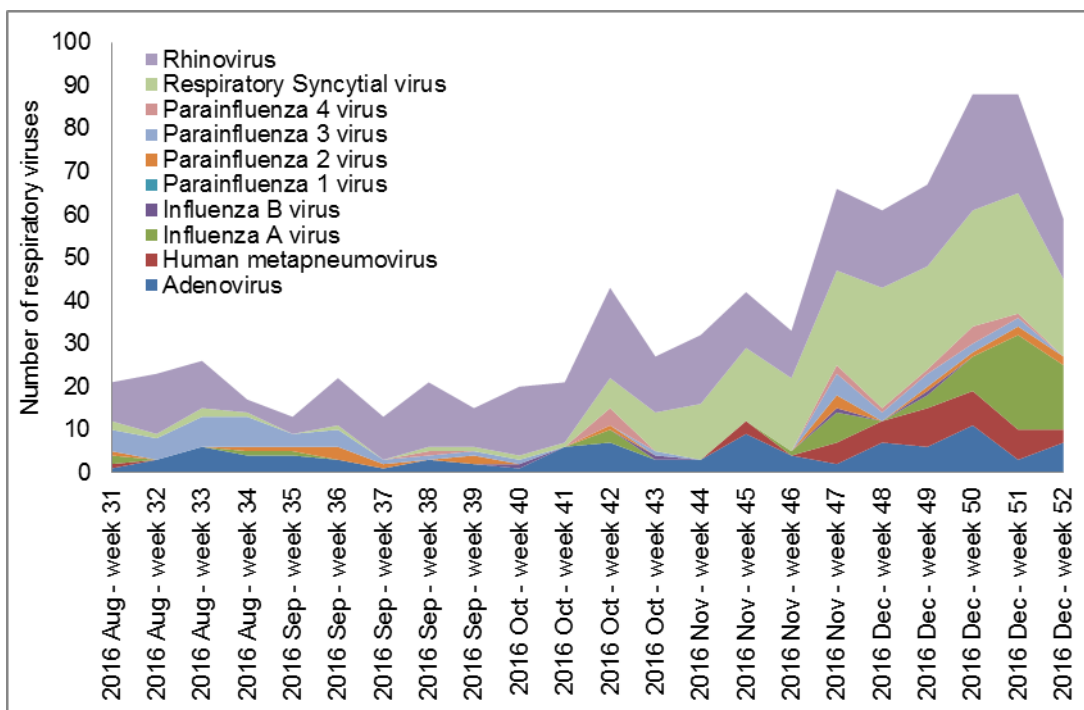


Figure 11. Trends in respiratory viruses detected at the Trust.

1.8 Surgical site infection

The Trust reports SSI rates following orthopaedic and cardiothoracic procedures.

Orthopaedics

- The 12 month rolling Trust average SSI (Jan - Dec 16) rate is:
 - 0.6%, two SSI of 324 knee replacement procedures; PHE national average 0.6%.
 - 1.0%, two SSI of 203 hip replacement procedures; PHE national average 0.6%.
- The latest quarter (Oct - Dec 16) has seen:
 - Zero SSI of 95 knee procedures .
 - One SSI of 47 hip procedures, deep-incisional, Gram-negative bacteria (2.1%).

Cardiothoracic

- The 12 month Trust average SSI (Jan - Dec 16) rate is:
 - 4.0%, 12 SSIs of 304 CABG procedures, PHE national average 4.5%
 - 3.3%, seven SSIs of 204 non-CABG procedures; PHE national average 1.2%.
- The latest quarter (Oct - Dec 16) has seen:
 - A rate of 9.5%, seven SSIs of 74 CABG procedures. This rate is considerably higher than the national average, and is being investigated by the cardiothoracic team, and by the Surgical Infection Group. A report will be prepared to summarise the outcomes of this investigation, and the actions that are being taken by the cardiothoracic team to reduce the rate of SSI in CABG procedures.
 - A rate of 2.6%, one SSI (superficial incisional) of 39 non-CABG procedures so far recorded on the PHE data capture system. There is an additional case, deep sternal wound infection, under investigation as a potential non-CABG SSI.

Each cases of deep SSI (in all surgical specialties) will be reported on the Trust's Datix incident reporting system, and may trigger an SI investigation. Individual cases of SSI are discussed at the monthly Surgical Infection Group, and on the weekly HCAI Taskforce call. In addition, the Surgical Outcome Group, chaired by Prof Justin Vale, takes a strategic approach to improving surgical outcomes including surgical infections. There are plans to build an IPC-based SSI surveillance programme to cover other surgical specialties and to strengthen the work already in place however there are costs associated with this. A business case has been prepared and is being considered as part of the business planning process.

1.8.1 SSI: implementing semi-automated surveillance

IPC, microbiology and the NIHR Health Protection Research Unit (at Imperial College London) are collaborating to implement improved SSI surveillance. The principle is to merge data from microbiology, pathology, procedure and diagnosis codes to algorithmically detect patients who might have an SSI for detailed case review. There are two overlapping work streams currently in progress: retrospective analysis of cardiothoracic SSIs, and implementing a real-time trigger for new suspicious cases for detailed review. The Trust's QlickView team continue to implement a module for viewing the results semi-automated SSI surveillance in cardiothoracic procedures. A preliminary tool is in place on QlickView; implementation and roll-out is being discussed at the Surgical Outcomes Group.

1.9 Carbapenemase-producing Enterobacteriaceae (CPE)

1.9.1 Detection of CPE

Risk-factor based screening of all admissions was introduced in June 2015 to extend universal screening that was being performed in high-risk specialties. The majority of cases are from screens, without evidence of clinical infection (Figure 12).

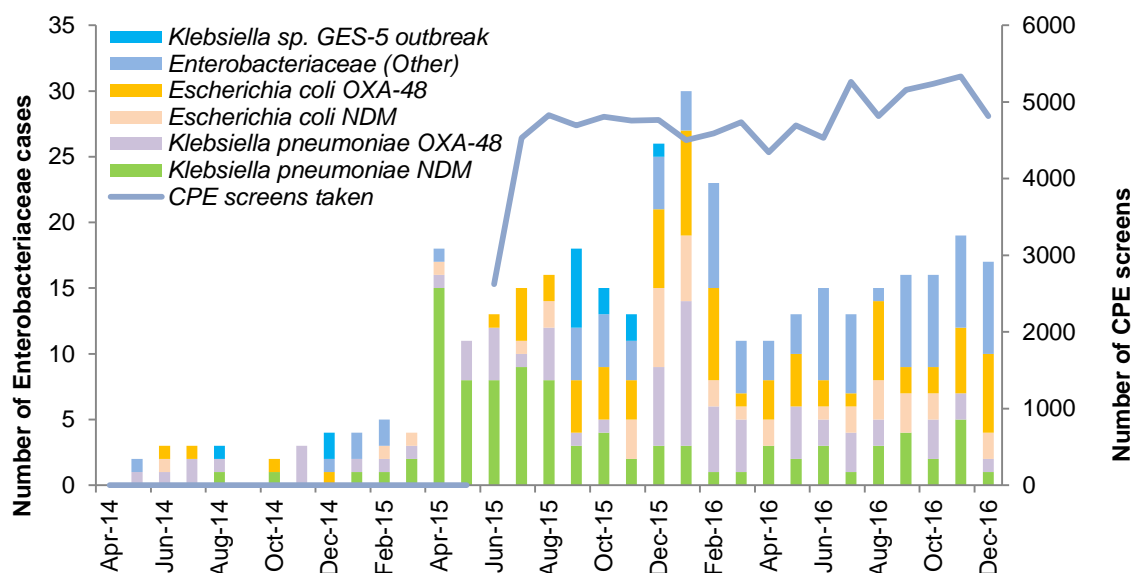


Figure 12: CPE cases identified at the Trust, Apr-14 to Dec-16.

1.9.2 CPE admission screening compliance

A number of high-risk specialties are performing universal admission screening (renal, vascular, ICUs and haematology wards). The rest of the Trust is performing risk-factor based admission screening of all admissions, identifying those patients with previous overnight hospitalisation in the past 12 months or overseas residents. CPE admission screening results (Figure 13) will be included in the Harm Free Care report from January 2017. This will prompt ward-level action to address areas of low compliance. A CPE Action Plan, which includes compliance with CPE screening, is reviewed monthly at the Medical Director's Quality and Safety Sub-Group. The learning gained from the improvement in CPE admission screening in a private patients ward at HH achieved in collaboration with NHS Improvement is being shared across the Divisions, for example, using Back to the Floor Friday, and the HCAI Taskforce call. The sharp decline in CPE admission screening compliance in haematology (Figure 12) is under investigation, and patient-level data will be used to understand why patient who should have been screened were not.

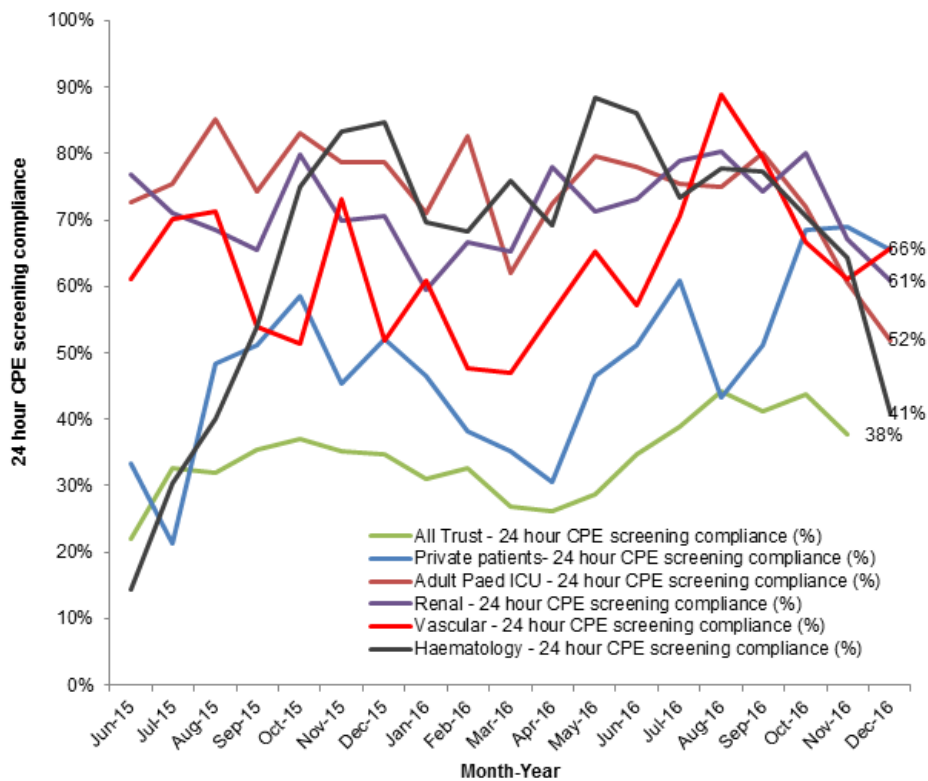


Figure 13: Compliance with CPE admission screening.

2 Antibiotic stewardship

Antibiotic Stewardship (AS) encompasses all activities intended to improve patient outcomes from infection while minimising negative consequences such as HCAI and limiting development of bacterial resistance. AS is considered a key aspect of patient safety.

2.1 Assurance regarding quality of antibiotic prescribing

2.1.1 Point Prevalence Results – Prescribing Indicators

The biannual antibiotic point prevalence study (PPS) (based on a review of inpatient data only) examines a suite of key antibiotic prescribing and safety indicators as advised by the Department of Health's "Start Smart then Focus" antibiotic programme and acts as a mechanism to identify areas for improvement. The latest results are from the June 2016 PPS.

Overall 1190 patients were reviewed, approximately 45% of inpatients were scheduled to receive an antibiotic. 865 antibiotics were prescribed (55% intravenous). Of these 865 antibiotics, 90% were prescribed according to policy or on the advice of infection teams with 95% having a documented indication on the drug chart or medical notes. Approximately 77% of antibiotics had a documented stop or review date. The Trust has a suggested compliance of 90% for these indicators (Table 4).

Division	Number of patients on antibiotic(s)/total patients seen (%)		Number of antibiotics prescribed		INDICATOR 1 % antibiotics in line with policy or approved by Microbiology/ID		INDICATOR 2 % indication documented on drug chart or in notes		INDICATOR 3 % stop / review date on drug chart	
	Average 15/16*	June 2016	Average 15/16	June 2016	Average 15/16	June 2016	Average 15/16	June 2016	Average 15/16	June 2016
Trust Results	499/1178 (42%)	533/1190 (45%)	824	865	89%	90%	94%	95%	70%	77%
Medicine	241/525 (45%)	240/531 (45%)	367	358	92%	89%	98%	99%	72%	85%
Surgery, Cardiovascular	175/386 (45%)	208/405 (51%)	315	354	84%	92%	93%	91%	71%	71%
Women's and Children's	66/208 (32%)	77/217 (35%)	114	141	94%	88%	83%	93%	60%	67%
Private	17/59 (29%)	8/37 (22%)	29	12	73%	92%	88%	100%	62%	83%
Trust Target 2016/1					90%		90%		90%	

Table 3: PPS June 2016 Summary of results

Whilst Indicator 3 (the recording of a stop/ review date on the drug chart) has improved since 15/16, it remains under the Trust target compliance of 90%. To address this, the results have started to be included in the IPC Scorecard sent to the Divisions monthly to increase awareness and antimicrobial stewardship has been included as an agenda item on the IPC taskforce call on the first Tuesday of every month. Divisional medical and nursing leads have been asked to consider how to improve compliance in this area.

2.1.1.1 New 48-72 hour review indicator

With the lower than expected compliance with indicator 3 (the recording of a stop / review data) in previous point prevalence surveys, an additional point prevalence data point was collected on whether or not a review of antibiotics was actually carried out within 72 hours of initial prescribing. The Trust overall figure was 88% [Medicine 89%, Surgery, Cardiovascular and Cancer 86%, Women's and Children 86%, Private Patients 100%]. The suggested target for this new indicator is 90%. This will be measured across the Trust formally again in early 2017.

2.1.1.2 Pilot of Monthly Review of Antibiotic Prescribing Indicators

To seek continued assurance that the point prevalence results are sustained, the infection pharmacists have, as part of their clinical reviews, been capturing compliance with the antibiotic prescribing indicators for a total of 50 (medical and surgical) patients a month. Compliance with documenting an indication and antibiotic choice is above 90%, with the review at 72 hours averaging 85%. In Q3, the infection pharmacists will move to reviewing 25 patients from each Division as a pilot after which it can be considered as part of the business plan for IPC going forward.

2.1.1.3 Antibiotic Prescribing Indicators within Acute Admissions

As acute admissions have a high proportion of patients on antibiotics at any one time, data on antibiotic prescribing indicators are collected monthly across Charing Cross and St Marys by the admissions pharmacy staff. These results are discussed at clinical and managerial meetings (department and Medicine IPC meeting) with educational messages via email promoted to drive improvement. Note: 48-72 hour review data is not collected in this area.

In addition, a new pilot led by an Infectious Diseases physician with the Acute Admission pharmacists have been identifying patients for antibiotic review within the St Mary's admission service to promote appropriate review and prescribing within this population.

2.1.2 Point Prevalence Results - Safety Indicators

As part of the biannual antibiotic point prevalence study there were 7391 antibiotic doses prescribed at the time of data collection with 289 doses (4%) being not given. Of these 289 doses, 141 were intravenous antibiotics. In addition, ninety-seven percent of patients who received an antibiotic had their allergy status completed.

This data will be collected again during the January 17 point prevalence study as it is hypothesized that Cerner introduction and roll out may have accounted for the rise in missed doses rates.

2.2 Antimicrobial Consumption

Work has started on try and automate the local analysis of antimicrobial consumption data detailing total use (split by inpatient and outpatient) together with intravenous versus oral antibiotic prescribing over a rate of 1000 admissions (Figure 14). The data will be able to be split by class of antibiotic, speciality and site to help target stewardship interventions and will be used with antibiotic resistance data and local point prevalence studies.

Of key interest will be the analysis of Gram-negative agents such piperacillin/ tazobactam, meropenem together with amikacin and colistin use which have shown an increase over the past year due to the rise in resistance Gram-negative infections. There has been a slight increase in antibiotics given to outpatients and decrease in inpatients.

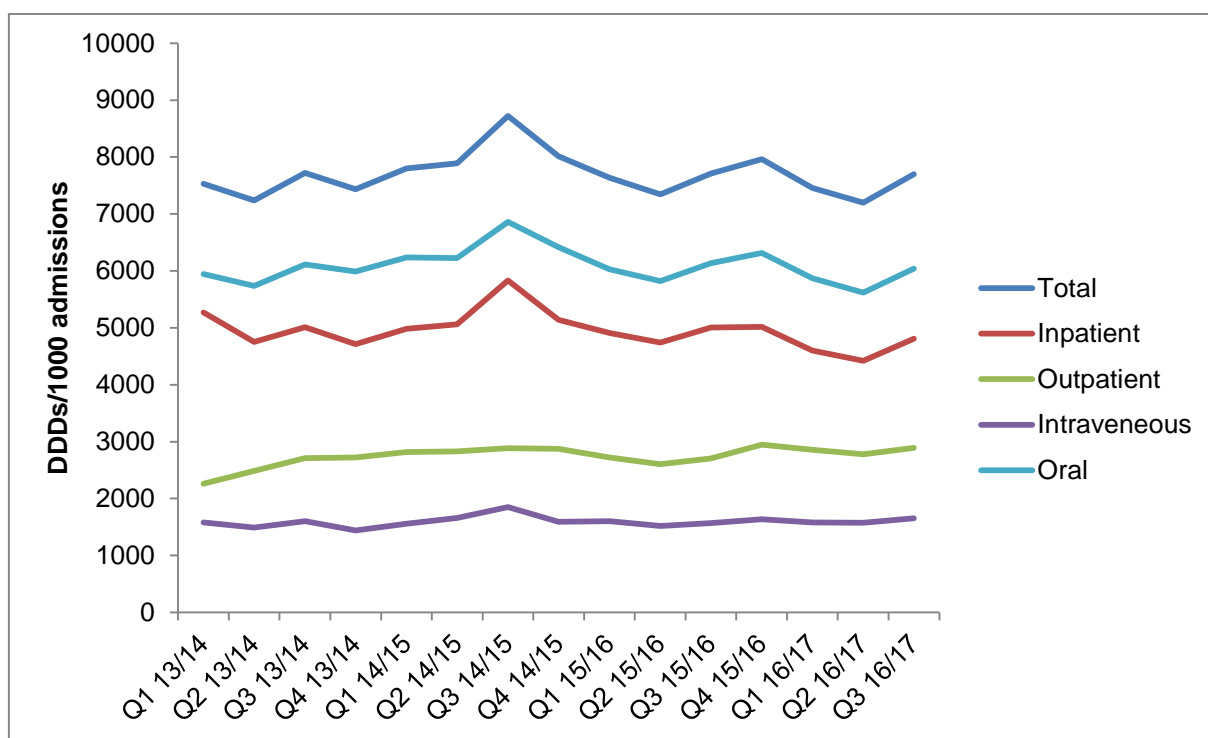


Figure 14: Trends in Trust-wide antibiotic usage from 2013-2017. DDD = defined daily dose, the assumed average maintenance dose per day for a drug used for its main indication in adults.

2.3 Antibiotic Expenditure

Antimicrobial expenditure can be used as a surrogate to monitor antibiotic use. Increases or decreases in trends can be associated with changes in contract prices and may not represent an accurate reflection of consumption.

For antibacterials, during April-December 2016 there were no known contract changes. There is a pan-London contract for echinocandins where cost is based on a volume based matrix of drug usage. From 1st September 2016, the cost of anidulafungin and micafungin decreased which was predicted to result in a cost saving. It should be noted that high cost antifungals are funded by NHS England with the exception of patients within 90 days of renal transplant or bone marrow transplant. A new antifungal policy is due to be launched at the start of Q4 which will promote micafungin as the Trust wide echinocandin and is predicted to result in further savings to the wider healthcare economy.

Trust-wide there was an average spend of £706k per quarter on antibacterials and £760k on antifungals in 2016/17 YTD. Unlike previous expenditure data, these figures include both inpatient and outpatient antibiotic use. The greatest antibacterial expenditure in Q1, Q2 and Q3 was on the St Mary's site (Figures 15). The greatest antifungal expenditure in Q1, Q2 and Q3 was on the Hammersmith and reflects use within haematology and renal populations (Figures 13).

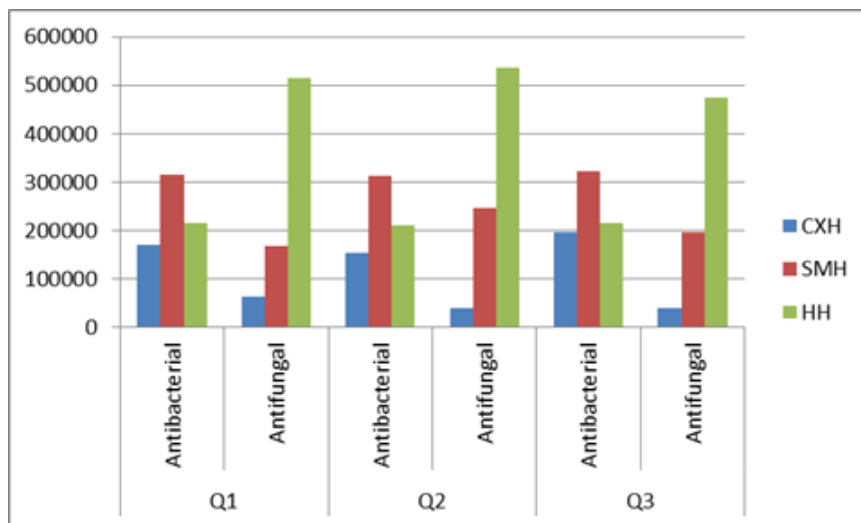


Figure 15: Antibiotic expenditure for inpatients and outpatients by site and quarter 2016/17 FY to date.

Figure 16 illustrates the expenditure on the **top 10 antibacterials** used as a percentage of the total antibacterial spend. A significant proportion of the total antibacterial spend was due to the top 10 drugs in all divisions except Womens, Childrens and Clinical support, where approximately 60% of the total antibacterial spend is attributed to antibacterials other than the Top 10.

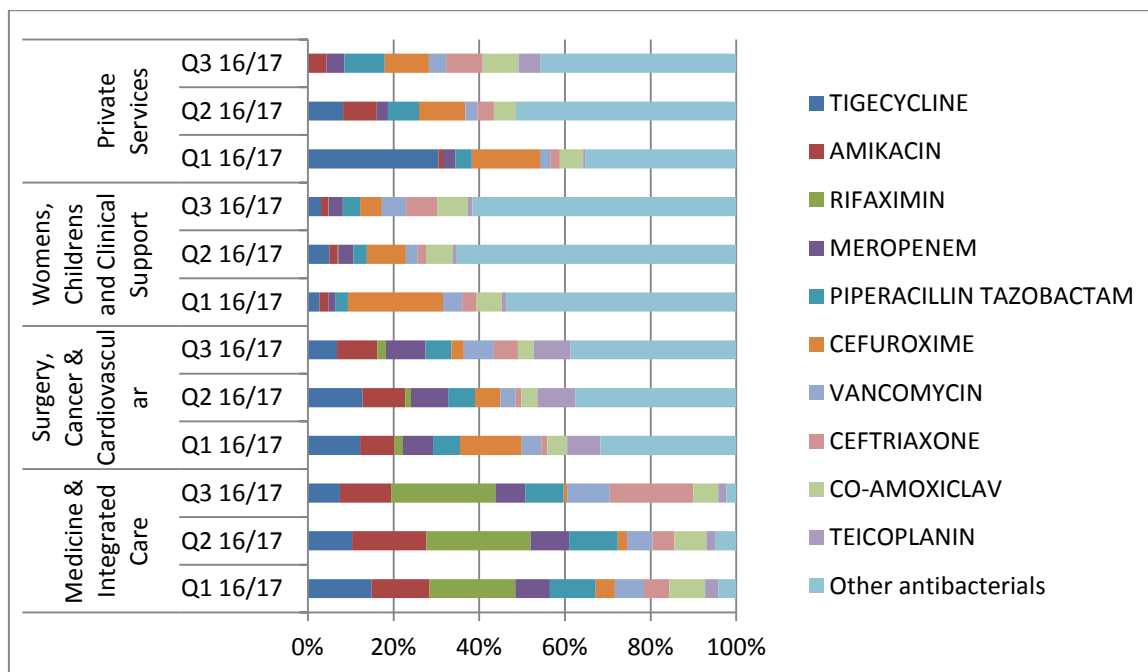


Figure 16: Top 10 antibacterials spend as a percentage of total antibacterials spend by division 2016/17 YTD.

Following the introduction of generic voriconazole in August 2016, there has been significant Trustwide savings in voriconazole. This is illustrated in Figure 17. In Q3 2016/17 there was approximately £100,000 less spent on voriconazole Trust-wide than there was in Q1 2016/17. However voriconazole is funded by NHS England, with the exception of patients within 90 days of renal transplant or bone marrow transplant, so this represents saving to the NHS as a whole rather than at a Trust level.

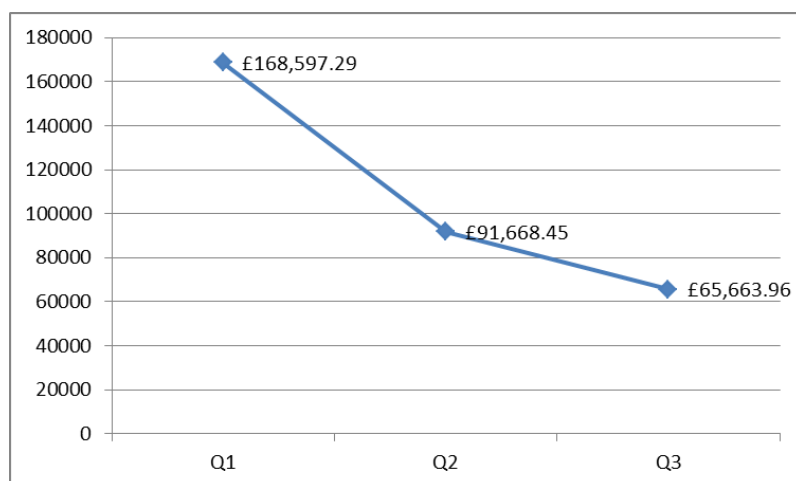


Figure 17: Trust-wide voriconazole expenditure YTD 2016/17.

2.4 Antibiotic Review Group

The Trust Antibiotic Review Group’s role is to improve antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams. The following policies were approved and updated in Q3:

- Imaging/Surgical Protocols: Prostate biopsy and embolization protocols
- Imaging guidelines: renal
- Supply of Varicella zoster immunoglobulin and hepatitis B immunoglobulin
- Antifungal Policy

- Care bundle for patients with decompensated liver disease
- Restricted antibiotic policy
- *Clostridium difficile* associated disease: adult guidelines for the treatment and management of patients
- Antibiotics in pregnancy & breastfeeding

The following policies are under review:

- Management of chickenpox in pregnancy
- Management of infection in neutropenic patients
- Western eye antibiotic guidelines

New drugs applications were reviewed and approved for:

- Moxifloxacin eye drops
- Ceftobiprole
- Cefazolin

2.5 Antibiotic resistance data

The Trust empirical antibiotic policy will be updated in April 2017, informed by antibiotic resistance data.

2.6 European Antibiotic Awareness Day / Antibiotic Amnesty

Imperial College Healthcare NHS Trust, “World Antibiotic Awareness Week (WAAW)” 2016 campaign which was run in partnership with Imperial College London and Lloyds outpatient pharmacy. The campaign was multidisciplinary in nature and comprised of healthcare (infection pharmacy, microbiology/infectious diseases) and non-healthcare (communications, media) professionals together with research staff and volunteers. The campaign had the support of the Medical Directors’ office, and Trust divisional medical and nursing directors.

During WAAW, patients, visitors and staff were asked to drop off unused antibiotics to our outpatient pharmacies. By the end of the week, 14 vials of ceftriaxone, 289 flucloxacillin capsules, 210 erythromycin tablets, 164 penicillin tablets, 23 amoxicillin capsules, 28 cefradine tablets, liquid preparations of ciprofloxacin, metronidazole and erythromycin and antibiotic eye drops had been handed in (Figure 18).

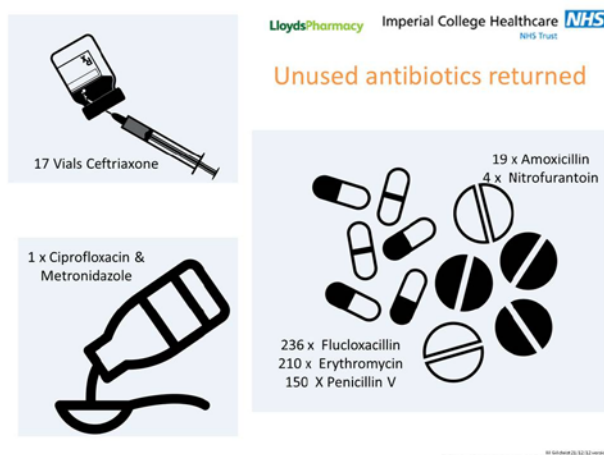


Figure 18: Graphical summary of the impact of the antibiotic amnesty during WAAW.

The antibiotic campaign generated 10,852 impressions on Twitter being retweeted approximately 500 times. On Facebook the campaign was viewed 7,300 times with LinkedIn receiving 12,000 impressions. In addition it was noted that Trust amnesty campaign poster

was the top #antibioticresistance tweet the day before WAAW being described as “Really effective campaign”.

Finally, 267 new antibiotic guardians were signed up during the week.

2.7 Sepsis

The Trust is developing the available Cerner sepsis module for use within the Trust. This coincides with the recent issuing of updated NICE guidance on sepsis management and the development of a Trust guideline on sepsis management to reflect this change. The module has now had the Trust Adult Treatment of Infection Policy incorporated to support clinical decision making; the module also promotes the principles of early use of broad spectrum antibiotics in septic patients. It will include reporting functionality to monitor time to first dose of antibiotics and help drive improvement around sepsis management.

2.8 Focused antimicrobial stewardship priority areas for 16/17

A patient safety alert (2015/007) was jointly issued in August 2015 by Health Education England, NHS England, and Public Health England (PHE) to help address antimicrobial resistance (AMR) through the implementation of AS programmes. Secondary care organisations were asked to review their AS programmes and their systems and ensure strategies were in place in accordance with the ‘Start Smart then Focus’ principles. The Trust reviewed its existing programme and identified eight key areas to develop further in 16/17.

Table 4 details these with progress monitored through Trust ARG and TIPCC:

Focused Stewardship Area in 16/17	Added Value to the Stewardship Programme	Progress to date
<ul style="list-style-type: none"> Developing information technology to enable electronic antimicrobial prescribing reporting 	<ul style="list-style-type: none"> To improve the efficiency of audit, quality improvement and act as a method for surveillance and epidemiology 	<ul style="list-style-type: none"> Initial work has started exploring Cerner antibiotic prescribing reports.
<ul style="list-style-type: none"> Developing further targeted antimicrobial stewardship rounds 	<ul style="list-style-type: none"> To improve staff engagement and education around appropriate prescribing, building on the already successful models in the Trust. 	<ul style="list-style-type: none"> Antimicrobial stewardship rounds by infections teams (ID/Micro/ Pharm) occur regularly within the organisation.
<ul style="list-style-type: none"> Review carbapenem and piperacillin/ tazobactam consumption 	<ul style="list-style-type: none"> To explore strategies to reduce consumption and utilise other narrow spectrum antimicrobial agents 	<ul style="list-style-type: none"> Weekly pharmacy reporting has commenced A pilot of a carbapenem sparing strategy within elderly medicine A review of where these agents are stocked.
<ul style="list-style-type: none"> Reviewing existing medical and surgical empirical policies to remind prescribers to consider the risks of resistant pathogens 	<ul style="list-style-type: none"> To ensure these policies offer alternatives regimens for resistant organisms 	<ul style="list-style-type: none"> This is scheduled for review in Q4, 2016.
<ul style="list-style-type: none"> To re-establish links around antimicrobial prescribing with primary care colleagues. 	<ul style="list-style-type: none"> To ensure that wider antimicrobial agenda is shared between primary and secondary care 	<ul style="list-style-type: none"> A web based reference source that presents national antimicrobial treatment guidelines for use in primary care has been developed by Imperial College HPRU and ICHNT. Attendance at quarterly IPC + antimicrobial stewardship network meetings. This is chaired by the lead CCG IPC team. CCG medicines management team have been invited to Trust ARG + TIPCC.
<ul style="list-style-type: none"> Exploring the role of the 	<ul style="list-style-type: none"> To ensure that the Trust 	<ul style="list-style-type: none"> Initial meetings regarding how to

nurse in antimicrobial stewardship.	antimicrobial stewardship programme responds to the needs of the nursing staff. <ul style="list-style-type: none"> To ensure expert opinion around the stewardship programme are included. 	engage further nursing staff within the wider AS agenda. <ul style="list-style-type: none"> Two academic nurse fellows have started Imperial College HPRU and are working closely with the Trust AS programme. Invitation to nursing colleagues to come to Trust ARG Nursing Summit around Antimicrobial stewardship planned on 24th January 2017
<ul style="list-style-type: none"> Exploring the role of the patient in antimicrobial stewardship. 	<ul style="list-style-type: none"> To ensure the patient’s voice is included in how the Trust approaches antimicrobial stewardship 	<ul style="list-style-type: none"> Patient experience videos are current in production around antimicrobial stewardship as part of plans for World Antibiotic Awareness Week in November.
<ul style="list-style-type: none"> Consider the recent Antimicrobial NICE Guidance & Quality Standards. 	<ul style="list-style-type: none"> To ensure the Trust stewardship programme is adhering to national best practice 	<ul style="list-style-type: none"> The NICE quality standards have been reviewed.

Table 4: Focused Stewardship Priority areas for 16/17

3 Aseptic Non Touch Technique (ANTT)

- ANTT compliance for the Trust is at 70.8% (5158/7289 clinical staff) (Figure 19). Non-ANTT compliant staff include 978 (13.4% of the total) whose ANTT has lapsed since their assessment >2 years ago, and 1153 (15.8%) who are yet to have an ANTT assessment.
- In order to increase compliance, a number of strategies are being discussed with the Divisions.
- During Q3, 860 clinical staff were assessed, which is an average of 286 per month.

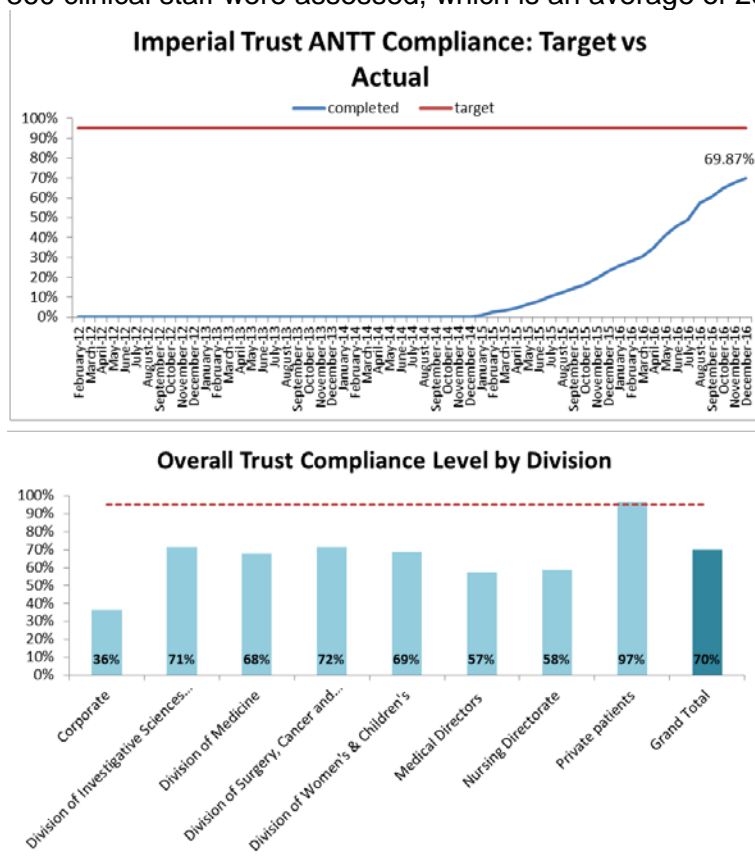


Figure 19: ANTT compliance

4 Hand hygiene

In Q3 FY16/17, an average of 79.7% of clinical areas submitted a total of 14,990 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week). The low rate of compliance is being addressed through the HCAI Taskforce. The average hand hygiene score was 98.4% and bare below the elbow was 98.4%.

We have developed a Hand Hygiene Strategy, which includes a regular audit of hand hygiene facilities, and improvements in the way that hand hygiene is observed and recorded. A successful pilot project was developed to move from observing Moment 1 of WHO hand hygiene Moments to all 5 of the Moments for Hand Hygiene involving 3 wards at one site. Plans to implement this across the Trust are being discussed with the Divisions. An update on the Trust's multimodal approach to improving and sustaining compliance with hand hygiene is provided in Table 5.

Component	Timeline	Progress	Status
Audit of the facilities available for hand hygiene in ward areas			
This audit was undertaken across 79 inpatient ward areas.	Q2 2016/17	Plans for follow up in place with Estates	In progress
Product consumption			
Quarterly analysis of alcohol gel and soap usage by ward to monitor usage and identify trends is under development and will form part of the composite hand hygiene reporting framework.	Q4	Ward-level consumption data obtained as part of the point prevalence survey at CX.	In progress
Compliance with hand hygiene competency assessment			
A monthly review and analysis of hand hygiene competency assessments undertaken as part of the ANTT competency assessment framework by ward level is underway and will form part of the composite hand hygiene reporting framework.	Initial results expected in Q3	Composite scorecard in development	In progress
Observation audit of hand hygiene			
Pilot of 5-moment observational audit at St. Mary's site	Q3	Measure impact of educational intervention	In progress (see above)
Move from 1 to 5 moments of auditing hand hygiene compliance	Q4	Synbiotix audit tool being modified	In progress
Rolling programme of 5-moment hand hygiene observational assessment across the Trust via IPC	Q4		In planning phase
Communication of new hand hygiene strategy including new audit process.	Q4	Initial discussions with the clinical divisions about embedding new observational audit process	Ongoing

Patient engagement			
A review of national and local data on patient experience and feedback relating to all elements of hand hygiene has been explored and next steps include exploring patient engagement and feedback as an indicator.	2017/18	Involving patients in addressing poor hand hygiene practice could further improve compliance	

Table 5: Hand hygiene strategy update.

5 Serious incident investigations

Serious incidents (SIs) reported during Q3 are listed in Table 6.

Steis number	Date reported	Description
2016/27762	14/10/2016	CPE related ward closure
2016/26959	18/12/2016	<i>C. difficile</i> related death
2016/27776	25/10/2016	CPE related ward closure
2016/33337	23/12/2016	VRE cross transmission

Table 6: SIs due to infection-related causes

Themes from these SI investigations:

- Varied level of understanding amongst clinical staff as to the key times that hand hygiene should be undertaken.
- Availability of single use blood pressure cuffs.
- Areas of damage within the ward which make cleaning difficult and are a potential environmental reservoir for bacteria.
- There are inconsistencies with CPE screening compliance on wards.

Actions are being addressed at the ward level, and through the HCAI Taskforce.

6 External visits

An invited peer external antimicrobial stewardship review has taken place within Renal by Paul Wade (Consultant Pharmacist Infectious Diseases at Guy's and St. Thomas' Trust). This review was part of a series of external reviews around the resistant Gram-negative bacteria challenges. The meeting was productive in reviewing processes around antimicrobial management. A full report is pending.

7 Compliance and Policies

- Cleaning audits are performed by Facilities.
- Trust -wide compliance with Infection Prevention and Control Level 1 is 78%, and with Infection Prevention and Control Level 2 is 83%. Areas of low compliance are being addressed with the clinical divisions through the HCAI Taskforce call.

7.1 Policies

In addition to the policies outlined in Section 2.4, policies and guidelines approved during the quarter:

- Respiratory Tuberculosis Infection Prevention and Control Policy.

- Infection Prevention and Control Management of Antibiotic Resistant Organism policy.
- *Clostridium difficile* associated disease: guidelines for the treatment and management of patients.
- Aseptic Non Touch Technique Guidelines.

Policies and guidelines under review during this quarter:

- Peripherally inserted central catheter (PICC) continuing care guidelines.
- Isolation of Patients to Prevent the Transmission of Infection Policy.
- Protective Isolation Policy.
- Peripheral cannula guidelines.
- Hand hygiene technique, PPE and ANTT competency assessment for patient safety policy.

8 Risks

Key risks for IPC include:

- New risk. The Trust is experiencing unprecedented activity levels this winter. This has led to special circumstances being approved by IPC to provide additional short-term bed capacity. This has introduced an accepted increased risk of transmission, which has been reflected on the risk register.
- Ongoing. Microbiology remains unable to provide Trust-wide antibiogram data for key pathogens and in key clinical areas. Discussion are underway with the microbiology laboratory to provide the appropriate antibiotic reporting. On-going. Occupational health service capacity. IPC is supporting the occupational health service in terms of potential outbreak management, influenza vaccination campaign, and establishing the immunization status of staff in the Trust.
- On-going. Challenges within Estates related to responsiveness, ventilation and, water hygiene management. IPC has met with Estates and developed a list of key Estates-related actions outstanding, which Estates are updating regularly. Estates has been asked to provide a monthly report to the HCAI Taskforce group, providing exception reports of areas of concern in terms of water hygiene and ventilation.
- On-going. A limited capacity to perform surveillance of HCAI, specifically related to surgical infections. The Trust is now considering a business case to build an SSI surveillance team.

9 Other issues

9.1 Influenza vaccination

The influenza vaccination campaign has failed to meet the target of 75% of frontline staff being immunised; currently around 30% of frontline staff have been immunised. Occupational health continue to join the weekly HCAI Taskforce call in an attempt to improve uptake of the vaccination.

9.2 Neonatal unit clusters

In mid July 2016, a weekly screening programme was implemented on the neonatal unit for Gram-negative organisms (including *E. coli* and *P. aeruginosa*). As a result of this enhanced screening, probable transmission has been identified (outlined below):

- *P. aeruginosa* transmission has occurred from twins (who were colonised from the mother at birth) to one other baby. This was identified on screening. One of the index cases developed a *Pseudomonas* bacteraemia 21 days post delivery. The secondary case was colonised but had no infection.

- There were two separate clusters of *Klebsiella pneumoniae* transmission during the same period that have similar typing affecting four babies. These four babies were all cared for in the same lower dependency nursery.
- Between November and December 2016, there were two cases of group B *Streptococcus* (GBS) seen as a result of screening. Both babies screened negative at birth, one baby developed a late onset bacteraemia, whilst the second baby remained well. Both of these babies were cared for in the same HDU nursery.

These transmission events have prompted a number of actions:

- Chlorine cleaning has been introduced.
- The number of alcohol gel bottles was increased around the cot spaces; this is audited in conjunction with the hand hygiene weekly audits.
- Use of gel following soap and water hand decontamination due to concerns around *P. aeruginosa* in tap water.
- Hand hygiene training was provided to all staff, with the use of the "glowbox" to assess compliance with technique.
- The number of cots remain at the lower agreed number of 24, with demarcation of the patient area on the floor completed.
- Hand hygiene champions identified and trained.
- Use of sterile water for neonatal skin care and washing of breast pumps.
- Pre-emptive isolation based on previous microbiology results.
- Re-reinforcement of basic IPC practice at handover.

9.3 VRE outbreak

32 cases of VRE have been identified on the ICU wards at CX since October 2016 (Figure 20). This rate is higher than the background level of VRE on the unit, and has included a bloodstream infection and one other clinical specimen. A number of actions are in place on the ward to prevent further transmission, and data in the first three weeks of January 2017 suggests that the number of new cases identified each week is returning towards baseline levels:

- Enhanced chlorine disinfection implemented, and cleaning audit performed.
- Weekly screening for VRE.
- Chlorhexidine bathing for all patients with VRE.
- Regular reinforcement of basic IPC practice.
- Cohorting of patients with VRE, and HPV decontamination of cohort areas when disbanded.
- Evaluation and re-assessment of ANTT.

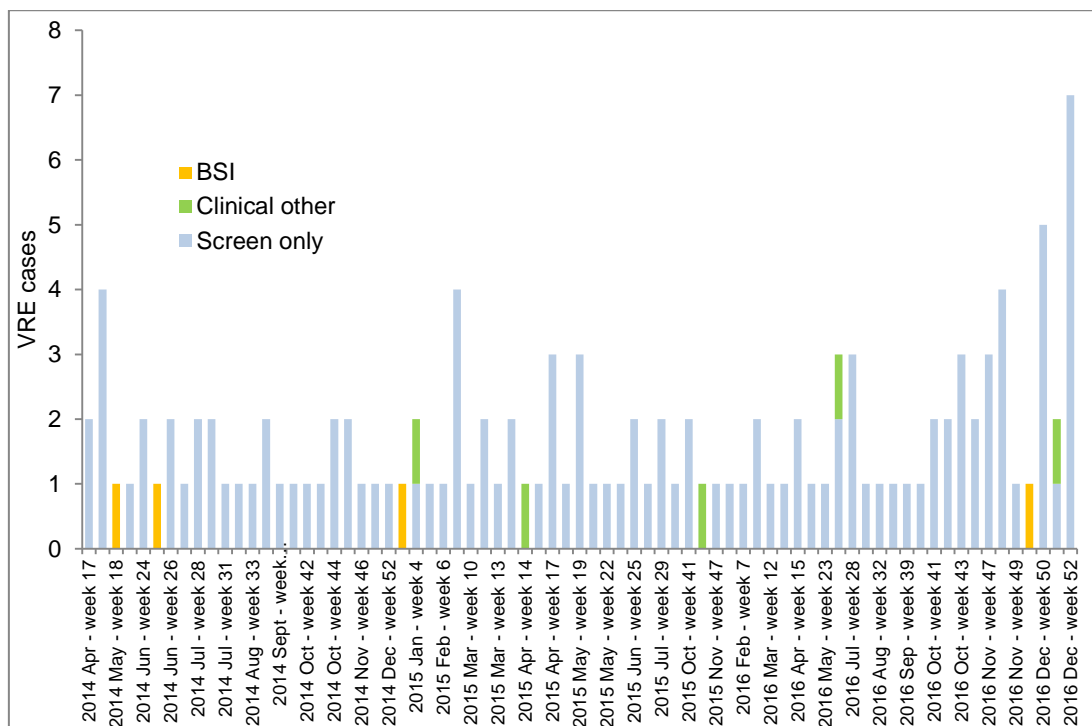


Figure 20: The number of new VRE cases identified by week on the ICU.

9.4 *Mycobacterium species in heater-cooler units: MHRA CAS alert*

There is an emerging global issue related to the use of water heater-cooler units (HCUs) used in cardiothoracic surgery. These HCUs become contaminated with bacteria (especially non-tuberculosis mycobacteria) and can release contaminated aerosols, which have been linked with surgical site infections. The Trust has experienced one surgical site infection possibly related to these devices. The manufacturer and PHE have issued guidance on the optimal management of these HCUs, which the Trust is following. The MHRA issues a CAS alert, which the Trust responded to in the required timeframe outlining the actions that have been taken, which are in line with national guidance. Updated guidance from PHE is expected soon.

9.5 *Candida auris*

A patient with known carriage of *C. auris* was admitted. The patient was an emergency admission who was identified as a *C. auris* carrier promptly in the admissions ward. A number of contacts were generated, who were screened on multiple occasions to confirm a negative carriage status. No secondary cases were identified. The prompt identification of the patient's carriage status, and efficient and careful contract tracing led by ward staff was crucial in preventing secondary cases.

10. Publications in Q3

Rawson TM, Charani E, Moore LS, Herrero P, Baik JS, Philip A, Gilchrist M, Brannigan ET, Georgiou P, Hope W, Holmes AH. Vancomycin therapy in secondary care; investigating factors that impact therapeutic target attainment. *J Infect.* 2016 [Epub ahead of print] PubMed PMID: 28043826.

Rawson TM, Charani E, Moore LS, Hernandez B, Castro-Sánchez E, Herrero P, Georgiou P, Holmes AH. Mapping the decision pathways of acute infection management in secondary care among UK medical physicians: a qualitative study. *BMC Med.* 2016 Dec 12;14(1):208.

Boakes E, Marbach H, Lynham S, Ward M, Edgeworth JD, Otter JA. Comparative analysis of phenol-soluble modulins production and *Galleria mellonella* killing by community-associated and healthcare-associated methicillin-resistant *Staphylococcus aureus* strains. *J Med Microbiol.* 2016 Dec;65(12):1429-1433.

Otter JA, Burgess P, Davies F, Mookerjee S, Singleton J, Gilchrist M, Parsons D, Brannigan ET, Robotham J, Holmes AH. Counting the cost of an outbreak of carbapenemase-producing Enterobacteriaceae: an economic evaluation from a hospital perspective. *Clin Microbiol Infect.* 2016 [Epub ahead of print]

Rawson TM, Moore LS, Hernandez B, Castro-Sanchez E, Charani E, Georgiou P, Ahmad R, Holmes AH. Patient engagement with infection management in secondary care: a qualitative investigation of current experiences. *BMJ Open.* 2016 Oct 31;6(10):e011040.

Castro-Sánchez E, Kyratsis Y, Iwami M, Rawson TM, Holmes AH. Serious electronic games as behavioural change interventions in healthcare-associated infections and infection prevention and control: a scoping review of the literature and future directions. *Antimicrob Resist Infect Control.* 2016 Oct 12;5:34.

Atta M, Brannigan ET, Bain BJ. Cold autoimmune hemolytic anemia secondary to atypical pneumonia. *Am J Hematol.* 2017 Jan;92(1):109. doi: 10.1002/ajh.24550. PubMed PMID: 27597386.

Boyd SE, Charani E, Lyons T, Frost G, Holmes AH. Information provision for antibacterial dosing in the obese patient: a sizeable absence? *J Antimicrob Chemother.* 2016 Dec;71(12):3588-3592.

Otter JA, Dyakova E, Bisnauthsing KN, Querol-Rubiera A, Patel A, Ahanonu C, Tosas August O, Edgeworth JD, Goldenberg SD. Universal hospital admission screening for carbapenemase-producing organisms in a low-prevalence setting. *J Antimicrob Chemother.* 2016 Dec;71(12):3556-3561.

Rawson TM, Butters TP, Moore LS, Castro-Sánchez E, Cooke FJ, Holmes AH. Exploring the coverage of antimicrobial stewardship across UK clinical postgraduate training curricula. *J Antimicrob Chemother.* 2016 Nov;71(11):3284-3292.

McCord J, Prewitt M, Dyakova E, Mookerjee S, Otter JA. Reduction in *Clostridium difficile* infection associated with the introduction of hydrogen peroxide vapour automated room disinfection. *J Hosp Infect.* 2016 Oct;94(2):185-7.

Vella V, Moore LS, Robotham JV, Davies F, Birgand GJ, Otter JA, Brannigan E, Dyakova E, Knight GM, Mookerjee S, Holmes AH. Isolation demand from carbapenemase-producing Enterobacteriaceae screening strategies based on a West London hospital network. *J Hosp Infect.* 2016 Oct;94(2):118-24.

Report to:	Date of meeting
Trust board - public	29 March 2017

Imperial College Healthcare Charity – change of name and update on volunteer programme

Executive summary:

Imperial College Healthcare Charity is changing its name to Imperial Health Charity and introducing a new clearer brand identity. This report will also update the Trust Board on progress on the volunteer service since its transfer from the Trust to the Charity in June 2016.

Quality impact:

The Charity exists to benefit the patients, staff and visitors to Imperial College Healthcare NHS Trust.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:

- 1) Has no financial impact for the Imperial College Healthcare NHS Trust.

Risk impact:

The management of the Volunteer Service by the Charity has been fully risk assessed and terms and conditions agreed by the Joint Planning Group of the Trust and Charity, which currently oversees the work.

Recommendation(s) to the Committee:

The Committee is asked to note the report.

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Ian Lush, Charity Chief Executive	-	22 March 2017

Imperial College Healthcare Charity – change of name, new brand identity and update on volunteer service

1 Change of Name

- Imperial College Healthcare Charity was formed in 2009 following the merger of the charities for St Mary's, Charing Cross and Hammersmith Hospitals.
- It became a fully independent charitable organisation on 1 April 2016.
- Its objects are primarily to support the work of the Imperial College Healthcare NHS Trust, along with other initiatives to benefit the health of the wider community.
- The Charity competes with other NHS charities in London as well as the wider health and social care charitable sector in its fundraising and marketing.
- The name, and in particular the reference to the College, has proved unhelpful in these goals, leading to some confusion and lack of recognition among potential donors, fundraisers and wider stakeholders.
- The Charity's senior team discussed this with the Trust in our regular Joint Planning Group meetings and it was agreed that keeping the link to the Trust, the BRC and the AHSC with the name 'Imperial' was important, but that dropping the name 'College' and simplifying by using 'Health' instead of 'Healthcare' would be advantageous.
- The College had to be approached for permission for the change to take place and this has now been granted.
- During April the Charity will therefore become 'Imperial Health Charity'.

2 New Brand Identity

- This has been the Charity's brand identity since 2011:



- Although featuring attractive colours, the logo itself is inflexible and when used on fundraising material such as t-shirts etc., the only word which stands out is 'Charity'.
- Working with Michelle Dixon (Trust Director of Communications and a Trustee of the Charity) and Caroline Lien (Trustee and former Policy Director of Comic Relief) a small number of agencies were identified to pitch for the work of creating a new brand identity for the Charity, and Premm Design were selected. They have considerable branding experience including for BT, the BBC, the London Stock Exchange and a wide variety of charity and arts organisations.
- The agency has offered a much reduced rate for the work to reflect the fact that we are a health sector charity client.
- Final designs are being selected as this report is being prepared and I will bring some printouts of the new logo to the meeting.

3 Volunteer Service

- The management of the volunteer service across the five hospitals was transferred to the Charity on 1 June 2016.
- The Charity invested £150,000 in the first year to ensure a smooth transition, and is increasing its investment year on year for the next three years.
- The Charity appointed Sam Morris as Head of Volunteering to manage the service, and three members of staff were transferred under the TUPE regulation. One has subsequently left to join another organisation.
- Some consolidation and reorganisation was undertaken in the first four months, following which Sam produced a strategy for 2017-2020. This has now been approved by the Joint Planning Group and the Charity's Board.
- A summary of this ambitious, but we feel achievable, strategy is appended.

Our Plan On A Page: 2017 - 2020

Our vision

An instantly recognisable community of volunteers who are visibly making a positive difference to the experience of all of our patients, visitors and staff.

- Volunteers who feel valued and well supported as part of the team to truly live our values in their roles.
- Staff who understand, work with and support volunteers to help them make a difference for our patients.

What we want to achieve by 2020

550 volunteers involved per year	Achieve the Investing in Volunteers accreditation
Increased satisfaction rate from volunteers	Increased retention of volunteers after one year of starting
Increased recommendation rate from patients who have been supported by volunteers	Teams who involve volunteers gain a quality mark in volunteer management

"It is important for volunteers to have sufficient help and support so that they are clear on how they can help and the boundaries of their role"

"I find it is difficult to ascertain who is volunteering and what for so patients may also struggle and not know who to ask for help"

"[Volunteers] make an amazing contribution and are invaluable to patients and services across the Trust."

"[Volunteers] are here for the patients because they want to be, not because they are being paid so their enthusiasm and interest is always genuine"

"the training as well as clear defined roles is essential to it being a success"

Feedback from NHS Staff about volunteering

The Big Volunteering Survey 2016

Our objectives

Create and develop volunteer roles to improve the patient experience



- Working in partnership with the Trust on areas where improvement and transformation is taking place.
- Develop and deliver training for volunteers to enable them to be more effective.
- Measuring the impact on the patient experience.

Grow the number of volunteers



- Create new roles at different times of the day and week to attract new groups of potential volunteers.
- Help staff understand that the ethos of volunteering is to improve quality, not reduce cost.
- Targeted recruitment activity to reach new audiences.
- Recruitment based on need for the roles identified.

Improve the quality of experience for volunteers and staff



- Streamline our administrative processes to speed up key parts of the volunteer journey in order to provide a higher quality service.
- Overhaul our induction and ongoing training scheme for volunteers to ensure they are warmly welcomed, fully equipped and safe.
- Make it easier for staff to engage volunteers in their work and develop a quality standard to recognise successful teams.
- Listen to volunteers and prospective volunteers to understand their motivations and interests.
- Develop new ways to reward our volunteers so that we can recognise more individuals for their contribution, in ways that are meaningful to them.
- Ensure volunteers are instantly recognisable and approachable within our hospitals.
- Communicate good news stories about our volunteers and the impact they have to both internal and external audiences.
- Bring in previously unknown and outlying volunteering activity within the overall volunteering programme.

Supporting infrastructure

Full time Volunteering Officers at each of the three main hospital sites with full time administrative support to manage all enquiries

Functional CRM system for managing volunteer data and automating key processes

Financial commitment to developing volunteering including reimbursement of out of pocket expenses

Effective relationships and mechanism for prioritising work with relevant Trust senior managers

New policies, processes and resources to support the management of volunteers

premm

IMPERIAL HEALTH CHARITY

Brand development

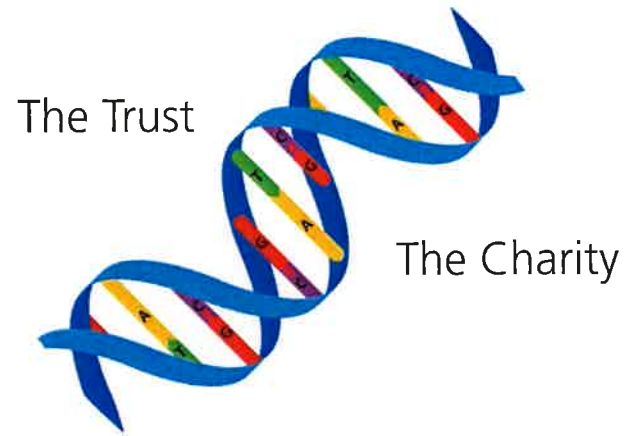
22 March 2017

BRAND CONCEPT

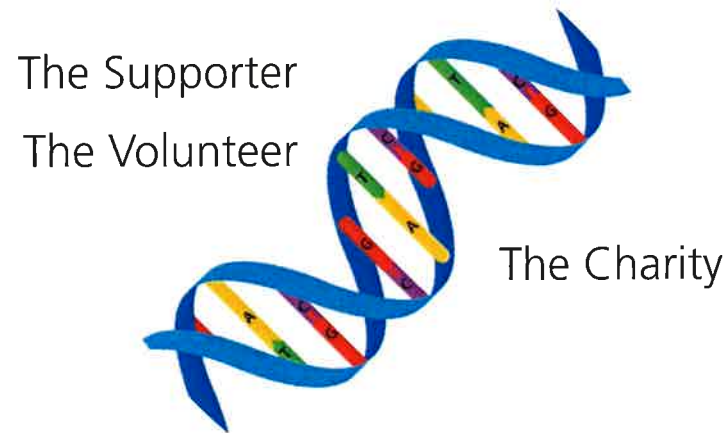
The [DNA] Strand

Stronger with other strands.
Combined strength, together.

DNA by definition is a molecule
that carries the genetic
instructions used in the growth,
development and functioning

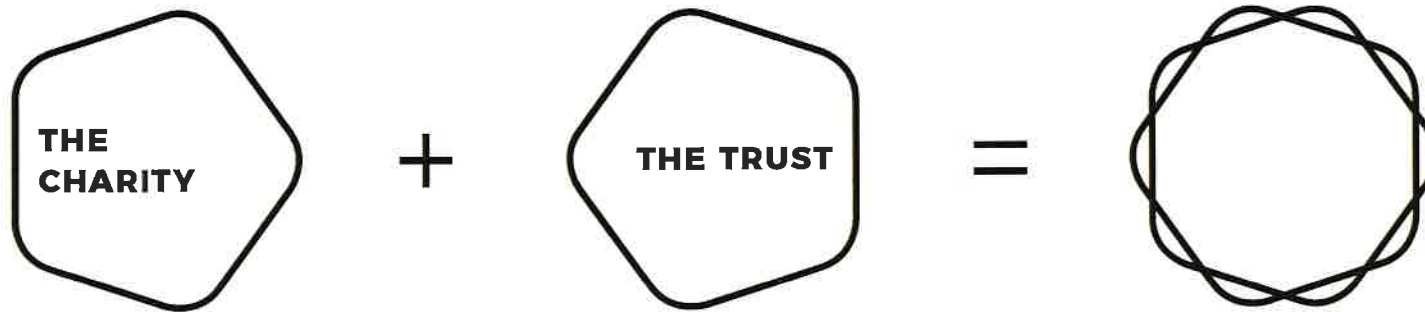


and











HELPING
OUR HOSPITALS
DO MORE

NHS
Imperial College Healthcare
NHS Trust



HELPING
OUR HOSPITALS
DO MORE



HELPING
OUR HOSPITALS
DO MORE

IMPACT REPORT 2016-17



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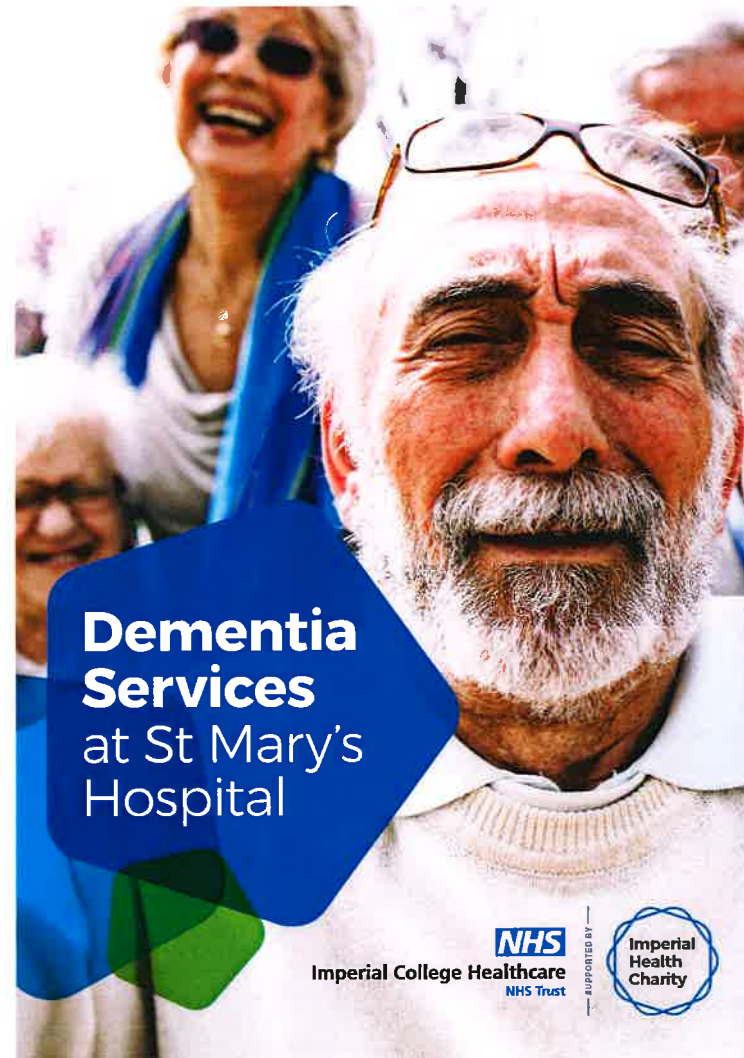
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Imperial College Healthcare
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HELPING OUR HOSPITALS DO MORE

Report to:	Date of meeting
Trust board - public	29 March 2017

Hospital Pharmacy Transformation Plan

Executive summary:

The Carter review of 2016 into operational efficiency¹ identifies how, by 2020 we will ensure that pharmacy resources are being best utilised to release the considerable savings potential within medicines expenditure whilst also improving quality, safety and patient flow.

As described by Carter:

“hospital pharmacy services and the optimisation of medicines are intrinsically interwoven and, from a value perspective, can’t be separated. Simply put, the NHS needs to focus the pharmacy workforce to drive optimal value and outcomes from the £6.7bn it spends on medicines”. p30

A key requirement of the Carter review is the development of a Hospital Pharmacy Transformation Plan (HPTP) outlining how we will address the reviews recommendations by 2020. A copy of our plan is enclosed.

In addition to meeting the requirements of the Carter review, our plan also supports the Trust’s particular objectives to:

- Improve our patient experience and operational performance, in particular in ensuring the best possible alignment of clinical pharmacy staff time with patient and service needs
- Deliver sustainable improvements in patient care, in particular maximising the patient facing role of clinical pharmacy staff and enhancing the safety of prescribing through our ePMA systems
- Lead strategic change, in particular through our collaboration with colleagues across North West London to review infrastructure
- Continue to improve staff experience, recruitment and retention by ensuring we have a clear model for the delivery of clinical pharmacy services, co-developed with staff.
- Build financial sustainability through ensuring maximum economic efficiency in medicines spend

The key aims of our plan are to ensure we:

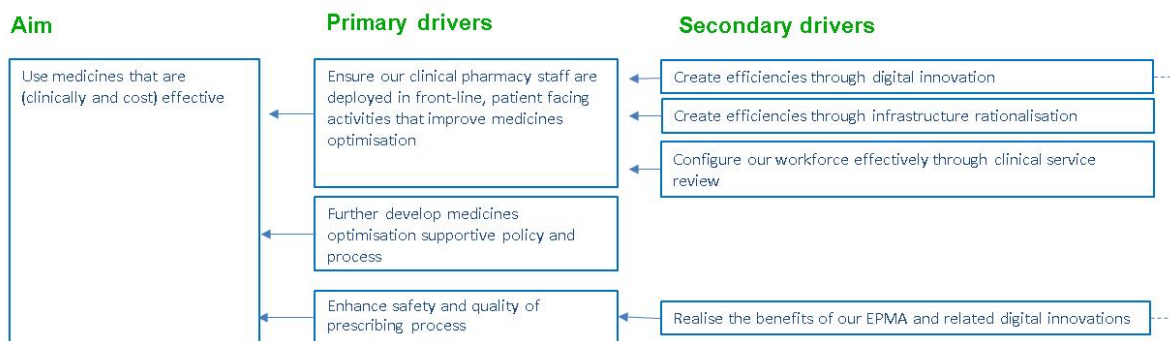
- use medicines that are (clinically and cost) effective;
- ensure our clinical pharmacy staff are deployed in front-line, patient facing activities

¹ Lord Carter of Coles *Operational productivity and performance in NHS Acute hospitals: Unwarranted variation* (February 2016)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

- that improve medicines optimisation;
- create efficiencies through digital solutions and infrastructure rationalisation which can in turn focus resources onto clinical pharmacy service;
- enhance safety and quality of the medicines management process, realising the benefits of our ePMA, whilst ensuring
- that the patient is at the centre of all that we do.

These aims are demonstrated in the diagram below:



In addition to driving medicines spend efficiency by effectively focusing pharmacy resources on medicines optimisation, the plan supports improvements in quality of care and in patient flow, as well as identifying how collaborative working across NWL can support pharmacy teams to deliver the STP. Its delivery utilises the Trust's Global Digital Exemplar strategy and quality strategy to achieve benefits for the whole organisation. Regional collaboration is a key enabler of the programme, to which end a statement of cooperation has been agreed by Chief Pharmacists across all sectors in North West London (annexe A).

The Trust is already in a strong position to deliver the recommendations of the Carter review having some of the key enablers already in place, including an electronic prescribing system, an outsourced outpatient dispensary, an established homecare service, a biosimilar switching programme and an independent prescribing programme.

The plan has used model hospital benchmark data (Carter metrics, including in annexe B²), along with other qualitative and quantitative data to identify four key areas of delivery. The plan focuses on:

- Rationalising our infrastructure; and
- Utilising digital innovation, particularly in the field of electronic prescribing; which will both
- Support clinical workforce optimisation; leading to
- Optimal use of medicines, in particular the use medicines that are (clinically and cost) effective

To support HPTP delivery, an implementation plan has been developed for 2017-18. The plan's delivery will be overseen by the Women's, Children's and Clinical Support Division (WCCS), with TG Teoh (Divisional Director) as the nominated executive lead. The SRO is Ann Mounsey, Chief Pharmacist. Delivery progress will be reported Executive

² Note that the version of the Carter Metrics presented in annexe B is a download of the centrally held data and there are a number of issues with its conclusions in terms of accuracy and timeliness – its inclusion is to show the range of data currently being collated. We continue to work with NHS Improvement on its development.

Transformation Committee and operational links will be maintained with the global digital exemplar programme; the CSIP programme; and the specialty review programme.

As per NHS Improvement recommendation, the plan is being presented to Trust Board in advance of final review and approval by NHSI. Following this we will be launching the strategy formally internally. We would like to thank colleagues from across the pharmacy department, the Trust and the NWL pharmacy community who have contributed to its development.

Quality impact:

A key aim of the HPTP is to maximise the benefits of the clinical pharmacy workforce. Key quality impacts of this and other actions contained within the plan include:

- Safe: ensuring appropriate pharmacy input into prescribing and medicines; supporting benefits realisation of ePMA
- Caring: focusing clinical pharmacy resources on patient facing roles, including counselling and advice to patients on medicines use, adherence/discharge support and in enhanced roles
- Responsive: supporting patient flow within the hospital including pharmacy support for medicines reconciliation and discharge, and ensuring safe and effective medicines distribution nearer the patient
- Effective: supporting medicines optimisation in particular the use medicines that are (clinically and cost) effective
- Well led: ensuring the directorate's operating model is appropriate for supporting a medicines optimisation role

Financial impact:

There are no costs directly associated or outlined within the plan. In fact, the transformation agenda outlined in the plan may require additional investment. This will however be costed on a business case by business case basis, for example additional investment in pharmacy medicines management technicians or the centralisation of Imperial aseptic services. These will be on an 'invest to save' basis.

The Carter report outlines that, £800 million of savings could be achieved from the annual NHS hospital medicines budget of £6.7 billion (and rising at 15% per annum as more complex and specialized medicines enter the market).

The trust pharmacy department has a proven track record of achievement and has already implemented a number of the recommendations in the Carter review which would contribute to the above savings and also be a means of enabling the transformation of our work force.

Across North West London (hospital sectors) the annual expenditure on medicines 2016/17 is in excess of £360m. Approximately 33% of this is within ICHNT (year-end projection of £118.6m). Only 19% of this expenditure however (£22.9m) sits with the Trust – the bulk of our expenditure relates to high cost, highly protocol driven medicines for which costs are passed directly to NHSE or our local commissioners.

ICHT pharmacy have a number of measures already in place which control and reduce medicines expenditure, including:

- Outsourced outpatient dispensary – saved approximately £7m from VAT savings in 2016-17 (after contract costs) split approximately 60:40 with our NHSE commissioners. Savings projections are on a similar trajectory for 17-18 with

additional smaller opportunities to expand scope.

- Homecare services - saved £4.8m from VAT savings in 2016-17. All of these savings are on commissioned medicines and for NHSE, savings currently sit with them (the majority). For those commissioned locally any year on year new savings achieved are risk/gain shared 50:50. We anticipate the value remaining largely unchanged for 2017-18.
- Our specific biosimilar switching programme – saved £1.8m during 2016-17. In an agreement with our local CCG commissioners – 50% of these savings were retained by the Trust. This programme will continue into 2017-18 and we are hopeful that savings next year will be similar to this year as new biosimilars come on board and full year effect.
- Negotiating best price and appropriate medicines substitutions (for the Trust) – saved over £800k during 2016-17 and we anticipate this to be in the same order for 2017/18. In addition in 2017/18 NHSE will be publishing a monthly list of savings initiatives and we look forward to working through these.
- Negotiating best price and appropriate medicines substitutions (for NHSE) – saved over £4 million for our NHSE commissioners during 2016-17. For 2017-19 we anticipate savings of £4.95 million as part of our new QIPP and Medicines Optimisation schemes (CQUIN value to the Trust approximately £2 million over two years).
- A reduction in stock holding as indicated by Carter from our current 21 days to 15 days will yield a one-off saving in the balance sheet (this does however need to be weighed up against the efficiency of the ordering and receipt process).
- Cost avoidance through removing unnecessary, uneconomic or unsafe prescribing – is an on-going role of the pharmacy team, which will be strengthened through greater resourcing of clinical pharmacy services, as highlighted in the Carter review (un-quantified at Trust level).

Risk impact:

The key risks to the delivery of the plan are:

- Trust cost saving programme leads to inability to invest infrastructure savings in clinical pharmacy services, reducing ability to deliver the more significant medicines savings outlined by Carter
- Reliance on other partners in particular the Global Digital Exemplar to deliver key elements of the plan
- Inability to secure additional resources to support sector wide infrastructure development projects and/or NHSE medicines optimisation CQUIN
- Lack of agreement on collaboration with local partners leads to inability to release savings
- Significant changes to arrangement with NHSE regarding outpatients or homecare VAT savings threaten model for infrastructure savings
- Existing different contracts or systems make it more difficult for standardisation/collaboration with external partners leading to inability to collaborate

The most significant risks associated with non-delivery of the plan are:

- Failure to deliver savings in medicines expenditure
- Failure to improve patient flow and length of stay
- Failure to retain staff in pharmacy

Recommendation(s) to the Board

The Board are asked to:




- Endorse the hospital pharmacy transformation plan for submission to NHS Improvement

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Ann Mounsey, Chief Pharmacist Emily Kessler, Associate General Manager, Pharmacy	TG Teoh	22 March 2017

Attachments

Hospital pharmacy transformation plan	 Microsoft Word Document
HPTP Annexe A: statement of cooperation	 Microsoft Word Document
HPTP Annexe B: Carter metrics	 Microsoft Word Document

Hospital Pharmacy Transformation Plan 2017-2020 Imperial College Healthcare NHS Trust

1. Introduction

ICHT Hospital Pharmacy Transformation Plan (HPTP) addresses the recommendations of the Carter review into operational efficiency. It describes how, by 2020, we will ensure pharmacy resources are best utilised to release the considerable savings potential within medicines expenditure, while also improving quality, safety and patient flow.

The key aims of our plan are to ensure we:

- use medicines that are (clinically and cost) effective
- ensure our clinical pharmacy staff are deployed in front-line, patient facing activities that improve medicines optimisation
- create efficiencies through digital solutions and infrastructure rationalisation which can in turn focus resources onto clinical pharmacy service
- enhance safety and quality of the medicines management process, realising the benefits of our electronic Prescription and Medication Administration (ePMA) system

In February 2016, Lord Carter of Coles published his final report 'Operational productivity and performance in English NHS acute hospitals' to the Secretary of State for Health identifying unwarranted variation across all of the main resource areas within the NHS.

Recommendation (3) applies entirely to hospital pharmacy with the report outlining how the NHS could save at least £800 million through transforming hospital pharmacy services to support medicines optimisation. The report states that *"hospital pharmacy services and the optimisation of medicines are intrinsically interwoven and, from a value perspective, can't be separated. Simply put, the NHS needs to focus the pharmacy workforce to drive optimal value and outcomes from the £6.7bn it spends on medicines."*

It recommends that all Trusts publish a HPTP describing how the review's recommendations will be adopted. This means reducing the cost of infrastructure services to reinvest in front line clinical pharmacy services. The HPTP is supported by the publication of the 'Carter Metrics' and Model Hospital Benchmarks.

In addition to supporting the delivery of Carter recommendations, our HPTP also outlines how in the next three years Imperial's hospital pharmacy services will support North West London's sustainability and transformation plan (STP) and the wider aims of Imperial pharmacy services to find new ways of delivering services to drive better use of medicine. In particular this supports

- The Trust's quality strategy
- The Trust's efficiency programme

It is supported by

- The Trust's quality improvement strategy, which will be a key enabler of our process redesign programme
- The Trust's clinical service improvement programme, which will support us to align pharmacy services to clinical need

- The Global Digital Exemplar Programme, through which much of our electronic prescribing and digital innovation agenda will be driven.

There is strong willingness from the pharmacy community across North West London to work collaboratively to achieve the aims of the Carter report and to maximise the benefits of the services. All Chief Pharmacists in the region have committed to closer working and have identified a number of key projects on which we will be working in the immediate future. This is shown in a statement of cooperation included in annexe A.

Delivery of this strategy by 2020 is supported by annual implementation plans. The plan's delivery will be overseen by the Women's, Children's and Clinical support (WCCS) Division, with TG Teoh (Divisional Director) as the nominated executive lead. The SRO is Ann Mounsey, Chief Pharmacist. Delivery progress will be reported to the Executive Transformation Committee and operational links will be maintained with the Global Digital Exemplar programme; the CSIP programme; and the speciality review programme.

2. Current position

The Carter Metrics and Model Hospital have been used, along with other qualitative and quantitative data, to help us identify our current performance and therefore areas of future focus. A copy of the current Carter metrics are included in annexe B.

Our current position is strong, with significant recommendations of the Carter review already implemented. At present the key strengths of pharmacy provision at Imperial are identified as:

- Strong relationship with existing outpatient dispensing partner
- Cerner ePMA already largely rolled out
- Strong pharmacy network within North West London
- Excellent staff engagement scores and other staff KPIs
- Established programme for independent prescribers
- Established network of specialist pharmacists
- Centre for Medication Safety and Service Quality (CMSSQ) brings valuable research component to what we do
- Significant reviews already taken place in key areas in the recent past following hospital mergers e.g. staff rotations; one stock control system; cross-site residency; medicines advisory service consolidation; in-house over-labelling service
- Strength in depth of a generalist workforce
- Existing strong performance in medicines switching, in partnership with commissioners

However a number of weaknesses were identified:

- Slightly above median benchmark for medicines spend compared to peers (London Teaching Trusts)
- Operational challenges created by Cerner implementation / impact on pharmacy time
- Inconsistent use of pharmacy technicians and assistants across services
- No formalised medicines optimisation strategy
- Operational challenges created by hospital capacity levels
- Inconsistent funding model for pharmacy teams across Trust and complex operating model
- Recruitment challenges in key areas

- Low profile of pharmacy across Trust/sector

Our hospital pharmacy transformation plan aims to build on these strengths and address these weaknesses as we move towards 2020, realising benefits for patients, the Trust and the wider health economy by 2020.

3. 2020 Hospital Pharmacy Transformation Plan Summary

Optimising the use of medicines is recognised as a key role undertaken well by pharmacy teams which can lead to better outcomes, improved safety whilst reducing waste and getting consistent, best clinical practice. The Carter report states that Trusts should ensure more clinical pharmacy staff are deployed in front-line, patient-facing activities to improve medicines optimisation. The aim is that 80% of all pharmacists will be working in these roles. The Trust is slightly below 80% for pharmacists however very significantly below for pharmacy technicians and support staff. We aim to reach 80% for pharmacists and significantly increase for all other staff groups by 2020.

To support this there are four key themes of our strategy, with together will deliver these benefits. They are:

- Rationalising our infrastructure; and
- Utilising digital innovation, particularly in the field of electronic prescribing; which will both
- Support clinical workforce optimisation; leading to
- Optimal use of medicines, in particular the use medicines that are (clinically and cost) effective

3.1 Medicines optimisation, in particular the use medicines that are (clinically and cost) effective

The Trust already has a long tradition of achieving medicines savings and ensuring best value on the purchasing of medicines. Existing controls include:

- maintaining a data base of ideas and active saving schemes, which is monitored and owned at executive level within the Trust;
- working cross organisations with the London Pharmacy Procurement programme;
- subscription to Define@;
- joint working with our NWL CCG pharmacist colleagues in relation to locally commissioned high cost medicines started in 2015/16 with the biosimilar programme. This is achieving great results for the Trust and our plan will include this work and similar continuing to mutual benefit.

Plans are in place to:

- Review and formalise our Trust medicines optimisation strategy
- Support the delivery of NHSE's medicines optimisation CQUIN 2017-19
- Continuing price review benchmarking exercises
- Ensure Trust colleagues have the information and support they need to control their drugs spend, including:
 - Support to specialist pharmacist role
 - Better access to transparent medicines spend information
 - Integration with existing Trust cost control mechanisms
 - Support for the imminent NHSI "top ten medicines savings" publications

- Work with our embedded NHS E pharmacist to review process for the coding of high cost medicines
- Further roll out BlueTeq for key areas, working closely with our NWL CCG colleagues on its development for locally commissioned medicines (in particular ophthalmology and rheumatology).

3.2 Clinical workforce optimisation

Our engaged and active workforce is a key strength of the directorate as shown by both internal and external benchmarks. During Year 1 of the HPTP we will be developing a complementary clinical workforce strategy which will identify the most appropriate operating model to best target pharmacy resource into core clinical services, given the changing operating environment presented by the introduction of Cerner ePMA, the development of new roles within the service and the changing needs of patients and clinical colleagues

Specific issues which will be addressed through this and other smaller projects include:

- Skill mix review across sites to support adoption and spread of existing best practice in areas such as availability of ward based technicians – “freeing up” pharmacist time
- Expanding the reach of independent prescribing pharmacists, in the first instance into areas with the largest potential impact on the wider multidisciplinary team, in particular in response to changes to junior doctor’s contracts and other workforce challenges. This will require addressing the rate limited factors of access to funding/courses and ability to release staff to undertake courses.
- Developing a shared vision across the Trust of the role of the Specialist Clinical Pharmacist and appropriate governance structures to support this role
- Ensuring best use from our discharge pharmacy service
- Identifying and agreeing an approach to 7-day working, which is a priority for our local commissioners but challenging to implement and resource
- Continuing the development of the dispensary assistant role
- Expanding the role of consultant pharmacist across a wider footprint
- Reviewing the use of Band 2-3 pharmacy assistants to support areas such as dispensary, aseptics and wards, and to take account of the Trust’s apprenticeship strategy
- Increasing the number of accredited checking technicians and medicines management technicians working at ward level.
- Expanding the use of pharmacists in clinics and other extended roles

Where services start to be shared and developed across acute Trust boundaries then we will work with our counterparts in NWL collaboratively.

3.3 Infrastructure services

We intend to review a number of our infrastructure services in depth to ensure maximum efficiencies and release savings to support our clinical services. Key areas of focus for us are:

- Aseptic services – we will reconfigure services onto one site and look to develop a longer term solutions with colleagues across NWL
- Supply chain– to identify solutions shared with colleagues across NWL to deliver greater efficiencies through the use of direct-to-ward deliveries
- Maximise the benefit of our commercial out-patient partner (Celesio) and further develop the local dispensing local delivery concept and other initiatives including patient compliance aids, medical devices and homecare (the latter in conjunction with NHS England)

- Push forward with digital systems integration to support direct efficiencies and greater transparency in medicines distribution, including
 - Buying office functionality with e-procurement and e-invoicing
 - Ensuring dm+d compliance
- Consolidation of medicines stock holding and rationalisation of deliveries
 - In light of Carter recommendations, reduce stockholding to 15 days and reduce the number of daily deliveries to five per site by 2020
 - Review the JAC stock algorithms to set a gradual review of stock holding and deliveries continuing our strategy of focusing medicines supply as close to the patient as possible to aid patient flow, including use of satellite dispensaries and review of ward stock holding including use of electronic cabinets
- Work will colleagues across NWL to develop approaches to waste reduction

3.4 Digital innovation, including Electronic Prescribing and Medicines Administration Systems

Electronic prescribing and medicines administration (ePMA) play an important role in enhancing the safety and quality of the prescribing process and it is a Carter requirement to implement an ePMA. Imperial introduced ePMA in 2015/16 and a core aim over the next period is to realise the benefits of this, in partnership with our colleagues at Chelsea and Westminster NHS Foundation Trust under our Global Digital Exemplar programme.

As of March 16th 2017, all wards (except one intensive care unit) are now live for ePMA. The main system in use is Cerner Millennium however there are pockets of other systems; ARIA (oncology), Medisoft (ophthalmology) and ICIP (intensive care). Discharge prescribing is still on the EDC system however Cerner Hospital Wide Discharge is currently being piloted.

Short to medium term objectives are to:

- consolidate the recent roll out of ePMA to paediatrics;
- roll out Cerner Hospital Wide Discharge (HWD) to replace EDC;
- explore and develop the reporting and audit functionality;
- work with C&W NHSFT on the shared system;
- further development the system and roll out, including sepsis and anaesthesia modules;
- explore system integration and interfacing e.g. JAC pharmacy medicines management; system, and
- review 'end to end, closed loop functionality' that ePMA systems support.

We will continue to work with the Centre for Medicines Safety and Service Quality on research studies involving ePMA systems and will continue to publish and disseminate our findings widely.

4. Risks and Issues

The following key risks have been identified to the delivery of the HPTP:

- Trust cost saving programme leads to inability to invest infrastructure savings in clinical pharmacy services, reducing ability to deliver the more significant medicines savings outlined by Carter
- Differing priorities between HPTP, Trust and Commissioners leads to lack of direction

- Significant changes to arrangement with NHSE regarding outpatients VAT service threaten model for infrastructure savings
- Inability to secure additional resources to support sector wide infrastructure development projects and/or medicines optimisation CQUIN
- Reliance on other partners in particular the Global Digital Exemplar to deliver key elements of the plan
- Lack of agreement on collaboration with local partners leads to inability to release savings. Existing different contracts or systems make it more difficult for standardisation/collaboration with external partners leading to inability to collaborate.

The following issues have been identified to the delivery of the HTPT:

- **Lack of shared IT platform with partners**
 - The recent agreement with C&W NHSFT is the start of addressing this issue.
- **Lack of capacity to deliver challenging change agenda**
 - We have identified a number of shared work streams and themes with colleagues from around the Trust for mutual delivery support
- **Lack of control over external organisational collaboration** for example JAC/Cerner interfaces
 - We will attempt to work with partners to leverage engagement at scale.
- **Multisite organisation with associated legacy infrastructure systems and processes** requiring on-going standardisation e.g. different prescribing system for oncology and rest of organisation
 - We will continue to highlight these issues and use existing Trust structures to reach solution
- **Current staffing model not facilitating increased % of independent prescribers**
 - To be reviewed as part of workforce strategy.
- **Current recruitment problems**
 - This will be looked into as part of our workforce strategy. Some of the issues will resolve automatically in time as more places adopt ePMA.

5. Implementation

Imperial start the three year period of hospital pharmacy transformation in a strong place. With many of the key Carter recommendation initiatives already in place, and with strong partnerships with pharmacy colleagues across the sector, with our outsourced dispensing partners and with our Global Digital Exemplar status we are now in a position to realise the benefits of a strong clinical pharmacy service in terms of patient safety, experience and medicines optimisation.

Our workforce are our key asset and supporting and developing them to provide the best possible medicines optimisation service to the Trust, utilising resources released by increased infrastructure efficiency, is our priority for the next three years. We believe we have developed a realistic and credible plan to achieve this including the development of annual implementation plans and links through to Trust wide transformation initiatives via the Trust's executive transformation committee. We look forward to updating the relevant partners on progress on a regular basis.

By separate attachment:

- Annexe A: Statement of co-operation between NWL Chief Pharmacists
- Annexe B: Carter metrics as 21.02.2017

Annexe B: NWL Hospital Pharmacy Transformation Plans – Joint Statement of Co-operation by North West London Pharmacy teams

The vision of the North West London Sustainability and Transformation Plan¹ (STP) is that everyone living, working and visiting here has the opportunity to **be well and live well**, to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country. Medicines are a key intervention to improve health and well-being but they consume a large proportion of the NHS non-pay budget within the sector. It is therefore important that the NWL STP is supported by a programme to optimise the use of medicines in order to improve outcomes and patient/carer experience, while reducing waste and costs along the entire patient pathway.

NWL sector hospital and CCG lead pharmacists are committed to delivering the aims of the STP through a joint medicines optimisation vision. Hospital Chief Pharmacists will build on a strong track record of co-operation to ensure delivery of safe, high quality and sustainable hospital pharmacy services.

Collaborative working by lead pharmacists, through the *North West London Medicines Optimisation Pharmacy Network*, is already well established in our region. The Imperial College Health Partners *Medicines Optimisation Roadshow* in March 2015 was the first of 15 national events that showcased local medicines research, best practice case studies and our commitment to a medicines optimisation strategy.

The network recognises that in the future, there are a number of areas where greater collaboration to release greater efficiencies is possible. First wave projects, where we are already establishing working groups to scope opportunities, include:

- Medicines manufacturing and aseptic preparation
- Homecare (in collaboration with London Procurement Partnership)
- Ward stock distribution
- Waste reduction

Future areas of joint work are likely to include procurement best practice; reducing unwarranted variation in expenditure; anti-infective stewardship; partnership working with primary care and community pharmacists to improve/support the increasing number of frail elderly in the community and new/expanded workforce roles, including adoption of apprenticeships.

There are also areas of common interest where the system as a whole can benefit from co-ordination and expertise sharing, including service centralisation, development of outsourcing arrangements, e-prescribing and use of medicines safety cabinets.

On an operational level, the group will continue to share good practice and innovation and strive for shared-approaches to issues of policy and delivery wherever practical and desirable. We look forward to continuing to work together to deliver pharmacy services into 2020 and beyond.

Deirdre Linnard, Chair of the North West London Medicines Optimisation Pharmacy Network

On behalf of

- Chief Pharmacists for North West London Acute, Community, Mental Health and Specialist Trusts
- NWL CCG Lead Pharmacists

¹ <https://www.healthnorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps/stp-october-submission-2016> p33

Annexe B Carter Metrics

Note that the version of the Carter Metrics presented in annexe B is a download of the centrally held data and there are a number of issues with its conclusions in terms of accuracy and timeliness – its inclusion is to show the range of data currently being collated. We continue to work with NHS Improvement on its development.

Imperial College Healthcare NHS Trust (RY) Pharmacy & Medicines, Trust Level

Category	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Money & Resources							
Pharmacy Staff & Medicines Cost per WAU	2015/16	£491	£474	£350			No trendline available
Medicines Cost per WAU	2015/16	£452	£433	£312			No trendline available
High Cost Medicines per WAU	2015/16	£237	£214	£112			No trendline available
Non High Cost Medicines per WAU	2015/16	£215	£206	£196			No trendline available
Choice of Paracetamol Formulations [% IV Paracetamol vs Total Spend]	2015/16	69%	59%	56%			No trendline available
Use of Generic Immunosuppressants [% Generic vs Total Spend (Selected Drugs)]	2016	80%	88%	60%			No trendline available
Use of Inhalation Anaesthetics - % Spend on Sevoflurane	2015/16	64%	66%	66%			No trendline available
Safe							
Total Antibiotic Consumption in DDD*/1,000 Admissions	2013/14	5,852	6,696	4,337			No trendline available
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Jun 2016	8.85%	6.41%	8.85%			
% ePrescribing Chemotherapy	2014/15	100%	100%	50%			No trendline available
% ePrescribing IP	2015/16	80%	60%	50%			No trendline available
% ePrescribing OP	2014/15	80%	20%	50%			No trendline available
% ePrescribing Discharge	2014/15	80%	100%	60%			No trendline available
Effective							
Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities]	2015/16	70%	76%	67%			No trendline available
% Pharmacists Actively Prescribing	2015/16	23%	12%	20%			No trendline available
% Medicines Reconciliation Within 24 Hours of Admission	2015/16	40%	78%	73%			
% Use of Summary Care Record (or Local System) per Month	Aug 2016	69.5%	51.8%	52.1%			
% Soluble Prednisolone of Total Prednisolone Uptake	Sep 2016	0.4%	2.2%	3.4%			
% Biosimilar Infliximab Uptake (Monthly)	Sep 2016	86.9%	71.6%	68.3%			
% Biosimilar Etanercept Uptake (Monthly)	Aug 2016	8.6%	17.0%	17.0%			
Total Spend on Etanercept in 2015/16	2015/16	£3.0m	£1.9m	£1.1m			No trendline available
Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands]	2015/16	0%	15%	42%			No trendline available
Number of Medication Incidents Reported to NRLS per 100,000 FCEs of Hospital Care	Mar 2016	279.4	277.9	285.6			
% Medication Incidents Reported as Causing Harm or Death/All Medication Errors	Mar 2016	11.8%	10.0%	9.7%			No trendline available
Number of Days Stockholding	2015/16	20.7	17.0	18.8			No trendline available
Pharmacy Deliveries per Day [Average Number of Deliveries]	2015/16	14	18	15			No trendline available
e-Commerce - Ordering (Alliance)	2015/16	91.0%	89.4%	90.4%			No trendline available
e-Commerce - Ordering (AAH)	2015/16	89.0%	76.6%	82.0%			No trendline available

	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Effective							
Data Quality of NHS England Monthly Data Set Submissions From Providers	Nov 2016	22	20	20			
Caring							
National Inpatients Survey - Medicines Related Questions	2015/16	77.3%	76.1%	73.1%			
Responsive							
Sunday ON WARD Clinical Pharmacy Hours of Service (MAU/Equivalent)	2015/16	5.5	8.2	7.0			
People, Management & Culture: Well-led							
% Sickness Absence Rate	2015/16	2.5%	3.0%	3.1%			
% Staff with Appraisals Completed	2015/16	100%	80%	85%			
% Staff with Statutory and Mandatory Training	2015/16	90%	84%	91%			
% Staff Turnover Rate	2015/16	11%	20%	14%			
% Staff Vacancy Rate	2015/16	6%	4%	6%			No trendline available

Report to:	Date of meeting
Trust board - public	29 March 2017
CQC Quarterly Update: Quarter 3, 2016/17	
Executive summary:	
<p>The following paper is split into two parts:</p> <p><u>PART 1: 2016/17 Quarter 3 update in relation to the Trust's CQC registration</u></p> <p>During quarter 3 (Q3), 2016/17:</p> <ul style="list-style-type: none"> • The Trust made 23 applications under the deprivation of liberties safeguards. • No patients died whilst being detained by the Trust under the Mental Health Act 1983. • No certified treatment was sought or delivered for Trust patients. • The CQC requested the Trust investigate four concerns raised with them. • An inspection of the core service of <i>Outpatients and diagnostic imaging</i> at the Trust took place in November 2016. • On 7 March 2017, the CQC arrived unannounced to carry out inspections of Maternity at St Mary's Hospital, and the core service of Medical care at St Mary's, Charing Cross and Hammersmith hospitals. <ul style="list-style-type: none"> ○ These were 'responsive' inspections. Maternity at St Mary's Hospital was previously rated as 'Good' in all five CQC domains and overall. However, concerns about the Trust's management of one serious incident had been raised with the CQC and the CQC wanted to check the service was still meeting its 'Good' ratings. ○ Medical care across the Trust was previously rated overall as 'Requires improvement' by the CQC. The CQC had recently had concerns raised with them about care and discharge arrangements. In line with the normal CQC inspection process, the Trust will receive inspection reports in due course which set out the full findings from these inspections. ○ Following the inspection no immediate serious concerns were identified. <p><u>PART 2: Changes to the CQC's Regulatory Framework for NHS Trusts and Implications for Imperial</u></p> <p>The CQC is making changes to its regulatory framework for NHS acute trusts which will take effect from 1 April 2017. Key proposed changes which are expected to impact the Trust include:</p> <ul style="list-style-type: none"> • A return to primarily unannounced inspections. • A return to an annual provider submission (this was last required in 2013/14). • At least one inspection each year which includes, at a minimum, an assessment of leadership at trust level and at least one core service. • The introduction of an assessment of resource management to its inspection framework. <p>The Trust's 2017/18 <i>Improvement and Assurance Framework</i> is being adapted to reflect these changes.</p>	
Quality impact:	
The report applies to all five CQC domains.	
Financial impact:	
This paper has no financial impact at present	
Risk impact:	

This paper relates to the following risks on the corporate risk register:

- **Risk 81:** *Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target*
- **Risk 87:** *Failure to deliver outpatient improvement plan*

Recommendation(s) to the Committee:

To note the paper

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion

Authors	Responsible executive director	Date submitted
Guy Young, Deputy Director of Patient Experience Kara Firth, Regulation Manager	Janice Sigsworth, Director of Nursing	9 March 2017

Part 1: CQC Quarterly Update: Quarter 3, 2016/17

1. Purpose

The following report is the regular quarterly report to this Committee providing an update in relation to the Trust's CQC registration. This report covers quarter 3 (Q3) of 2016/17.

2. Registration Status

The Trust continues to be registered at all sites without any conditions.

3. Notifications made to the CQC

3.1. Mental health notifications

- The Trust made 23 applications under the deprivation of liberties safeguards.
- No patients died whilst being detained by the Trust under the Mental Health Act 1983.
- No certified treatment was sought or delivered for Trust patients.

4. Concerns and complaints raised by the CQC

The CQC asked the Trust to investigate four concerns and complaints which were raised with them about the Trust in Q3, and the Trust responded to the CQC as requested. No whistleblowing alerts were made to the CQC about the Trust in Q3.

5. CQC Inspections and Reviews

5.1. Inspections

5.1.1. Outpatients and diagnostic imaging at the Trust

The core service of *Outpatients and diagnostic imaging* was inspected in November 2016 at St Mary's, Charing Cross and Hammersmith hospitals. Areas visited included main outpatients and devolved services which are managed divisionally. Imperial Private Healthcare was not included in the inspection.

High level feedback given by the CQC at the end of the site visit did not raise any immediate or serious concerns; however, the full findings from the inspection will not be known until the inspection reports are received. The reports could arrive any time from approximately mid-March to May 2017 (the CQC has recently been publishing inspection findings between four and six months following inspections).

5.1.2. DHL – Patient Transport Services

The Trust's sub-contractor for patient transport, DHL, was inspected by the CQC in February 2017. While this was not an inspection of the Trust, the Trust will need to take account of the inspection findings if concerns are raised about the service DHL is providing to its patients. DHL's inspection reports are expected to be published between June and August 2017.

5.1.3. Unannounced Inspections of Maternity and Medical care in Q4

On 7 March 2017, the CQC arrived unannounced to carry out 'responsive' inspections of Maternity at St Mary's Hospital, and the core service of Medical care at St Mary's, Charing Cross and Hammersmith hospitals.

- Maternity was previously rated as 'Good' in all five CQC domains and overall. However, concerns about the Trust's management of one serious incident had been raised with the CQC and the inspection aimed to check if the service was still meeting the 'Good' ratings.
- Medical care across the Trust was previously rated overall as 'Requires improvement'. The CQC had recently had concerns raised with them about care and discharge arrangements.

In line with the normal CQC inspection process, the Trust will receive inspection reports in due course which set out the full findings from these inspections. Following the inspection no immediate or serious concerns were raised.

5.2. National and Themed CQC Reviews

The Trust did not participate in any national or thematic reviews carried out by the CQC during Q3.

Recommendations to the board

To note the paper.

END OF PART 1

Part 2: Changes to the CQC's Regulatory Framework for NHS Trusts and Implications for Imperial

1. Purpose

This paper presents proposed changes to the CQC's regulatory framework for NHS acute trusts, due to take effect from 1 April 2017, and the implications for the Trust.

2. Background

The CQC's previous regulatory strategy for NHS trusts concluded in March 2016. In May 2016, the CQC published a high level strategy which set out how it would change its approach to regulation for 2016-2021. In December 2016, the CQC launched a consultation on the proposed changes to its regulatory framework. Some changes may be made as a result of responses to the consultation; however, major changes to the main components of the framework are not expected. Changes needed to the Trust's *Improvement and Assurance Framework* are now being considered.

3. What's Not Changing

The regulatory framework will still include the following components:

- Inspections will continue to be prioritised based on risk, i.e. that patients are either being harmed or are at risk of harm based on the CQC's safety and quality standards not being met.
 - Assessments of risk will be informed in part by what was previously called 'intelligent monitoring'; this is now called 'CQC insight' and refers to a wide range of data and information that the CQC continuously monitors.
 - The CQC previously published its monitoring reports for trusts, but there has been no indication that 'insight' reports will be published or otherwise accessible to trusts.
 - Routine / planned inspections will be carried out; however these will become unannounced
 - Responsive inspections will be carried out when concerns have been identified via the CQC's 'insight'.
- Inspection methodology will continue to:
 - Be based on the five domains (Safe, Effective, Caring, Responsive and Well-led).
 - Be organised by core service.
 - Follow standardised key lines of enquiry in order to assess how trusts are performing against the five domains.
 - Include the award of ratings (inadequate, requires improvement, good and outstanding) based on performance, in line with the existing approach to ratings.
- Progressive enforcement will be used to take action against trusts in response to inspection findings.

4. Key Changes with Implications for the Trust

4.1. Provider Information Return

Once each financial year, the Trust will be required to submit to the CQC a 'provider information return' (PIR) which summarises recent and current performance in key areas.

- The PIR is described in the CQC's consultation document as an online tool.
- A proposed format has not been published, so we do not yet know if the PIR will be organised for the trust as a whole, or by core service.
- Regardless of how the tool is organised, a single submission will be required for each trust (i.e. we know that services won't make separate submissions).
- There has been no indication whether evidence will be need to be submitted as part of the PIR.

Each trust will receive a written request to submit its PIR by a set deadline.

4.2. Inspection scheduling

Once each year, the CQC will review its ‘insight’ (see section 3 above) about the Trust and will use this to develop an annual inspection plan for the Trust. The plan will include at least one inspection each financial year and will include, at a minimum:

- An assessment of the Well-led domain at Trust level (i.e. this is not well-led within individual services), **and**
- A full inspection across all five domains of at least one core service.

Inspection scheduling for unannounced inspections will be risk-based as set out above. Inspections may also be carried out where there is ‘insight’ which suggests that significant improvement has been made and an improved rating may be warranted. Additionally, the CQC may inspect a core service which was rated overall as ‘Good’ or ‘Outstanding’, in order to ensure the level of performance has been maintained. Maximum intervals between core service inspections are proposed to be as follows:

- One year where the overall rating is ‘Inadequate’.
- Two years where the overall rating is ‘Requires improvement’.
- Three and a half years where the overall rating is ‘Good’.
- Five years where the overall rating is ‘Outstanding’.

The approach to inspecting the Well-led domain at trust level will be piloted in collaboration NHS Improvement before it is rolled out across all Trusts.

4.3. Inspections of core services will be unannounced

In order to ensure that interviews can be organised with key people, the annual inspection of the Well-led domain at trust level will be announced, although we do not yet know how far in advance of the site visit this will be. There will be no pre-inspection PIR submission as there is now for announced inspections, however, as the new annual PIR will be used.

Inspections of core services will always be unannounced. Requests for data and information will be expected following a visit to inspect a core service.

5 Inspection methodology

5.1 Splitting of two existing core services

Core services are the same for all NHS acute trusts, where they are offered. The current 10 core services are being split into 12: ‘Maternity and gynaecology’ and ‘Outpatients and diagnostic imaging’ are being split. For the Trust, this means these two core services will become four: Maternity, Gynaecology, Outpatients, and Diagnostic imaging, and will have separate inspections. The Trust currently delivers nine of the core services; this will increase to 11 in April 2017 following the split.

Core services tend to cross the Trust’s divisions and Imperial Private Healthcare.

5.2 Changes to the key lines of enquiry

Whether a service or trust is meeting the safety and quality standards relating to a particular CQC domain is determined by following key lines of enquiry (KLOEs) during inspections. The CQC has proposed a new set of generic KLOEs which move some existing KLOEs around the domains and / or have some minor changes to wording.

Additionally, new KLOEs have been introduced which cover certain aspects of care in greater detail, for example there are now KLOEs specific for medicines management, recruitment process, end of life care,

which will be asked during inspections of every core service (note, however, that 'end of life care' remains a standalone core service as well).

KLOEs for the Well-led domain have been a particular focus; the revised set has been agreed jointly between the CQC and NHS Improvement. Both organisations will use these KLOEs to assess the domain for the purpose of their individual remits.

5.3 Assessment of the Trust's use of resources

NHS Improvement is working with the CQC to develop an assessment tool and approach to rating how NHS acute trusts make use of resources. The purpose of the joint working is to align NHS Improvement's assessment with the CQC's approach to assessing the Well-led domain, as the use of resources is considered to be strongly linked to leadership.

Assessments will be carried out by NHS Improvement (NHSI) wholly separate from CQC inspections; however, during its inspections the CQC will take account of these findings and the associated rating recommended by NHSI (using the CQC's four ratings categories). Assessments are expected to cover four themes, using financial and productivity metrics:

- Finance: How effectively is the trust managing its financial resources?
- Clinical services: How well is the trust maximising patient benefit, given its resources?
- People: How effectively is the trust using its workforce to maximise patient benefit?
- Operational: How well is the trust maximising its operational productivity?

The assessment of use of resources is related to, but separate from, the existing Single Oversight Framework. The final version of the tool is expected to be published by April 2017 and will be piloted during 2017/18. There is no action for the Trust to take at present in relation to this.

6. Changes to the Trust's *Improvement and Assurance Framework*

The Trust will assume a continuous state of 'inspection readiness' in order to respond to the routine of inspections being unannounced. This will be achieved by putting in place a standardised and robust manner for gaining assurance that services continuously meet the CQC's safety and quality standards, and to effectively manage unannounced CQC inspections.

- Directorate triumvirates (clinical lead / directors, lead nurse and general managers) will act as leads of Trust's core services.
- Divisional triumvirates (divisional directors, directors of nursing and directors of operations) will ensure their division have a rolling programme of self-assessments / reviews against the CQC standards and domains across their core services, and will produce a quarterly report for this committee to provide assurance about CQC readiness among their core services.
- In addition to continue its current functions relating to the Trust's CQC registration, the Trust's CQC team, will
 - Facilitate a regular forum which brings core service leads together to review readiness activities and performance, with a view to identifying key risks and the action needed to address them.
 - Providing a CQC link between activities relating to CQC readiness, such as the forum for core service leads, and existing quality and safety mechanisms, for example with its existing presence at the Quality and Safety Sub-Group.

7. Next steps

- The detail of the Trust's 2017/18 *Improvement and Assurance Framework* will be developed as far as possible pending publication of the CQC's final version of its regulatory approach.
- The final CQC framework and the Trust's *Improvement and Assurance Framework* for 2017/18 are expected to be reported to the Trust's committees and the Trust board in May 2017.

Recommendations the board

To note the paper.

END OF PART 2

Report to:	Date of meeting
Trust board - public	29 March 2017

NHS Mandate March 2017

Executive summary:

This paper provides a summary of the key points in the NHS Mandate 2017. It includes the objectives for NHS England, the deliverables for 2017/18 and draws attention to those with the greatest relevance to the Trust.

Quality impact:

NHS England's objectives include a continuing commitment to improving quality, safety and accessibility of services.

Financial impact:

No direct impact.

Risk impact:

No direct impact.

Recommendation to the Committee:

The Committee is asked to note the update.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Anne Mottram Director of Strategy	Dr Tracey Batten Chief Executive	22 March 2016

NHS Mandate March 2017

1. Introduction

The government's mandate to NHS England sets out the direction for the NHS, and helps to ensure that the NHS is accountable to Parliament and the public.

Building on the previous multi-year mandate, which came into effect on 1 April 2016 and set long term objectives and goals to 2020, this new annual mandate focuses on the same seven high-level objectives. It sets out the key deliverables in each area for 2017/18 in order to achieve the 2020 goals.

The mandate includes financial directions.

2. NHS England's Seven Objectives

1. Through better commissioning, improve local and national health outcomes, and reduce health inequalities (this also includes supporting the delivery of agreed Sustainability and Transformation Plan (STP) actions)

2. To help create the safest, highest quality health and care service

3. To balance the NHS budget and improve efficiency and productivity

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives

5. To maintain and improve performance against core standards

6. To improve out-of-hospital care

7. To support research, innovation and growth

3. Assessing NHS England's Performance: Deliverables 2017/18

A detailed list of deliverables for each of the seven objectives is provided *in annex 1 of appendix 1*. Several of these have great importance to the Trust and map to themes in our corporate objectives including:

- A commitment to delivering the NHS Constitution standards
- Making progress against STP metrics
- Moving towards Care Quality Commission (CQC) good or beyond
- Implementation of the Maternity Transformation Programme, including the Saving Babies' Lives care bundle
- Developing an implementation plan for taking forward the recommendations set out in the Government's response to the end-of-life care Choice Review
- Taking forward the Government's commitment to recover up to £500m from overseas chargeable patients
- Implementing the A&E recovery plan and deliver aggregate A&E performance above 90% in September 2017
- Supporting 100,000 people to reduce their risk of diabetes through the NHS Diabetes Prevention Programme
- Taking steps to better manage demand in acute services through implementation of programmes including New Care Models, Right Care and Self Care, to achieve 20% coverage of the population by the New Care Model that can be replicated across the country
- Achieve accelerated implementation of health and social care integration, including sharing electronic health records and making progress towards integrated assessment and provision,
- Developing with Genomics England, the approach to begin to embed genomics into routine care.

4. NHS Budget

To support overall financial balance in the NHS, £1.8bn of NHS England's budget for 2017/18 will be allocated through the Sustainability and Transformation Fund (STF) to support providers, in particular emergency services, payable through commissioning or as other support.

NHS England's indicative revenue and capital budgets for each year of the Parliament were also set out in the mandate for 2017/18. This is a total revenue budget of £109,960m and £260m capital budget. Further information is presented in the financial directions available here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600613/Financial_Directions_to_NHS_E_2017-18.pdf



Department
of Health

The Government's mandate to NHS England for 2017-18

March 2017

The Government's mandate to NHS England for 2017-18

A mandate from the Government to NHS England:
April 2017 to March 2018

Presented to Parliament pursuant to Section 13A(1) of the National Health Service Act 2006

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Foreword

The NHS has a unique place at the heart of our society and is – by some distance – the institution that makes us most proud to be British.

It is because of this that the 2017-18 mandate to NHS England goes further than ever before to ensure that we not only deliver the best care and support to today's NHS patients, but also deliver the reform and renewal needed to sustain the NHS for the future.

There is widespread recognition that the NHS has been under sustained pressure for a number of years. Since 2010, the number of people over 80 has risen by 340,000 and life expectancy is up by twelve months. Demand is unprecedented: every day, the NHS undertakes 5,000 more operations, looks after 1,400 more mental health patients and treats 130 more cancer patients than it did just six years ago.

And yet despite these pressures, the NHS approaches its 70th year delivering outstanding care and with record levels of public support. Research shows that we feel safer in NHS hospitals and that patients are treated with more dignity and respect than ever before. The NHS continues to be rated as one of the best health services in the world, with some of the fastest improvements in Europe for stroke care and heart disease prevention and with cancer survival rates at a record high. All of this is testament to the diligence, professionalism and expertise of the NHS's 1.3 million staff, who go above and beyond to deliver outstanding care for patients, each and every day, across the country.

And yet we know that there is more to do, which is why, at the heart of this mandate, is a commitment by the Government to support the NHS's own reform programme. We have backed this with a real terms increase in NHS funding every year of this Parliament, which will transform the service for the years to come.

To drive this transformation, 2017-18 should be the year in which we see concrete progress on local Sustainability and Transformation Plans, with NHS England supporting local leaders to work with their communities to drive real improvements in patient care and outcomes. As part of this effort, the Government has already made £325 million of capital funding available for the best STPs over the next three years. In the autumn a further round of local proposals will be considered.

2017-18 should also be the year when the NHS delivers the productivity and efficiency gains necessary to maintain financial balance by tackling unwarranted variation, reducing waste, bearing down on the exorbitant costs of agency staff and better managing demand. In this way, NHS leaders can ensure that the Government's investment is spent on better care and treatment for patients.

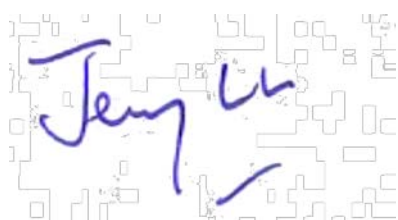
This mandate also makes clear that the NHS must continue to put quality and safety at the heart of everything it does. I am proud of our record levels of harm-free care, but I am clear that

The Government's mandate to NHS England for 2017-18

more needs to be done to transform clinical standards across specialities, create a strong learning culture and deliver truly high quality services seven days a week. This will be as true for mental health as it is for physical health conditions, which is why this mandate sets out our commitment to one of the most ambitious expansion plans for mental health services in Europe, ensuring one million more people can access services by 2020.

I have been clear that a critical element of patient safety is A&E performance, and equally clear that there have been instances of unacceptable performance in some hospitals in recent months. That is why, central to this mandate, is delivery of the NHS's A&E turnaround plan which should see hospitals return to meeting the 4 hour target, supported by £2 billion extra investment in social care and £100 million in capital funding for A&E departments.

By working closely with leaders across the health and care system, this mandate is about making real progress to deliver the care that our patients need, not only safeguarding the NHS's immediate future but also ensuring this for generations to come. I expect to see clear progress against the measures in this mandate in the months ahead.



Rt Hon Jeremy Hunt MP
Secretary of State for Health

1. Introduction

- 1.1. The Government is committed to providing for patients and the public the highest quality, most compassionate health and care service in the world, built on the guiding principles of the NHS: that access to health care is based on need and not the ability to pay, and that services are comprehensive and available to all.

The mandate to NHS England

- 1.2. NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the Government's objectives and any requirements for NHS England, as well as its budget.¹ In doing so, the mandate sets the direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public. Every year, the Secretary of State must publish a mandate to ensure that NHS England's objectives remain up to date.²
- 1.3. Every government department has produced a plan setting out its objectives to 2020 and how it will achieve them. The mandate sets out NHS England's contribution to the Government's goals for the health and care system as a whole, as outlined in the Department of Health's single departmental plan, in line with the manifesto commitments.
- 1.4. The mandate for 2016-17 set out enduring objectives to 2020, and set NHS England's budget for five years. Setting a multi-year mandate with a multi-year budget enabled the NHS to plan more effectively to deliver our long-term aims. For the first time, the objectives in the 2016-17 mandate were underpinned by specific annual deliverables, and goals to be achieved by 2020 or beyond, as set out in the Annex.
- 1.5. This mandate continues the approach set out for 2016-17, maintaining the direction set and defining annual deliverables for 2017-18 that will keep us on track for meeting our longer-term goals. In some objectives, there are changes and clarifications to reflect developments since the 2016-17 mandate was set.
- 1.6. NHS England is legally required to seek to achieve the objectives, and comply with the requirements in this document.³ In doing so, NHS England is **required** to comply with its responsibilities and delegated authorities as set out in the *Framework Agreement between the Department of Health and NHS England*⁴ and *Managing Public Money*⁵.
- 1.7. We will assess NHS England's performance against its objectives, by reviewing progress against agreed yearly deliverables and metrics, alongside improvement in outcomes measures. Our assessment will be published in the Secretary of State's annual assessment of NHS England. In turn, we expect NHS England to ensure clinical commissioning groups (CCGs) play their part in delivering the mandate.

¹ NHS England's legal name is the National Health Service Commissioning Board.

² In accordance with section 13A(1) of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

³ This requirement is at section 13A(7) of the National Health Service Act 2006.

⁴ <https://www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england>

⁵ <https://www.gov.uk/government/publications/managing-public-money>

The Five Year Forward View and a seven-day NHS

- 1.8. The Government is committed to delivering an NHS that offers all its citizens the safest, most compassionate, highest quality healthcare in the world. Spending will continue to increase in real terms every year in this Parliament, and the NHS will receive £10 billion more per year above inflation by 2020-21 than in 2014-15. This investment supports the NHS's Five Year Forward View, published in October 2014.⁶
- 1.9. In this mandate to NHS England to 2020, the Government is entrusting NHS England with the NHS budget to help deliver these commitments, and to meet the evolving needs of the population in a way that is sustainable now and into the future. We believe the NHS should be there when you need it and be accessed easily and conveniently. The quality of care you receive shouldn't depend on the day of the week that you access it and access to crisis care shouldn't depend on your condition. The objectives the Government has set for NHS England will help the NHS to deliver changes and seven-day services that mean:
 - Access to consistent standards of urgent and emergency hospital care, senior doctors and diagnostics no matter which day of the week you are admitted.
 - Weekend and evening access to primary care.
 - Faster, more streamlined access to urgent care, seven days a week through the 111 phone number.
 - 24/7 access to mental health crisis care in both community and A&E settings.
- 1.10. We will hold NHS England to account for its leadership of and contribution to delivery of the Five Year Forward View, including progress made towards a seven-day NHS.

Key measures of success

- 1.11. We expect the NHS to deliver the Five Year Forward View and close the gaps in the quality of health, care and NHS finances through Sustainability and Transformation Plans (STPs). For the first time local service leaders in every part of England, both on the commissioner and provider side, have come together to develop these plans, with the aim of transforming health and care in the communities they serve. A number of metrics will be used to measure progress across STP footprints in delivering the Five Year Forward View, linking performance of the NHS at a local level more explicitly to national accountability.

⁶ <https://www.england.nhs.uk/ourwork/futurenhs/>

2. NHS England's objectives

- 2.1. This mandate is based on the shared priorities of Government and its partner organisations for health and care – the priorities we believe are central to delivering the changes needed to ensure the NHS is always there whenever people need it most. As leader of the commissioning system, but working with others, NHS England has a central role to play. This mandate sets objectives for NHS England that reflect its contribution to these ambitions to 2020.
- **OBJECTIVE 1: Through better commissioning, improve local and national health outcomes, and reduce health inequalities.**
 - 2.2. To do this, we need greater transparency about the quality and outcomes of care. We expect NHS England to maintain the CCG improvement and assessment framework, to enable local areas to see how their services and outcomes compare to others and make consistent improvements. We expect NHS England to demonstrate improvements against the NHS Outcomes Framework, and work with CCGs to reduce inequalities in access, quality of care and outcomes at a local level.⁷ NHS England must ensure commissioning focuses on measurable reductions in inequalities in access to health services, in people's experience of the health system, and across a specified range of health outcomes, which contribute to reducing inequalities in life expectancy and healthy life expectancy.
 - **OBJECTIVE 2: To help create the safest, highest quality health and care service.**
 - 2.3. Everyone deserves high quality care that is safe, compassionate and effective, at all times and which is right for them, regardless of their condition. We want NHS England to help ensure the NHS provides the same standards of care, seven days a week, for people who need urgent and emergency hospital care, and that harm is minimised by avoiding unnecessary complications or admissions to hospital. We want the NHS to become the world's largest learning organisation, with a culture that uses all sources of insight, including from complaints⁸, to improve services and quality of care, particularly for the most vulnerable. NHS England should ensure the NHS helps to identify violence and abuse early and supports victims to get their lives back sooner, including through improved data sharing with community partners.
 - 2.4. NHS England should ensure the NHS meets the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality. We want people to be empowered to shape and manage their own health and care and make meaningful choices, particularly for maternity services, people with long term conditions and as set out in the Government's response to the end-of-life care Choice Review.⁹ Carers should routinely be identified and given access to information and advice about the support available.

⁷ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017>

⁸ <http://www.healthwatch.co.uk/resource/my-expectations-raising-concerns-and-complaints-report>

⁹ <https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response>

- 2.5. A priority for NHS England will be to improve early diagnosis, services and outcomes for cancer patients, as outlined in Achieving World-Class Cancer Outcomes: A strategy for England 2015-20.¹⁰
- **OBJECTIVE 3: To balance the NHS budget and improve efficiency and productivity.**
 - 2.6. Meeting the demands of today's and tomorrow's patients and carers from within the existing NHS budget depends on the system stabilising its finances and delivering the wider changes called for by the Five Year Forward View. The Government is supporting the NHS's Five Year Forward view, increasing its annual funding by £10 billion above inflation by 2020-21, compared to 2014-15. This funding and the NHS budget is entrusted to NHS England.
 - 2.7. We expect NHS England to ensure overall financial balance in the NHS, working with NHS Improvement (which has statutory responsibility for trust financial control) to support local areas in developing credible, financially balanced operational plans, which build on, and align with, STPs.
 - 2.8. We want NHS England to ensure that aggregate spending by commissioners does not exceed mandate funding, that appropriate contingency funding is maintained and to make sure that commissioners discharge their duties in a way which enables all parts of the system (commissioners and providers) to meet their control totals. We also expect commissioners to work collaboratively with local authorities to make the most efficient and effective use of health and social care funding. Working with NHS Improvement, NHS England should determine pricing arrangements that are affordable for commissioners and allow providers to meet their financial duties – in doing so helping to spend taxpayers' money more efficiently and reduce waste, and ensuring we get maximum value for patients, their carers and service users from every pound spent.
 - 2.9. NHS England must seek to achieve this whilst continuing to deliver high quality care and delivering against the objectives set out in this mandate.
 - **OBJECTIVE 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.**
 - 2.10. The escalating demands of ill health driven by our lifestyles also threaten the long-term sustainability of the NHS. Across the health and care system, we want the NHS to do more with partners on the broader prevention agenda, such as tackling smoking, alcohol and drug misuse and physical inactivity. We fully support the focus in the Five Year Forward View on preventing avoidable ill health and premature mortality. We ask NHS England to lead a step-change in the NHS on helping people to live healthier lives by tackling obesity and preventable illness. In particular, this includes contributing to the Government's goal to reduce child obesity and doing more to reach the five million people at high risk of diabetes and improve the management and care of people with diabetes. As part of the 2020 Dementia Challenge, we expect NHS England to make measurable improvements in the quality of care and support for people with dementia, and to increase public awareness.

¹⁰ <https://www.england.nhs.uk/cancer/strategy/>

- **OBJECTIVE 5: To maintain and improve performance against core standards.**

2.11. Our NHS should always provide the best care for everyone – wherever they are and whenever they need it, in line with the NHS Constitution. The Government has committed to real terms growth in the NHS budget to ensure that the service can continue to perform well over the next four years, with the capacity to deal with rises in demand during the winter months, and to play its part in any national emergency. We expect NHS England to support the NHS to improve and, where possible, maintain access to timely, quality services for all patients.

- **OBJECTIVE 6: To improve out-of-hospital care.**

2.12. We want to see more services provided out of hospitals, a larger primary care workforce and greater integration with social care, so that care is more joined up to meet people's physical health, mental health and social care needs. We expect NHS England to ensure everyone has easier and more convenient access to planned GP services, including appointments in the evenings and at weekends where this is more convenient for them, and effective access to quality urgent and emergency care 24 hours a day across the whole week.

2.13. We want to see more power and control devolved to more areas, enabling communities to design and develop new models of care tailored to meet the needs of their local populations. NHS England should support the NHS to achieve the Government's aim that health and social care are integrated across the country by 2020, including through the Better Care Fund.

2.14. People with mental health problems should receive better quality care at all times, accessing the right support and treatment throughout all stages of life. We expect NHS England to strive to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and support them to live full, healthy and independent lives. This will require great strides in improving care and outcomes through prevention, early intervention and improved access to integrated services to ensure physical health needs are addressed too. In particular, vulnerable children, homeless people, veterans, unpaid carers, offenders and people in places of detention, including immigration removal centres, should receive high quality, integrated seven-day services that meet their health needs. To close the health gap for people of all ages, we want to see a system-wide transformation in children and young people's mental health¹¹, with a greater focus on prevention and early intervention, as well as improvements to perinatal mental health. Central to this approach, we expect NHS England to work with partners to deliver, and support the delivery of, the Five Year Forward View Implementation Plan. Overall there should be measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution, particularly for those in vulnerable situations.

- **OBJECTIVE 7: To support research, innovation and growth.**

2.15. Just as a strong NHS depends on a strong economy, so a strong NHS can contribute to the growth of a strong economy, especially in health and life sciences. We ask NHS England to promote and support participation by NHS organisations, patients and carers

¹¹ <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

in research funded both by commercial and non-commercial organisations, so that the NHS supports and harnesses the best research and innovations and becomes the research partner of choice. We expect to see NHS England help the NHS contribute to economic growth, to support the NHS to reduce the impact of ill health and disability, and to support and harness research and innovation to enable cost effective, affordable, transformative new treatments to reach patients and their carers more quickly, whilst also securing better value from companies. As part of this, we expect NHS England to work with the life sciences sector and Government as it develops a life sciences strategy that makes the UK the best place in the world to invest in life sciences and develop innovative, cost effective and affordable new products. NHS England should also support the NHS to make better use of digital services and technology to transform patients' and their carers' access to and use of health and care, including online access to their personal health records.

3. NHS England's budget

- 3.1. NHS England's indicative revenue and capital budgets for each year of the Parliament were set out in the mandate for 2016-17.¹² Details of NHS England's revenue and capital budgets for 2017-18 and the indicative budgets for the remaining years of this Parliament are set out in the table below. A further breakdown of these figures is provided in the financial directions.¹³

	2016-17 (Revised)	2017-18	2018-19 (Indicative budget)	2019-20 (Indicative budget)	2020-21 (Indicative budget)
Total revenue budget (£m)	106,528	109,960	112,461	115,506	119,606
Capital budget (£m)	260	260	260	305	305

- 3.2. NHS England will need to comply with the financial directions made under the National Health Service Act 2006, which set out further technical limits, including spending on administration.
- 3.3. NHS England is responsible for allocating the budgets for commissioning NHS services. This prevents any perception of political interference in the way that money is distributed between different parts of the country. The Government expects the principle of ensuring equal access for equal need to be at the heart of NHS England's approach to allocating budgets. This process must be transparent, and must ensure that changes in allocations do not result in the destabilising of local health economies.
- 3.4. NHS England will ensure overall financial balance in the NHS, working with NHS Improvement, which has statutory responsibility for trust financial control. To support this, £1.8bn of NHS England's budget for 2017-18 will be allocated through the Sustainability and Transformation Fund to support providers, in particular of emergency services, payable through commissioning or as other support.

¹² The 2016-17 figures have been revised to take account of updated budget figures.

¹³ See section 223D of the NHS Act 2006 (financial duties of the Board); the revenue and capital budgets are the amounts specified as the limits on total resource use under subsections (2) and (3).

Annex: How we will assess NHS England's performance

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2017-18. The majority of these goals will be achieved in partnership with the Department of Health, NHS Improvement and other health bodies such as Public Health England, Health Education England, the Care Quality Commission and NHS Digital. It also sets out requirements for NHS England to comply with in paragraph 6.2.

We expect NHS England to provide assurance about how they will meet the deliverables set out below.

<p>1.</p>	<p>Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.</p>
<p>1.1 CCG and STP performance</p>	<p><i>Overall 2020 goals:</i></p> <ul style="list-style-type: none"> • Consistent improvement in performance of CCGs against the CCG improvement and assessment framework, increasing the proportion of CCGs that are rated 'Good' or 'Outstanding'. • With NHS Improvement, support local areas to ensure delivery of agreed plans within each STP area, including progress against metrics. <p><i>2017-18 deliverables:</i></p> <ul style="list-style-type: none"> • By July 2017, publish the results of the CCG improvement and assessment framework for 2016-17. This will continue to include independent assessment of CCG performance for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes. • With NHS Improvement, ensure commissioners and providers deliver their 2017-18 operational plans, which will deliver year one of locally agreed STPs.
<p>2.</p>	<p>To help create the safest, highest quality health and care service.</p>
<p>2.1 Improving service quality and achieving seven-day services</p>	<p><i>Overall 2020 goals:</i></p> <ul style="list-style-type: none"> • Roll out of seven-day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Working with NHS Improvement, continue to support providers to develop and publish a Board level service quality improvement plan that will achieve significant and measureable improvements in the quality of services, thereby reducing deaths, severe harm and other adverse outcomes attributable to problems in healthcare. • Support NHS Improvement to significantly increase the number of trusts rated 'Good' or 'Outstanding', including significantly reducing the length of time trusts remain in special measures.

	<ul style="list-style-type: none"> • Under the Maternity Transformation Programme¹⁴, work with the Department of Health and partners in a system-wide effort to achieve the national maternity ambition, to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020, demonstrating progress towards the national ambition to reduce rates by 50% by 2030. • Support the NHS to be well-led and demonstrate open, learning cultures with good leadership and quality interactions evident across and between organisations; where staff feel valued, feedback on care and workplaces is welcomed and problem behaviours are tackled promptly. • Measurable improvement in antimicrobial prescribing, resistance rates and healthcare associated infection rates to support the Government to meet its ambition to halve inappropriate prescribing of antibiotics and halve Gram-negative infections by 2020. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • By working with NHS Improvement, rollout the seven-day services in hospitals four priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by November 2017. • Work with NHS Improvement to ensure that providers improve transparency and public engagement in developing their service quality improvement plan, using data on adverse outcomes as a catalyst for positive change. • Begin implementation of the Maternity Transformation Programme, including the Saving Babies' Lives care bundle. • With the Department of Health, support the development and publication of a baseline on brain injuries in babies that occur during or soon after birth. • Continue to participate in the Leadership Development and Improvement Board and deliver actions agreed as part of the Leadership Development and Improvement framework for 2017-18. • Support the Government's ambitions on antimicrobial resistance by taking action to improve prescribing and surveillance and reduce E.Coli blood stream infections in line with performance set out in the quality premium indicator for 2017-18. • Work with partners to ensure NHS services play their part in the Government's Prevent programme, including involvement of services in multi-agency processes and response to individuals' health needs.
<p>2.2 Patient experience</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • With NHS Improvement, improve the percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions.

¹⁴ <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/>

	<ul style="list-style-type: none"> • Ensure that patients, their families and carers are involved, through co-production, in defining what matters most in the quality of experience of services and assessing and improving the quality of NHS services. • 50,000-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 7,600). • Significantly improve patient choice, including in maternity, end-of-life care, elective care and for people with long-term conditions. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Implement findings from phase 1 and 2 of the Maternity Experience Challenge Fund to strengthen the perceived value of and cultural approach to feedback, ensuring the effectiveness of the Friends and Family Test (FFT) alongside other sources of feedback to drive service improvements, and that any changes to the FFT guidance are put in place for April 2018. • Development and adoption of externally validated co-production improvement methodologies, including the rollout of always events in 100 providers by April 2018. • Develop proposals for how complaints, whistleblowing and wider feedback can be used more effectively to support patients, their carers and staff, to drive up quality and improve patient safety in primary care and specialised commissioning. • Continue to make measurable progress to embed Personal Health Budgets for those with a legal right and expand their use in other groups, including wheelchair users, those with learning disabilities, and in end-of-life care and expand the Integrated Personal Commissioning programme. • Identify metrics to assess quality and choice in end-of-life care, ready for inclusion in the CCG improvement and assessment framework for 2018-19. • Develop an implementation plan with clear milestones and metrics for taking forward the recommendations set out in the Government's response to the end-of-life care Choice Review¹⁵, in collaboration with partners.
2.3 Cancer	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Deliver recommendations of the Independent Cancer Taskforce. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Set out clear priority milestones for 2017-19 and deliver those agreed for 2017-18, building on Achieving World-Class Cancer Outcomes: Taking the strategy forward.¹⁶ • Achieve the 62-day cancer waiting times standard, and maintain performance against the other cancer waiting times standards.

¹⁵ <https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response>

¹⁶ <https://www.england.nhs.uk/cancer/strategy/>

	<ul style="list-style-type: none"> • With partners, including NHS Digital, develop IT infrastructure and national guidance to enable routine collection of data for the new 28-day faster diagnosis standard to begin in April 2018. • Improve the proportion of cancers diagnosed at stages 1 and 2 over the previous year. • Work with partners across the cancer community to pilot an approach to measuring long-term quality of life for people living with and beyond cancer, and agree an implementation plan to begin data collection in 2018-19. • Invest up to £340m in providing cancer treatments through the Cancer Drugs Fund (CDF), including those recommended by NICE for use in the CDF.
3.	To balance the NHS budget and improve efficiency and productivity.
3.1 Balancing the NHS budget	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Ensure overall financial balance in the NHS, working with NHS Improvement, which has statutory responsibility for trust financial control, and that the necessary efficiency and productivity improvements are realised, while continuing to improve the quality of care. • Ensure that commissioners discharge their duties in a way which enables all parts of the system (commissioners and providers) to live within their control totals, as individual organisations, across Sustainability and Transformation Plan footprints, and in aggregate. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3% each year), including from reducing growth in activity, improving the quality of care and maximising cost recovery. • Work with NHS Improvement to determine pricing arrangements that are affordable for commissioners, allow providers to meet their financial duties, and are consistent with the strategic direction of the Five Year Forward View. • With NHS Improvement, support the Government's goal to raise £2bn and free space for 26,000 new homes by 2020 from releasing surplus NHS land. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Ensure overall financial balance in the NHS, working with NHS Improvement, which has statutory responsibility for trust financial control. • Ensure that aggregate spending by commissioners (NHS England and CCGs) does not exceed mandate funding for 2017-18, including the maintenance of appropriate contingency funding against risks that system control totals are exceeded. • With NHS Improvement, before the end of the 2017-18 contracting round, provide formal assurance to the Department of Health that operational plans deliver mandate objectives and are based on consistent, credible planning assumptions across commissioners and providers, or where not, agree and implement an action plan to address

	<p>outstanding issues.</p> <ul style="list-style-type: none"> • Ensure CCGs take steps to better manage demand in acute services through effective implementation of programmes including New Care Models, Right Care and Self Care. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Ensure commissioning aims are consistent with and support the delivery of provider productivity, including working with NHS Improvement in securing Carter efficiency savings and reducing spend on agency staff. • Support the Department of Health to take forward the Government's commitment for the NHS to recover up to £500m from overseas chargeable patients, including by: <ul style="list-style-type: none"> ○ providing an assessment, by August 2017, of the barriers to CCGs assuring themselves that providers are identifying chargeable patients, and making recommendations for tackling those barriers. ○ working with NHS Improvement, ensuring CCGs contribute to efforts to maximise cost recovery within an initial cohort of 20 trusts identified by NHS Improvement, and disseminating lessons learned across the country. ○ working with the Department of Health and other stakeholders, developing implementation plans to extend charging of overseas patients into primary care, and exploring the practicalities of extending it into A&E. • Ensure that every CCG has a strategic estates strategy that is consistent with progress towards the 2020 national goals.
<p>4.</p>	<p>To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.</p>
<p>4.1 Obesity, diabetes and prevention</p>	<p><i>Overall 2020 goals:</i></p> <ul style="list-style-type: none"> • Measurable reduction in child obesity as part of the Government's childhood obesity plan.¹⁷ • 100,000 people supported to reduce their risk of diabetes through the NHS Diabetes Prevention Programme. • Measurable reduction in variation in the management and care for people with diabetes, including improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs. • With support from Public Health England, contribute to the reduction of preventable illness and associated hospital admissions through the implementation of tangible, preventative interventions in the NHS. <p><i>2017-18 deliverables:</i></p> <ul style="list-style-type: none"> • With the Department of Health, set out, by September 2017, NHS

¹⁷ <https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action>

	<p>England's contribution to the Government's childhood obesity plan.</p> <ul style="list-style-type: none"> • At least 60,000 people referred to the Diabetes Prevention Programme. • Fund, and deliver with Public Health England, a programme from April 2017 to March 2019, that will support the implementation of identified preventative interventions at scale by the NHS, in collaboration with local health and care partners.
<p>4.2 Dementia</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Deliver the actions as outlined in the Challenge on Dementia 2020 Implementation Plan.¹⁸ <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Continue to develop an evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge, including to improve the quality of post-diagnosis treatment and support.
<p>5.</p>	<p>To maintain and improve performance against core patient access standards.</p>
<p>5.1 A&E, Ambulances and Referral to Treatment (RTT)</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • 95% of people attending A&E seen within four hours. • A 24/7 integrated urgent care service implemented in each footprint, including a clinical hub that supports 111, 999 and out-of-hours calls from the public and all healthcare professionals. • Meet ambulance response time standards for the most urgent calls and the A&E standard. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks from referral; and less than 1% of patients waiting for a diagnostic test to wait more than 6 weeks from referral. • Ensure the NHS plays its part in significantly reducing delayed transfers of care by developing and applying new incentives. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Co-implement the agreed A&E recovery plan with NHS Improvement and deliver aggregate A&E performance in England above 90% in September 2017, with the majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% within the course of 2018, including by: <ul style="list-style-type: none"> ○ making A&E streaming mandatory throughout the system. ○ ensuring all care home residents at risk of admission to hospital

¹⁸ <https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan>

	<p>are first seen by a GP or ambulance 'see and treat' model.</p> <ul style="list-style-type: none"> ○ implementing the agreed process to address hospital bed capacity issues. ○ implementing changes to ambulance and 111 delivery models to reduce the rate of growth in demand for A&E services. <ul style="list-style-type: none"> • Agree a plan for staged rollout of integrated urgent care to 2020, and implement for 2017-18. • With NHS Improvement, meet agreed standards on A&E, ambulances, diagnostics and referral to treatment. • Test new ambulance service performance metrics which reflect the clinical needs and outcomes for patients contacting 999 in England. • Working with NHS Improvement and local government partners, reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas) by: <ul style="list-style-type: none"> ○ setting clear trajectories for improvement for each area, based on previous performance. ○ ensuring that each area fully implements evidence-based approaches to reducing delays, including a 'discharge to assess' model, and a 'trusted assessor' agreement. ○ piloting and evaluating models for providing hospital services to people in their own homes, to avoid unnecessary admissions and support more timely discharge. ○ providing targeted intervention and support for the most challenged areas. <p>Continue this performance for the remainder of 2017-18 and set out plans for a more ambitious goal for 2018-19.</p> <ul style="list-style-type: none"> • Develop and implement plans to moderate avoidable growth in demand for elective services, including through sharing benchmarking data with CCGs and advice and guidance services.
<p>6.</p>	<p>To improve out-of-hospital care.</p>
<p>6.1 New models of care and General Practice</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Implementation of the measures to support general practice set out in the General Practice Forward View¹⁹, including: <ul style="list-style-type: none"> ○ improved access to primary care, ensuring 100% of the population has access to weekend/evening routine GP appointments. ○ 5,000 extra doctors in general practice, delivered jointly with Health Education England. • Measurable reduction in age standardised emergency admission rates and inpatient bed-day rates; more significant reductions through the New

¹⁹ <https://www.england.nhs.uk/gp/gpfv/>

	<p>Care Model programme covering at least 50% of the population.</p> <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Deliver 2017-18 core requirements for access to enhanced GP services, including evening and weekend access, to a total of 40% of the population. • Work with the Department to agree a programme of work to assess how best to meet the commitment that all over-75s will be able to access a same-day appointment with a GP if they need one. • Support NHS Digital and the Department of Health to provide practices with clinical data by named GP. • Achieve 20% coverage of the population by the New Care Model programme. • Assess progress of the vanguards and identify models consistent with the multispecialty community providers, integrated primary and acute care systems and enhanced health in care homes vanguard frameworks that can be replicated across the country.
<p>6.2 Health and social care integration</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against relevant indicators within the CCG improvement and assessment framework, including new models of care. Areas can graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Implement the Better Care Fund in line with the Integration and Better Care Fund Policy Framework for 2017-19. • Working with partners, achieve accelerated implementation of health and social care integration, including through sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of those local devolution deals which include health proposals, subject to NHS England's devolution criteria, in order to support local transformation objectives for improved population outcomes, experience of care and value for money. • With the Department of Health, increase the proportion of NHS Continuing Healthcare assessments undertaken outside of an acute setting. • Collaborate with local authorities to support the sustainability of social care, including on programmes such as New Care Models, Urgent Care and Right Care. <p>2017-18 requirements:</p> <ul style="list-style-type: none"> • NHS England is required to: <ul style="list-style-type: none"> ○ ring-fence £3.582bn within its allocation to CCGs to establish the

	<p>Better Care Fund in 2017-18, and ensure the amount spent from within this on schemes identified in Better Care Fund plans as 'social care' in 2016-17 is maintained in line with inflation in every area (Better Care Fund national condition 2);²⁰</p> <ul style="list-style-type: none"> ○ consult the Department of Health and the Department for Communities and Local Government before approving BCF plans drawn up by each local area; and ○ consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the Integration and BCF Policy Framework.
<p>6.3 Mental health, learning disabilities and autism</p>	<p>Overall 2020 goal:</p> <ul style="list-style-type: none"> • To implement the Mental Health Five Year Forward View²¹ recommendations and ensure 1 million more people with mental health problems are accessing high quality care. • At least 70,000 more children and young people to access evidence based treatment. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Deliver the 2017-18 Mental Health Five Year Forward View Implementation Plan²² recommendations. • Work with system partners to deliver the Mental Health Five Year Data Plan, the Mental Health Workforce Strategy, the Future in Mind recommendations, and support Government priorities and commitments to improving mental health for children and young people and prisoners and offenders in the community. • Embed access and waiting time standards for mental health services for Early Intervention in Psychosis, Improving Access to Psychological Therapies and eating disorders. • Develop and implement a 5 year improvement programme for crisis and acute mental health care, including investing in liaison psychiatry and crisis resolution and home treatment teams as part of seven-day services, as well as continuing to collaborate with partners to support the ongoing work to improve care for people detained under s.136 of the Mental Health Act, including provision of health based places of safety. • Work with the Department of Health and NHS Digital to ensure robust data on acute out of area placements is collected, reporting is embedded and a baseline position is established during 2017-18. Plans should be agreed in 2017-18 to deliver year-on-year reductions to eliminate inappropriate acute out of area placements by 2020-21. • Reduce reliance on inpatient care for children, young people and adults

²⁰ In addition, within NHS England's indicative budget for 2018-19, NHS England is expected to be required to ring-fence £3.65bn within its allocation to CCGs to establish the Better Care Fund in 2018-19.

²¹ <https://www.england.nhs.uk/mental-health/taskforce/>

²² <https://www.england.nhs.uk/mental-health/taskforce/imp/>

	with a learning disability and/or autism who display behaviour that challenges to achieve a bed reduction of 35-50% by March 2019.
7.	To support research, innovation and growth.
7.1 Research and growth	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals, initiatives and deliverables in the NHS England research plan. • Measurable improvement in NHS uptake of innovations prioritised by the Accelerated Access Partnership, focusing on those that are affordable and cost-effective. • Work with Genomics England to embed genomic medicine and application of genomic technologies into NHS care building upon the 100,000 Genomes Project and the UK Strategy for Rare Diseases. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Evaluate the implementation of the Excess Treatment Costs guidance to understand its impact and to further support implementation, and agree further actions that need to be taken with partners. • Promote and support participation by NHS organisations and patients in research funded both by commercial and non-commercial organisations, demonstrating progress through publication of the NHS England research plan and monitoring its deliverables. • Improve NHS commissioner input into identifying research needs in the NHS. • Work with the Department of Health to agree a clear role for NHS England in implementation of the recommendations of the Accelerated Access Review²³, to be set out in the Government response. • Develop, jointly with Genomics England, the approach to begin to embed genomics into routine care and engage other national partners including NHS Improvement, NHS Digital, Health Education England and Public Health England.
7.2 Technology	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Support delivery of the National Information Board Framework on Personalised Health and Care 2020.²⁴ • 95% of GP patients to be offered e-consultation and other digital services. • Ensure all clinical correspondence and transfers of care are shared electronically and the opening up of systems to enable sharing of care

²³ <https://www.gov.uk/government/publications/accelerated-access-review-final-report>

²⁴ <https://www.gov.uk/government/publications/personalised-health-and-care-2020>

	<p>records.</p> <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • Robust data security standards in place and being enforced for patient confidential data, implementing, with NHS Digital and NHS Improvement, the 2016 National Data Guardian for Health and Care review²⁵ recommendations on data security. • Ensure high quality appointment booking app with access to full medical record available, implementing the new national opt out model to be finalised following the 2016 independent review. • Each practice to have a minimum of 10% of patients accessing primary care services online or through apps. In addition, the overall number of patients accessing primary services online or through apps will increase by 20% (to 12 million patients) in line with trajectory and the plan for achieving a significant increase by 2020. • Make measurable progress towards achieving 100% of GP to first outpatient referrals through NHS e-RS by October 2018.
<p>7.3 Health and work</p>	<p>Overall 2020 goal:</p> <ul style="list-style-type: none"> • Contribute to reducing the disability employment gap. • Contribute to the Government's goal to increase integrated working between health services and work-related interventions, including through increasing the use of Fit for Work. <p>2017-18 deliverables:</p> <ul style="list-style-type: none"> • With the Work and Health Unit and local partners, implement health-led employment trials from spring 2017, which will run for between two to three years. • With the Work and Health Unit and NHS Digital, create the right environment to support an increase in referrals by GPs to occupational health support, including Fit for Work. • Work with Government to identify opportunities for regular collection of data about incidence, prevalence, clinical activity and outcomes of musculoskeletal patients and services in England.

²⁵ <https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs>

Report to:	Date of meeting
Trust board - public	29 March 2017
STP Joint health and care transition group - Meeting Summaries	
Executive summary:	
<p><u>19 January 2017</u></p> <p>Finance</p> <p>As with our last meeting finance topped the agenda today. Keith Edmunds (Chief Finance Officer CWHHE CCGs) confirmed that following meetings of the STP finance group and the main transformation group, four bids for the first tranche of Sustainability and Transformation Funding (STF) had been submitted to NHS England. There was a good discussion about the importance of showing how these bids fit with the original priorities set out in the October submission of the STP, and how we as a system need to work with NHSE to ensure that future funds are targeted at our key priorities across health and local government.</p> <p>Milestones</p> <p>Juliet Brown (STP Programme Director) updated the group on the milestones and how the different delivery boards are looking to prioritise and how they will go forward with bids. The first business cases will be ready next month.</p> <p>Updates from the five delivery areas:</p> <p>1) <i>Radically upgrading prevention and well being</i></p> <p>Juliet Brown provided a high level summary, noting that the delivery board met last week and continues to work on the business cases. Good progress is being made albeit we are still fairly early in the process. Tom Shakespeare (Head of Health & Wellbeing, West London Alliance) added that the team is now fully resourced thanks to Brent Council providing a secondee to work on the programme.</p> <p>2) <i>Eliminating unwarranted variation and improving long term condition management</i></p> <p>As an overall delivery area we are still at an early stage, with Rob Larkman (Chief Officer Brent, Harrow & Hillingdon CCGs) agreed as SRO and a board being set up. There is however lots of work on-going on individual projects around primary care with a substantial part focussed on the delivery of the Strategic Commissioning Framework (SCF) and GP Forward View (GPFV) - so our recently submitted plans and our work on accessible, coordinated and proactive care all form part of this DA.</p> <p>3) <i>Achieving better outcomes for older people</i></p> <p>Carolyn Downs (Chief Executive Brent local authority) noted that we are making good progress and a real feeling of momentum on where we are. We have five different projects but all are very interrelated. We have now had the first care and clinical reference group which was well attended by geriatricians, GPs, carers, patients, social care and other clinicians and care givers from across NW London. The group has the remit to ensure that work being undertaken to improve outcomes for older people across NW London is focussed.</p> <p>4) <i>Improving outcomes for children and adults with mental health needs</i></p> <p>Fiona Butler (Chair West London CCG) set out that the focus had been on the mental health bids for STF funding, with Fiona thanking everyone across the system for their help in getting the bids ready for submission. The IAPT bid is focussed on psychological therapies which is a very new area for us and a model which is focussed on prevention. We are also working on perinatal services across all eight boroughs.</p>	

5) *Ensuring we have safe high quality sustainable acute services*

Clare Parker (Chief Officer CWHHE CCGs) said that the seven day services programme was going well, with pilots being very successful, including some staff feedback that "we don't want to go back to five day working". Seven day services is an important part of the drive to improve the care and quality of service patients receive whatever the time or day of their admission. Clare also noted that some of the work on radiology and diagnostics has gone in under the cancer bid.

Workforce

Lizzie Smith (Director, Health, Education England, London North West) talked about work done so far to underpin the strategy and the work that was on-going in particular around scenario planning to help ensure better staff retention.

Digital

Bill Sturman (Director Informatics, NW London Collaboration of CCGs) confirmed that the local digital roadmap will be submitted in the next couple of days. This document sets out a number of key benefits such as every patient in NW London having access to virtual consultations with a GP by April 2019.

Communications & Engagement

Christian Cubitt (Director of Communications & Engagement NW London Collaboration of CCGs) shared with the group the evaluation of the online engagement activity around the publication of the October version of the STP, provided an update on the forthcoming engagement event in the town hall at RBK&C on 31 January, and talked through next steps on the emerging engagement strategy around Ealing Hospital.

Leadership team

Finally, at a subsequent meeting of the STP leadership team it was agreed to formalise this group as the executive team with a specific remit to support the JHCTG.

16 March 2017

Budget discussions

Dr Mohini Parmar, Chair Ealing CCG and STP system leader, opened the meeting by noting the previous week's Budget statement from the Chancellor and the commitment made to provide additional resource for both social care and STPs. City of Westminster Chief Executive Charlie Parker then outlined his understanding of how this additional investment would impact on social care spending within local government. Dr Parmar then outlined the specific impact on the NHS of the funding commitment. Finally Dr Parmar noted that the announcement on devolution of health care in London which was expected in the budget had been delayed.

Finances

Moving onto the financial position of the health and care system in NW London Charlie Parker introduced the finance papers with a focus on how we look at investment and resource and where we need to be prioritising our efforts, before handing over to Steven Mair, Treasurer for the City of Westminster, to look at the principles of our funding flows and how we set out the criteria for ensuring we get a good rate of return on our investment. Keith Edmunds, Chief Financial Officer for Central London, West London, Hounslow, Hammersmith & Fulham and Ealing CCGs, then outlined how we would decide which bids would go through to this financial assessment pathway.

This was followed by a good discussion on how these important principles can be applied to the projects moving forward on the ground, with an agreement to use the alcohol prevention project in DA1 (Radically upgrading prevention and well being) as a test case to try and deliver this. Members of the group agreed that it is essential to ensure clinical quality is retained in this process and that there is a proper governance structure for final agreement on any funding.

Collaborative working

The third item was a discussion led by Councillor Sachin Shah, Leader Harrow Council, on how we can work better as an integrated health and care system to deliver the highest possible quality of care for all our patients and residents. There then followed a good discussion emphasising the importance of collaboration between all the partners across the system and the need for transparency and trust.

Delivery area updates

Dr Parmar then called for quick updates from delivery areas:

1) *Radically upgrading prevention and well being*

Michael Lockwood, chief executive Harrow Council, updated the group on the good progress being made in the development of the business case on alcohol misuse which will shortly be ready to go. He also noted the significant progress being made on the substance misuse and long term mental health work stream.

3) *Achieving better outcomes for older people*

Tom Shakespeare, Head of Health & Wellbeing West London Alliance, noted that the last board meeting had been positive with the focus on two priority areas – crisis response and discharge to assess.

4) *Improving outcomes for children and adults with mental health needs*

Dr Fiona Butler, Chair West London CCG, talked about the clinical model of care for mental health going through the process of sign off.

5) *Ensuring we have safe high quality sustainable acute services*

Clare Parker, Chief Officer Central London, West London, Hounslow, Hammersmith & Fulham and Ealing, and Tracey Batten, Chief Executive Imperial College Healthcare NHS Trust, noted we are making progress in particular on some of the seven day service work streams.

Communications & engagement

Christian Cubitt, Director of Communications and Engagement NW London STP, updated the group on recent STP public scrutiny sessions with both Hammersmith & Fulham council and the Greater London Assembly (GLA). He also outlined the latest engagement activity taking place across the eight boroughs with a focus on understanding how people want to communicate on health issues, with over 1,000 residents having been surveyed as part of this process.

Quality impact:

The STP is focused on improving the integration and delivery of health and care services across NW London.

Financial impact:

No direct financial impact.

Risk impact:

Ensuring effective meeting structures and programme oversight will reduce the risk of poor integration of service developments.

Recommendation to the Trust board:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with care compassion.

To pioneer integrated models of care with our partners to improve the health of the communities we serve.

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
STP team	Dr Tracey Batten, Chief executive	18 January 2017

Report to:	Date of meeting
Trust board - public	29 March 2017

Sustainability and Transformation Plans update

Executive summary:

This paper seeks to update the Trust board on national developments related to Sustainability and Transformation Plans (STPs) including budget allocations and new policy directives. It also provides an update on the Trust STP Forum.

Quality impact:

Financial impact:

No direct impact.

Risk impact:

No direct impact.

Recommendation to the Trust board:

The Trust board is asked to note the update.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.
 To educate and engage skilled and diverse people committed to continual learning and improvements.
 To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Anne Mottram Director of Strategy	Dr Tracey Batten Chief Executive	22 March 2016

Update on Sustainability and Transformation Plans (STPs): Budget Allocations, National Policy and Trust Governance

1. Spring Budget 2017

The Spring Budget 2017 recognised pressures on health and social care through its allocation of additional funds and gave an early indication of some of the system reforms that are planned to occur this year. The key challenges the budget sought to address included: greater multi-agency collaboration, capacity issues related to A&E and freeing up beds by improving the discharge of older patients, developing a sustainable funding approach to older people's care and a re-focusing on the delivery of NHS England's Five Year Forward View Plan. Sustainability and Transformation Plans (STPs) featured prominently in the budget, as both policy and investment priorities. In summary the key allocations are as follows:

- Additional funding of £2bn to social care in England over the next three years, with £1b available in 2017-18
- Measures to identify and support local authorities with the greatest needs to be announced by the Health and Communities Secretaries including greater collaborative working under STPs
- Options for the future financing of Social Care in a Green Paper later this year
- Close working between the Department of Health and the Treasury over the summer in relation to funding already committed to STPs and further capital investments, including prioritisations for capital investment
- The Autumn Budget will announce a multi-year capital programme to support implementation of approved high quality STPs, it was also noted that the Health Secretary expects a small number of the strongest STPs may be ready ahead of Autumn Budget and therefore an additional £325m of capital will be allocated to allow the first selected plans to proceed
- Capital funds of £100m available for up to 100 new triage projects at NHS hospitals to develop onsite GP triage in A&E departments to reduce A&E waiting times.

2. National Policy: STP Footprint Governance

During a Public Accounts Committee (PAC) hearing in early March 2017, NHS England Chief Executive Simon Stevens revealed plans to give STP footprints greater local governance rights.

2.1 Five Year Forward Delivery Plan

In a joint letter to STP leads on 27 February 2017 from NHS England and NHS Improvement the intention to publish a Five Year Forward View Delivery Plan by the end of March 2017 was outlined. The delivery plan will set out the role STPs will play going forward and importantly it will describe what the NHS will deliver in the next two to three years, within the resources available, while introducing extra investment for mental health and cancer services, priorities for strengthening general practice and improving hospital services, changes to urgent and emergency care and using technology so that patients get the right care in the right place.

2.2 STP Footprints as Accountable Care Organisations

Between six and 10 STP footprints will be chosen as 'accountable care organisations or systems', ending the 'purchaser-provider split' in place since 1990. Mr Stevens has said these changes could be carried out within the confines of current legislation and that the formal lines of accountability would remain the same, while bringing about an integrated funding and delivery mechanism for the STP footprint. Others present opposing views and state that abolishing the purchaser-provider split would be at odds with the existing legislation and governance of the NHS, notably the Health and Social Care Act and that such plans have no statutory force or authority as the act contains provisions on competition and market access, leaving the plans open to legal challenge.

Some central transformation funding will be freed up for STPs identified as having the most advanced plans or partnerships to fast-track their progress including developing exemplars for elective and emergency care, accelerating accountable care systems. STP footprints will be encouraged to develop vanguards as solutions to address demand issues in emergency admissions.

The importance of developing better primary care services is seen in the allocation of additional central funding to support the formation of primary care hubs or networks. STP leaders will oversee this transformation funding.

2.3 Appointment of STP Leads

A formal appointment process will be introduced to designate STP leaders. Among their responsibilities will be the ability to bring together staff from partner and national organisations to support the delivery of local STPs.

A small amount of one-off funding on a pro rata basis will be made available to STPs as a contribution to operating costs and to build STP leadership teams (from £175-360k per STP).

Two examples of newly appointed STP leads are Julie Moore for the Birmingham and Solihull STP and the North London STP has appointed Helen Peterson as chief officer and accountable officer designate.

2.4 Trust STP Governance

The Trust STP Forum was established as the primary co-ordinating and oversight function in ensuring that the Trust, at corporate level, is sighted on opportunities and risks arising from the North West London (NWL) STP delivery areas and the enabling programmes.

The forum brings together Trust STP work stream members to share information related to specific projects, to provide the mechanism for effective dissemination of information to the executive and divisional teams and to build greater staff awareness, involvement and engagement in the delivery of the NWL STP in relation to both Trust business as usual and sector wide transformation.

The first meeting of the Trust STP Forum will take place on the 28 March 2017 and will report upwards to the Executive Transformation Committee.

Report to: **Trust board**
Report from: **Finance & Investment Committee (22 March)**

KEY ITEMS TO NOTE

The Committee:

- Noted that the Trust had met its plan in-month (month 11), was £0.4m favourable year to date, and was forecasting to improve on the planned deficit of £41m by £0.5m, not including Sustainability and Transformation Fund funding.
- Discussed the proposed revised business planning submission, noting the plan to improve on the £47.8m deficit position submitted in December 2016, and sought to understand the robustness of the savings plans, and areas for longer term savings.
- Reviewed the PwC report on underlying causes of the Trust's deficit position which was considered to be a helpful analysis (e.g over a third of the deficit relates to the estate, age and multi-site), particularly in outlining which areas the Trust could seek to address, and those which needed support from stakeholders in resolving.
- Reviewed the capital plan for 2017/18, noting that within the total spend (including charitable contributions) of £46.3m, £16.2m was planned to be spent to address backlog maintenance. It was reported that 'over-programming' of £4m would be put in place to ensure any funding which became available due to programme slippage could be effectively utilised.
- Supported for approval by the Trust board the outline business case for the replacement of the existing radiotherapy equipment (LINACs) at Charing Cross Hospital, at an expected total cost of £6.4m, of which the Trust will be eligible to receive up to £5m from NHS England.
- Reviewed, and approved the approach that the Trust was planning to take in procuring the upcoming patient transport contract tender, and also approved the extension of the existing transport contract by three months to 30 June 2018. The Committee also noted the improvements achieved in recent months in patient experience of the service, and in compliance with eligibility criteria.
- Agreed the overall work plan for the coming year, seeking to achieve a balance between immediate operational requirements and an appropriate focus on longer term strategic items.

Action requested by Trust board

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee

Report author: Jan Aps, Trust Company Secretary

Next meeting: 17 May 2017

Report to: Trust board
Report from: Redevelopment committee report (22 February & 22 March 2017)

KEY ITEMS TO NOTE

The planning application for the comprehensive outpatient and diagnostic facility for patients continues to be reviewed by planning officers; a number of consultee responses have been received. The Trust understands that the application will be heard at the May 2017 Westminster planning committee.

The Trust has been advised that the Strategic Outline Business case has been approved by the Department of Health. The Trust is now commencing preparation of the Outline Business Case.

On 6 February, the Mayor of London granted stage 2 planning permission for the Paddington Quarter 'Cube' planning application. The Mayor has instructed Transport for London (TfL) to ensure that outstanding issues relating to the Trust's and London Ambulance Service's safety concerns are resolved prior to sign the section 106 legal agreement. The committee considered its appropriate response to TfL, and how continued broader stakeholder engagement should be achieved.

At a workshop on 22 March, the committee considered the development of an agreed property development strategy for St Mary's and Western Eye Hospitals. The redevelopment programme objectives were re-affirmed, and key principles agreed in relation to clinical facilities, property assets, financial requirements, partnership and delivery options.

RECOMMENDATION:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Report from: Sir Richard Sykes, Chairman
Report author: Jan Aps, Trust company secretary
Next meeting: 26 April 2017

Report to: **Trust board**

Report from: **Quality Committee (15 March 2017)**

KEY ITEMS TO NOTE

Divisional Director's risk register update: The Committee reviewed the divisional risks:

A&E: work was in progress to put mitigations in place for continued increased capacity.

Junior Doctor rotas: the Committee were pleased to note that the risk relating to Junior Doctor rotas had tentatively reduced following the improvement of recruitment issues; this would continue to be monitored within the division.

Radiotherapy: The Committee noted that a new EU directive relating to the reduced dosing of radiation was being reviewed by the division and would possibly be added to the risk register.

Quality report: The Committee noted the CAS alert relating to water heater-cooler units which had led to a national action to notify patients to the risk of infection, and to advise patients experiencing symptoms to get in contact with their GP's or local acute provider. The Committee noted that a resuscitation committee would be developed which would review out of ICU cardiac arrests; the palliative care team would join this committee and provide support and training in order to improve the DNAR process, the Committee welcomed this work. The Committee were pleased to note that the patient experience team had been working to improve services for patients with learning disabilities as part of the on-going equality and diversity work.

CQC quarter 3 update: The Committee noted that there had been an unannounced inspection the previous week; with the inspectors assessing medical wards across all three sites and maternity services at St Mary's. The Committee were pleased to note that the feedback immediately following the inspection had been positive, with no significant concerns raised; the inspectors had thanked staff for their warm welcome during the visit.

SI monitoring report: The Committee noted that nine safety improvement workstreams, relating to SI themes, had been defined which included safer surgery, pressure ulcers and fetal monitoring. The Committee noted that in response to concerns about the quality of a number of SI investigations and reports, a more rigorous quality assurance process was now being followed which had led to an increased number of overdue reports. The Committee were assured that a concerted effort was being made to close overdue SI actions and were pleased to note that actions were now more specific and measurable.

End of life care – 6 monthly report: The Committee noted that there had been an increased focus on training and education which included how to have difficult conversations including discussions with families about DNAR requests.

Health and safety report: The Committee were concerned to note that there had been an increase in the number of violence and aggression incidents that had been reported and welcomed the work in place to improve this.

RECOMMENDATION:

The Trust board is requested to:

- Note the report

Report from: Dr Rodney Eastwood, acting Chairman, Quality Committee

Report author: Jessica Hargreaves, Deputy Board Secretary

Next meeting: 10 May 2017

Report to: **Trust board**
Report from: **Audit, Risk & Governance Committee (8 March 2017)**

KEY ITEMS TO NOTE

External audit plan 2016/17: The Committee noted the proposed audit plan and the scope of the planned audit work. Commenting on the audit of the quality account, members were pleased to note that the document would be more concise than in previous years.

Internal audit and counter-fraud report: The Committee noted that nine audits had not progressed as planned and sought assurance that these would not be delayed any further, highlighting the importance of ensuring that the plan was accurate and included the appropriate executive sponsors. In reviewing the most recent audit reports, the Committee requested that detail of the assurance received would be included in future reports. Committee noted the draft plan and suggested additional areas of focus for the following year

Management action plans following audits which had received a limited or no assurance rating: The Committee noted and supported the action plans being implemented in relation to diagnostics services and the automated inventory management system cabinets.

Losses and special payments register: The Committee noted the report. It was also assured that robust processes were in place for monitoring losses and write-offs.

Corporate risk register: The Committee noted the changes to the risk register since the previous update and were pleased to note that a review of the risk management effectiveness was undertaken by TIAA which demonstrated reasonable assurance; six recommendations had been made and these were being implemented.

EPRR business continuity work programme: The Committee acknowledged the work programme in place, with milestones identified post re-structure and to meet the new British ISO standard. TIAA would review business continuity plans following the completion of the work programme and report to the Committee in March 2018.

Recruitment and retention: The Committee supported the implementation of the recruitment and retention plan which sought to address the increasing risk relating to the vacancies in band 2-6 nursing and midwifery posts.

NWL Pathology external peer review: The Committee were pleased to note the positive and supportive outcome of the external peer review, noting that the recommendations were in the process of being implemented.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Dr Andreas Raffel, acting as Chairman, Audit, Risk & Governance Committee

Report author: Jessica Hargreaves, Deputy board secretary

Next meeting: 5 July 2017 (extraordinary Audit meetings to approve annual report and accounts would be held during April and May)

Report to: **Trust board**
Report from: **Remuneration Committee (29 September 2016)**

Key points to note:

Chief information officer: The Committee supported the proposed remuneration for the chief information officer, following agreement between the Trust and Chelsea & Westminster NHSFT to second Kevin Jarrold part-time to C&W (for one year, in the first instance). The Committee sought assurance that the joint role would not negatively impact the Trust's ICT developments; the audit, risk and governance committee (in December) were provided with an assurance paper demonstrating how this risk would be mitigated and managed.

Update on secondment arrangements for the chief operating officer: The Committee agreed to a three months extension of notice period (funded by the trust at which Steve McManus was working on secondment), and welcomed the news of his substantive appointment to chief executive at Royal Berkshire NHS FT commencing 1 January 2017.

Recommendation:**The Trust Board is requested to:**

- Note the report

Report from: Sarika Patel, chairman, Remuneration committee

Report author: Jan Aps, Trust board secretary

Next meeting: 14 December 2016

Report to: **Trust board**
Report from: **Remuneration Committee (14 December 2016)**

Key points to note:

Executive team succession arrangements: The committee discussed the potential succession planning for each of the executive posts, and agreed that this should be kept under review.

Strengthening performance management arrangements: The committee discussed the idea of de-linking performance rating from increment payments to encourage more effective management of poorer performance; discussed proposed amendments to the timing of reviews; and suggested that one directorate in each division be given early support to implement the proposals.

Director of nursing remuneration: The committee noted that NHSI and DH had agreed the proposed remuneration for the Director of nursing following the significant broadening of Prof Sigsworth's portfolio.

Recommendation:**The Trust Board is requested to:**

- Note the report

Report from: Sarika Patel, chairman, Remuneration committee

Report author: Jan Aps, Trust board secretary

Next meeting: 29 March 2017