Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
24 September 2014
10am – 12pm
Oak Suite, W12 Conference Centre,
Hammersmith Hospital,
London W12 0HS

Agenda Number		Presenter	Timing	Paper No.	Page No.
1	**Administrative Matters**				
1.1	Chairman's Opening Remarks	Chairman	10.00	Oral	
1.2	Apologies	Chairman		Oral	
1.3	Board Member's Declarations of Interests	Chairman		1	3
1.4	Minutes of the meeting held on 30 July 2014	Chairman		2	5
1.5	Matters Arising and Action Log	Chairman		3	13
2	**Operational Items**				
2.1	Patient Story	Director of Nursing	10.05	Oral	
2.2	Chief Executive's Report	Chief Executive	10.15	4	15
2.3	Operational Report	Chief Operating Officer	10.25	5	23
2.4	Integrated Performance Scorecard	Chief Operating Officer	10.35	6	35
2.5	Finance Performance Report	Chief Financial Officer	10.40	7	81
3	**Items for Decision**				
3.1	Annual Operating Plan	Chief Financial Officer	10.50	8	101
3.2	NHS Trust Development Authority Self-Certifications • Compliance June • Board Statement June • Compliance July • Board Statement July	Chief Financial Officer	11.00	9	117
3.3	Trust Policies: Health & Safety at Work & Fire Safety Policies	Director of Governance & Assurance	11.10	10	129
3.4	Standing Orders	Chief Financial Officer	11.20	11	191
4	**Items for Discussion**				
4.1	Hammersmith Hospital Emergency Unit Closure Update	Chief Operating Officer	11.30	12	195
4.2	CQC Chief Inspector of Hospitals' Visit	Director of Nursing	11.35	13	201
4.3	Infection Prevention and Control	Director of Infection Prevention & Control	11.40	14	205
4.4	Trust Board Calendar	Director of Governance & Assurance	11.45	15	211
5	**Board Committee Items**				

5.1	Quality Committee To receive the minutes of the meeting of 9 July 2014	Prof Sir Anthony Newman Taylor	11.50	16	215
	To note the report of the meeting of 20 August 2014			17	221
5.2	Audit, Risk and Governance Committee To note the report of the meeting of 10 September 2014	Sir Gerald Acher		18	223
	To receive the minutes of the meeting of 18 June 2014			19	225
5.3	Finance and Investment Committee To note the oral report of the meeting of 18 September 2014	Sarika Patel		Oral	
5.4	Foundation Trust Programme Board To note the oral report of the meeting of 16 September 2014	Dr Rodney Eastwood		Oral	
6	**Items for Information**				
7	**Any other Business**				
			11.55		
8	**Questions for the Public relating to Agenda items**				
9	**Date of Next Meeting**				
	26 November, 10am – 12.30pm, Oak Suite, W12 Conference Centre, Hammersmith Hospital				
10	**Exclusion of the Press and the Public**				
	'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960				

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Board Members' Register of Interests – September 2014

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

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

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

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

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

Professor Sir Anthony Newman-Taylor Non-Executive Director

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

Sarika Patel Non-Executive Director

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

Dr Andreas Raffel Designate Non-Executive Director

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

Dr Tracey Batten Chief Executive

- Nil

Bill Shields Chief Financial Officer

- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Board member, NHS Shared Business Services
- Board member, NHS Supply Chain
- Member of the CIPFA Remuneration Committee

Steve McManus Chief Operating Officer

- Chair – National Neurosciences Managers Forum
- FTN COO/Director of Operations Network

Professor Janice Sigsworth Director of Nursing

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

Dr Chris Harrison Medical Director

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

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

10.00am – 12.30pm
Wednesday 30 July 2014
Oak Suite, W12 Conference Centre
Hammersmith Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Non-Executive Director
Sir Thomas Legg	Non-Executive Director
Sir Anthony Newman Taylor	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director
Sarika Patel	Non-Executive Director
Dr Tracey Batten	Chief Executive Officer
Prof Chris Harrison	Medical Director
Steve McManus	Chief Operating Officer
Bill Shields	Chief Financial Officer
In attendance:	
Michelle Dixon	Director of Communications
Ian Garlington	Director of Strategy
Jayne Mee	Director of People and Organisational Development
Cheryl Plumridge	Director of Governance and Assurance
Dr Senga Steel	Deputy Director of Nursing
Carolyn Cullen	Interim Corporate Governance Manager (Minute taker)

1	**General Business**
1.1	**Chairman's Opening Remarks** The Chairman welcomed Board members, staff and members of the public to the meeting.
1.2	**Apologies for Absence** Apologies for absence were received from Jeremy Isaacs, Dr Andreas Raffel, Prof Janice Sigsworth, and Kevin Jarrold.
1.3	**Board Members' Declarations of Interest and Conflicts of Interest** There were no additional conflicts of interests declared at the meeting other than the standing declarations.

1.4	**Minutes of the Meeting held on 28 May 2014** The minutes of the meeting held on 28 May 2014 were agreed as a true record.
1.5	**Matters Arising and Action Log** Sir Richard Sykes clarified when the pharmacy review would be considered by the Board and it was agreed that it would be at the November meeting, after consideration at the Audit, Risk and Governance Committee in September. The Board **noted** the updates to the action log.
2	**Operational Items**
2.1.1	**Patient Story** Dr Senga Steel reported to the Board that the patient, due to give their story, was unable to attend today and would be rescheduled for a future meeting.
2.2	**Chief Executive's Report**
2.2.1	Dr Tracey Batten reported on progress on the delivery of key strategic priorities. This included updating the Board on the staff engagement survey and the OSC&R staff awards, progress on developing whole systems integrated care and the genomics 100k project. Dr Batten was delighted to inform the Board that St Mary's Major Trauma Centre has been judged by peers as the highest performing major trauma centre in England. This is an excellent outcome for the service which now sees 2,500 trauma cases per annum.
2.2.2	Sir Gerald Archer asked what progress had been made on the executive development day, which had included a facilitated session from PWC, in embedding risk management in the Trust. Dr Batten stated that senior managers were more aware of risk and that work was on-going on the development of the corporate risk register.
2.2.3	The Trust Board **noted** the report.
2.3	**Operational Report**
2.3.1	Steve McManus highlighted three key areas: on finances the first quarter performance was behind plan; on timeliness the Trust had underperformed on three Referral to Treatment (RTT) measures in June; and on efficiency there was a need for the Trust to improve theatre utilisation. Corrective actions were identified and were being implemented. Prof Harrison stated that the Trust's standardised mortality rate remained amongst the lowest nationally; but there had been one never event in June, and two MRSA cases had been attributed to the Trust.
2.3.6	The Trust Board **noted** the report.
2.4	**Integrated Performance Scorecard**
2.4.1	Steve McManus introduced the report which provided key headlines on performance indicators for Monitor, CQC and TDA frameworks. Whilst overall performance was within target, the Trust was red rated for theatre utilisation, the average length of stay for elective patients, the 18 week RTT, the number of complaints received by the Trust and the completion of safeguarding of adults training. Corrective actions had been identified and were being implemented.
2.4.2	Sarika Patel pointed out that comparatively the Trust had had more instances of Clostridium Difficile this year. Prof Chris Harrison explained that rates can be attributed to clustering at certain times of the year and Dr Alison Holmes, Director of Infection Prevention and Control would give an update to the September Board on the Trust's MRSA and C-diff rates and update the Board on the Trust's approach to infection control in light of recent warnings on the Ebola virus. **Action:** Dr Alison Holmes to provide update on infection control and prevention to the September Board meeting.
2.4.3	Sir Anthony Newman Taylor asked what progress was being made to improve local induction rates. Jayne Mee assured the Board that there was a plan to

	deliver local induction and that induction was being given to new starters but that often this was not being recorded.
	The Trust Board **noted** the report.
2.5	**Finance Report**
2.5.1	Bill Shields introduced the report. The Trust's Income and Expenditure (I&E) position at the end of June was in deficit; with an adverse variance against plan of £3.7m. The financial position continued to deteriorate and presented a major challenge to delivery of the Trust's objectives for the year, including achievement of Foundation Trust status. The reasons for the adverse variance were identified as: the cost improvement plans (CIPs) being behind plan by £6.7m, expenditure on Cerner implementation greater than expected and temporary staff pay costs significantly higher than budgeted for. The revenue capture issues with Cerner were also highlighted.
2.5.2	Sir Gerald Archer asked whether CIP performance was a timing issue or whether savings had been foregone. Bill Shields commented that some CIPs were expected to deliver later in the year but the same was not necessarily true for income based CIPs. Regular monitoring meetings were being held with Directorates and a specialist support team was being assembled to help Directorates implement their CIP schemes and identify opportunities for future efficiencies.
2.5.3	The Trust Board **noted** the report.
3	**Items for Decision**
3.1	**Revised Vision & Strategic Objectives**
3.1.1	Dr Tracey Batten introduced the revised vision and strategic objectives for the Trust, which had been refined in the light of the consultation on the clinical strategy. Patient care was now at the heart of the vision for the organisation and staff had wanted to emphasise that the Trust's aim was to deliver effective services with compassion.
3.1.2	The Trust Board **approved** the vision and strategic objectives.
3.2	**Unlocking our potential to transform Health and Care, Clinical Strategy 2014-2019**
3.2.1	Dr Tracey Batten presented the Clinical Strategy 2014-2019 explaining that the strategy had been developed by understanding how services are currently delivered, exploring best models of care in the UK and across the world and putting forward plans for a clinical transformation to deliver 21st century healthcare. Nearly one third of all clinical staff at the Trust had attended consultation events, and written submissions had been received from many specialties, and together these had helped shape the proposals. The strategy also outlined plans for investment and redevelopment of the estate in order to meet service needs. Dr Batten explained that the Trust would be working closely with local commissioners to develop a major engagement programme to involve staff and local communities in shaping plans further. The plans would go forward to the NHS Trust Development Authority (TDA) for approval to secure funding.
3.2.2	Sarika Patel asked what operating models had been considered for day case surgery at Charing Cross Hospital. Dr Tracey Batten explained that the strategy had been driven by clinicians and hence the clinical strategy reflected what clinician believed was the best configuration and practice to manage day cases.
3.2.3	Sir Gerald Archer asked what plans were in place to ensure that services remain safe and effective at St Mary's Hospital whilst major construction work was taking place. Ian Garlington assured the Board that detailed plans for decant and transitional working arrangements would be brought to the Board as part of the Full Business Case (FBC).
3.2.4	Sir Thomas Legg asked how local GPs and CCGs had been involved in the development of the strategy. Dr Tracey Batten responded that the strategy had

	been developed as a response to North West London CCGs own proposals called Shaping a Healthier Future. North West London CCGs had been integral to the development of the strategy and were fully supportive.
3.2.4	The Board **approved** the Clinical Strategy**.**
3.3	**NHS Trust Development Authority Self-Certifications for February 2014 and March 2015**
3.3.1	Bill Shields presented the certificates for April and May 2014. These were required for compliance with TDA licence requirements for all NHS Trusts. The Trust was compliant for both months.
3.3.2	The Trust Board **approved** the following Self-certifications: • April 2014 Compliance • April 2014 Board Statement • May 2014 Compliance • May 2014 Board Statement
3.4	**2014/15 Workforce Plan**
3.4.1	Jayne Mee presented the 2014/15 Workforce Plan which has been prepared in line with TDA requirements.
3.4.2	Sarika Patel asked that benchmarks with other Trusts be used to assure that there was sufficient staff for the size of hospital, number of patients and complexity of case mix. Jayne Mee assured the Board these arrangements met the criteria for safe practice and that benchmarking would be included in future.
3.4.3	The Trust Board **approved** the 2014/15 Workforce Plan.
3.5	**Hotel Services Tender**
3.5.1	Ian Garlington presented the report which sought retrospectively to ratify the appointment of Sodexo to provide hotel services to the Trust, mainly comprising patient catering, cleaning and portering across all sites. The service would start in October 2014 and approximately 1100 staff will be TUPE-transferred from the incumbent contractor to the new supplier. The appointment of Sodexo had previously been considered at the Trust Board Seminar in June under Chairman's executive Standing Orders urgency 5.2 and was coming to the Board for ratification.
3.5.2	Sarika Patel assured the Board that the appointment had been fully considered by the Finance and Investment Committee which had supported the proposal.
3.5.3	The Trust Board **ratified** the decision to appoint Sodexo to provide hotel services.
4	**Items for Discussion**
4.1	**Update on progress towards the safe closure of the Emergency Unit at Hammersmith Hospital**
4.1.2	Steve McManus presented an update on progress with plans to close the A&E at Hammersmith Hospital on 10th September 2014. An Urgent Care Centre will remain and is already open 24/7. Capacity is being enhanced at St Mary's Hospital and Charing Cross Hospital. Comprehensive work is being done on new pathways and operating procedures to support the closure have been tested and there is a high level of confidence given the clinical assurance by the appropriate clinicians.
4.1.3	Sir Anthony Newman Taylor assured the Board that the safe closure of the Emergency Unit at Hammersmith Hospital had been fully considered by the Quality Committee and that the proposals for the reconfiguration of A&E services addressed long held concerns about the level of consultant and junior doctor staffing.
4.1.4	Sir Gerald Acher asked how it had been assured that transfers between sites would be made safely and what processes had been put in place to ensure that patients were not reassessed following transfer. Prof Chris Harrison assured the Board that the transfer policy had been fully reviewed, the reconfiguration of

	services meant that patients would be treated at the most appropriate hospital, which was more important than where the patient presented; and that there were no clinical concerns.
4.1.5	The Board **endorsed** the closure of the Emergency Unit at Hammersmith Hospital to proceed as planned on 10 September 2014.
4.2	**Monitor's NHS Foundation Trust Code of Governance Assessment**
4.2.1	Cheryl Plumridge presented a proposal to assess governance arrangements against Monitor's Code of Governance Practice. The work would be undertaken jointly by lead directors referenced in the report and the Governance Team. **Action:** Cheryl Plumridge to undertake an assessment of Trust governance against the Monitor code of good practice and bring the findings to the September Trust Board.
4.2.2	The Board **noted** the report.
4.3	**CQC Chief Inspector of Hospitals' Assessment September 2014**
4.3.1	Dr Senga Steel presented the report which updated the Board on preparations for the CQC Chief Inspector of Hospitals visit. Dr Chris Harrison assured the Board that patient confidentiality and dignity would be respected at all times during the assessment.
4.3.2	The Board **noted** the report.
4.4	**Responsible Officer's Annual Report**
4.4.1	Dr David Mitchell, Associate Medical Director and Responsible Officer, presented the report which summarised compliance with regulations for the year ending 31 March 2014. Dr Mitchell explained that the first annual organisational audit had been submitted to NHS England in May 2014. The audit had highlighted some areas for improvement and an action plan had been developed to address these.
4.4.2	Prof Chris Harrison informed the Board that Dr David Mitchell was retiring. Dr Tracey Batten proposed a vote of thanks from the Board for all the work Dr Mitchell had done for the Trust over many years. The Board considered a tabled paper on the appointment of Prof Chris Harrison as the responsible officer for the Trust. The Board agreed the appointment of Prof Chris Harrison as responsible officer for the Trust with effect from 1 August 2014.
4.4.3	The Board **noted** the report and **agreed** that the statement of compliance be submitted to NHS England.
4.5	**Monthly report on safe Nurse/Midwife staffing levels at Imperial College Healthcare NHS Trust**
4.5.1	Dr Senga Steel presented the report. Overall the Trust reported above 95% for the average fill rate for registered and unregistered nursing/midwife staff during the day and night for the month of May; and above 90% for June. Where some wards areas where below the required 90% staffing target, at no time had patient safety been compromised.
4.5.2	The Board **noted** the report.
4.6	**Update on Progress with the Implementation of Cerner**
4.6.1	Steve McManus presented the report which updated the Board on progress with the implementation of Cerner Millennium Patient Administration System. Since successfully cutting over to the new system in April the Trust had been going through a post go-live stabilisation process. Steve McManus recognised that issues were still to be resolved on coding and budget overruns, on data quality, staff training and support, and on resolving issues around outpatients.
4.6.2	Sir Gerald Acher reported that Audit, Risk and Governance Committee had reviewed the preparation and post implementation position for the new patient administration system. Issues were being addresses and there had been exemplary effort to get things right. Steve McManus outlined the gateway approach for managing implementation which gives assurance on governance

	and quality. A further report will be going to the Audit Risk and Governance Committee in September to report on progress. **Action:** Steve McManus to provide a progress report on Cerner implementation to the September Audit, Risk and Governance Committee.
4.6.3	The Board **noted** the report.
4.7	**Annual Programme of Work**
	The Board **noted** the report.
5	**Board Committee Items**
5.1	**Quality Committee** **The Board noted the report of the meeting on 9 July 2014.** **The Board received the minutes of the meeting of 11 June 2014.** **The Board received the minutes of the meeting of 13 May 2014.**
5.1.1	Sir Anthony Newman Taylor provided an update report of the Quality Committee held on 7 July 2014. In particular, he highlighted the work being done with Macmillan (the cancer charity), the updates the Committee now received from the Director of People and Organisation Development, and the reports from the Divisions on quality assurance of CIPs. Sir Richard Sykes asked what work the Quality Committee had programmed on infection control in light of concerns over infections overseas. Sir Anthony reported that Professor Alison Holmes would be providing an update on the screening facilities for patients who had travelled, or had been in receipt of care, overseas to the October Quality Committee. **Action:** Professor Alison Holmes to provide an update on the screening facilities available for patients who had travelled, or had been in receipt of care, overseas to the October Quality Committee.
5.2	**Audit, Risk & Governance Committee** **The Board noted the report of the meeting of 18 June 2014** **The Board received the minutes of the meeting of 28 May 2014**
5.2.1	Sir Gerald Acher presented the update report of the Audit, Risk and Governance Committee meeting held on 18 June 2014. Sir Gerald reported that the Committee had held a private session with both the internal and external auditors and no additional matters were brought to the Committee's attention although the Trust did need to implement the internal auditors' actions more speedily. Sir Gerald stated that a timetable for undertaking data quality audits would be agreed at the September meeting, and he was pleased with the progress made in developing the Trust's corporate risk register but wanted this progress maintained. Sarika Patel asked that the internal audit (TIAA) report on bank and agency staffing be reconsidered in the light of the current need to tighten controls for authorising agency staff. Bill Shields agreed to revisit the report with the internal auditors (TIAA). **Action:** Bill Shields to ask the internal auditors to revisit their report on bank and agency staffing and report back to the Audit, Risk and Governance Committee on any new recommendations made.
5.3	**Finance & Investment Committee** **The Board noted the oral report of the meeting of 24 July 2014** **The Board received the minutes of the 22 May 2014**
5.3.1	Sarika Patel reported that the Committee had considered the Finance Report, the Cost Improvement Programme (CIP) Quarter 1, the OBC for SaHF and the North West London Pathology full business case. The Committee had asked for a further briefing on the benefits to the Trust of being part of the pathology consortium to be prepared.
5.4	**Foundation Trust Programme Board**

	The Board noted the report of the meeting of 17 July 2014 **The Board received the minutes of the meeting of 29 April 2014**
5.4.1	Dr Rodney Eastwood provided an update to the Board on the FT programme timeline which now needed to take account of the timing of the feedback from the CQC inspection before the readiness review with the TDA could take place. Dr Rodney Eastwood informed the Board that a revised constitution for the Trust would be prepared for consideration by the Board at their September meeting.
5.5	**Remuneration and Appointments Committee** **The Board noted the oral update of the meeting of 25 June 2014**
5.5.1	Jayne Mee updated the Board on the meeting of 25 June 2014. The Committee had reviewed salary benchmarking information in line with good practice.
6	**Items for Information** There were no items.
7	**Any other Business** No other business was submitted
8	**Questions from the Public relating to Agenda Items**
8.1	A number of questions were asked by members of the public in relation to the proposed closure of Hammersmith Hospital Emergency Unit, the Clinical Strategy and other matters. These included whether: • there was sufficient resources for the implementation of phase two of the Cerner patient administration system; • the impact of the number of patients from Hammersmith who would now be attending A&E at St Mary's had been fully modelled; • consideration had been given to the public transport difficulties for patients and their relatives from the Hammersmith and Acton areas now required to attend A&E at Paddington; • presenting at one hospital but being referred to second hospital for treatment would require reassessment and how notes would be transferred with the patient; and • there was sufficient bed capacity to admit patients at Charing Cross hospital. • Dr Tracey Batten provided explanations to each question and encouraged members of the public to email any further questions to chief.executive@imperial.nhs.uk. Andrew Slaughter, MP for Hammersmith and Fulham, addressed the meeting. He expressed concerns on behalf of his constituents as to whether the proposals for all three hospital sites fully took account of the rise in the population and the proposed development of 50,000 new homes in the area, the difficulties with transport, whether there was sufficient staff and services at St Mary's to offset the impact of closure of the A&E department at Hammersmith Hospital, whether there had been sufficient consultation with the community, and that communications to residents over the closure of the A&E department had only been sent out six weeks before the changes and during the school holidays when residents may be away and whether overall the proposals were cost driven. Sir Richard Sykes said that there had been considerable consultation in relation to this project as part of Shaping a Healthier Future. Dr Tracey Batten would be meeting community groups and the Save Our Charing Cross campaign; and there would be further engagement with the local community on the development of plans for services in their area.
9	**Date and time of next meeting**

	Wednesday 24 September 10am - 12.30pm, W12 Conference Centre, Hammersmith Hospital, London W12 0HS.
10	**Exclusion of the Press and the Public** The Board resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960

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ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
28 May 2014

Minute Number	Action	Responsible	Completion Date	September 2014 Update
1.5	May TB: 3.2.5 Closure of the Emergency Unit at Hammersmith Hospital An update report on any financial impact of the changes to be reported to the Finance & Investment Committee. July update: Above to be reported to TB.	Chief Financial Officer	TB September 2014	**Completed.** Agenda item.
2.3.4	The performance of pharmacy scripts specifically during out of hours to be considered at an Audit, Risk & Governance meeting.	Chief Operating Officer	ARGC December 2014	**Completed**. ARGC meeting September.
4.2	Annual Summary of the Trust's quality impact assessment process for cost improvement programmes (2013/14) Post-implementation reports to be submitted to the Trust Board for review.	Medical Director		On forward plan

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
30 July 2014

Minute Number	Action	Responsible	Completion Date	September 2014 Update
1.5	A review of pharmacy services would be considered by the Board at its November meeting, after first being considered at the Audit, Risk and Governance Committee in September.	Chief Operating Officer	TB November 2014	On forward plan
2.4	An update on MRSA and C-diff rates and the Trust's approach to infection control, in light of recent warnings on the Ebola virus, to be reported to the September Trust Board.	Director of Infection Prevention and Control	TB September 2014	**Completed.** Agenda item.
4.2.1	An assessment of the Trust's governance arrangements to be under taken against the Monitor code of good practice and reported to the September Trust Board.	Director of Governance & Assurance	TB November 2014	On forward plan

4.6.2	A progress report on Cerner implementation to be considered at the September Audit, Risk and Governance Committee.	Chief Operating Officer	Audit, Risk and Governance Committee September 2014.	**Completed.** Agenda item.
5.2.1	The internal auditors (TIAA) to be asked to revisit their report on bank and agency staffing and report back to the Audit, Risk and Governance Committee in September on new recommendations made.	Chief Financial Officer	Audit, Risk and Governance Committee September 2014.	**Completed**. ARGC meeting September.

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Trust Board Public

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

Executive Summary:

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

Recommendation(s) to the Board/Committee:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Key Strategic Priorities

1. Chief Inspector of Hospitals Visit

The Care Quality Commission (CQC) Chief Inspector of Hospitals (CiH) inspection of Imperial College Healthcare NHS Trust took place on 2 – 5 September.

Approximately 50 inspectors attended our announced component of the inspection. Our staff indicated that there were no surprises in terms of services and areas visited, areas of focus or questions during staff focus groups and interviews. The inspection team did identify a few concerns such as the cleanliness of the Accident and Emergency department at St. Mary's Hospital, drug fridge temperatures, compliance with the Do not attempt Cardiopulmonary Resuscitation (DNACPR) Orders in Hospital Policy and a back log of patient letters in gastroenterology. The directors responsible for these areas have provided assurance that all of these issues have now been addressed.

Following the conclusion of the announced component of the inspection, on 5 September the CQC delivered brief, high level feedback to the Trust Chair, CEO, five domain leads and Deputy Director of Nursing. They said that all the staff they met were helpful, open, honest and engaged and that nothing significantly untoward was noted. There was no indication of the outcome of the inspection. Further review of the data and possible unannounced inspections are anticipated in the next two weeks.

In eight to ten weeks (mid-November) we will receive five draft inspection reports: one report for each hospital (St. Mary's, Charing Cross, Hammersmith, and Queen Charlotte's and Chelsea) and an overall report for the Trust. A quality summit will then follow this (early December) when factual accuracy checks will be finalised and the Trust will be awarded its final rating.

2. Clinical Strategy/Outline Business Case

In July the Trust Board approved the Outline Business Case (OBC) for the implementation of service and site changes as part of ICHTs response to Shaping a Healthier Future (SaHF). Due to the complexity of the sector wide changes in NW London it has been necessary for the CCG's to consider each organisation's business case in the context of each other to ensure that the entire sector is ready for the shift in clinical activity. The CCG's are now drafting the NWL sector wide Investment Making Business Case (IMBC) prior to forwarding to NHS England and the Trust Development Authority (TDA) later in the year. Work will therefore continue at ICHT on developing our plans, but the full business case (FBC) may not be progressed until early next year once the OBC receives approval.

Following the approval of the clinical strategy at the Trust Board in July, work will now commence on the Clinical Transformation Programme that will be required over the next few years to effect the changes in the models of care required to implement our clinical and sites strategy. External and internal engagement proposals will be developed around our clinical strategy/estates redevelopment with the intention to work collaboratively with CCGs

and the broader NWL health sector.

3. Cerner Implementation

The Cerner Patient Administration System (PAS) went live across the Trust over the Easter break. Overall, the transfer over to the new system was successful and demonstrated an enormous team effort by our staff. However, post implementation, a number of anticipated issues, particularly around data quality, have continued to challenge the stabilisation process. We now have a well-coordinated approach to the data quality issues and challenges that impact on operational delivery, performance targets and income recovery and a good dialogue has been established with Commissioners on the impact of these issues.

Progress is being made with an established improvement methodology tracked through the 'Go to Green' Plans but there is still a way to go. The gateway process will be internally tested in late September and steady state is anticipated by the end of December.

4. Financial Sustainability

The Trust's financial position for month five was a surplus of £0.8m, which is a favourable variance of £0.2m in month. The Trust is reporting a year-to-date deficit of £1.9m which is an adverse variance against the plan of £6.1m. There was an improvement in the month due to a reduction in Bank & Agency expenditure of £1.6m and Non-Pay of £2.1m when compared to the previous month. The main reasons for the YTD adverse variance relate to Cost Improvement Plans (CIPs), which are behind plan by £8.1m (46%); expenditure on the Cerner implementation was much greater than expected and year to date expenditure remains above plan; and temporary staff pay costs are significantly higher than plan but the introduction of new controls has had a significant impact this month.

There is on-going dialogue with the TDA about the impact of the proposed Project Diamond funding reductions on the Trust's financial position in both current and future years. Any reductions in funding will mean that the Trust's year end forecast will have to reduce accordingly.

5. Hammersmith A&E Closure

The Hammersmith A&E department closed on 10 September 2014. The closure took place with the full backing of the CCG's, NHS England and the Trust Development Authority (TDA) after we provided them with the assurance that the plans were robust and safe. The Urgent Care Centre at Hammersmith Hospital has now extended its hours of operation to 24/7 and new pathways and additional capacity are in place at Hammersmith, St. Mary's and Charing Cross. The staff involved in the changes are to be commended for their support, positive engagement, co-operation and hard work to ensure the safe closure of the unit.

6. Stakeholder Engagement

As August is traditionally a quiet month for stakeholder contact, the only significant external meeting to have taken place is with Westminster City Council Health Urgency Sub-

Committee to present the clinical strategy. This month we have continued to engage a range of external stakeholders, particularly on the development of our clinical strategy, which includes a number of meetings with Healthwatch Central and Save our Hospitals group. The North West London Joint Health Overview and Scrutiny Committee also visited St. Mary's hospital to review our urgent and emergency care services. The Trust's Annual General Meeting (AGM) is taking place on 24 September. We are expecting a strong attendance from shadow members, our patients and the public, which provide a good opportunity to begin to increase engagement around our plans for the future.

7. Memorandum Of Understanding agreement with Macmillan

Following poor cancer patient experience scoring in the Trust, discussion began with Macmillan to better understand the patients' cancer journey and their experience as a cancer patient in the Trust. A project was outlined to deliver solutions to improve specific areas of patient experience. Macmillan Cancer charity has had a long association with ICHT, supporting over the years the development of our Clinical Nurse Specialist (CNS) team, the Palliative Care Team, the information and advice pods, complementary therapies and psychology services. This partnership is continuing and a Memorandum Of Understanding (MOU) outlines Macmillan's commitment to work with ICHT over the next 3 years to support new developments in cancer care.

The Executive Committee has endorsed the Financial Agreement sitting under the Macmillan MOU. The MOU has been signed and is effective from 1 July 2014.

8. Heads of Agreement for Cancer Services and Research

As Directors are aware, a Heads of Agreement was signed between Imperial College, ICHT, The Royal Marsden and the Institute of Cancer Research in February 2014 to explore opportunities to become a world class partnership for cancer services and research by leveraging our respective and complementary strengths. The Heads of Agreement is for 12 months but within 6 months the parties were expected to be in a position to update their Boards on the proposals that would further this initiative. To date, there have been a number of very constructive discussions held between the parties with proposals now being formed for further discussion and consideration by the respective executive teams and the Cancer Board. It is anticipated that these proposals will be finalised over the coming months in time for respective Board consideration prior to the expiration of the Heads of Agreement in February 2015.

9. Staff engagement survey

Our fourth local engagement survey ran for 3 weeks in late July and early August. The results showed a very positive increase in the response rate from 31% to 45% (total responses 1415). This brings the total responses across the first year to 3276.The results showed:-

- 1% Increase in our Engagement score to 38%
- Our Friends and Family Test question "Would you recommend this Trust for care or treatment" remained constant at 78%, and "Would you recommend this Trust as a place to work" increased by 3% to 60%
- The lowest performing questions remained the same as in previous surveys but

there were signs of improvement
  - "Senor Leaders inspire and empower me to deliver exceptional performance" – increase of 4%
  - "My job is good for my health" – increase of 3%
  - "My organisation takes positive action on health and wellbeing" -increase of 3%
- The number of people who believe action will be taken as a result of the survey has increased from 51% to 55%. It is likely that this indicator links to the extent to which people can see action being taken by their local managers.

The results are now being communicated across the Trust and managers are working on their action plans in response to the survey. The results of the two Friends and Family Questions are now a mandatory CQUIN requirement and the first quarterly submission has been made using Survey 3 results. These results will be published for the first time on September 25th on the Department of Health website and the NHS Choices website, allowing a national comparison of our position with other Trusts. The National NHS Staff Survey will be launched on 22 September to a sample of 850 across the Trust. This remains a mandatory survey for all NHS Trusts and provides data to the CQC on our results. This survey runs until December and result are available in February/March 2015.

10. Opening of the Endoscopy Unit

The state-of-the-art Thomas C Hunt Endoscopy Unit at St Mary's Hospital was officially opened by the CEO and the clinical lead for endoscopy, Dr Jonathan Hoare, on Thursday 11 September 2014. The purpose built endoscopy unit will improve services for patients at the Trust and also showcases new artwork by leading British artist Julian Opie. The facility has been redesigned to make sure that patient experience is as seamless as possible and meets the highest levels of dignity and privacy. The endoscopy unit will meet the growing demand of patients needing a range of tests to examine their digestive tract and airways. It is estimated that around 7,500 patients will be seen in the new endoscopy department each year.

11. Appointment of Imperial College Healthcare Charity CEO

Imperial College Healthcare Charity has announced the appointment of Ian Lush as the new Chief Executive of the Charity. Ian will be joining the charity on 1 December 2014, taking over from Jane Miles who has successfully led the Charity since its formation in 2009. Ian brings a wealth of experience with him, working currently as the chief executive of the Architectural Heritage Fund (AHF) where he has been since 2003. His career has seen him play the viola with the Iceland Symphony Orchestra in Reykjavik and the Royal Liverpool Philharmonic Orchestra, before a successful eight years working as the marketing director for the Barbican Centre. Ian then became the managing director of the London Mozart Players in 1995 before joining the AHF. Outside of his work as chief executive, Ian is the Lead Governor for Great Ormond Street Hospital NHS Foundation Trust, having previously been a lay advisor to the board during their transition to Foundation Trust status.

12. Appointment of Board Secretary

Interviews for the position of Trust Secretary are being held on Friday 19 September 2014. The interview panel comprises the CEO, Andreas Raffel and Jayne Mee. A verbal update will be provided at the meeting.

Key Strategic Issues

1. NHS Genomics Medicine Centre: Response to ITT

The Department of Health (DH), through NHS England, has issued an Invitation To Tender (ITT) for NHS Trusts to become NHS Genomic Medicine Centres. This is to realise the Prime Minister's 100,000 Genomes initiative; the ultimate aim being for the NHS to use genetic and genomic data as a matter of course in treating patients. Imperial College Healthcare NHS Trust (ICHT) is in a prime position and responded to the ITT on 29 August 2014. Delivery of this initiative will be key when re-applying for the NIHR Imperial BRC in 2016/17. Royal Brompton & Harefield NHS Foundation Trust (RBH&FT) and Chelsea & Westminster Hospital NHS Foundation Trust (C&WHFT) are key partners in this bid. If successful, ICHT will be invited to submit a more detailed response, followed by discussions with NHS England / Genomics England, and contract signature. The current aim is to begin the project by January 2015, to last until Q1 2017 in the first instance.

2. NHS Five Year Forward View ("5YFV")

On the 15th August, NHS England published its criteria for the Five Year Forward View. The purpose of the document is to consider why change is needed, what success might look like, and how we might get there. In summary the Forward View will provide a clear vision, setting out the particular contribution that the NHS and others can make to the health of our nation. It will provide a shared understanding of the extent and nature of the gap between where we are and where we need to be and develop a range of care models that could deliver transformation. Finally it will identify priority areas for targeting transformation, identifying what needs to happen to support delivery and the potential benefits for patients and taxpayers that we can take nationally to create the conditions for local action. The complete 5YFV document is expected to be published this autumn.

3. Whole Systems Integrated Care (WSIC)

As one of 14 national Pioneer areas, NWL health economy is designing and placing into shadow operating models, revised ways of working that are truly patient centred. The initiative, called 'Whole Systems Integrated Care' (WSIC) is the main vehicle for the delivery of potential new models of integrated care. Our clinical strategy has integrated care as one of its three core strands, and we are tackling this on a number of levels, primarily because the national pilot requires any early adopter to be able to identify and model a capitated budget. The pilots are targeted towards patients older than 75 years with multiple co-morbidities. It is thought that the Whole Systems approach will be rolled out in April 2015.

Further work is required for ICHT to review and understand the strategic importance and opportunity of becoming an accountable care organisation. A discussion paper is under development for consideration by the Executive.

4. Better Care Fund (BCF)

The Better Care Fund (BCF) is aimed at joining up health and social care.
The CCGs and Local Authorities will be working with providers in the coming months to develop these plans further and will facilitate the transformation in services required by the Better Care Fund. Under new guidance, councils and CCGs will be required to share plans for reducing emergency admissions with acute providers, who will be invited to comment. For ICHT, this has been scheduled for the 16 September 2014.

The Key theme for Tri-Borough and the biggest impact across providers is the development and roll out of the Community Independence Service (CIS) which provides a range of functions including rapid response services, in-reach/supported discharge, rehabilitation and reablement. This service will be put out to tender later this year and ICHT will need to seriously consider the strategic opportunity provided by tendering for delivery of these community services.

5. Barker commission report

The Independent Commission on the Future of Health and Social Care in England, led by economist Dame Kate Barker, published a report on 4 September which has recommended that the NHS and social-care systems in England should be merged. Currently the NHS is free at the point of need, while payment for care homes support is means-tested, but the Barker Commission said the distinction was unfair and must end. It said the cost of providing free social care could come from a mix of new taxes and cuts to benefits and prescription exemptions. Dame Kate said the country was facing “difficult questions” but added the current system was simply “not fit to provide the kind of care we need and want”. There is no planned comment by the Government.

6. Dalton review

As detail surrounding the Dalton Review continues to be discussed, we are starting to see in the press some of the speculation become quantified. One claim is that the Buddying scheme offers better value for money than consultancies. Another suggestion, by Cabinet Office minister Francis Maude, is that more NHS hospitals and youth services should be taken out of public hands and owned by the people who run them as a mutual. The Dalton Review aims to report by October 2014.

7. Private Patients

During the month there has been considerable interest in the total income received by NHS Trusts for Private Patient work. It has been researched and reported that the amount earned by NHS trusts from treating private patients has barely risen since rules introduced last year allowed a higher percentage of turnover to be raised from non-NHS work. In 2013/14, non-NHS income made up less than 1.6% of the total operating income for the foundation trust sector and private patient income stood at 0.92%, only a small rise on the year before.

8. Care Quality Commission (CQC)

Two new regulations are being introduced under CQC registration with effect from 1 October 2014. The Duty of Candour regulation requires providers to be open and honest when things go wrong and people are harmed. We are currently reviewing our policy to ensure compliance. The Fit and Proper Person: Directors Regulation is to ensure the Trust undertakes appropriate assessments of individuals who will form part of its 'controlling mind' i.e. who have a direct influence on the organisation's culture and values. We are awaiting CQC guidance due for release shortly on how best to demonstrate compliance with this regulation.

The CQC have also announced that from October 2014 the special measures regime will be extended to general practice and any surgery which the CQC deems to be "inadequate" will be given up to six months, but in some cases only a few weeks, to draw up and implement an action plan of improvements. Any that fail to address concerns quickly enough will be put into special measures. If, after a further period of no more than six months, problems are still evident, the CQC will cancel the practice's registration, meaning it will have to close. NHS England said it would make arrangements for patients affected by any closures to start being treated at other local practices or by a new GP taking over the running of the closed surgery.

Imperial College Healthcare NHS Trust

Trust Board Public

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

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

Recommendation(s) to the Board/Committee: The Board is asked to note the contents of this report. A discussion is recommended as to the appropriate domain lead for the Efficiency section.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Title : Operational Report

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

Introduction: This report relates to activity within M5 (August) 2014/15.

A. Shadow Monitor compliance

Foundation Trust governance risk rating (shadow): Amber

Rationale: The Trust under-delivered on two of the three RTT standards and the Cancer breast symptomatic two week wait referral standard in July (cancer data reported one month in arrears). We are confident that the reported RTT under-performance is directly related to bedding-in issues with the new patient administration system and that our actual, underlying RTT performance remains strong.

B. Safety

Mortality Rates & Incidents

Mortality Rates:
The Trust's Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) remain amongst the lowest of the non-specialist acute providers nationally with statistically significantly low figures.

Incident Reporting:
The incident reporting rate (number of incidents per 100 admissions) continues to increase. In August the rate was 9.4 compated to 8.6 in July and 8.3 in June. This is the third consequtive month that the Trust reporting rate is above our peers (7.98). This is an important indicator of the safety culture in the organisation. There has been no increase in the harm caused by the incidents.

Serious Incidents (SIs) & Never Events:
The year to date reported total of SIs is 47, compared to 59 for same time period last year.

No confirmed never events were reported in August.

3 Never Events have been reported by the Trust in the last year, two of which related to mis-placed naso-gastric (NG) tubes. The following actions have been taken to prevent reoccurence and improve awareness:

- NG policy amended to add a radiology review of any x-rays taken to confirm placement before feeding and to remove a step in the paediatric policy regarding the "whoosh test";
- Communication has gone out and a letter sent from the MD (with confirmation by the DDNs & DDs that ward managers, consultants and junior doctors have received the message);
- Moodle training module now in place for junior doctors which includes this new step – launched at induction in August with programme of assurance now running to capture all doctors;
- Review of the NG policy (to include longer term decision re introducing competency

based assessment for junior doctors or continuing with radiologist review) underway by Dr Williams (Chair of the NSG);
- Results of trust-wide snapshot audit of compliance with policy to be reported to ExCo – Quality & Safety in October 2014;
- Nursing competency and training assurance being managed by the DDNs;
- Meeting arranged with Medical Director and divisional leads for 26th September to follow up actions.

Infection Prevention & Control

See separate board report this month – agenda item 4.3

Cost improvement programme (CIP) quality impact assessments (QIA)

- **2014/15 schemes**

The Medical Director and Director of Nursing met with all four divisions in August to discuss 2014/15 CIP schemes. Currently, there is only one scheme that has a risk assessment score of 12 with the remaining schemes being scored at 9 or below. Where risk has been identified, mitigating actions are in place. It was acknowledged that work is currently being undertaken within the divisions to revise/develop additional schemes for the remainder of the year. The QIAs for these will be discussed at the next set of meetings in October.

- **2013/14 schemes: post-implementation evaluations**

The division of medicine presented four post-implementation evaluations for 2013/14 schemes, at the meeting in August. The purpose of the evaluations are to consider if there has been any adverse impact on quality after the scheme has been implemented, using key performance indicators such as complaints, incidents, infection rates and workforce indicators. Divisions will present further post-implementation evaluations at the meetings in October and these will be reported back to the Trust Board in November.

C. Patient Centeredness

Friends and Family Test

Overall response rates remain above the threshold in August. However, the response rate for St Mary's A&E was relatively low in August; this has been reviewed with the department and the rate has improved at the time of writing.

There was a dip in the inpatient score in August. It is not yet clear why this was the case. Analysis of the free text comments associated with "detractor" responses has not highlighted any themes that would account for the dip. There are no national benchmark data available for August at this time, so it is not possible to see if this is an issue wider than the trust. We will review once national benchmark data for August and ICHT's September data are available.

At 50, the A&E FFT score is lower than the previous month (although this score should still be considered a good net promoter score). This downward trend has been seen across London and nationally. Benchmark data are not available for August but in July ICHT's score (54) remained above the London and UK averages (49 and 53 respectively).

The Trust is expecting to receive the results of the 2014 national cancer patient experience survey in September, but these were not available at the time of writing.

Complaints & PALS

A rise in formal complaints and PALS complaints had been previously reported. This was attributed to a number of issues, but specifically to outpatient administrative issues associated with the introduction of the electronic patient administration system. This trend now seems to be reversing, with reductions in both formal complaints and PALS enquiries in July and August. The category most closely aligned to patient administration system related issues also has decreased, although it should be noted that this category still accounts for over 40% of the total complaints/PALS enquiries.

Previously reported concerns about the proportion of complaints responded to within the agreed timescales appear to be being addressed with a 10% overall improvement in August. The average time to respond has gone up in August, but this number is skewed because divisions have been working hard to clear a backlog of outstanding complaints.

D. Effectiveness

National Clinical Audit

The Medical Director's Office has proposed a new process for centralised reporting of national clinical audit, which has been approved at ExCo:

- A new national audit summary sheet has been created for completion by audit clinical leads, which includes benchmarking data and areas of good practice and concern;
- The clinical lead will be requested to complete the new audit report template and agree actions within the specialty ;
- This will be submitted to the directorate quality meeting in the first instance, prior to reporting to the monthly divisional quality board, ExCo – Quality & Safety, followed by the Quality Committee and Trust Board by exception;
- A schedule of all national audits, an updated list of clinical leads and a reporting schedule are being collated for submission to ExCo in October;
- The additional resource required to effectively implement and manage clinical effectiveness will be reviewed at the Strategic Investment Group in September.

E. Efficiency

Performance against some of the key efficiency measures is reported in the Integrated Performance Scorecard. The Trust performs well against peers for pre-operative length of stay (0.69 days), post-operative length of stay (4.34 days) and admission on the day of surgery (87.02%).

However, there is improvement needed in theatre utilisation and outpatient did not attend (DNA) rates. Over the last month there has been a drive to improve theatre utilisation and this has started to be reflected in performance figures. Further work, led by the Clinical Transformation Programme, will support increased productivity and improved utilisation. Outpatient DNA rates have worsened in recent months. Since the implementation of Cerner, the Trust had to turn off its text messaging reminder service for patients as there were technical reasons which needed to be resolved. The service will be partially switched on at the end of September and this will result in improved attendance rates for outpatient

appointments.

F. Timeliness

Accident and Emergency

In August, the Trust continued to deliver the 4-hour waiting time standard in our A&E department. The Trust consistently delivers this standard each month.

NW London Trusts were invited to apply for additional funding for schemes to the Tri-Borough, which has received confirmation of funding for £4.522m to support resilience over the winter period. The performance of the schemes will be monitored via the Urgent Care Board. The successful ICHT bids were:

- Expanding the Older Persons Assessment Service to 7 day working;
- Ensure the presence of a GP 24/7 in the Urgent Care Centre at St Marys;
- Further resilience to the Site Operations team, to include additional senior nursing and administrative support to strengthen the SITREP and ensure robust reporting arrangements to escalate patient delays externally at the earliest opportunity to facilitate rapid spot-purchase of additional capacity as appropriate;
- Extending the Cancer Assessment Unit to 7 day working;
- Additional senior clinical decision makers in ED, care of the elderly medicine and acute medicine.

In addition to ICHT schemes, several schemes from other agencies were approved and will positively impact on the ICHT system:

- 18 CLCH step down beds in partnership with ICHT to be housed on the Charing Cross Hospital site;
- Improvements to support 7 day discharge with Hammersmith & Fulham;
- Expansion of the CIS service.

Referral to treatment

In August, the Trust continued to meet the Referral to Treatment (RTT) standard for patients treated on a non-admitted pathway (as an outpatient). Reported performance remained challenged for patients treated on an admitted pathway (as an inpatient) and for incomplete pathways (patients waiting for treatment). Since implementing a new Patient Administration System (PAS) in April, the Trust has been going through a period of stabilisation and familiarisation. It was expected that there would be a number of data quality issues that would need to be resolved following the switch over. One of the key problems is that the number of patients waiting on our system is showing as higher than the true number of patients. These issues are being managed during weekly meetings with divisional teams. However, there are still some challenges with both ensuring that staff record data correctly onto the system, and the volume of validation that needs to happen to ensure appropriate prospective monitoring of patients waiting for treatment.

The Trust is committed to both improving data quality through validation and supporting staff in ensuing that they understand how to correctly record patient encounters on the PAS system to reduce data quality issues. Funded through the national RTT resilience funding, announced in the press during early August, a temporary staff team has been recruited to support the validation of data exercise and a team of experienced RTT trainers will be training front line staff on the correct way to record RTT pathways to reduce the

manual data correction needed at the end of the month. A further team will start with the Trust on 22nd September to ensure that the entire waiting list is validated. The overall size of the waiting list (incomplete pathways) is now starting to reduce on a weekly basis as a result of the intensive validation and is on track to be complete by the middle of December.

The Trust reported 5 patients waiting over 52 weeks for treatment in August 2014. Three of these were due to reduced capacity over the summer period in Ophthalmology. The service has a new consultant that started with the Trust in September and additional work has been put on to clear the backlog of work. The other two pathways related to waits for a particular orthopaedic surgeon. The Trust has offered alternative surgeons to the patients but they have requested to wait. This surgeon is gradually reducing the amount of operating time at ICHT and is not accepting referrals from new patients so this will not be an on-going issue.

At a national level, and locally agreed, we have an agreed level of reported underperformance in relation to our admitted and incomplete performance with an expectation that performance will be achieved for all three specialities from October. This is under review with commissioners with the potential that the national position changes so that performance is recovered in December, instead of October, to allow the Trust to treat additional backlog patients. This would provide extra resilience over the winter period.

Cancer

In September, performance is reported for the cancer waiting times standards in July. In July, the Trust achieved seven of the eight cancer standards. The Trust did not meet the breast symptomatic standard, reporting performance of 85.6% against a 93% target, making July the third month of under-delivery against this standard. This was due to the continued impact of the reduction in breast clinic capacity identified in Quarter 1 2014-15.

The Trust has since recovered this position in August, with current performance for the month reporting at 98% against the breast symptomatic standard. This recovered position has been maintained through September and the expectation is that the recovery is sufficient enough to meet the 93% target for Quarter 2 2014-15.

The Trust recovered the 62-day first treatment and 62-day screening standards in July. The Trust is now working with local providers to redesign their diagnostic pathways. This is to ensure that patients are transferred to ICHT for treatment earlier in their pathways in order to reduce the number of shared pathway breaches, the predominant cause of 62-day breaches for the Trust.

G. Equity

Progress continues to be made in relation to strengthening systems and processes that support adult safeguarding work. Extensive training was undertaken in July and August, which provides increasing confidence that we are moving towards the year-end target of 85% compliance with level 1 training.

There were also major efforts in August to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

H. People

Talent Development

Talent Management
A new Talent Management process was launched in September, initially aimed at more senior leaders. This process will include an assessment of both performance (linked to the PDR process) and potential, in order to create a Trust succession plan for all senior leadership positions. This will be reported back to the ExCo in the autumn after the results have been compiled and calibrated, and the Trust Board early in the new calendar year. This represents Phase 1 of a wider roll out of Talent Management within the Trust.

Mandatory Training
Mandatory training have been working hard to push up compliance with an exercise of auditing staff records to ensure that all staff who have completed all their e-learning are moved to compliant status. Total compliance has increased to 72% as a result of this audit.
There is still much to do and an ongoing programme of work is underway to improve data quality and the systems and processes which affect data quality.

An "August Amnesty", led by the central team also took place to identify people who had not completed Local Induction. This has brought about an increase in the compliance rate from 73% in July to 91% in August. In addition, the compliance rate for attendance at Corporate welcome has seen an increase to 90% in August.

Employee relations

Make a Difference recognition scheme
Nominations for the instant recognition element of the Make a Difference people recognition scheme continue at a high rate. We estimate that more than a 1000 nominations have been made of which about half have come from patients and other service users

Strike Action
Some NHS trade unions are balloting their members on a proposed four hour strike, followed by a period of action short of strike action. The ballots are in response to the 2014/15 pay award. Other public sector unions including teachers and care workers may strike on the same day. The following unions are participating: UNITE, UNISON, GMB, The Society of Radiographers, the RCM and the Hospital Consultants and Specialists Association. The Chartered Society of Physiotherapists may also ballot. The RCN and the BMA are *not* balloting. Trade unions are obliged to confirm ballot results as soon as possible and then give at least seven days' notice of strike action. We have been told informally that the strike will take place on the morning of 13 October. It is our intention to maintain activity and ensure no cancellation of elective activity. One of our key objectives is to ensure that our positive local industrial relations climate is not disturbed by the national dispute.

Health & Wellbeing

Wellbeing Week
Wellbeing week commences on Monday September 22, 2014, with the launch of the Wellbeing Website. Our people will be incentivised to register to the site through a prize draw which will be advertised next week on the source and at Wellbeing Week.

Thus far we have received **no** cash donations from our suppliers; everything has been collateral items which will be used as giveaways across the week (and beyond), through competitions and challenges and also as prizes for feedback from our people on the service and their ideas for improvement.

Look out for the posters on all sites!

Flu Vaccinations
Flu vaccinations will be launched as part of Wellbeing Week where we hope to vaccinate as many staff as possible. We anticipate attendance of 300-400 people per site per day, so with an active audience, this would allow us to make a good start on our flu effort for this year. With an ambitious target of 75% front line staff this will give us the start we need.

Smoking Cessation
The Trust has been invited to sign up to the NHS Statement of support for Tobacco Control, making clear our commitment to tackle the harm smoking causes our community. This is a document that the Trust will sign up to in partnership with our local Health & Wellbeing Board. With ICHT moving towards Smoke Free from October and to ensure effective blanket ban on smoking across all hospital sites, this is timely.

The Health and Wellbeing team, through the Smoking project group are working closely with Public Health and patient facing colleagues on this agenda. We had a total of 114 referrals into Kick It in the past quarter, with roughly 55% of these individuals signposted to engage with smoking cessation clinics within the Tri-borough Alliance catchment area. We expect the number of referrals to increase significantly following Wellbeing Week and the build-up to the Stoptober signal launch events.

Safe Nurse/Midwife Staffing

Performance in July
In July, the Trust reported above 95% for the average fill rate for registered nursing/midwifery staff during the day and night and also for unregistered staff at night. The fill rate for unregistered staff during the day was reported as above 90%.

Performance in August
In August, the Trust reported an average fill rate of above 95% for registered and unregistered nursing/midwifery staff during the day and night.

Please refer to Appendices 1 and 2 in the Integrated Performance Scorecard for ward level data.

For both months there were some ward areas where the fill rate was below 90%. Key

reasons for this include; vacancies and/or inability to fill with temporary staff due to specialist skills required, patients requiring unplanned one to one care, small numbers in some areas which showed a bigger impact on the overall fill rate for that area and complexities with how to reflect case mix change and/or reduced bed occupancy on the roster system.

On these occasions senior nurses have made decisions to mitigate any risk to patient safety by strategies such as; using the cover of matrons/ward sisters, reducing activity and bed occupancy and redeploying staff from other areas, where appropriate.

Staffing levels and the monitoring of these remain a top priority for the Trust to ensure the correct number of staff are available on a shift by shift basis.

I. Finance

The Trust's Income & Expenditure (I&E) position at the end of August was a Year-to-Date (YTD) deficit of £1.9m (after adjusting for the impairment of fixed assets and donated assets), an adverse variance against the plan of £6.1m. There was an improvement in the month due to a reduction in Bank & Agency expenditure of £1.6m and Non-Pay of £2.1m when compared to the previous month. The main reasons for the YTD adverse variance are:-

- Cost Improvement Plans (CIPs) are behind plan by £8.1m (46%);
- Expenditure on the Cerner patient administration system implementation was greater than expected and year to date expenditure remains above plan;
- Temporary staff pay costs are higher than plan but the introduction of new controls has had a significant impact this month.

There is on-going dialogue with the TDA about the impact of the proposed Project Diamond funding reductions on the Trust's financial position in both current and future years. Any reductions in funding will mean that the Trust's I&E control total will have to reduce accordingly.

J. Education

GMC Trainee Survey Action Plans

In August 2014, the Trust submitted action plans in response to the GMC trainee survey for each specialty with a red flag. Actions to be taken include the following:

Emergency Medicine F2:

- Rota has been changed so sequencing follows best practice, with breaks allocated and implemented;
- Additional nursing support in Urgent Care Centre provided, especially overnight Genito-urinary medicine;
- Continuing review of and change to the structure of outpatient services, moving towards more team-based clinics;
- A review at Consultant level of the degree of hand-over for out-of-hours inpatient care.

Medical Microbiology:

- A review of all educational resources across all rotation sites/infection group sites.

Neurology:

- Review of trainees' clinical commitments already undertaken, with resulting revision of TIA clinic arrangements and on-call rota underway.

Prior to publication of the survey results, the Trust was required to respond with action plans to the immediate safety concerns and bullying and undermining issues as soon as they are raised by trainees.

There were 6 immediate safety concerns raised by the survey in 2014, in comparison to 33 safety concerns in 2013. Three of these related to ITU capacity and nursing at Charing Cross. The following actions are being undertaken to deal with the issues raised:

- ITU capacity and nursing at Charing Cross (3) - action being taken by Division to support additional capacity and escalation
- ODP availability in maternity - action to ensure clear escalation and prioritisation
- Radiology report amendments - standard operating procedure in place; usage being monitored
- Acute medicine and relationship to UCC at Hammersmith - effects will be negated by EU closure, UCC referral patterns monitored as part of EU closure project.

There were 5 reports of bullying and undermining, which have been dealt with individually by the divisions using the Trust's Bullying & Harassment Policy.

K. Research

Local Clinical Research Network

The network was required to provide a plan within a specified template format of how we will deliver against a set of key performance indicators; High Level Objectives, Specialty Specific Objectives and Cross Cutting Objectives. These are detailed within a Performance and Operating Framework as part of the hosting contract and are also part of the step-down contracts with our partner organisations. Our performance against these objectives has been RAG rated and are subject to approval by the Medical Director. The only major risk identified was the delivery of a Local Portfolio Management System by 1st April 2015.

As a condition of receiving National Institute of Health Research Funding to support the Clinical Research Network, an operational and financial plan was developed. Plans were produced with input from network Clinical Specialty Leads, Partner organisations and existing Research Delivery Managers from each of the former Topic and Comprehensive Networks who provided local intelligence. Due to timelines for submission, the plan was circulated to the Network Executive Group for comment, was signed off by the Medical Director and submitted in draft form on 9th April. The plan was tabled for discussion at the AHSN board meeting on June 11th and was ratified by ExCo on 5th August.

The procurement of a local portfolio management system (LPMS) for the region, rated red in the plan, is being taken forward as part of a consortium approach with the Central and East London and South London Networks to achieve best value for money. The procurement process is being led by Imperial on behalf of the other networks. The process closes on 29th September. We expect to have identified a system by early 2015 within expected timelines.

NIHR Imperial Biomedical Research Centre (BRC)

Mid-term Review
A mid-term external review of the NIHR Imperial BRC will take place on 2nd October 2014. This review will inform the remaining two and a half years of the programme and shape our plans for re-application in 2016. An independent external panel of national and international experts has agreed to participate and a teleconference was held on 9 September to highlight issues and clarify requirements around the process. The Dean of the Faculty of Medicine is chairing the review and the ICHT Chief Executive is a member of the panel.

Indicators presented in the Integrated Performance Scorecard
The key performance indicators for R&D are intended to assess the timely initiation and delivery of commercial and non-commercial clinical research studies taking place at ICHT, as well as growth in activity. The first 3 indicators in the list reflect the important NIHR 70-day metric for recruiting the first patient into clinical trials. As of Q1 2014/15, ICHT performance is behind comparator organisations and hence 'red'. However, as presented and discussed at recent meetings of the ExCo and Joint Executive Group, a number of new governance structures, additional resources, and revised processes have been introduced into the Divisions over the past 6 months which are beginning to improve performance in this area. There is a substantial time lag between introducing these new ways of working, and it being reflected in the quarterly statistics, due to the methodology the NIHR uses to collect data. As per the ExCo report last week, however, we have analysed very recent data and have identified a significant improvement in performance which should feed through into these 3 metrics from Q2 14/15 onwards.

Indicator number 4 in the list reflects ICHT's performance in delivering commercial interventional clinical trials to time and target, and we are currently above many of our comparator / competitor Trusts in this respect.

Indicator number 5 reflects the time take to provide local R&D approval for studies hosted at ICHT. This metric has recently been introduced by the NWL Clinical Research Network (NWL CRN) and is different from previous years – Trusts are currently adapting to this new measure. Compared to other Trusts in NWL, as of July 2014, ICHT is rated as amber.

ICHT is performing well in terms of NIHR Portfolio study activity, as measured by indicators 6 to 9. Compared to the same period last year, ICHT has recruited more patients to Portfolio studies (commercial and non-commercial), despite a reduction in funding support. There are also more commercial Portfolio studies being recruited to.

L. Health and Safety

An Extraordinary Health & Safety Committee was held on 27 August to consider and approve a number of H&S Policies that were due for review. In all some 30 policies were considered and are now being passed through Executive Committee for ratification. The two over-arching policies – on Fire and Health & Safety are on the Trust Board Agenda for ratification on 24 September 2014. The next meeting of the Health & Safety Committee is on 29 September 2014 and a more detailed update will be provided to the Board at its

November meeting.

In terms of RIDDOR (incidences reportable as part of injuries, diseases and dangerous occurrences regulations), there have been 4 incidents since April 2014. These were: a broken toe sustained when a linen trolley fell on a member of staff; a fractured ankle when a member of staff slipped on a drain cover at St Mary's Hospital; and members of staff tripping upon entering a lift at Charing Cross and dislocating a shoulder, and falling (on a public footpath) outside QEQM at St Mary's. This compares with 10 incidents in the same period last year.

There were 43 fire alarm activations in August 2014 and 26 fire alarm activations to date in September 2014. The number of actual fires is four since 1 April 2014 (compared with 10 in the same period last year). These were: a fire in waste paper bin on ward at Charing Cross Hospital; a power surge on Pickering 2nd floor at St Mary's Hospital causing smoke; an incident in the toilets at QEQM at St Mary's; and a lit cigarette being inappropriately discarded outside Charing Cross Hospital. The number of fire alarm activations is high – there have been 200 activations since 1 April 2014, but changes to our fire alarm system including replacing FS90 Fire alarm panels, which are not supported after August 2015 by the manufacturer, should bring this number down.

In terms of Employers' Liability (EL) and Public Liability (PL) Claims, there are currently 29 open claims and the general trend is an overall increase in numbers of about 50% over the previous year although it is difficult to be more specific as claims vary in the length of time they take to settle and can sometimes be classed as open when only the costs are still under discussion. Of the 29 currently open, 13 are for slips and trips, with the remainder split between manual handling, defective equipment, sharps injuries and assault. The oldest of these claims go back to 2010 (3 claims), two relate to 2011, and 6 relate to 2012. Five claims have been submitted since April 2014 – four relate to slips and trips and one to a sharps injury.

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

Imperial College Healthcare NHS Trust

Trust Board Public

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

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

Recommendation(s) to the Board: The Trust Board are asked to note the contents of this report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Integrated Performance Scorecard

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

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

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

This month the Integrated Performance Scorecard includes additional efficiency measures. The safe staffing figures are also presented as appendices to this report.

Regulatory reforms

The NHS Trust Development Authority has recently published *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards*, which sets out how the TDA will work alongside trusts to support the delivery of high quality, sustainable services for patients. The methodology for rating is subject to an element of subjectivity. Once the rating for ICHT is published, this will be also published in the Integrated Performance Scorecard.

Leading/lagging indicators

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

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

Source framework

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

Future development

In a rolling programme of improvement, the scorecard will be continued to be developed by:

- Ensuring that all indicators have a threshold so it is clear in the summary pie

charts how the indicator is performing. Where no threshold is available, an explanation will be provided in a definitions page about how the indicator has been rated. A benchmarking exercise has begun to allow thresholds to be set for the efficiency measures that do not currently have a threshold;

- Include further comparison data, when this becomes available to allow benchmarking to be made with other London Trusts, the Shelford Group and against the national average;
- It is proposed that the Integrated Performance Scorecard is developed into a QlikView application with an initial version to be presented to the Trust Board members in October 2014. This will allow for the complex data feeds to be fully embedded into the scorecard and will allow full testing of the iPad friendly version of QlikView which is soon to be released. QlikView will allow Trust Board members to drill down into further detail into the indicators that are presented. This could be to divisional or speciality level.

Recommendation(s) to the Board: The Trust Board is asked to note the contents of the Integrated Performance Scorecard.

Trust Board Performance Report
Report Period Month 5
(to end August 2014)

Trust Board Wednesday 24th September 2014

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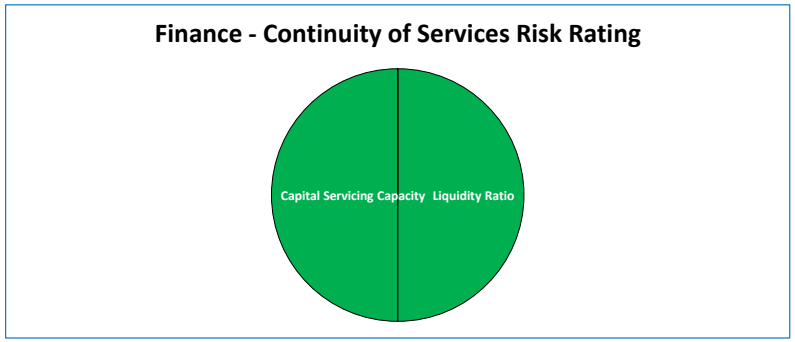
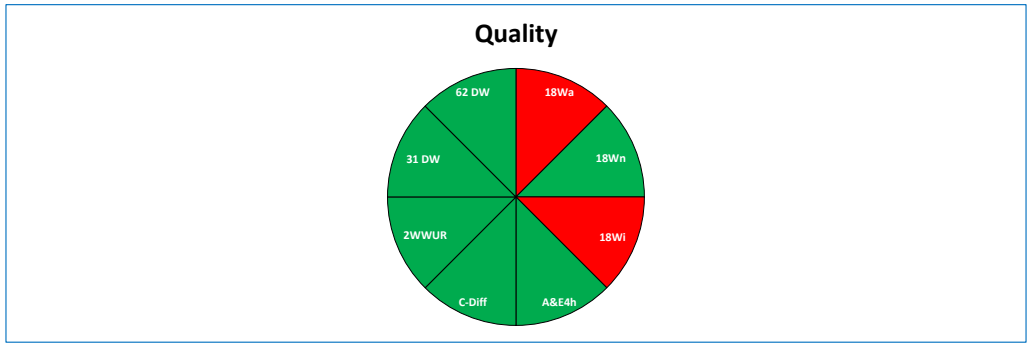




2014/2015 Area	Indicator	Threshold	Performance to date 14/15 Q1	Q2	*Forecast* *Qtr 3 14/15*	*Qtr 4 14/15*	*Qtr 1 15/16*
Finance	Capital Servicing Capacity		3	3			
	Liquidity Ratio		3	4			
	Continuity of Services Risk Rating		3	4			
Access	18 weeks referral to treatment - admitted	90%	88.90%	85.09%			
	18 weeks referral to treatment - non admitted	95%	94.31%	95.20%			
	18 weeks referral to treatment - incomplete pathway	92%	92.20%	88.03%			
	2 week wait from referral to date first seen all urgent referrals	93%	93.70%	93.00%			
	2 week wait from referral to date first seen breast cancer	93%	88.40%	85.60%			
	31 days standard from diagnosis to first treatment	96%	97.40%	96.80%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	99.60%	100.00%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.60%	99.00%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.90%	97.10%			
	62 day wait for first treatment from NHS Screening Services referral	90%	91.00%	90.70%			
	62 day wait for first treatment from urgent GP referral	85%	85.40%	85.50%			
	A&E maximum waiting times 4 hours	95%	95.90%	95.90%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	25	16			
	Governance Risk Rating						

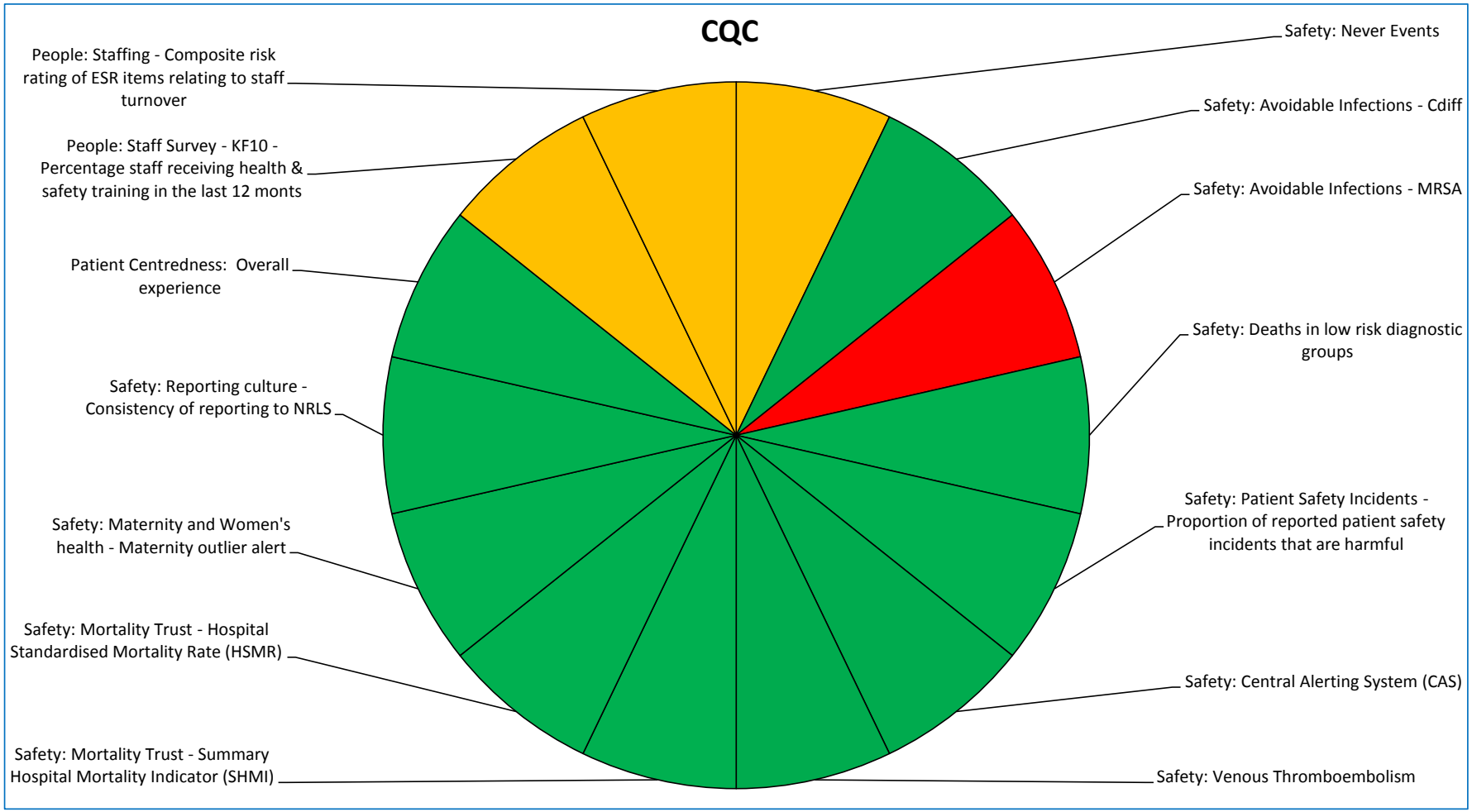
Other triggers of governance concern not addressed in Integrated Performance Scorecard

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

	Threshold met
	Threshold NOT met

	Some areas of concern
	Data not available

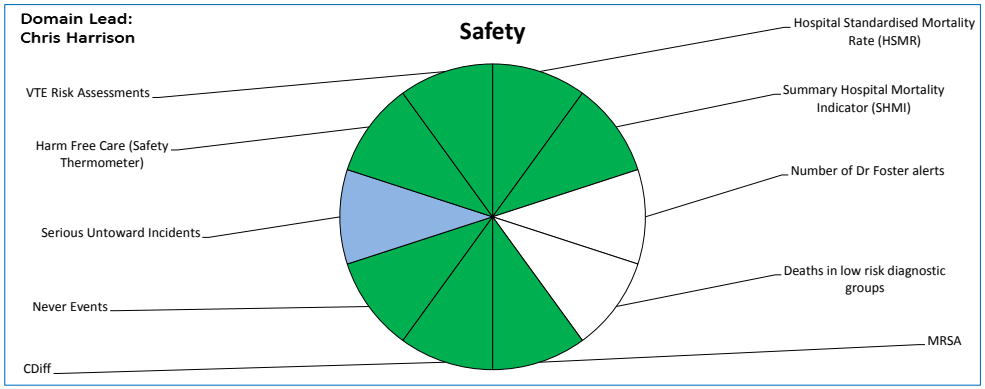
CQC Rating as at July 2014



No evidence of Risk | Risk | Elevated Risk

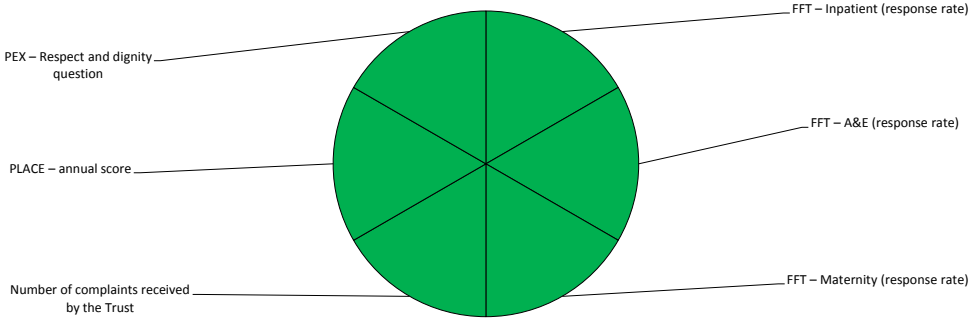
Domain Lead: Chris Harrison

Safety



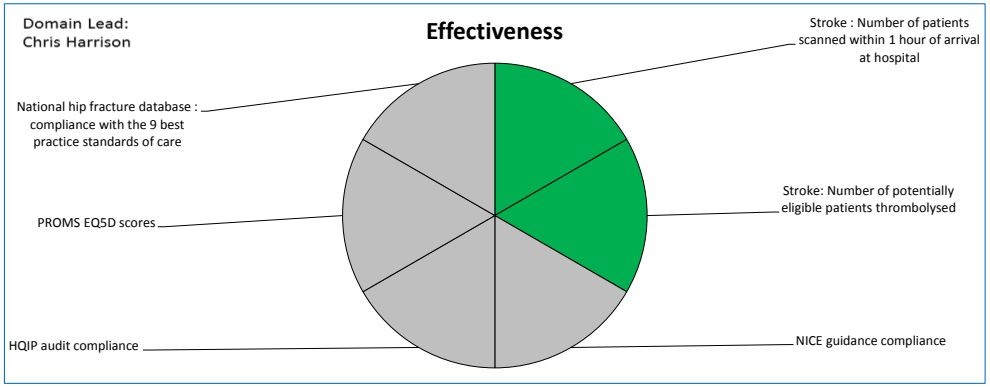
Domian Lead: Janice Sigsworth

Patient Centredness



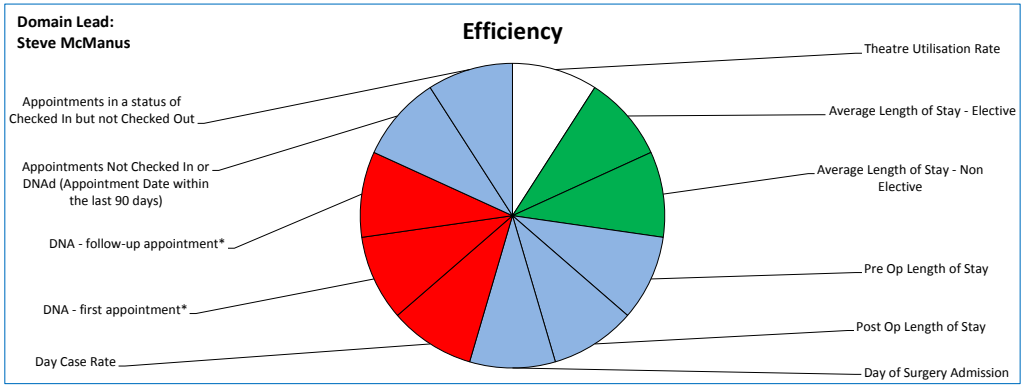
Domain Lead: Chris Harrison

Effectiveness



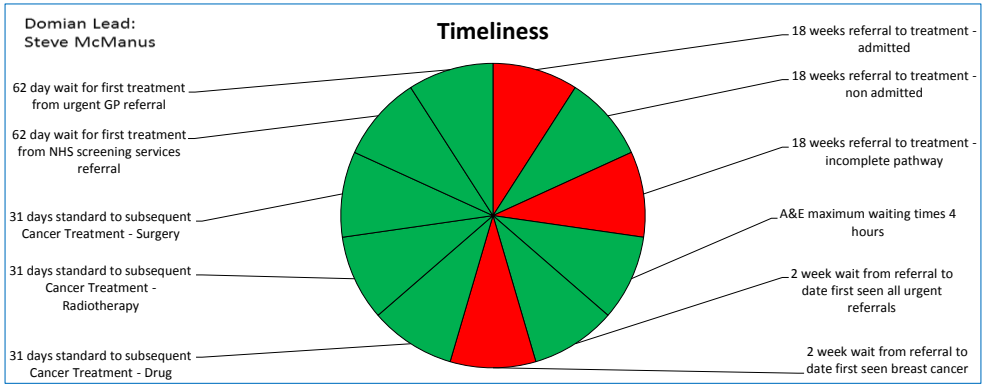
Domain Lead: Steve McManus

Efficiency



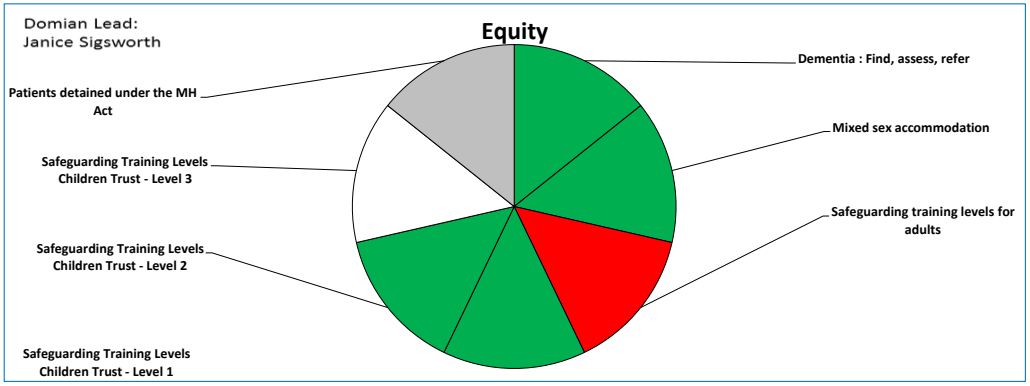
Domian Lead: Steve McManus

Timeliness



Domian Lead: Janice Sigsworth

Equity



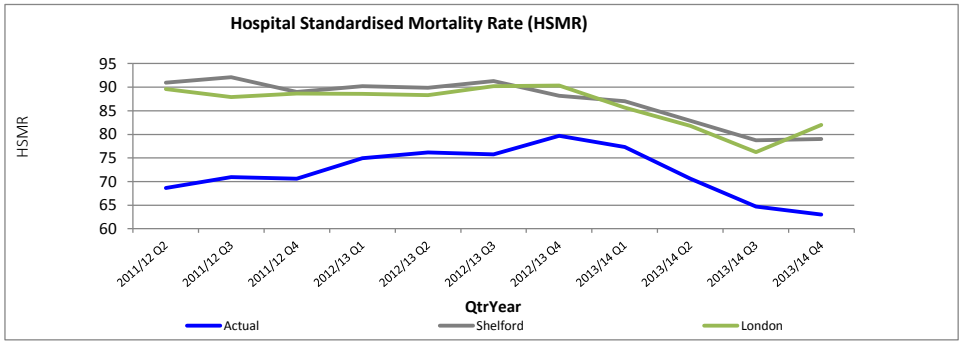
	CQC/Threshold met
	CQC/Threshold NOT met

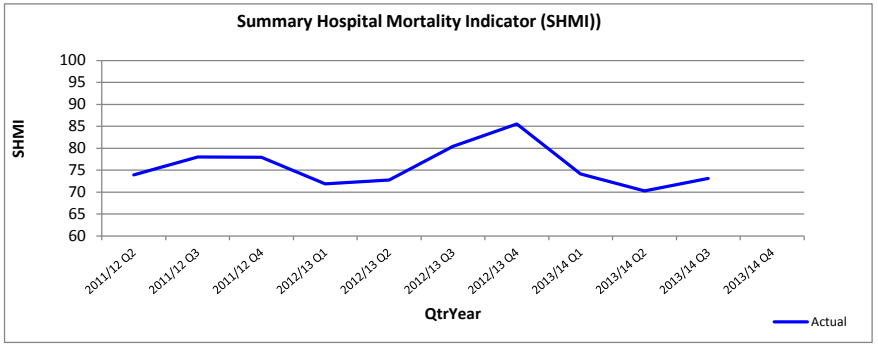
	To be developed (NO Data - NO Threshold)
	Have Data - NO Threshold

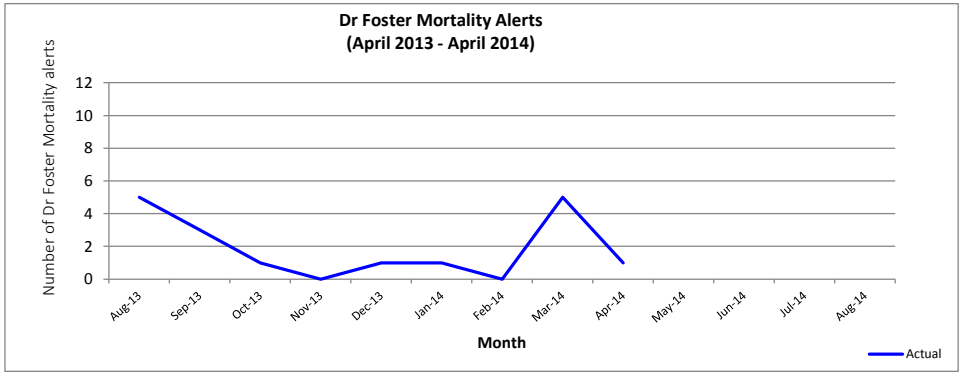
	Data not available

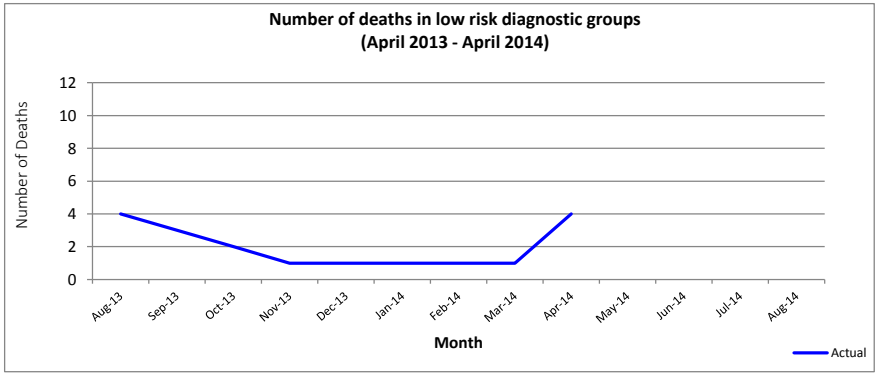
Indicator	Leading	Frequency	2012/2013 Qtr3	Performance in 2013/14 Q1	Q2	Q3	Q4	YTD	Forecast Qtr 1 14/15	Qtr 2 14/15	Qtr 3 14/15	Source Framework
Mortality Indicators												
Hospital Standardised Mortality Rate (HSMR)	-	Quarterly	79.70	77.32	70.63	64.70	63.00					CQC
Summary Hospital Mortality Indicator (SHMI)	-	Quarterly	85.52	74.10	70.30	73.10						CQC

Indicator	Leading	Frequency	Performance in Apr-13	Performance in Qtr1 13/14	Performance Current Current Month	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	YTD	Forecast 2014/15 Q2	2014/15 Q3	2014/15 Q4	Source Framework
Dr Foster Alerts														
Number of Dr Foster mortality alerts	-	Quarterly	1	10	Data Not available					1				CQC
Deaths in low risk diagnostic groups														
Number of deaths in low risk diagnostic groups	-	Quarterly		6	Data Not available					4				CQC



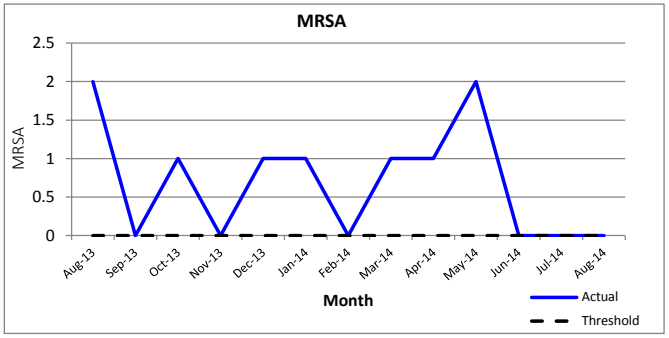


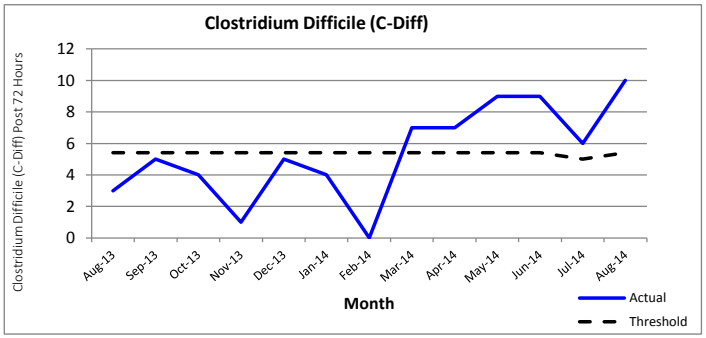


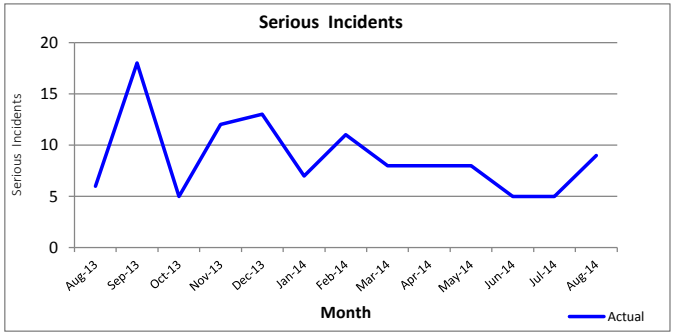


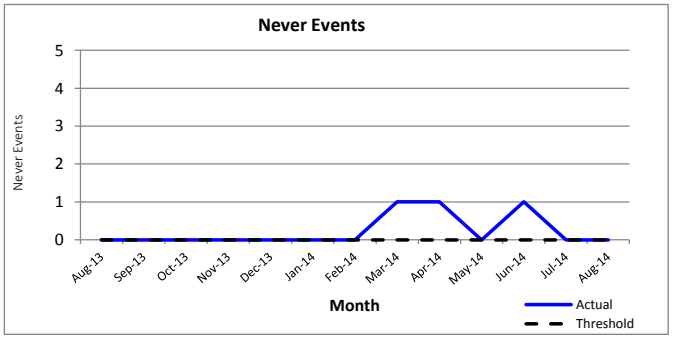
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Infection Control*															
MRSA	-	Monthly	0	2	4	0	3				3				TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	-	Monthly	<65 p/a	3	11	10	25				41				Mon, TDA, CQC
Incidents*															
Never Events	-	Monthly	0	0	0	0	2				2				TDA, CQC
Serious Incidents	-	Monthly	n/a	6	40	9	21				35				TDA, CQC
Safety Thermometer*															
Harm Free Care (Safety Thermometer)	-	Monthly	>90%	94.9%	95.4%	96.86%	95.78%				96.20%				TDA, CQC
VTE															
VTE Risk Assessments	✓	Monthly	>95%	95.8%	96.1%	95.69%	95.30%				95.67%				CQC, Contractual

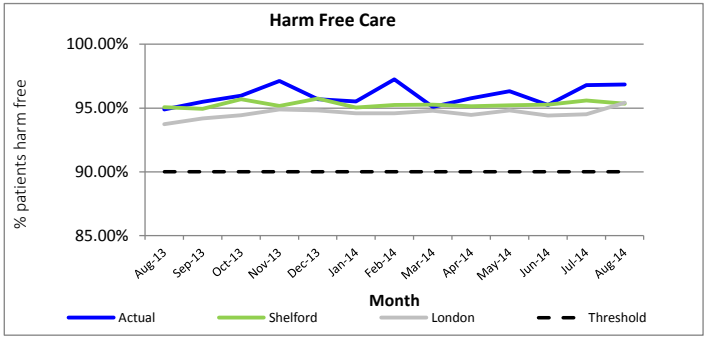
* Includes Private Patients

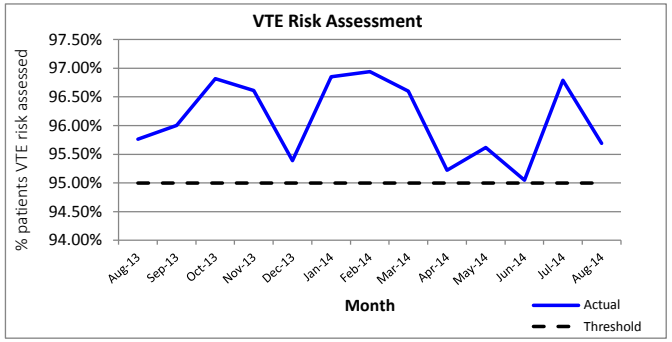








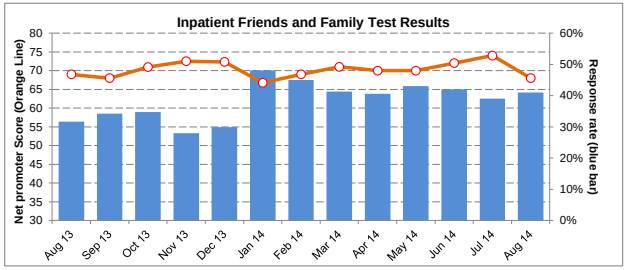


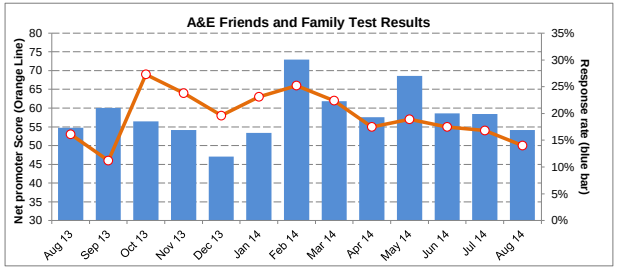


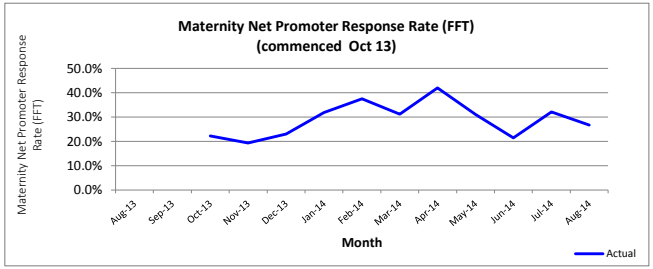
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Friends & Family Test															
Inpatients Net Promoter Score (FFT)	✓	Monthly	0	69	69	68	71				71				Contractual
Inpatients Net Promoter Response Rate	✓	Monthly	>25%	31.63%	30.04%	41.00%	41.86%				41.12%				
A&E Net Promoter Score (FFT)	✓	Monthly	0	53	50	50	56				54				Contractual
A&E Net Promoter Response Rate	✓	Monthly	>15%	17.30%	19.20%	16.90%	22.10%				20.62%				
Maternity Net Promoter Score (FFT)	✓	Monthly	0	n/a	n/a	36	62				52				Contractual
Maternity Net Promoter Score Response Rate	✓	Monthly	>15%	n/a	n/a	26.70%	31.47%				30.64%				Contractual
Complaints & Compliments*															
Number of complaints received	-	Monthly	<100	62	197	96	319				531				CQC
Environment															
PLACE - Cleanliness	-	Annually	*>95%*	99.03%	Aug-13	Awaiting Survey data									*tbc*
PLACE - Food	-	Annually	*>84%*	80.91%	Aug-13	Awaiting Survey data									*tbc*
PLACE - Privacy, Dignity & Well being	-	Annually	*>82%*	88.60%	Aug-13	Awaiting Survey data									*tbc*
PLACE - Facilities	-	Annually	*>83%*	89.22%	Aug-13	Awaiting Survey data									*tbc*
Patient Experience															
(LQ36) Have you been treated with dignity and respect by staff on this ward?	-	Monthly	*>85%*	96.83%	97.20%	97.0%	96.30%				96.62%				CQC
Safeguarding															
Safeguarding Adults : Referrals per month	-	Monthly	*>39*	41	114	55	109				212				CQC

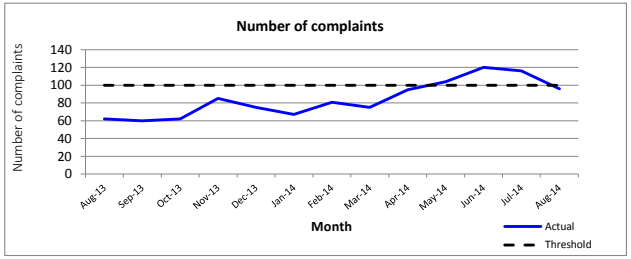
Indicators to developed
Patient Exp. - Cancer

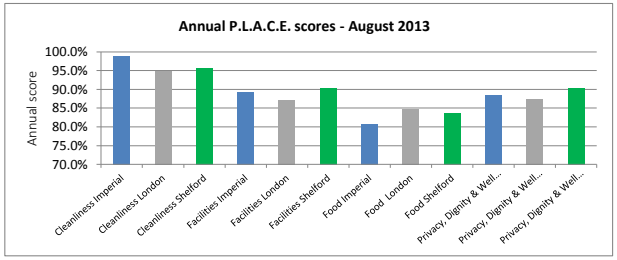
* Includes Private Patients

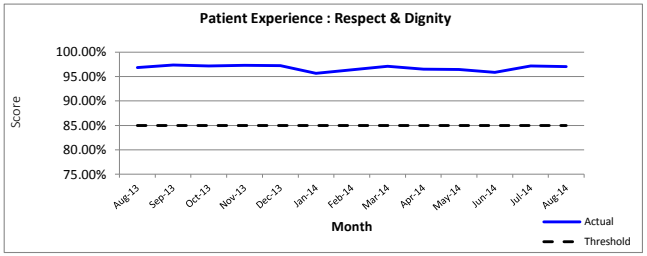


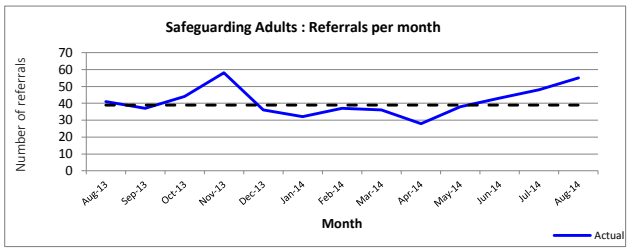






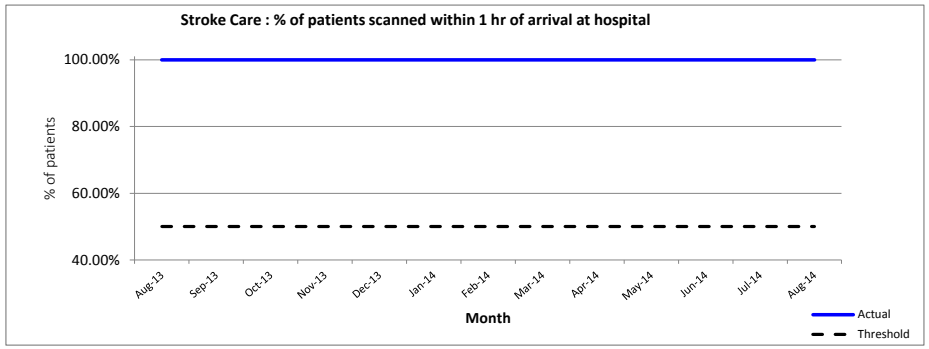


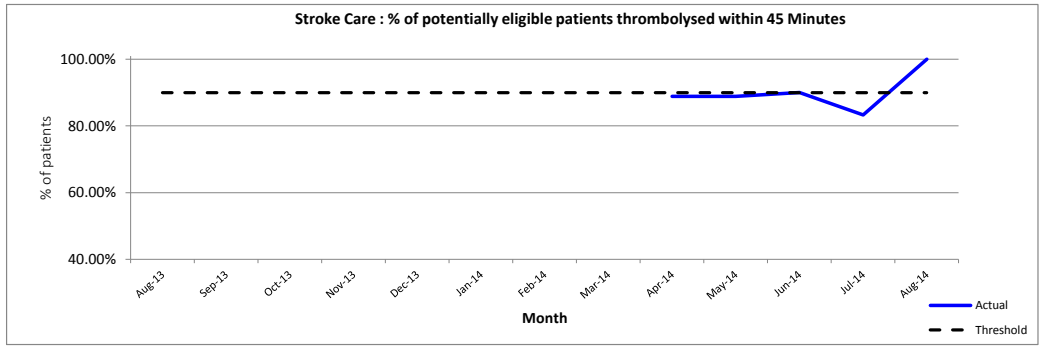




Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Stroke Care															
Stroke Care : % of patients scanned within 1 hr of arrival at hospital	-	Monthly	>50%	100.0%	100.0%	100.00%	100.00%				100.00%				CQC
Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes	-	Monthly	>90%	n/a	n/a	100.00%	89.26%				90.22%				CQC

Indicators to developed
Nice Guidance Compliance
HQIP Audit Compliance
PROMS ESQD Scores
National Hip Fracture Database : Compliance With 9 Best Practice Standards

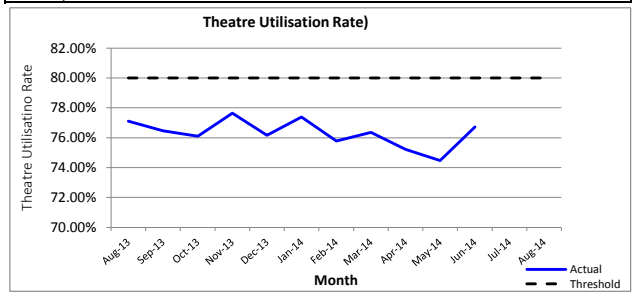


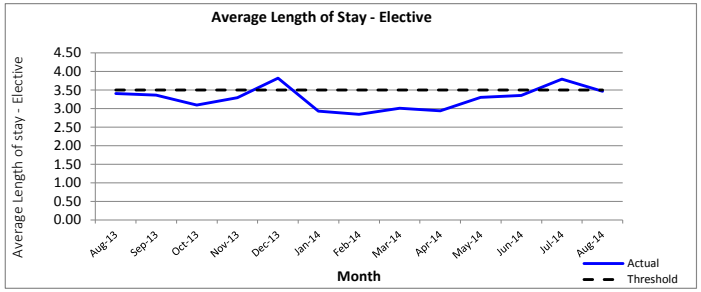


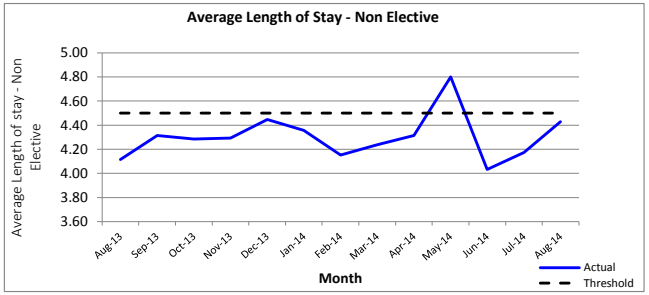
Indicator	Leading	Frequenc	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Productivity															
Theatre Utilisation Rate	✓	Monthly	>81%	77.10%	77.40%	Data not available	75.48%				75.48%				CQC
Average Length of Stay - Elective	✓	Monthly	<3.5	3.40	3.41	3.47	3.20				3.37				Internal
Average Length of Stay - Non Elective	✓	Monthly	<4.5	4.12	4.27	4.43	4.38				4.35				Internal
Pre Op Length of Stay	✓	Monthly	*tbc*	0.65	0.69	0.69	0.87				0.81				Define
Post Op Length of Stay	✓	Monthly	*tbc*	4.19	4.36	4.34	4.34				4.42				Define
Day of Surgery Admission	✓	Monthly	*tbc*	89.75%	89.38%	87.02%	87.20%				88.00%				Define

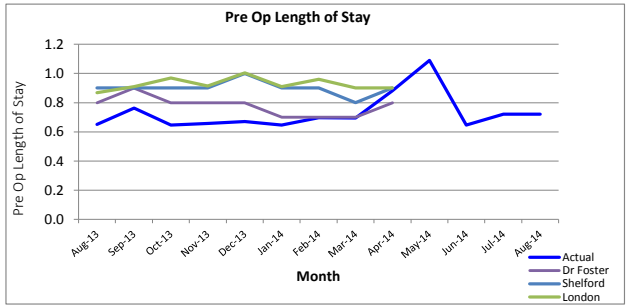
Indicators to developed

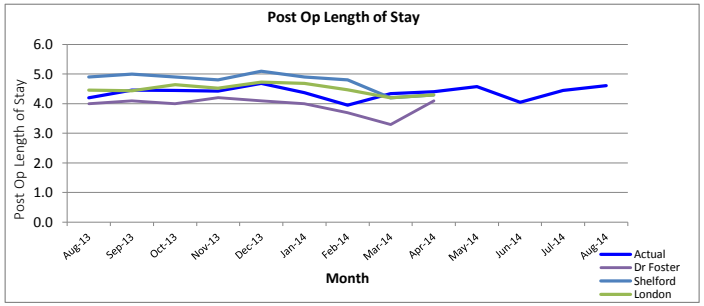
*BADS Day Case Rate - Paediatric**

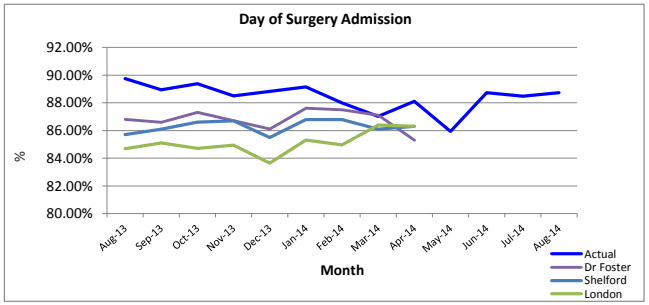




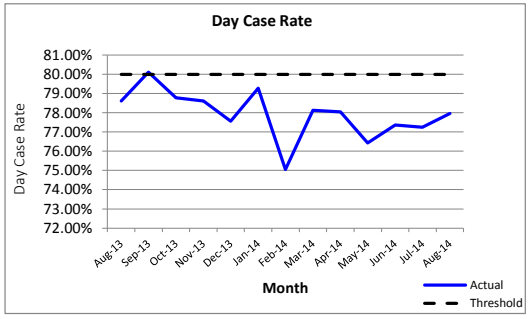


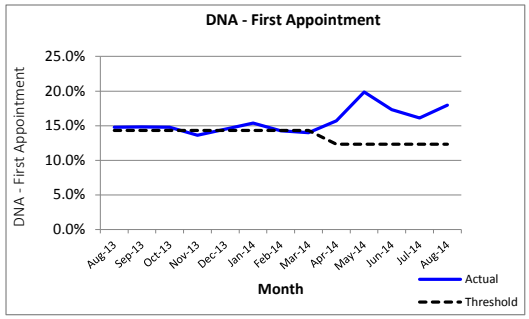


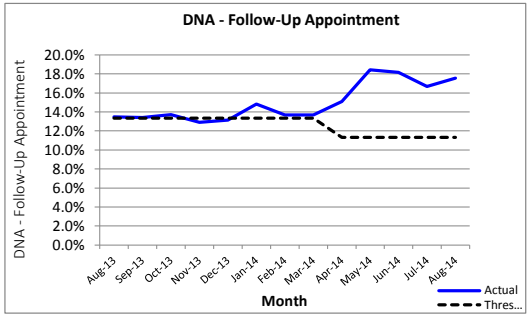


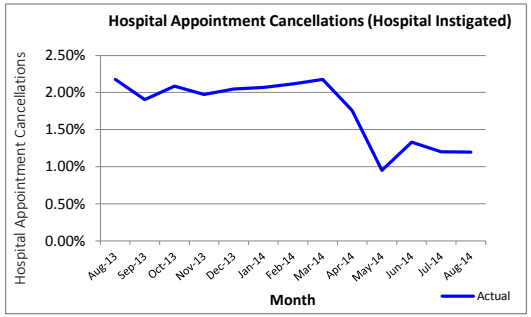


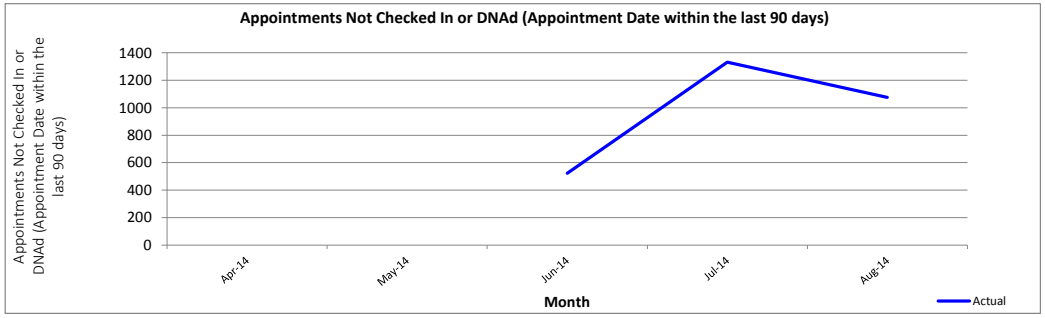
Indicator	Leading	Frequenc	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Productivity															
Day Case Rate	✓	Monthly	>80%	78.61%	79.63%	77.96%	77.28%				77.41%				CQC
DNA - first appointment	✓	Monthly	<12.31%	14.78%	14.56%	17.96%	17.64%				17.40%				Internal
DNA - follow-up appointment	✓	Monthly	<11.33%	13.46%	13.22%	17.53%	17.22%				17.17%				Internal
Hospital Appointment Cancellations (hospital instigated)	✓	Monthly	*tbc*	2.18%	2.04%	1.20%	4.04%				6.43%				Internal
Data Quality															
Appointments Not Checked In or DNAd (Appointment Date within the last 90 days)	✓	Monthly	*tbc*	n/a	n/a	524	524				2932				Internal
Appointments in a status of Checked In but not Checked Out	✓	Monthly	*tbc*	n/a	n/a	609	770				1992				Internal

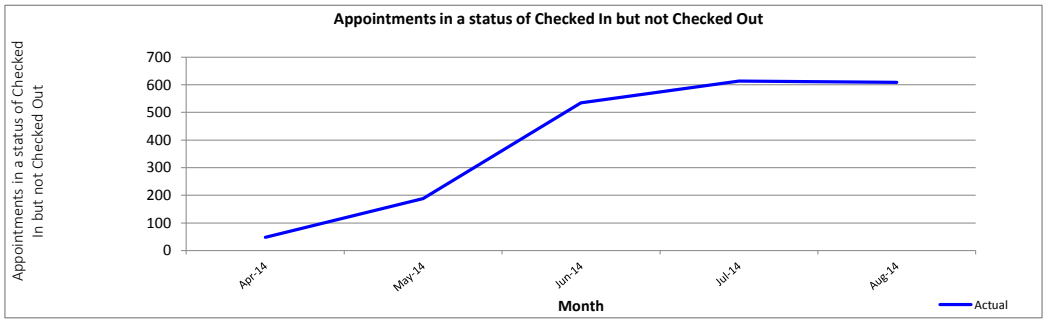




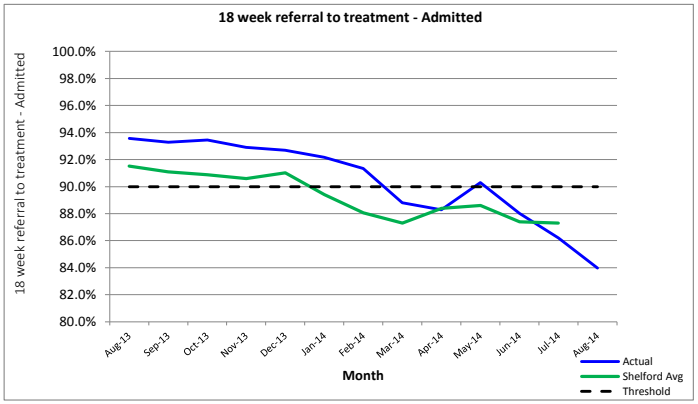


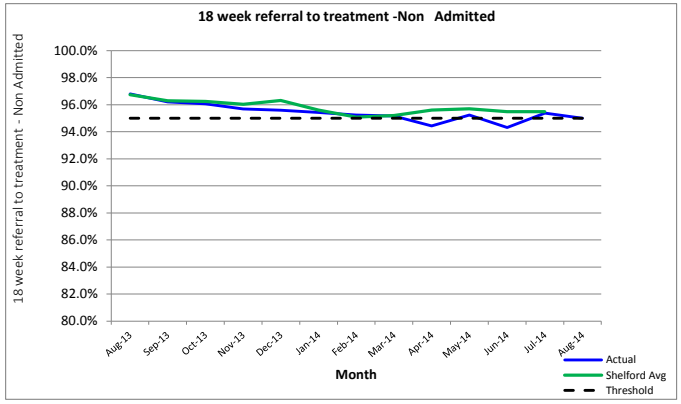


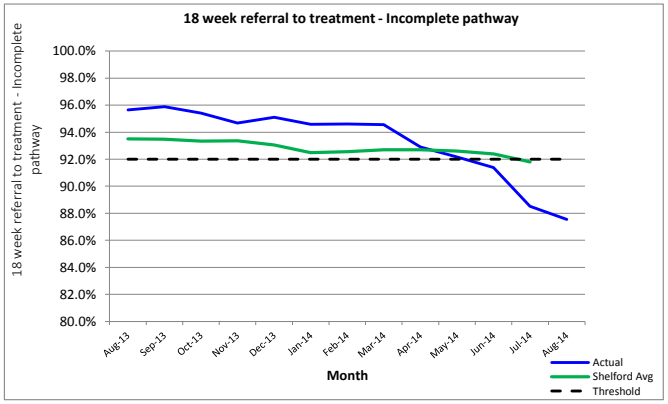


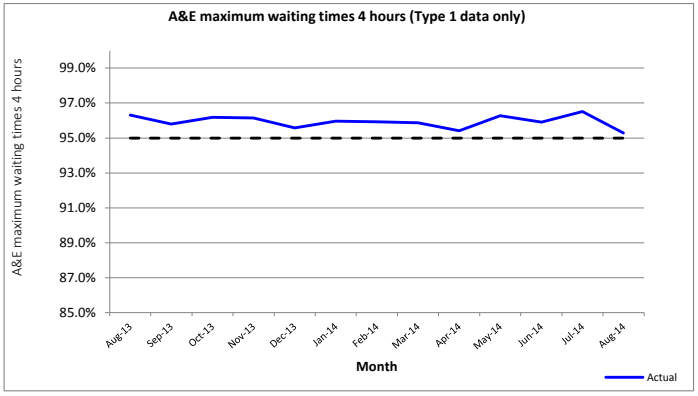


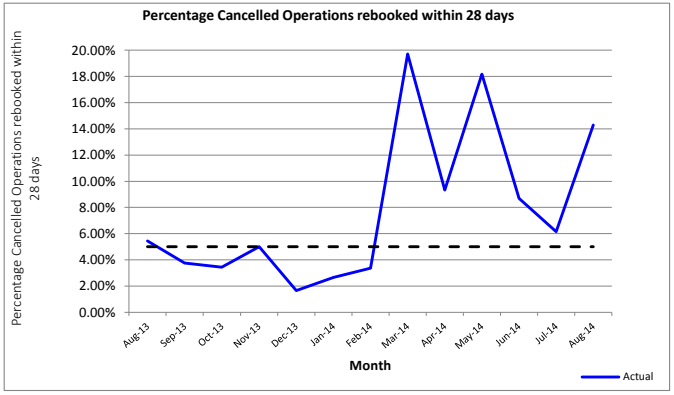
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Elective Access															
18 weeks referral to treatment - admitted	-	Monthly	>90%	93.6%	93.3%	84.0%	88.87%				87.35%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	-	Monthly	>95%	96.8%	96.8%	95.0%	94.66%				94.88%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	-	Monthly	>92%	95.7%	96.0%	87.5%	92.15%				90.50%				Mon, TDA, CQC
A&E Access															
A&E maximum waiting times 4 hours	✓	Monthly	>95%	96.3%	96.7%	95.3%	95.86%				95.88%				Mon, TDA, CQC
Other Access Measures															
Percentage Cancelled Operations rebooked within 28 days	✓	Monthly	<5%	5.5%	4.7%	14.3%	12.30%				11.15%				TDA, CQC
Percentage Non Clinical Cancelled Operations	✓	Monthly	<0.8%	0.7%	0.7%	0.5%	0.82%				0.76%				Define

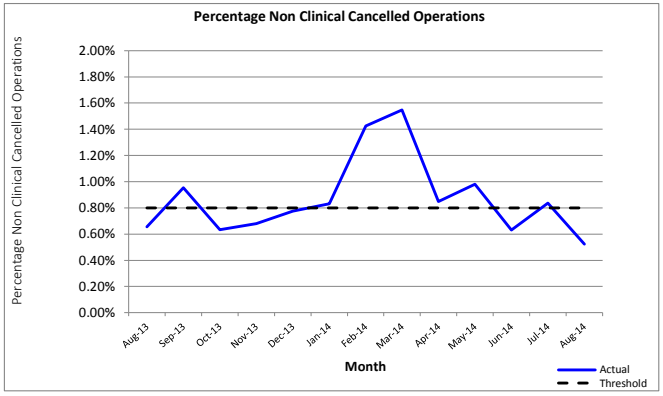




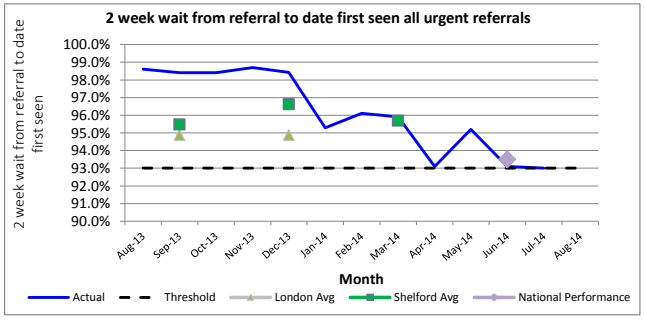


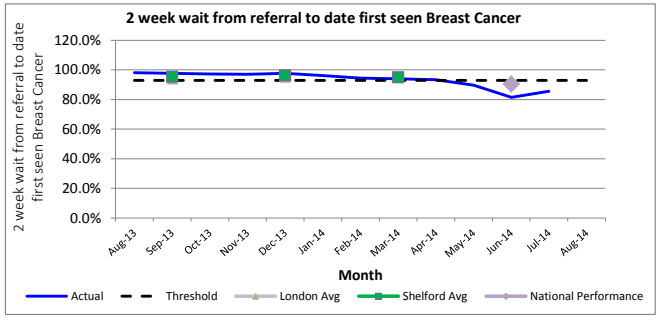


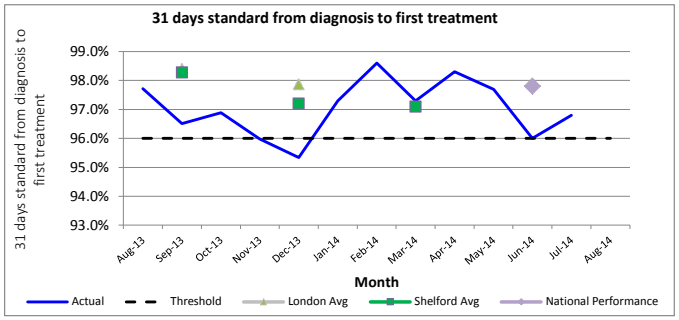


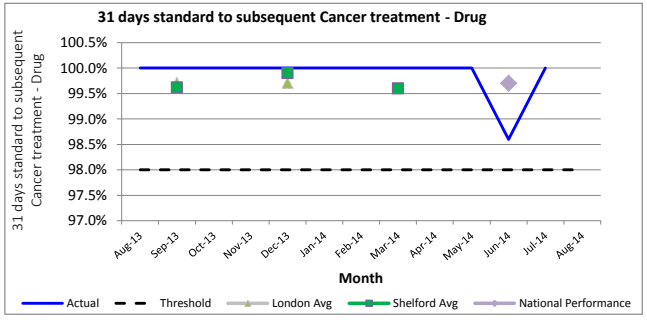


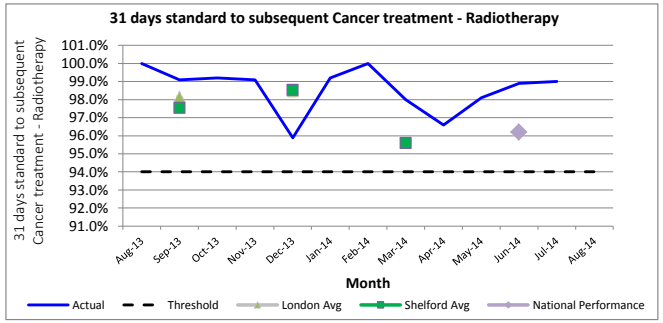
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 July	Performance in 2013/14 Q1-13	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Cancer Access Waiting Times															
2 week wait from referral to date first seen all urgent referrals	✓	Monthly	>93%	98.1%	98.4%	93.0%	93.7%				93.6%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	✓	Monthly	>93%	97.2%	97.6%	85.6%	88.4%				87.5%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	-	Monthly	>96%	96.4%	96.9%	96.8%	97.4%				97.2%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	-	Monthly	>98%	98.4%	99.5%	100.0%	99.6%				99.7%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	-	Monthly	>94%	97.1%	98.7%	99.0%	97.6%				98.2%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	-	Monthly	>94%	94.7%	95.5%	97.1%	96.9%				96.5%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	-	Monthly	>90%	95.5%	95.6%	90.7%	91.0%				91.7%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	-	Monthly	>85%	79.7%	74.0%	85.5%	85.4%				87.6%				Mon, TDA, CQC

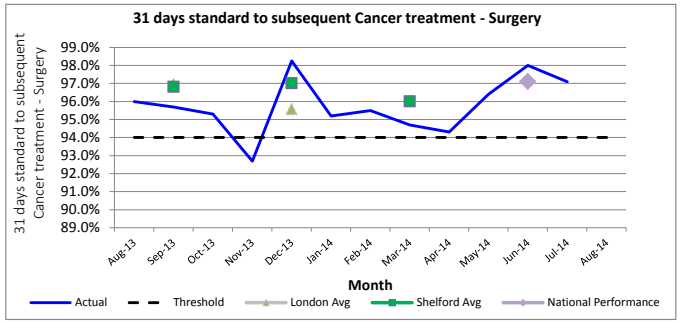


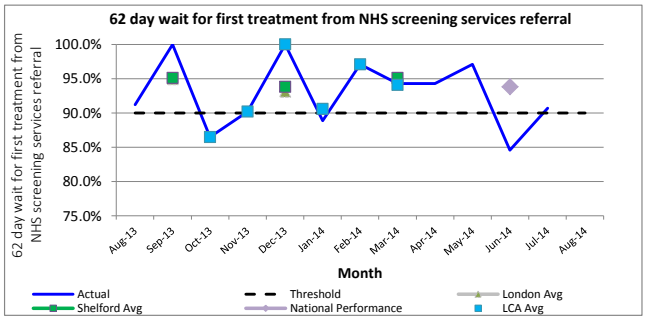


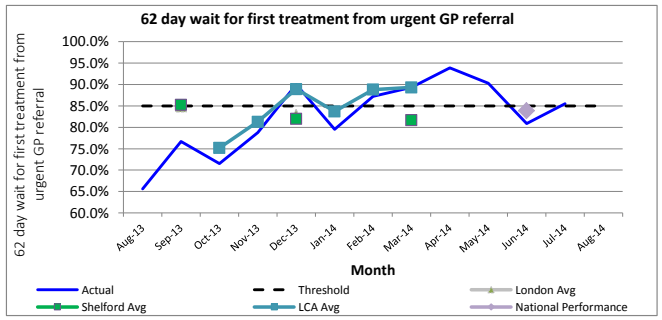




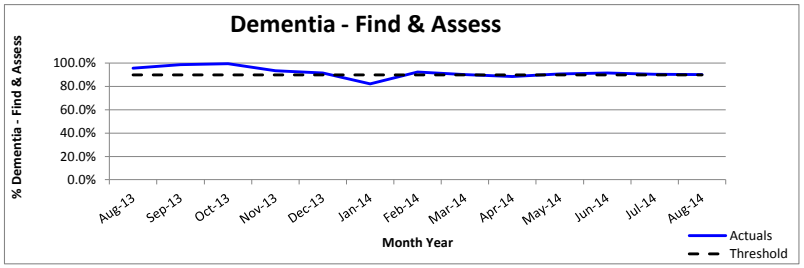


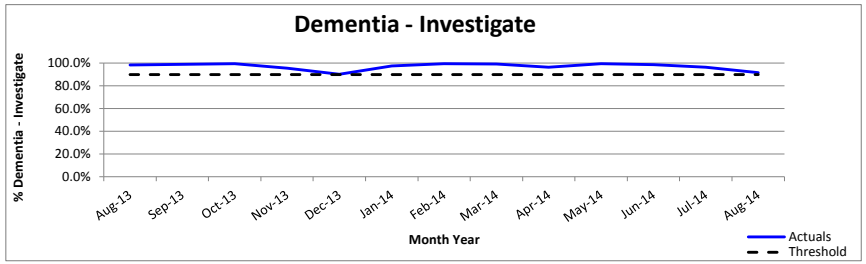


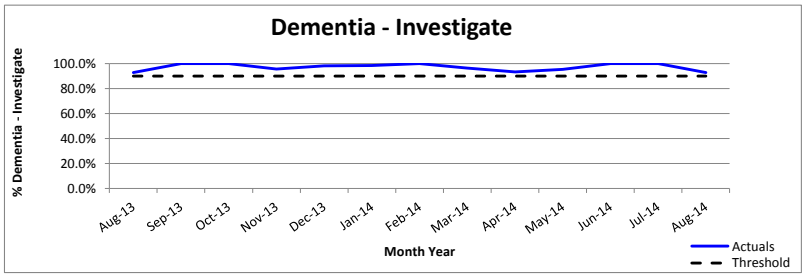


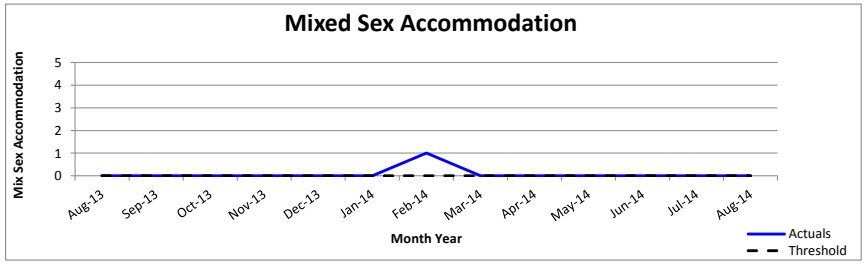


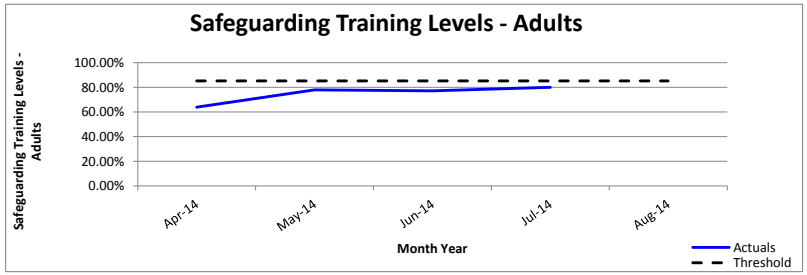
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
CQUIN - Dementia															
CQUIN - Dementia - Find & Assess	-	Monthly	>90%	96%	97%	90.24%	90.19%				90.23%				Contractual
CQUIN - Dementia - Investigate	-	Monthly	>90%	98%	98%	91.48%	95.58%				96.44%				Contractual
CQUIN - Dementia - Refer	-	Monthly	>90%	93%	95%	92.59%	98.47%				96.79%				Contractual
Accomodation															
Mixed Sex Accommodation	-	Monthly	0	0	0	0	0				0				TDA
Safeguarding Training Levels															
Safeguarding Training Levels Adults	-	Monthly	>85%	n/a	n/a	Not data available	72.87%				74.61%				Define
Safeguarding Training Levels Children Trust - Level 1	-	Monthly	>80%	n/a	n/a	76.0%	77.0%				78.0%				Define
Safeguarding Training Levels Children Trust - Level 2	-	Monthly	>80%	n/a	n/a	129.0%	132.0%				133.0%				Define
Safeguarding Training Levels Children Trust - Level 3	-	Monthly	>80%	n/a	n/a	129.0%	116.0%				117.5%				Define
Indicators to developed															
*Patients detained under the MH Act **															

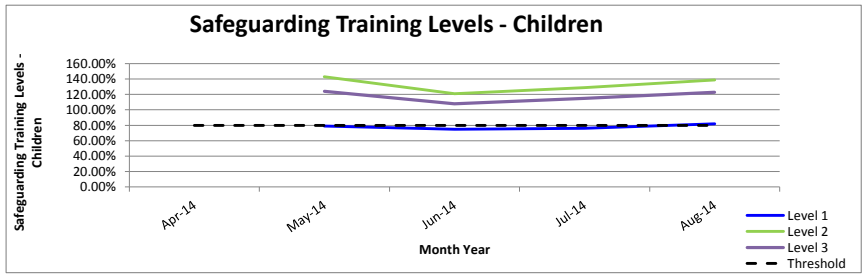


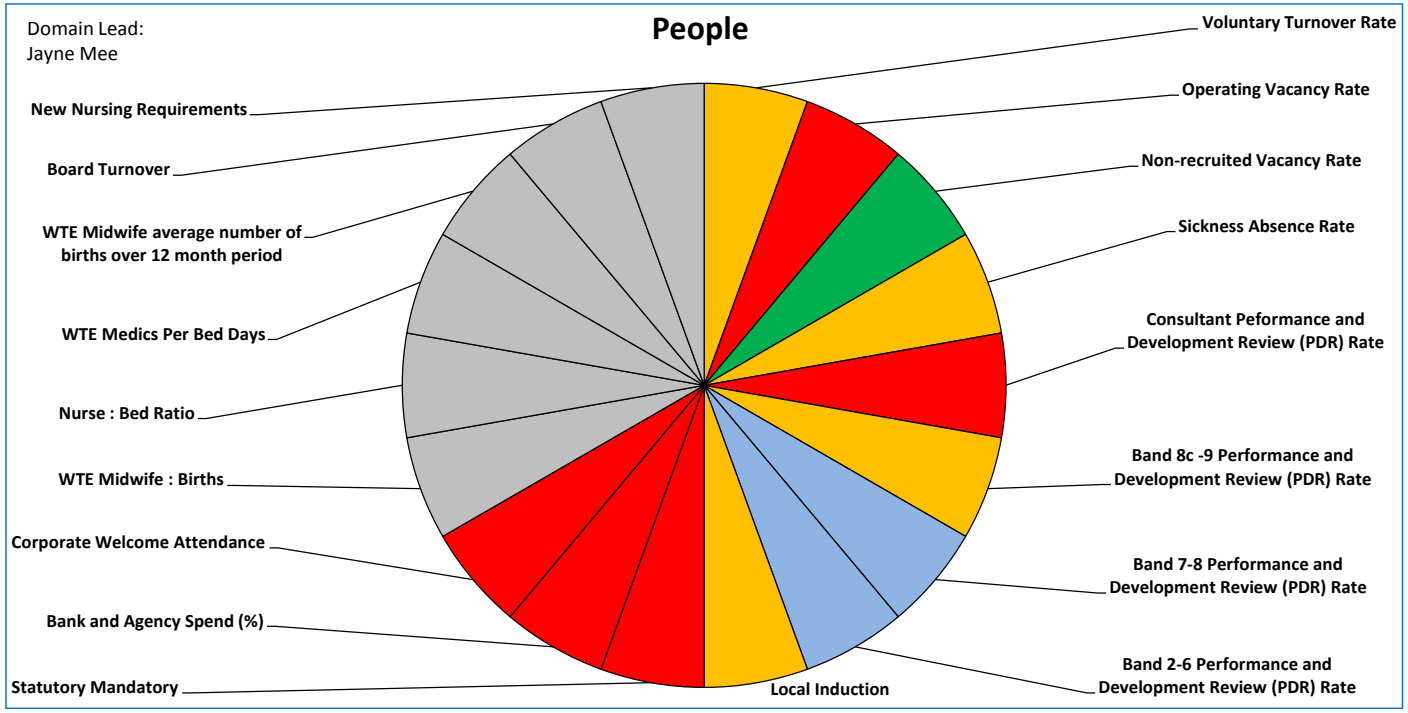












*Clarity as to how these indicators are measured and which domain they are included in is being proposed and will be refreshed in the next integrated performance scorecard.

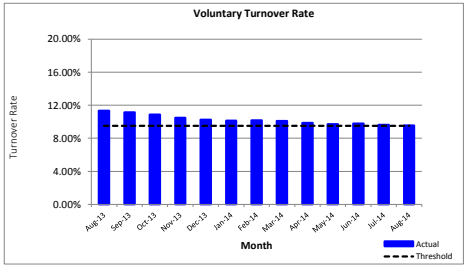
Current performance which meets or exceeds target

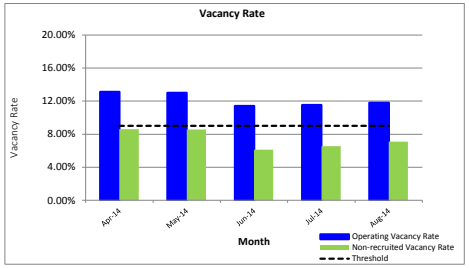
Current performance which is not meeting target but is within 10% of target

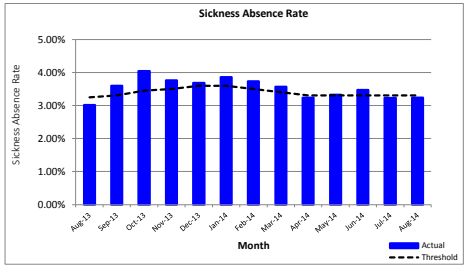
Current performance which is not meeting target within 10%

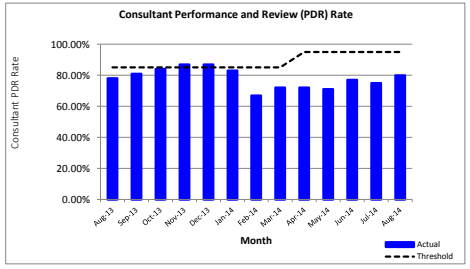
Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Turnover & Vacancy Rate															
Voluntary Turnover Rate	✓	Monthly	<9.50%	11.33%	11.27%	9.54%	9.78%				9.54%				TDA
Operating Vacancy Rate	✓	Monthly	<9.00%	n/a	n/a	11.80%	12.17%								CQC
Non-recruited Vacancy Rate	✓	Monthly	<9.00%	n/a	n/a	7.10%	7.77%								CQC
Sickness Absence Rate	✓	Monthly	<3.4%	3.01%	3.19%	3.24%	3.34%				3.55%				CQC
Appraisal Rates															
Consultant Peformance and Development Review (PDR) Rate	✓	Monthly	>95.00%	78.00%	78.67%	80.00%	73.33%								Define
Band 8c -9 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	92.59%	43.48%								Define
Band 7-8 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	22.73%	n/a								Define
Band 2-6 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	5.75%	n/a								Define
Training Compliance															
Local Induction	✓	Monthly	>95.00%	73.81%	74.91%	91.18%	77.01%								Define
Statutory Mandatory	✓	Monthly	>95.00%	69.35%	69.45%	71.86%	69.20%								Define
Bank and Agency Spend															
Bank Spend (%)	✓	Monthly	<7.00%	n/a	n/a	4.80%	5.61%				11.62%				Define
Agency Spend (%)	✓	Monthly	<7.00%	n/a	n/a	6.38%	8.10%								Define
Corporate Welcome															
Corporate Welcome Attendance	✓	Monthly	>100.00%	n/a	n/a	87.50%	90.12%								Define

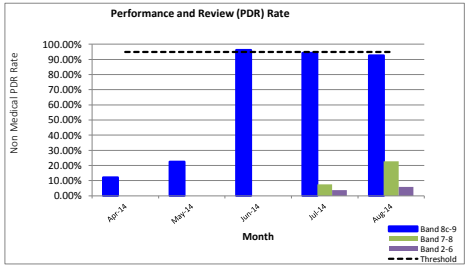
Indicators to be developed
WTE Midwife : Births
Nurse : Bed Ratio
WTE Medics Per Bed Days
WTE Midwife average number of births over 12 month period
Board Turnover
New Nursing Requirements

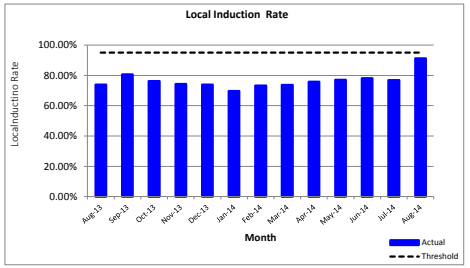


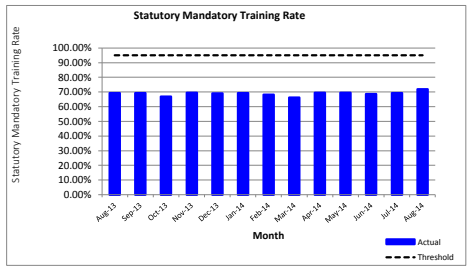


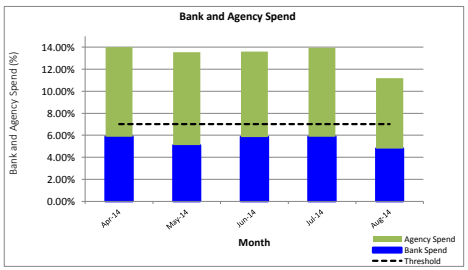


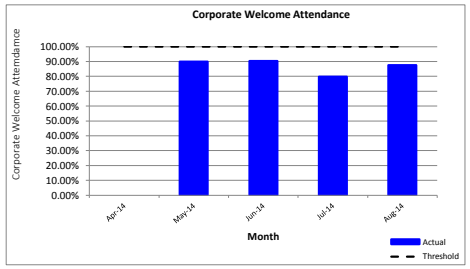










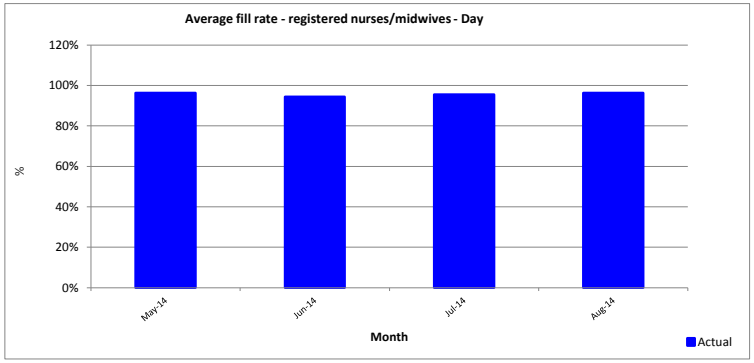


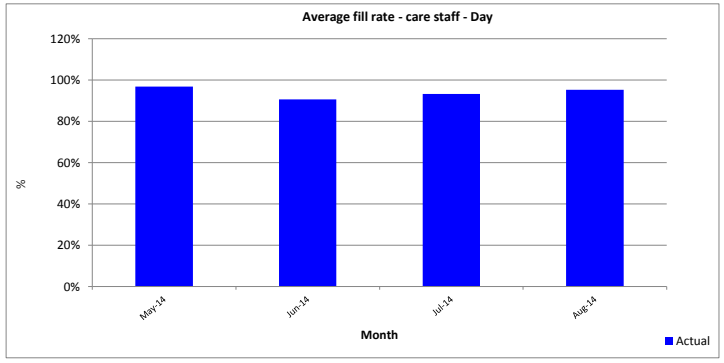
People KPI Report ~ Current Performance - August 2014

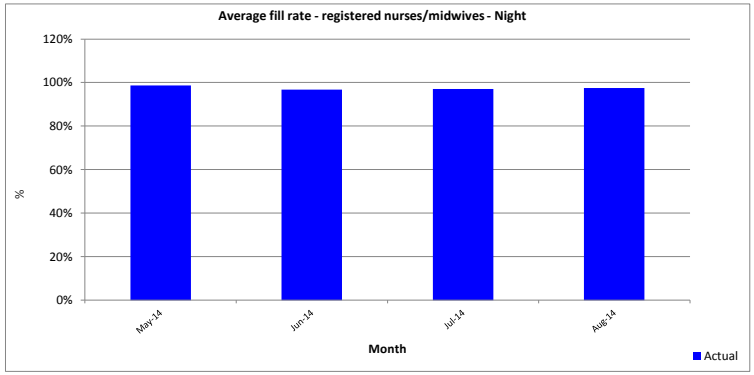
Occupational Group	General Ledger (GL) Establishment WTE	ESR Established WTE	Variance GL & ESR Post WTE	ESR Inpost WTE	Worked Bank WTE	Worked Agency WTE	Total People WTE (inpost/b&a)	Variance Total People against ESR Establishment	Variance Total People against GL Establishment
Trust Overview	10,024	10,232	208	9,023	513	710	10,246	14	222

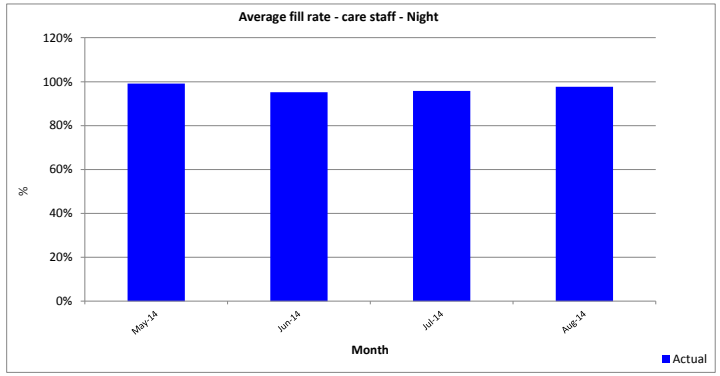
Month 5 August 2014	Period	KPI Target	Current Performance	Performance Flag	Current Performance and Plans to Improve
Vacancy Rate %	in month	9.00%	11.80% operational vacancy rate & 7.10% non-recruited to vacancy rate	red - operating vacancy rate & green - non-recruited vacancy rate	At the end of August, we directly employed (excl.hosted services) 9,023 WTE; 63 WTE more than the end of July. Within this increase, 14 WTE is attributed to the inclusion of people supporting research across the Divisions and Imperial Private Healthcare due to a re-alignment of cost centres to a Corporate Directorate. The remaining increases were within the Medical & Dental (36 WTE), Nursing & Midwifery (16 WTE) and Administrative & Clerical (22 WTE) occupational groups; a decrease of 11 WTE was also seen within the Scientific, AHP & Pharmacist groups. The post establishment increased by 106 WTE during August, of which 20 WTE relates to the research re-coding, 63 WTE approved through the ERAF process and the remainder through other requests supported by Finance BP approval. The overall effect being that the operating vacancy rate has increased marginally from 11.52% to 11.80%. We currently have 483 successful candidates who are waiting to join the Trust, which adjusts the vacancy rate to a non-recruited figure of 7.10%. The ERAF approval process continues to work to support recruitment that is appropriate and required for the delivery of safe high quality care for our patients.
Ward / Inpatient Staffing Levels	current operating band 2~6 vacancy rate on ward/inpatient areas is 13.52% (up from 13.18% in July) with an adjusted non-recruited vacancy rate of 5.75%, taking into account candidates waiting to join including those from the recent Division of Surgery recruitment campaign to India				In month, the band 2-6 vacancy level for Nursing and Midwifery staff within our ward and inpatient areas increased marginally from 13.16% to 13.52%; due to an overall increase of 16 WTE in the number of posts within the establishment. There are currently 261 WTE band 2 - 6 Nursing & Midwifery candidates waiting to join the Trust, bringing the non-recruited to vacancy rate for this group to 5.75%. Monitoring of the band 2-6 vacancies within our Divisions continues to be supported by detailed monthly reporting at Divisional, ward and banding level as well as the development and use of a bespoke strategic people plan for each Division, to pro-actively manage the vacancies and turnover associated with this specific group. The central Resourcing Team continue to work with the Divisions to facilitate these plans through the centralised recruitment process, actively supported by the Nursing & Midwifery Recruiters.
B & A Spend as % of total paybill	in month	6.70%	11.18% (6.38% agency & 4.80% bank)	red	Bank and agency spend, as a % of our total paybill, decreased from 13.60% in July to 11.18% in August ; 6.38% agency spend and 4.80% bank spend. During August, total requests for Nursing & Midwifery temporary staffing reduced from 702 WTE in July to 627 WTE, of which, 521 WTE was filled and worked (down from 595 WTE in July). Support for Cerner continues to reduce, down from 77 WTE in July to 64 WTE, with fixed-term recruitment continuing to the 70 WTE (2-year funded) Cerner support roles. In terms of spend, a total of £5.00m was spent during August on bank and agency by the Divisions and Corporate Directorates, showing a decrease from the £6.41m spent in July (22% reduction). The WTE number allocated to bank & agency in August shows an overall reduction of 181 WTE down from 1,404 WTE to 1,223 WTE in August. When compared to the same month last year, August's bank & agency spend shows an increase of £520k more ; £545k more agency spend & £25k less bank spend.
	rolling 12-mths	7.00%	11.62%	red	
Turnover Rate %	rolling 12-mths	9.50%	9.54%	amber	Voluntary turnover (rolling 12-month period) continues to reduce; down from 9.64% in July to 9.54% in August. This steady reduction in voluntary turnover has been seen since June 2013 when the rate was at 11.61%. Similarly, we have seen an increase in our stability index across the same period (measuring the retention of our people with more than 12 months service) from 78.93% to 86.46%. Our voluntary turnover rate remains one of the lowest when compared to other London Acute Teaching Trusts. Information from exit interviews and Engagement Survey's continue to be used within the Divisions to understand why our people choose to leave with appropriate actions plans put into place to improve our people experience. Supporting this is the information received from our on-boarding survey.
Sickness Absence Rate %	in month	3.15%	3.24%	amber	No real change was seen during August in the levels of recorded sickness absence. The in-month sickness absence rate of 3.24% brings the rolling 12-month position to 3.55% against the 14/15 target of 3.30%. A total of 48,200 working hours were lost to illness during August which is the equivalent of 296 WTE, of which 97 WTE related to long-term illness (33%). Across the organisation, sickness absence levels vary in-month; within Divisions from 2.92% in SC & CV to 4.40% in W&C, within Corporate Directorates from 0.33% in Press & Comms to 3.26% in ICT. Also by occupational group, ranging from 0.36% for our Doctors in Training to 3.90% for Administrative & Clerical to 6.24% for Unqualified Nursing & Midwifery support. Monitoring of safe staffing levels, to ensure that sickness absence has minimal impact, is done through dialy reviews with the GM's and senior sitenurse as well as monthly meetings with managers to ensure proactive management of sickness absence.
	rolling 12-mths	3.30%	3.55%	amber	
Performance & Development Review (PDR) % - bands 8c~9	in month	95.00%	92.59%	amber	Performance Development and Review (PDR) compliance for our band 8c - 9 people was 92.59% at the end of August (target is 95%) and the first calibration assessment was carried out reviewing the band 8c - 9 PDR grading spread. Future milestones are the end of September, when we expect all of our band 7 - 8b people to have had a PDR, and December for our band 2 - 6 people. Over 1,400 Trust managers have booked to attend the bespoke PDR training which accompanies the Trust's PDR process, of which, 1,000 have already attended, completed and been licensed to carry out PDR's with their people. During August, the first of a new monthly PDR report was sent to each Division and Corporate Directorate looking at the compliance rates for all three banding groups and the rating spread for bands 8c - 9 (showing comparison to Trust performance). In addition, the monthly MPI report includes details of all people who are yet to have a PDR to enable proactive management of this important management and engagement process.
Consultant Appraisal %	in month	95.00%	80.00%	red	The Trust Consultant Appraisal rate has increased in-month from 75% to 80% but remains significantly below the 95% target. With the process for revalidation requiring appraisal's to be completed and evidenced, for a defined period of years, there is a risk that with revalidation will not being approved if the appraisal's have not been completed. Across the Divisions, compliance for this people metric varies from 73% in the Division of Medicine (up from 67% in July) to 89% in the Division of Investigative Sciences & Clinical Support (down from 90% in July) with the Divisions of Women's & Children's at 85% and Surgery, Cancer & Cardiovascular at 78%.The Medical Director's office are proactively monitoring the compliance rates through Divisional reporting along with a personal invitations to non-compliant Consultants to meet with the Medical Director. Chiefs of Service, within the Divisions are leading the drive within the Divisions to ensure compliance of this core people metric.
Corporate Welcome	June joiners	100.00%	87.50% in-month & 91.18% YTD	red - in-month compliance & amber - YTD compliance	All new joiners are required to attend a Corporate Welcome session within the first 8 weeks of their employment, with the expectation that they attend as soon possible. The metric measures performance against this expectation with a 100% compliance target. The August compliance figure of 87.50% is reporting on those who joined us during June who, depending on when in June they joined, had until the end of August to attend Corporate Welcome. The compliance rate for June joiners is below target and full detail, of those joiners who have not attended, will be provided on the monthly MPI report to all Divisions and Corporate Directorates. The YTD compliance rate is at 91.18% and varies across the divisions from 83.78% in Medicine to 92.93% in Investigative Sciences and, within the Corporate Directorates, from 83.33% to 100%. The central Statutory & Mandatory Training team do a monthly audit of all individuals who are non-compliant with a full diagnostic as to the contributing reasons for that non-attendance. Following up either directly with the individual or recruiting manager requesting urgent attendance.
Statutory Mandatory Training Compliance (non-medical) %	in month	95.00%	71.86% full compliance & 83.21% including partial compliance	red - fully compliant & red - full & partial compliance	Full Statutory & Mandatory training compliance for all of our people (excluding doctors in training) increased from 69.39% to 71.86%during the month of August. This remains below the target of 95% however, when you add to this those who have partially completed their Statutory & Mandatory training, the compliance rate increases to 83.21%. All of those who are partially compliant are detailed within the monthly MPI report to all Divisions and Corporate Directorates for directed management. Supporting this are the Compliance Surgeries which the Head of Statutory & Mandatory Training is holding within all of the Divisions and Corporate Directorates to work through recording issues, to direct completion of partial training and resolve queries. In addition, Statutory & Mandatory Training Team continues to work to; (1) Review ESR and ICT systems and processes which affect data quality of mandatory training data (2) Review the WIRED reporting tool (3) Improve completion of e-learning rates for new starters and those due for refresher training (4) Review the denominator for Mandatory training.
Local Induction Compliance %	in month	95.00%	91.18%	amber	Local Induction compliance has increased significantly from 76.91% in July to 91.18% in August reflecting the focused work across all Divisions and Corporate Directorates to ensure that all of our new people receive a local induction when they join the Trust. This is the first time that compliance for this key metric has reached an amber rating and a number of strategies are in place within the Divisions to ensure compliance for this key people metric. All OLM coordinators are equipped with information data which allows them to target, contact and educate the managers regards the training requirements and completion of this training. Weekly and monthly monitoring discussions, with line managers responsible for areas with low compliance, take place with locally agreed improvement plans for progress. Also departments are identified that have specific issues to focus support and help improve their performance against this metric.

Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Staffing: Nursing, midwifery and care staff															
Average fill rate - registered nurses/midwives (%) - Day		Monthly	tbc	n/a	n/a	95.48%	95.32%				95.59%				Contractual
Average fill rate - care staff (%) - Day		Monthly	tbc	n/a	n/a	93.33%	93.82%				94.08%				Contractual
Average fill rate - registered nurses/midwives (%) - Night		Monthly	tbc	n/a	n/a	97.12%	97.75%				97.53%				Contractual
Average fill rate - care staff (%) - Night		Monthly	tbc	n/a	n/a	95.72%	97.16%				96.93%				Contractual

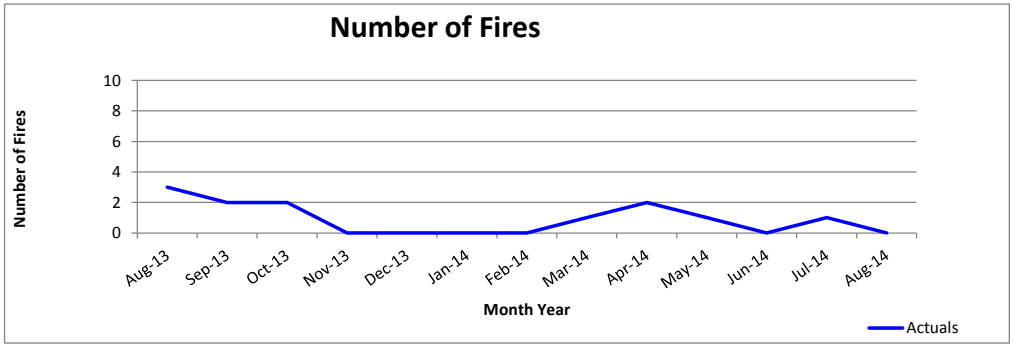


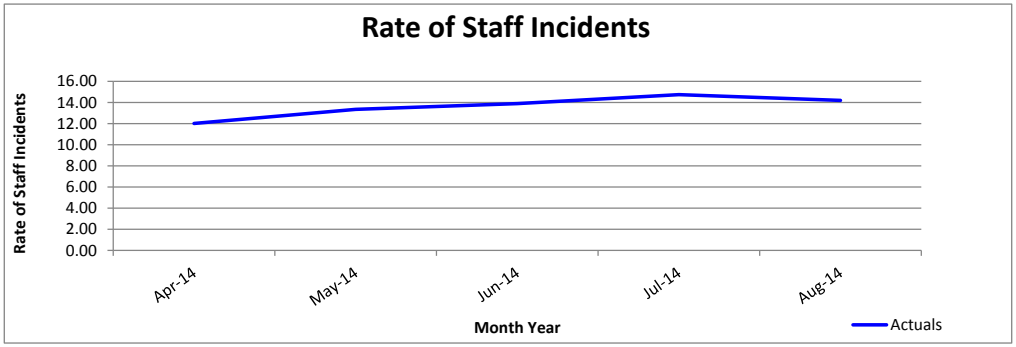






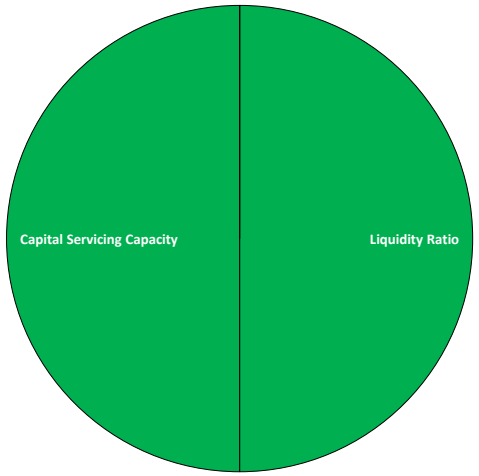
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Health and Safety															
Number of Fires	-	Monthly	tbc	3	8	0	3				4				Internal
Rate of Staff Incidents	-	Monthly	tbc	n/a	n/a	14.20	13.50				13.64				Internal





Domain Lead:
Bill Shields

Finance - Continuity of Services Risk Rating



Financial & Continuity of Service Risk Rating

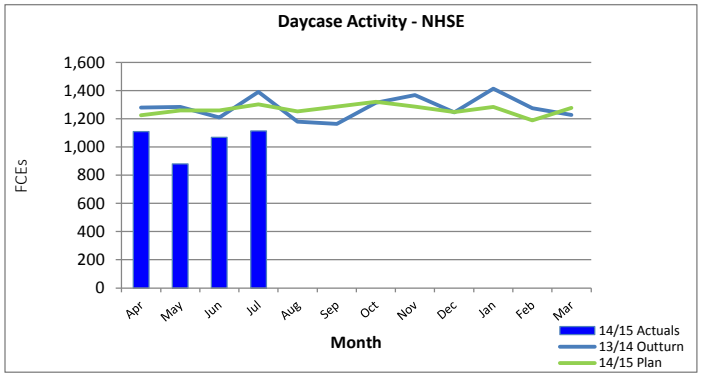
Imperial College Healthcare NHS
NHS Trust

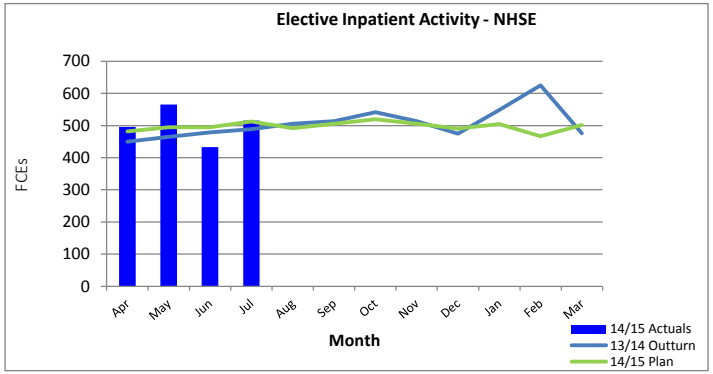
Indicator	Leading	Frequency	Weighting	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Continuity of Service Risk Rating														
Liquidity Ratio		Monthly	>50%	n/a	2	3	3							
Capital Servicing Capacity		Monthly	>50%	n/a	2	4	3							
Overall Continuity of Service Risk Rating						4	3							

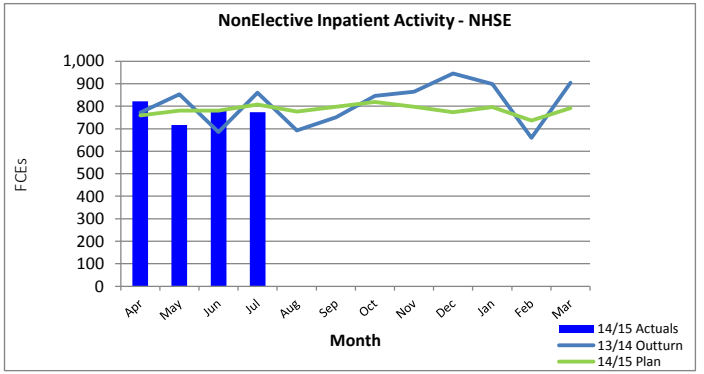
Activity performance against plans commissioned by NHSE

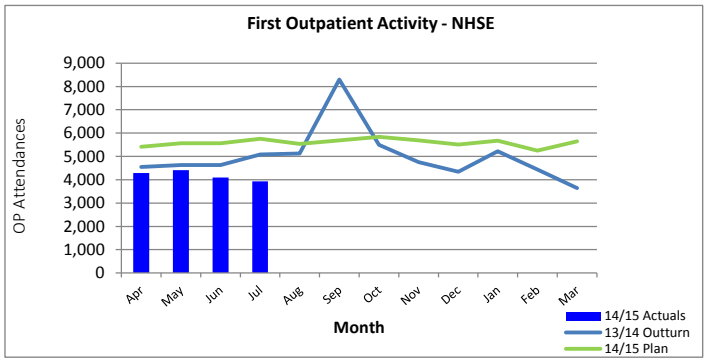
Imperial College Healthcare NHS Trust

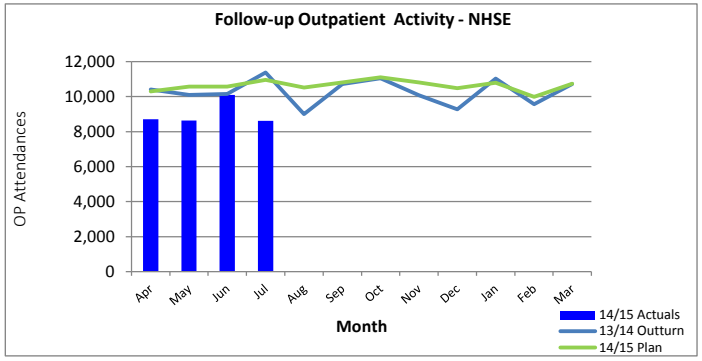
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Jul	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Daycase		Monthly	>1303	1,390	3,775	1,114	3,056				4,170				Contractual
Elective Inpatients		Monthly	>512	489	1,394	515	1,494				2,009				Contractual
NonElective Inpatients		Monthly	>808	860	2,310	773	2,320				3,093				Contractual
First Outpatient		Monthly	>5759	5,078	13,813	3,929	12,793				16,722				Contractual
Follow-up Outpatient		Monthly	>10951	11,375	30,674	8,624	27,434				36,058				Contractual
Adult Critical Care		Monthly	>1421	1,115	4,378	2,314	3,907				6,221				Contractual

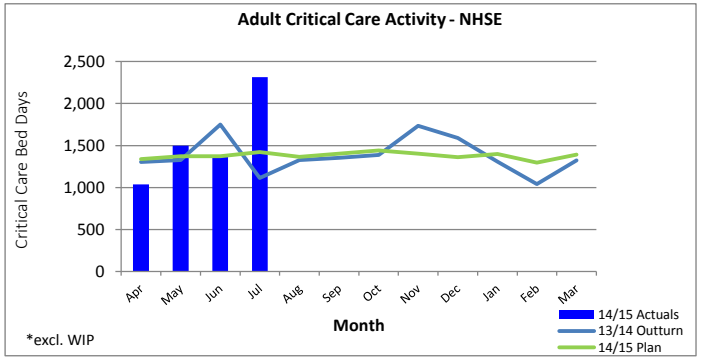








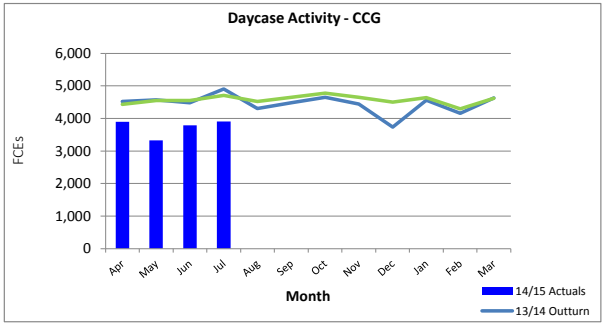


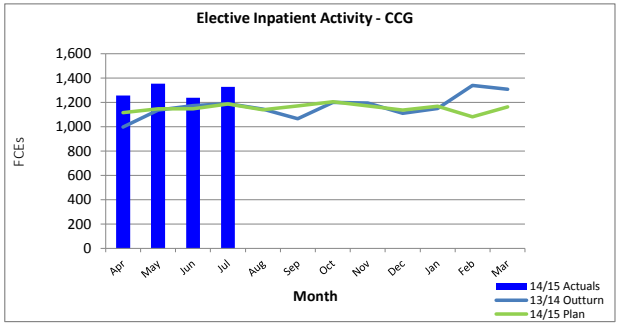


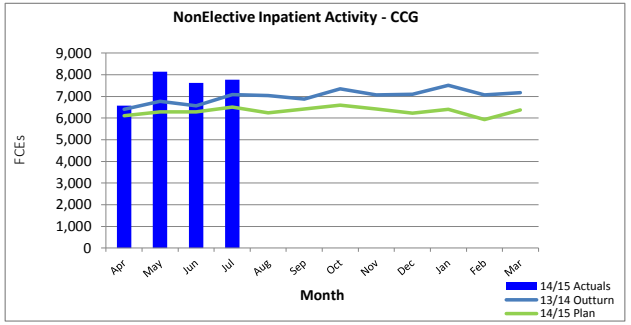
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are included in the "Other" tab. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently not shown.

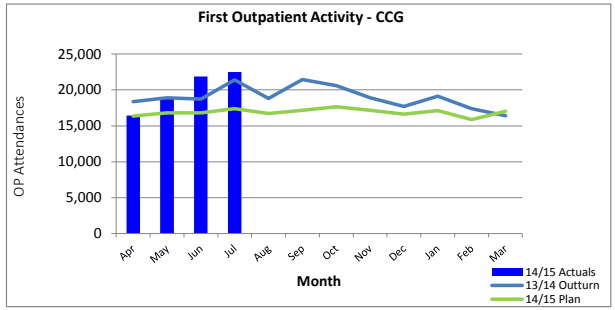
Activity performance against plans commissioned by CCG

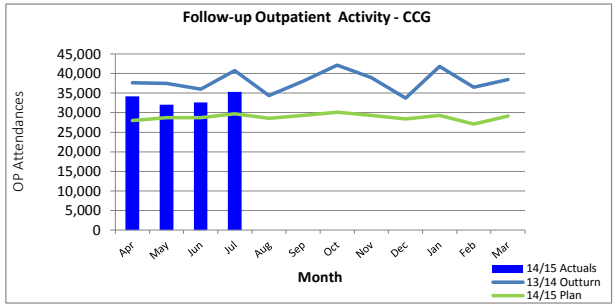
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Jul	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Performance Current Year To Date Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Daycase		Monthly	>4710	4,908	13,574	3,905	11,017				14,922				Contractual
Elective Inpatients		Monthly	>1187	1,189	3,307	1,328	3,847				5,175				Contractual
NonElective Inpatients		Monthly	>6502	7,078	19,740	7,773	22,348				30,121				Contractual
First Outpatient		Monthly	>17394	21,385	56,007	22,464	57,299				79,763				Contractual
Follow-up Outpatient		Monthly	>29716	40,777	111,085	35,288	98,845				134,133				Contractual
Adult Critical Care		Monthly	>1938	1,789	5,567	2,127	6,064				8,191				Contractual
A&E Attendances		Monthly	>17216	17,446	50,068	17,147	52,754				69,901				Contractual

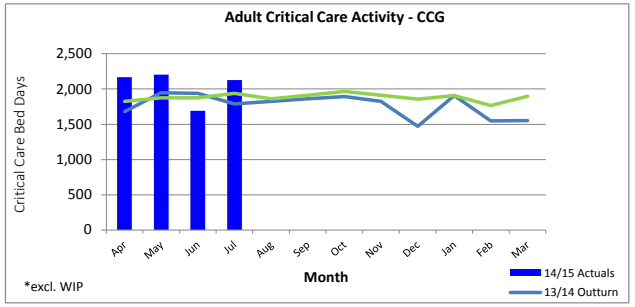


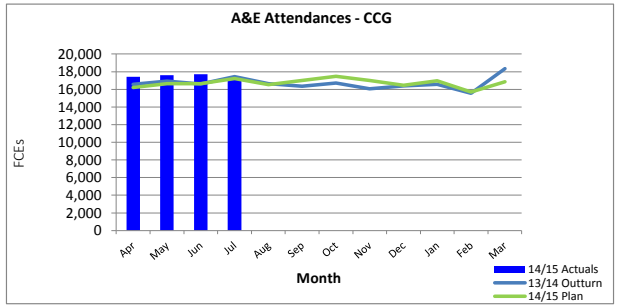








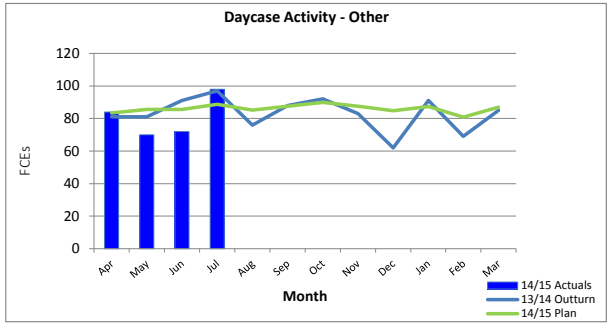


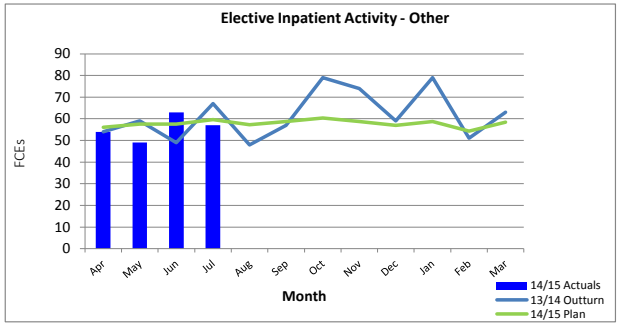


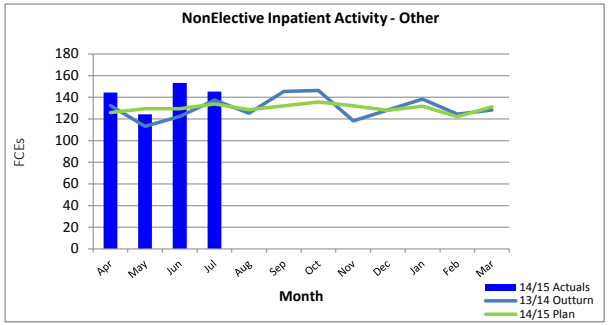
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are included in the "Other" tab. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently not shown.

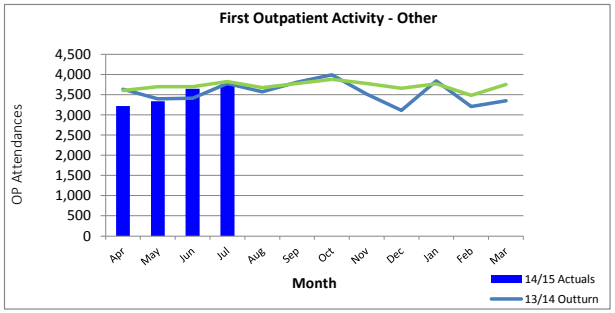
Activity performance against plans commissioned by Other

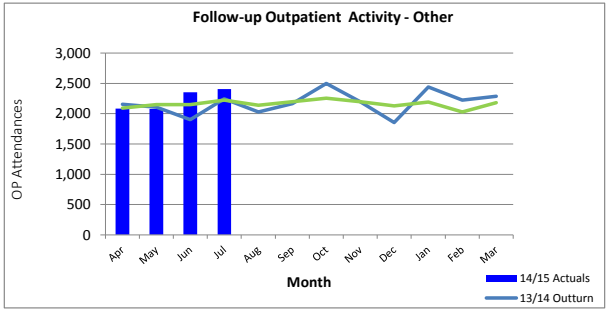
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Jul	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Daycase		Monthly	>89	97	253	98	226				324				Contractual
Elective Inpatients		Monthly	>60	67	162	57	166				223				Contractual
NonElective Inpatients		Monthly	>134	137	368	145	422				567				Contractual
First Outpatient		Monthly	>3828	3,781	10,440	3,761	10,205				13,966				Contractual
Follow-up Outpatient		Monthly	>2225	2,246	6,168	2,403	6,513				8,916				Contractual
Adult Critical Care		Monthly	>71	179	513	181	479				660				Contractual
A&E Attendances		Monthly	>469	514	1,241	468	1,396				1,864				Contractual

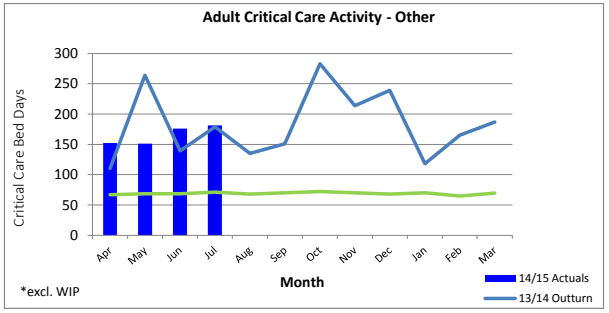


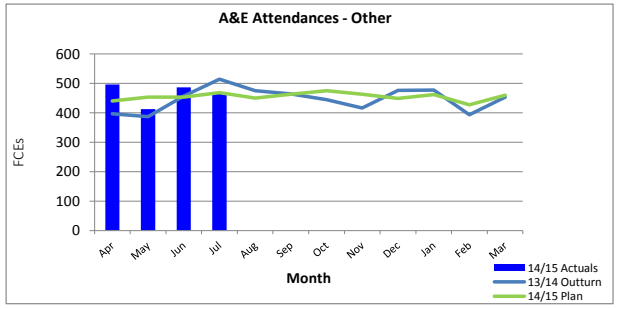












Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are shown here. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently not shown.
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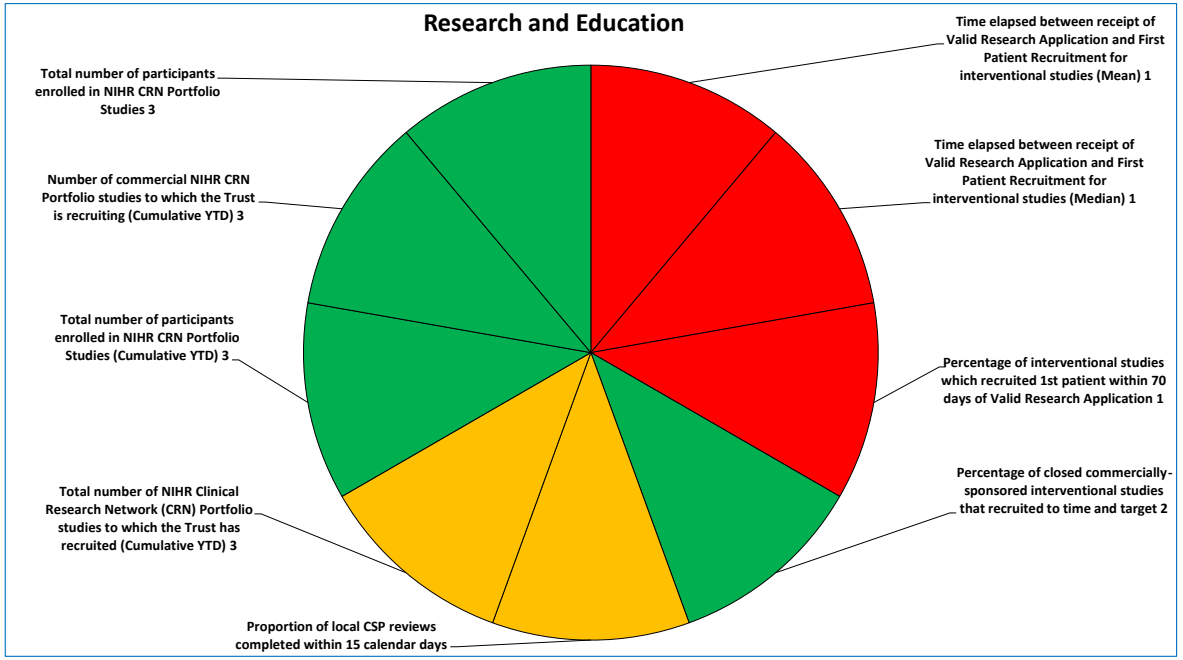
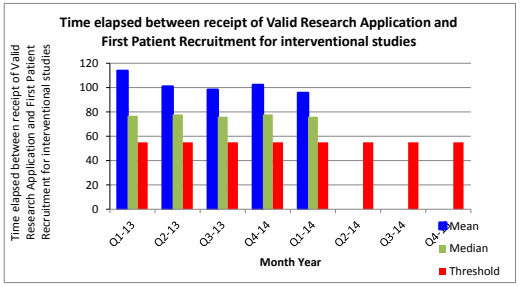

Research and Education
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Mean) 1
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Median) 1
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 1
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 2
Proportion of local CSP reviews completed within 15 calendar days
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 3
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3
Total number of participants enrolled in NIHR CRN Portfolio Studies 3

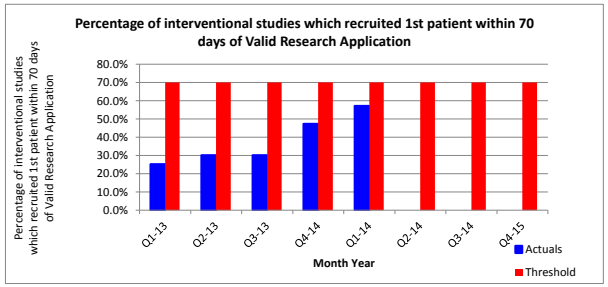
Indicator	Leading	Frequency	Threshold	Performance in 2013/2014 Q1	Performance Current Q1-14	Q2-14	Q3-14	Q4-15	YTD	Forecast 2014/15 Q2	2014/15 Q3	2014/15 Q4	Source Framework
Research & Development													
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Mean)** 1		Quarterly	<=70	114	95.7				96				Define
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Median)** 1		Quarterly	<=55	77	76.0				76				Define
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 1		Quarterly	>=70%	25.2%	57.1%				57.1%				Define
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 2		Quarterly	>=60%	57.1%	70.4%				70.4%				Define
Proportion of local CSP reviews completed within 15 calendar days		Quarterly	>=70%	58.0%	47.2%				47.2%				Define
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 3		Quarterly	>350	182	176				176				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3		Quarterly	>12675	2857	2933				2933				Define
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3		Quarterly	>66	18	24				24				Define
Total number of participants enrolled in NIHR CRN Portfolio Commercial Studies Cumulative YTD) 3		Quarterly	>800	101	128				128				Define

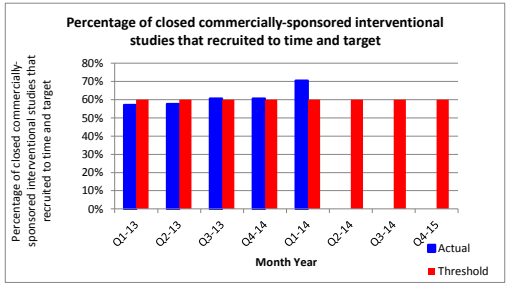
[1] Data source: IC BRC quarterly returns to NIHR CCF.

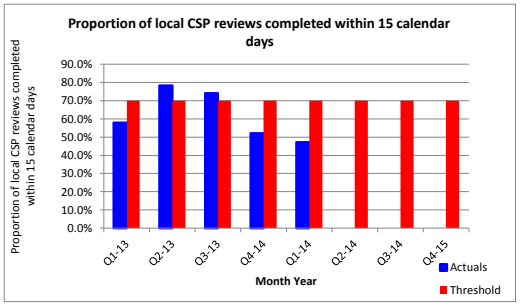
[2] Data source: monthly performance reports from NWL CLRN; data include all study suspensions.

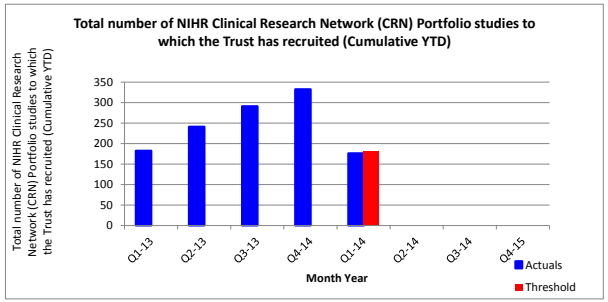
[3] Data source: CLRN Recruitment Summary – Individual CLRNs reports from NIHR portal for 15 March 2014.
Period analysed = Q1 (April to June); Q2 (April to September); Q3 (April to December) in each FY.
COSMOS study not included in recruitment totals.

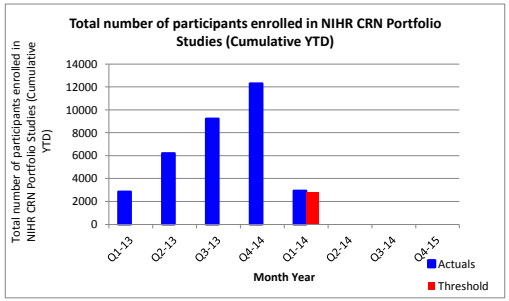


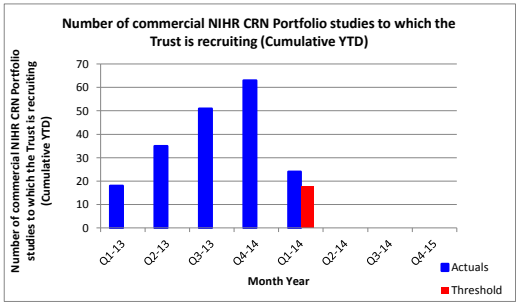


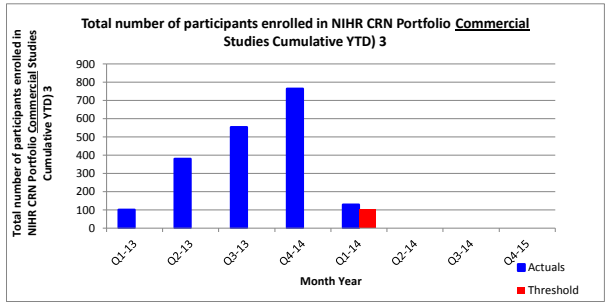


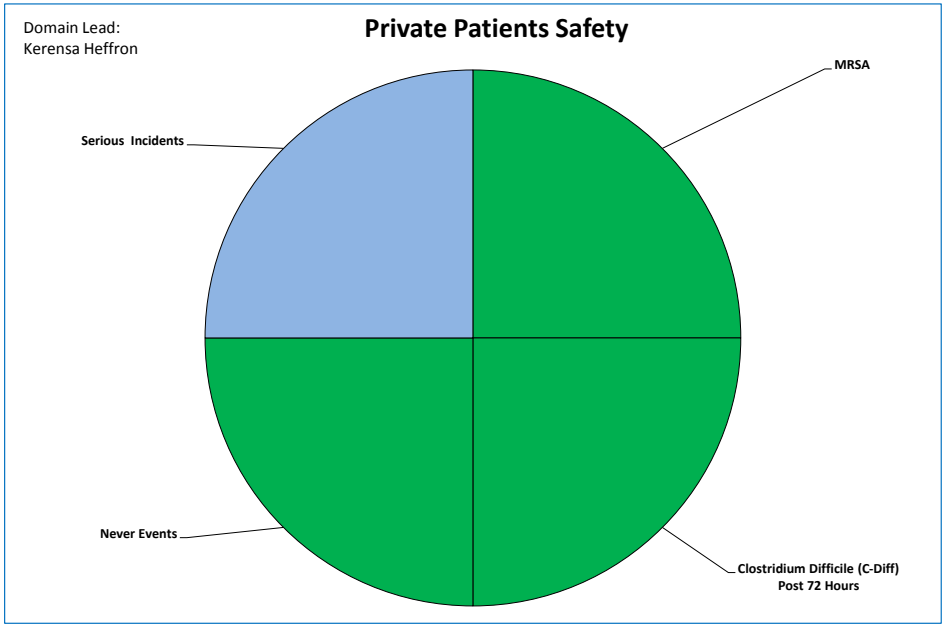


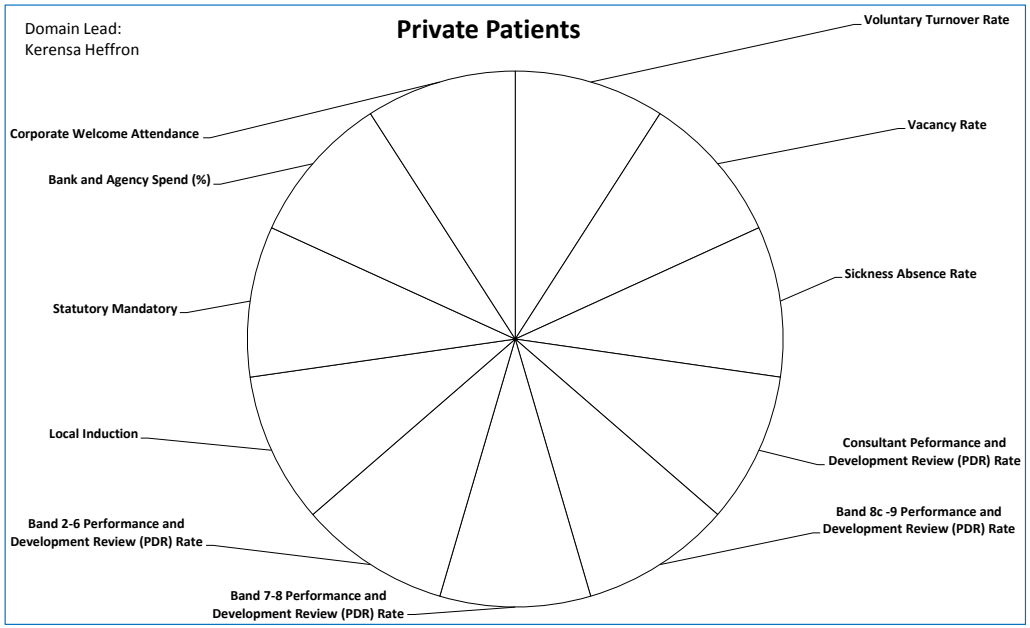




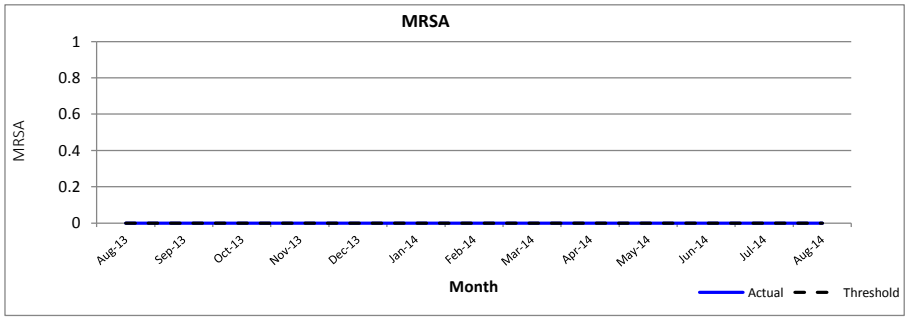


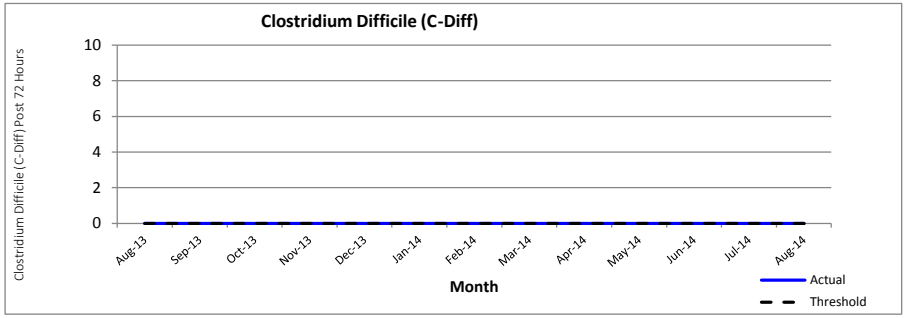


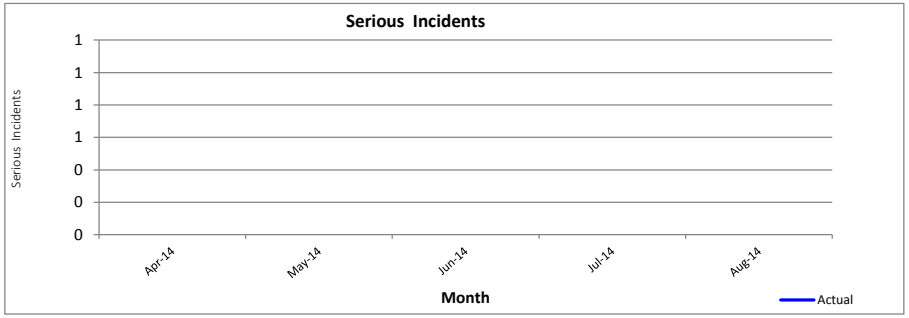

Domain Lead:
Kerensa Heffron
Private Patients Safety
MRSA
Serious Incidents
Never Events
Clostridium Difficile (C-Diff)
Post 72 Hours

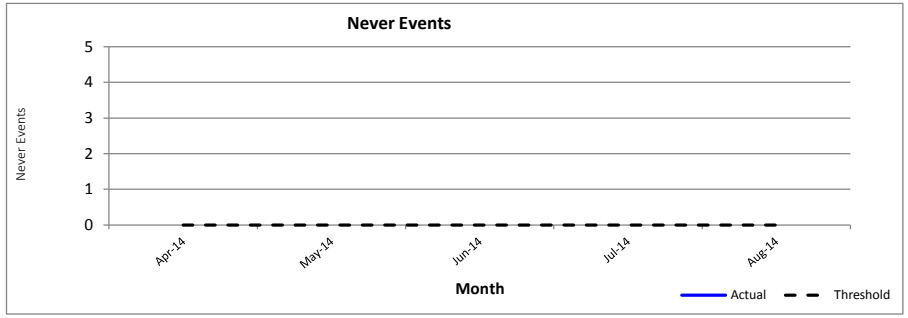

Domain Lead:
Kerensa Heffron
Private Patients
Voluntary Turnover Rate
Vacancy Rate
Sickness Absence Rate
Consultant Peformance and
Development Review (PDR) Rate
Band 8c -9 Performance and
Development Review (PDR) Rate
Band 7-8 Performance and
Development Review (PDR) Rate
Band 2-6 Performance and
Development Review (PDR) Rate
Local Induction
Statutory Mandatory
Bank and Agency Spend (%)
Corporate Welcome Attendance

Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Infection Control															
MRSA	-	Monthly	0	0	0	0	0				0				TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	-	Monthly	0 p/a	0	0	0	0				0				Mon, TDA, CQC
Incidents															
Never Events	-	Monthly	0	0	0	0	0				0				TDA, CQC
Serious Incidents	-	Monthly	n/a	0	0	0	0				0				TDA, CQC

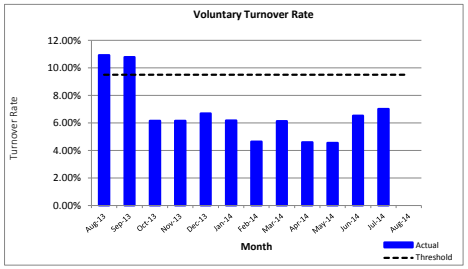


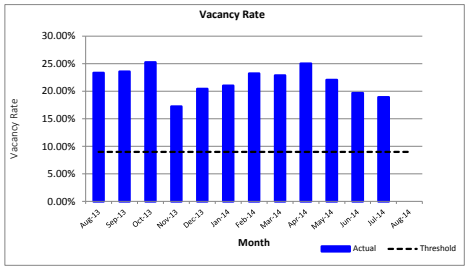


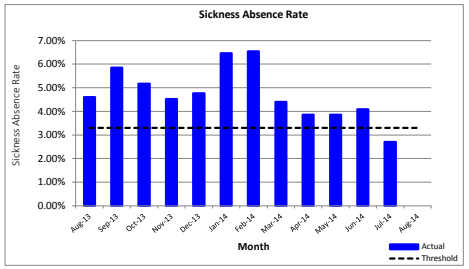


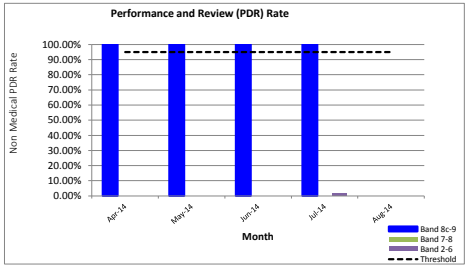


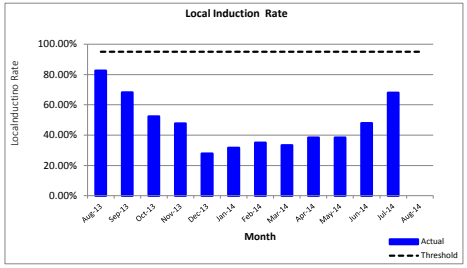
Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Aug-13	Performance in 2013/14 Qtr2	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Turnover & Vacancy Rate															
Voluntary Turnover Rate	✓	Monthly	<9.50%	10.91%	10.36%		5.22%								TDA
Vacancy Rate	✓	Monthly	<9.00%	23.36%	22.87%		21.43%								CQC
Sickness Absence Rate	✓	Monthly	<3.4%	4.60%	5.00%		3.93%								CQC
Appraisal Rates															
Band 8c -9 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a		100.00%								Define
Band 7-8 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a		n/a								Define
Band 2-6 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a		n/a								Define
Training Compliance															
Local Induction	✓	Monthly	>95.00%	82.61%	77.80%		41.64%								Define
Statutory Mandatory	✓	Monthly	>95.00%	72.43%	71.15%		66.32%								Define
Bank and Agency Spend															
Bank Spend (%)	✓	Monthly	<7.00%	n/a	n/a		20.45%								Define
Agency Spend (%)	✓	Monthly	<7.00%	n/a	n/a		10.95%								Define
Corporate Welcome															
Corporate Welcome Attendance	✓	Monthly	>100.00%	n/a	n/a		70.84%								Define

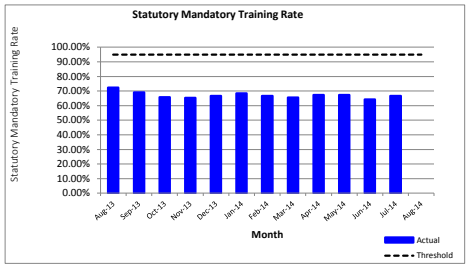


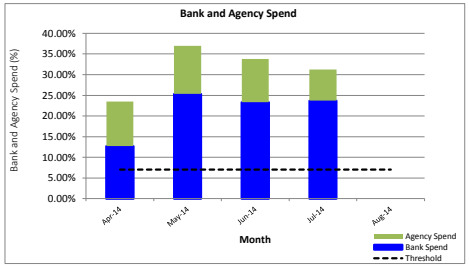


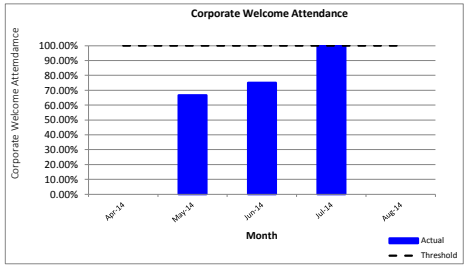












Domain	Sub-domain	Page number	Indicator title	Description	Rating
Summary	Finance	3	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.	Scored between 1-4: '4' – Low risk '3' – Emerging or residual '2' – Financial position may '1' – as with '2' and may
Summary	Finance	3	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.	as with Capital Servicing
Summary	Access	3	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so. The Trust's service-level waiting times can be compared to other Healthcare Providers across England.	Operational standards: Admitted ≥90% Non-admitted ≥95% Incomplete pathway ≥92%
Summary	Access	3	2 week wait from referral to date first seen all urgent referrals	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected.	Operational standards: ≥93%
Summary	Access	3	2 week wait from referral to date first seen breast cancer	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where breast cancer is suspected.	Operational standard: ≥93%
Summary	Access	3	31 days standard from diagnosis to first treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to the start of their treatment.	Operational standard: ≥96%
Summary	Access	3	31 days standard to subsequent cancer treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to their subsequent treatment.	Operational standard: Drug-based ≥98% Radiotherapy ≥94% Surgery ≥94%
Summary	Access	3	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer.	Operational standard: NHS Screening Services ≥90% GP referral ≥85%
Summary	Access	3	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.	Operational standard: ≥95%
Summary	Outcomes	3	Clostridium Difficile (C-Diff) Post 72 hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance. This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.	Threshold: 65 cases
Summary	Governance	3	CQC Judgements – warning notice issued, civil and / or criminal action initiated	TBD	TBD
Summary	Governance	3	Third party reports from e.g. GMC, Ombudsman, medical Royal Colleges etc – judgement based on severity and frequency of reports	TBD	TBD
CQC	CQC	4	MRSA (latest CQC report)	This rating indicates the total number of incidences of MRSA within the Trust, as reported in the most recent CQC report.	Operational Standard: 0 incidences
CQC	CQC	4	Clostridium Difficile (latest CQC report)	This rating indicates the total number of incidences of C-Diff within the Trust, as reported in the most recent CQC report.	Operational Standard: 0 incidences

Domain	Sub-domain	Page number	Indicator title	Description	Rating
Quality	Safety	6	Hospital Standardised Mortality Rate (HSMR)	The HSMR is an indicator of healthcare quality that measures the number of deaths in the Trust, during the patients' stay at the Trust, and which is adjusted for a variety of factors (i.e. age, poverty, treatments offered). A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.	TBD
Quality	Safety	6	Summary Hospital Mortality Indicator	The SHMI is an indicator of healthcare quality that measures whether the number of deaths in the Trust, or within 30 days of the patient's discharge, is higher or lower than you would expect. A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.	TBD
Quality	Safety	6	Number of Dr Foster morality alerts	Dr Foster Mortality alerts are sent to the Chief Executive of the Trust when the HSMR has, on at least one occasion in the preceding three months, reached double the expected rate for a particular diagnosis or procedure. This rating indicates the total number of Mortality alerts that have been sent to the Chief Executive of the Trust and may require investigation of the safety and quality of clinical care provided.	TBD
Quality	Safety	6	Number of deaths in low risk diagnostic groups	This indicator aims to identify deaths that are likely to be attributable to health care errors by measuring deaths in patients admitted with, or for, a condition or procedure that has a low associated risk of death (i.e. headaches; tonsillectomy). This rating indicates the total number of deaths in low risk diagnostic groups during the reporting period.	TBD
Quality	Safety	7	MRSA	Methicillin-Resistant Staphyloccocus Aureus (MRSA) is a type of bacterial infection that is resistant to a number of widely used antibiotics. This rating indicates the total number of incidences of MRSA within the Trust during the reporting period.	Operational Standard: 0 incidences
Quality	Safety	7	Clostridium Difficile (C-Diff) Post 72 Hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance. This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.	Operational Standard: 66 incidences per annum
Quality	Safety	7	Never Events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (i.e. wrong site surgery; wrong route administration of chemotherapy; retained instrument post-operation). The incidence of Never Events may indicate unsafe care. This rating indicates the number of Never Events that have occurred within the Trust during the reporting period.	Operational Standard: 0 incidences
Quality	Safety	7	Serious Untoward Incidents (SUI)	An SUI is a serious incident or event which led, or may have led, to the harm of patients or staff (i.e. Grade 3/4 pressure ulcer; data loss; HCAI outbreak; Never Events) This rating indicates the number of SUIs that have occurred within the Trust during the reporting period.	TBC
Quality	Safety	7	Harm Free Care (Safety Thermometer)	Delivering Harm Free Care is a core component of the care that we provided to our patients. Harm Free Care is care that is provided in the absence of the four common harms: Pressure Ulcers; Falls; Catheter Associated Urinary Tract Infections (CAUTIs); and Venous Thromboembolism (VTE). This rating indicates the percentage of patients that received Harm Free Care at the Trust. A decreasing trend may indicate issues with the quality and safety or care provided to patients.	Operational Standard: ≥90%
Quality	Safety	7	VTE Risk Assessments	A VTE (Venous Thromboembolism) is a blood clot that forms within a vein and is a serious, potentially fatal, medical condition. VTE Risk Assessments should be undertaken for every patient within 1 hour of admission. The rating indicates the percentage of patients that had a VTE risk assessment undertaken within 1 hour of admission.	Operational Standard: ≥95%

Domain	Sub-domain	Page number	Indicator title	Description	Rating
Quality	Patient Centredness	8	Inpatients Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Inpatient services to their friends and family if they needed similar care or treatment. The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.	TBC
Quality	Patient Centredness	8	Inpatients Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	A&E Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's A&E services to their friends and family if they needed similar care or treatment. The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.	TBC
Quality	Patient Centredness	8	A&E Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	Maternity Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Maternity services to their friends and family if they needed similar care or treatment. Women will be asked for their views on their maternity services at three touch points: antenatal care; birth and care on the postnatal ward; and postnatal community care.	TBC
Quality	Patient Centredness	8	Maternity Net Promoter Response Rate	The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would. It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	Number of complaints received	When things do not go according to plan, a patient may decide to formally complain to the organisation. This will usually result in an investigation into the concerns raised and a formal response to the complainant. This rating indicates the total number of complaints received by the Trust within the reporting period. A high number of complaints, or an unexpected or prolonged rise in complaints, may warrant extra investigation into the matter.	
Quality	Patient Centredness	8	PLACE – Cleanliness; Facilities; Food; Privacy, Dignity, & Well being;	PLACE (Patient-led Assessments of the Care Environment) replaced the PEAT (Patient Environment Action Team) inspections in 2013. These are undertaken annual by teams, which include local people, to assess how the environment supports the patients' privacy and dignity, food, cleanliness, and general building maintenance. This rating indicates how the Trust fared for each of the separate areas (i.e. cleanliness, food). The higher the percentage, the better the score.	

Domain	Sub-domain	Page number	Indicator title	Description	Rating
Quality	Patient Centredness	8	(TC6) Involvement in care	"The most important goal of a modern health service is to achieve authentic patient participation. The lessons of the Francis inquiry into Stafford hospital are that the absence of patient participation is the root cause of poor care." - Tim Kelsey, Director, NHS-England. Engagement increases the likelihood of successful treatment, whilst also improving our patients' experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff have involved patients in the development of their treatment plans.	
Quality	Patient Centredness	8	(TC7) Worries and Fears	Patients attending the Trust may require support in dealing with their worries and fears during their visit. Overcoming these obstacles is more likely to increase patient engagement with our services, whilst also improving their overall experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff provide sufficient support to patients to overcome their worries and fears.	
Quality	Patient Centredness	8	(LQ35a) Did you get enough help from staff to eat your meals?	Some people may require extra help to ensure that they receive adequate nutrition whilst in hospital. It is important that we identify these patients and support them appropriately, as eating and drinking well while in hospital can help our patients get better sooner and reduce the risk of complications.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff assisted our patients to eat their meals.	
Quality	Patient Centredness	8	(CLQ14) Do you think hospital staff did everything they could to help control your pain?	Good pain control can help to reduce risks and reduce the patient's length of stay in the hospital. If it is not well controlled, patients may, for example, not be able to breathe deeply or cough, increasing their risk of developing a chest infection; or they may not be able to walk or sit out in a chair, thereby increasing their risk of developing a deep vein thrombosis.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff are suitably skilled to ensure that our patients were as comfortable, and pain free, as possible during their stay.	
Quality	Patient Centredness	8	(CLQ29) Did you have confidence and trust in the doctors treating you?	It is important that patients have confidence in our doctors, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our doctors to treat them.	
Quality	Patient Centredness	8	(CLQ10) Did you have confidence and trust in the nurses treating you?	It is important that patients have confidence in our nurses, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our nurses to treat them.	
Quality	Patient Centredness	8	(LQ36) Have you been treated with dignity and respect by staff on this ward?	It is important to ensure our patients are treated with dignity and respect, as evidence has shown a link between a failure to do so with a drop in both the patient experience and the quality of care that they experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that the organisation treats our patients with dignity and respect in a consistent manner.	
Quality	Patient Centredness	8	Safeguarding Adults : Referrals per month	The NHS has a key role to play in preventing all forms of harm, abuse and neglect, to our patients. Where abuse is suspected (whether physical, verbal, sexual, financial, or neglect), there is a duty to report this by raising a Safeguarding Alert. Safeguarding alerts generally regard external organisations (i.e. nursing homes; NHS providers).	
				This rating indicates the total number of safeguarding adults referrals were made in the previous month. A significant increase in the number of referrals may warrant further investigation and escalation to our commissioners, whilst a significant decrease may indicate underreporting of safeguarding concerns.	
Quality	Effectiveness	9	Stroke Care : % of patients scanned within 1 hr of arrival at hospital	Stroke is a preventable and treatable disease that affects approximately 110,000 people in England each year. A stroke occurs when the blood supply to part of the brain is cut off, which can be caused by a blockage within one of the vessels within the brain or a bleed in the brain. Early intervention is linked with better patient outcomes, including reduced morbidity and dependency.	Operational standard:
				This rating indicates the proportion of patients that had a brain scan within 1 hour of arrival at the hospital. A higher percentage means that we are ensuring that our patients are receiving the right diagnostic intervention at the right time.	≥50%
Quality	Effectiveness	9	Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes	Thrombolysis is the use of drugs to break up a blood clot. When given in a timely manner, this can significantly improve the outcome for patients, such as a decreased likelihood of complications.	Operational standard:
				This rating indicates the proportion of eligible patients that were treated with thrombolysing drugs within 45 minutes of arrival at the hospital.	≥80%

Domain	Sub-domain	Page number	Indicator title	Description	Rating
Quality	Efficiency	10	Theatre Utilisation Rate	Theatres are used to undertake surgical procedures. Well-organised theatres can treat more patients within the same timeframe, making them more efficient. Low utilisation rates may indicate problems with the environment, staff attendance, or poor organisation. This can then impact on the timeliness of care provided to patients awaiting surgery.	TBC
Quality	Efficiency	10	Average Length of Stay - Elective	This indicator aims to highlight the average number of days a patient spends in the hospital in relation to a specific elective surgery. An elective surgery is surgery that is scheduled in advance because it does not involve a medical emergency (i.e. a mastectomy or inguinal hernia surgery). Shorter lengths of stay indicates more efficient and effective care, whilst also meaning that the patient is able to return home earlier and recuperate in a familiar surrounding.	TBC
				This rating denotes the average number of days a patient spends in hospital in relation to an elective surgery.	
Quality	Efficiency	10	Average Length of Stay – Non Elective	This indicator aims to highlight the average number of days a patient spends in the hospital in relation to a specific non-elective surgery. A non-elective surgery is surgery that occurs as a result of a medical emergency (i.e. an injury or illness that is acute and poses an immediate risk to a person's life or long term health). Shorter lengths of stay indicates more efficient and effective care, whilst also meaning that the patient is able to return home earlier and recuperate in a familiar surrounding.	TBC
				This rating denotes the average number of days a patient spends in hospital in relation to non-elective surgery.	
Quality	Efficiency	10	Pre Op Length of Stay		TBC
Quality	Efficiency	10	Post Op Length of Stay		TBC
Quality	Efficiency	10	Day of Surgery Admission		TBC
Quality	Efficiency	11	Day Case Rate		TBC
Quality	Efficiency	11	DNA – first Appointment	A DNA (Did Not Attend) occurs where a patient fails to attend an arranged appointment without cancelling it beforehand. DNAs cost the NHS an average of £108 per appointment. When a patient DNAs their first appointment, they may be discharged back to their GP.	TBC
				This rating details the proportion of first appointments that were marked as 'DNA'.	
Quality	Efficiency	11	DNA – follow-up appointment	A DNA (Did Not Attend) occurs where a patient fails to attend an arranged appointment without cancelling it beforehand. DNAs cost the NHS an average of £108 per appointment. When a patient DNAs two follow-up appointments, they may be discharged back to their GP.	TBC
				This rating details the proportion of follow-up appointments that were marked as 'DNA'	
Quality	Efficiency	11	Hospital Appointment Cancellations (hospital instigated)	Appointments are sometimes cancelled by a service within the hospital. This should only occur in very limited circumstances - such as in an emergency or when a member of staff is ill. Hospital instigated cancellations also impact on the hospital's efficiency and potentially delays treatment for our patients.	TBC
				This rating details the proportion of appointments that were cancelled by the hospital. A high percentage may indicate areas of concern which require further investigation.	
Quality	Efficiency	11	Appointments Not Checked In or DNA'd (Appointment Date within the last 90 days)	Within any organisation, it is important to monitor and investigation incidences of data quality issues. This indicator aims to highlight potential data quality issues regarding registering patients upon their arrival to the hospital.	TBC
				This rating indicates the total number of appointments showing as either 'Not Checked In' (i.e. arrived at the hospital) or 'DNA' (Did Not Attend) within the last 90 days.	
Quality	Efficiency	11	Appointments in a status of Checked In but not Checked Out	Within any organisation, it is important to monitor and investigation incidences of data quality issues. This indicator aims to highlight potential data quality issues regarding registering patients upon their arrival to the hospital.	TBC
				This rating indicates the total number of appointments showing as 'Checked In' (i.e. arrived at the hospital) within the last 90 days, but where they have not been 'Checked Out' (i.e. had their appointment)	

Domain	Sub-domain	Page number	Indicator title	Description	Rating	
Quality	Timeliness	12	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so.	Operational standards:	
				The Trust's service-level waiting times can be compared to other Healthcare Providers across England.	Admitted Non-admitted Incomplete pathway	≥90% ≥95% ≥92%
Quality	Timeliness	12	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.	Operational standard:	
					≥95%	
Quality	Timeliness	12	Percentage Cancelled Operations rebooked within 28 days	Where a patient's surgery appointment has been cancelled by the hospital, they have a right to be provided a new appointment date that occurs within 28 days of the original operation.	Operational standard:	
				This rating indicates the percentage of cancelled operations that were rebooked to occur within 28 days of the original operation.	<5%	
Quality	Timeliness	12	Percentage Non Clinical Cancelled Operations	Surgical operations may be cancelled for both clinical and non-clinical reasons. The former relates to, for example, where a patient is too unwell to undergo surgery, thereas the latter might occur in instances whereby the theatre is required for an alternate emergency operation. Whilst some cancellations may be unavoidable, it is important to minimise these as it reduces the efficiency of Trust and may be distressing and inconvenient for patients.		
				This rating provides a percentage of operations that were cancelled for non-clinical reasons.		
Quality	Timeliness	13	2 week wait from referral to date first seen all urgent referrals 2 week wait from referral to date first seen breast cancer	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected.	Operational standards:	
				These ratings indicate the percentage of patients that were seen within the 2 week target.	≥93%	
Quality	Timeliness	13	31 days standard from diagnosis to first treatment 31 days standard to subsequent cancer treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat (either as initial or subsequent treatment) to the start of their treatment.	Drug-based Radiotherapy	≥98% ≥94%
				This rating indicates the percentage of patients that were treated within 31 days of a cancer diagnosis, or within 31 days of deciding that subsequent treatment is required.	Surgery	≥94%
Quality	Timeliness	13	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer.	NHS Screening Services	≥90%
				This rating indicates the percentage of patients that were treated within 62 days of referral for suspected cancer.	GP referral	≥85%
Quality	Equity	14	CQUIN – Dementia: Find & Assess; Investigate; & Refer	Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and usually occurs in people over the age of 65. Most types of dementia cannot be cured, but its progression can be slowed down it detected early. Therefore, it is important to assess patients at risk of developing patients for This indicator is a combination of three ratings. The first indicator highlights the percentage of eligible patients that were risk assessed. The second highlights the percentage of appropriate patients that underwent further investigation, with the third being the percentage of appropriate patients that were referred onto specialist services.	TBC	
Quality	Equity	14	Mixed Sex Accommodation	Being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore, all providers of NHS-funded care are expected to eliminate mixed-sex accommodation (except where it is in the overall best interest of the patient or reflects their personal choice). Hospitals can face a fine of up to £250 for breaching same-sex accommodation guidance.	TBC	
				This rating highlights the total number of times that the same-sex accommodation guidance was breached during the reporting period.		
Quality	Equity	14	Safeguarding Training - Adults; Children (levels 1 - 3)	Everyone has a responsibility for safeguarding vulnerable people, whether children or adults. Safeguarding is the protection of our patients from maltreatment, such as neglect; emotional, physical, sexual, discriminatory, institutional or financial abuse. Our responsibilities include training our staff to ensure that they are competent to identify, and then act on, safeguarding concerns.	TBC	
				This rating indicates the percentage of staff that have attended their Safeguarding training within the last 3 years.		

Domain	Sub-domain	Page number	Indicator title	Description	Rating
People	People	16	Turnover Rate	The turnover rate highlights the rate at which an employer loses and gains employees. A certain amount of turnover is unavoidable, although too much may indicate areas of concern within the organisation. The staff turnover rate indicates the percentage of staff that have left the organisation during the reporting period.	TBC
People	People	16	Operating Vacancy Rate		TBC
People	People	16	Non-recruited Vacancy Rate		TBC
People	People	16	Sickness Absence Rate		TBC
People	People	16	Consultant Performance and Development Review (PDR) Rate		TBC
People	People	16	Band 8c-9 Performance and Development Review (PDR) Rate		TBC
People	People	16	Band 7 - 8a Performance and Development Review (PDR) Rate		TBC
People	People	16	Band 2-6 Performance and Development Review (PDR) Rate		TBC
People	People	16	Local Induction		TBC
People	People	16	Statutory Mandatory	Certain training courses are mandatory and are designed to ensure the safety and well-being of all our staff and patients. It also ensures that staff keep up to date with professional standards. The training includes, amongst others, Fire Training; Safeguarding Training; & Equality and Diversity Training. This rating indicates the percentage of staff that are compliant with their staturtory and mandatory training.	TBC
People	People	16	Bank Spend (%)		TBC
People	People	16	Agency Spend (%)		TBC
People	People	16	Corporate Welcome Attendance	The Corporate Welcome Attendance is mandatory for all new staff and is an opportunity for staff to familiarise themselves with the Trust, meet new colleagues, and undertake face to face mandatory training courses. This rating highlights...	TBC
People	People	18	Average fill rate – nurses / care staff; day / night	The Francis report explicitly stated that poor staffing levels at Mid Staffordshire led to poor quality care. Organisations are now required to publish details of staffing levels on each of their wards every month, including the percentage of shifts that met the safe staffing requirements. This rating indicates the percentage of shifts that met the agreed safe staffing requirements.	TBC
Finance	Finance	20	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.	TBC
Finance	Finance	20	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.	TBC
Finance	Finance	21 - 23	Daycase	Daycases are elective surgeries that do not usually require a patient to be admitted to hospital (i.e. have an overnight stay). Elective surgeries are scheduled (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of daycase surgeries that were undertaken during the reporting period.	TBC
Finance	Finance	21 - 23	Elective Inpatients	Elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for a scheduled surgical procedure (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of elective inpatients during the reporting period.	TBC
Finance	Finance	21 - 23	Non Elective Inpatients	Non-elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for emergency medical intervention (i.e. an injury or illness that is actue and poses an immediate risk to a person's life or long term health). This rating denotes the total number of non-elective inpatients during the reporting period.	TBC
Finance	Finance	21 - 23	First Outpatient	First outpatient appointment are primarily for the patient to discuss their concerns with an appropriate clinician and to coordinate their future care plan with the clinician (including which diagnostic tests to undertake, or which medical intervention is required). This rating denotes the total number of first outpatient appointments that took place during the reporting period.	TBC
Finance	Finance	21 - 23	Follow-up Outpatient	Follow up outpatient appointment are primarily for the patient to discuss any new concerns with a clinician, to discuss any investigations that may have been undertaken, and, if appropriate, to agree an appropriate treatment plan. This rating denotes the total number of follow up outpatient appointments that took place during the reporting period.	TBC
Finance	Finance	21 - 23	Adult Critical Care	Adult critical care encompasses patients that require high dependency or intensive care following, for example, surgical interventions or serious illnesses or traumatic injuries. In the UK, it costs around £1,328 per bed, per day, for an adult intensive care unit. This rating denotes the total number of adult patients that required critical care during the reporting period.	TBC
Finance	Finance	22 - 23	A&E Attendances	There are over 21 million attendances at A&E (Accident & Emergency) departments in England each year. A&E departments assess and treat patients with serious injuries or illnesses (i.e. loss of consciousness; chest pain; severe bleeding that cannot be stopped). This rating denotes the total number of A&E attendances in the Trust during the reporting period.	TBC

Domain	Sub-domain	Page number	Indicator title	Description	Rating
Research & Education	Research & Education	25	Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (mean)	Research is a major priority at Imperial College Healthcare NHS Trust. Medical research is essential for developing new and improved medical treatments to improve the health of both adults and children. It is, therefore, important that research is undertaken in a timely manner after research applications have been approved. There are two ratings associated with this indicator - the mean and median. The mean provides the average length of time elapsed between receipt of a valid research application and the first patient recruitment, whilst the median provides the 'middle number' in a list of these times. The median indicator are used to ensure that anomalous results have not significantly affected the average (i.e. skewing it).	TBC
Research & Education	Research & Education	25	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	This indicator is identical to the above, although the rating indicates the percentage of studies which recruited their first patient within 70 days of a Valid research application.	
Research & Education	Research & Education	25	Percentage of closed commercially-sponsored interventional studies that recruited to time and to target	Imperial College Healthcare NHS Trust works closely with commercial enterprises, such as pharmaceutical companies, in the undertaking of medical research to develop and improve new treatments. It is, therefore, important that research is undertaken in a timely manner after applications have been approved, in accordance with bespoke targets to the research item involved. This rating provides a percentage of commercially-sponsored interventional studies that recruited to time and to target.	TBC
Research & Education	Research & Education	25	Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days		TBC
Research & Education	Research & Education	25	Total number of NIHR Clinical Research Network (CRN) portfolio studies to which the Trust has recruited (Cumulative YTD)		TBC
Research & Education	Research & Education	25	Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD)		TBC
Research & Education	Research & Education	25	Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD)		TBC
Research & Education	Research & Education	25	Total number of participants enrolled in NIHR CRN Portfolio Studies		TBC

APPENDIX 1

July 2014

Monthly planned Nurse/Midwife staffing hours versus Nurse/Midwife hours actually worked

		Main two Specialities on each ward		Day						Night					
				Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Hospital Site Name	Ward Name	S1	S2	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled
Charing Cross Hospital - RYJ02	10 North Ward	400 - NEUROLOGY	400 - NEUROLOGY	1852.5	1703.5	91.96%	529.5	483	91.22%	851	839.5	98.65%	639	621	97.18%
Charing Cross Hospital - RYJ02	11 South Ward	150 - NEUROSURGERY	150 - NEUROSURGERY	2846.5	2580.5	90.66%	564	494.5	87.68%	2339	2242.5	95.87%	504.5	483	95.74%
Charing Cross Hospital - RYJ02	4 South Ward	340 - RESPIRATORY MEDICINE	340 - RESPIRATORY MEDICINE	1209	1132	93.63%	563.5	563.5	100.00%	846.5	782	92.38%	682.5	655.5	96.04%
Charing Cross Hospital - RYJ02	5 South Ward	192 - CRITICAL CARE MEDICINE		1910	1843.5	96.52%	0	0	100.00%	1782.5	1728	96.94%	0	0	100.00%
Charing Cross Hospital - RYJ02	5 West Ward	300 - GENERAL MEDICINE		2307.5	2077.5	90.03%	639.25	621	97.15%	1820	1736.5	95.41%	681	665.5	97.72%
Charing Cross Hospital - RYJ02	8 South Ward	302 - ENDOCRINOLOGY	302 - ENDOCRINOLOGY	2060.5	1897.5	92.09%	1384	1295	93.57%	1132	1104	97.53%	1063	1023.5	96.28%
Charing Cross Hospital - RYJ02	8 West Ward	430 - GERIATRIC MEDICINE		1582	1540.5	97.38%	1085.5	1069	98.48%	1069.5	1058	98.92%	713	710	99.58%
Charing Cross Hospital - RYJ02	9 North Ward	400 - NEUROLOGY		2648	2423.5	91.52%	1000.5	976.5	97.60%	2116	2012.5	95.11%	380.5	359.7	94.53%
Charing Cross Hospital - RYJ02	9 South Ward	301 - GASTROENTEROLOGY	301 - GASTROENTEROLOGY	1749	1663	95.08%	925.75	861.75	93.09%	819.5	816.5	99.63%	1137	1092.5	96.09%
Charing Cross Hospital - RYJ02	9 West Ward	400 - NEUROLOGY		1466	1329.5	90.69%	724.5	701.5	96.83%	713	667	93.55%	862	839.5	97.39%
St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	350 - INFECTIOUS DISEASES	350 - INFECTIOUS DISEASES	1064.5	1064.5	100.00%	564.5	547	96.90%	725.5	724.5	99.86%	556.5	540.5	97.12%
St Mary's Hospital (HQ) - RYJ01	AMU	300 - GENERAL MEDICINE		1220	1105.75	90.64%	398.75	372	93.29%	1142.5	1081	94.62%	394	391	99.24%
Hammersmith Hospital - RYJ03	B1 Ward	300 - GENERAL MEDICINE		1556.5	1453	93.35%	380.5	356.5	93.69%	1058	1058	100.00%	405.5	402.5	99.26%
Hammersmith Hospital - RYJ03	C8 Ward	300 - GENERAL MEDICINE		1619	1502	92.77%	322	297	92.24%	1162.25	1057.25	90.97%	356.5	345	96.77%
Hammersmith Hospital - RYJ03	Christopher Booth Ward	340 - RESPIRATORY MEDICINE	340 - RESPIRATORY MEDICINE	2210.5	2134.5	96.56%	734	633	86.24%	1082	1081	99.91%	579	575	99.31%
St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	192 - CRITICAL CARE MEDICINE		1991	1910	95.93%	0	0	100.00%	1831.5	1782.5	97.32%	62.5	57.5	92.00%
Hammersmith Hospital - RYJ03	Dewardener Ward	361 - NEPHROLOGY		1523.75	1491.5	97.88%	0	0	100.00%	1386	1342	96.83%	135.5	135.5	100.00%
Hammersmith Hospital - RYJ03	Fraser Gamble Ward	302 - ENDOCRINOLOGY	302 - ENDOCRINOLOGY	1791	1695.5	94.67%	1157.5	1059	91.49%	1107	1082	97.74%	714	701.5	98.25%
St Mary's Hospital (HQ) - RYJ01	Grafton Ward	400 - NEUROLOGY	400 - NEUROLOGY	1414.5	1380	97.56%	709	682.5	96.26%	713	701.5	98.39%	713	713	100.00%
Hammersmith Hospital - RYJ03	Handfield Jones Ward	361 - NEPHROLOGY		1533	1475.26	96.23%	716.5	702	97.98%	1023	1001	97.85%	377.5	363.5	96.29%

APPENDIX 1

July 2014

Monthly planned Nurse/Midwife staffing hours versus Nurse/Midwife hours actually worked

		Main two Specialities on each ward		Day						Night					
				Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Hospital Site Name	Ward Name	S1	S2	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled
Hammersmith Hospital - RYJ03	John Humphrey Ward	350 - INFECTIOUS DISEASES	410 - RHEUMATOLOGY	1563.5	1421.5	90.92%	741	661.57	89.28%	713	712.25	99.89%	719	713	99.17%
St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	300 - GENERAL MEDICINE		1420.5	1343.5	94.58%	360	333.5	92.64%	1293.5	1217	94.09%	439	399.5	91.00%
Hammersmith Hospital - RYJ03	Kerr Ward	361 - NEPHROLOGY		1616.5	1554	96.13%	875.55	759.75	86.77%	1023	1012	98.92%	595	573	96.30%
Charing Cross Hospital - RYJ02	Lady Skinner Ward	430 - GERIATRIC MEDICINE		1143.5	1134.77	99.24%	506.5	497.35	98.19%	701.5	701.5	100.00%	975.93	950.5	97.39%
St Mary's Hospital (HQ) - RYJ01	Manvers Ward	340 - RESPIRATORY MEDICINE		1743.5	1717.5	98.51%	749.5	678.5	90.53%	1550	1506	97.16%	775.5	770.5	99.36%
Hammersmith Hospital - RYJ03	Peters Ward	361 - NEPHROLOGY		1288.5	1168.5	90.69%	724.75	666.5	91.96%	682	671	98.39%	400.5	375.5	93.76%
St Mary's Hospital (HQ) - RYJ01	Rodney Porter & Crusaid Ward	302 - ENDOCRINOLOGY	410 - RHEUMATOLOGY	848	847.5	99.94%	356.5	356.5	100.00%	713	713	100.00%	356.5	356.5	100.00%
St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	301 - GASTROENTEROLOGY	301 - GASTROENTEROLOGY	1913	1729	90.38%	831	769.5	92.60%	1408.5	1368	97.12%	730	678.5	92.95%
St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	302 - ENDOCRINOLOGY	410 - RHEUMATOLOGY	1451	1336	92.07%	788	747.5	94.86%	1069.5	1046.5	97.85%	455.5	437	95.94%
St Mary's Hospital (HQ) - RYJ01	Witherow Ward	430 - GERIATRIC MEDICINE		1179.5	1155.5	97.97%	930	847	91.08%	713	713	100.00%	900.5	885.5	98.33%
Charing Cross Hospital - RYJ02	10 South Ward	- ORAL & MAXILLO FACIAL SURG	120 - ENT	2320	2222	95.78%	1071.166667	935.43	87.33%	1651	1621.5	98.21%	407	332	81.57%
Charing Cross Hospital - RYJ02	6 North Ward	800 - CLINICAL ONCOLOGY	315 - PALLIATIVE MEDICINE	1926.5	1822.5	94.60%	1000	857	85.7	1069.5	1046.5	97.85%	767	701.5	91.46%
Charing Cross Hospital - RYJ02	6 South Ward	800 - CLINICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1580	1512.4	95.72%	1350	1196	88.6	1000.5	977.5	97.70%	104.5	103.5	99.04%
Charing Cross Hospital - RYJ02	7 North Ward	100 - GENERAL SURGERY	101 - UROLOGY	2049	2035.5	99.34%	712.5	675.5	94.81%	1426	1426	100.00%	644	632.5	98.21%
Charing Cross Hospital - RYJ02	7 South Ward	110 - TRAUMA & ORTHOPAEDICS	110 - TRAUMA & ORTHOPAEDICS	2275	2062	90.06%	850	731	86.0	1107	1000.5	90.38%	406.5	379.5	93.36%
Hammersmith Hospital - RYJ03	A6 CICU	70 - CARDIOTHORACIC SURGER	170 - CARDIOTHORACIC SURGERY	3930	3930	100.00%	0	0	100.00%	3606	3591	99.58%	0	0	100.00%
Hammersmith Hospital - RYJ03	A7 Ward & CCU	320 - CARDIOLOGY	320 - CARDIOLOGY	2510.75	2477.5	98.68%	356.5	345	96.77%	2039	2024	99.26%	356.5	345	96.77%
Hammersmith Hospital - RYJ03	A8 Ward	100 - GENERAL SURGERY	100 - GENERAL SURGERY	2052.55	1940.8	94.56%	724.5	701.5	96.83%	1356	1299.5	95.83%	25	23	92.00%
Hammersmith Hospital - RYJ03	A9 Ward	70 - CARDIOTHORACIC SURGER	170 - CARDIOTHORACIC SURGERY	1536	1523.5	99.19%	356.5	356.5	100.00%	1069.5	1069.5	100.00%	345	333.5	96.67%
St Mary's Hospital (HQ) - RYJ01	Albert Ward	314 - REHABILITATION	314 - REHABILITATION	1538.5	1493.8	97.09%	1048.5	1000.5	95.42%	1069.5	1058	98.92%	1206	1058	87.73%
St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	100 - GENERAL SURGERY	100 - GENERAL SURGERY	2503	2487	99.36%	674	609.5	90.43%	1782.5	1782.5	100.00%	644	609.5	94.64%
Hammersmith Hospital - RYJ03	D7 Ward	303 - CLINICAL HAEMATOLOGY	303 - CLINICAL HAEMATOLOGY	1348.5	1348.5	100.00%	192	192	100.00%	682	682	100.00%	341	341	100.00%
Hammersmith Hospital - RYJ03	Dacie Ward	303 - CLINICAL HAEMATOLOGY	303 - CLINICAL HAEMATOLOGY	1825	1784.5	97.78%	159.5	150.5	94.36%	1023	981	95.89%	0	11	100.00%
Charing Cross Hospital - RYJ02	Intensive Care CXH	192 - CRITICAL CARE MEDICINE	192 - CRITICAL CARE MEDICINE	5254	5122.5	97.50%	790.5	760.5	96.20%	5180.5	5017.5	96.85%	347.5	333.5	95.97%
Hammersmith Hospital - RYJ03	Intensive care HH	192 - CRITICAL CARE MEDICINE	192 - CRITICAL CARE MEDICINE	5667.75	5177.25	91.35%	668	637.5	95.43%	5658	5232.5	92.48%	225	207	92.00%
St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	192 - CRITICAL CARE MEDICINE	192 - CRITICAL CARE MEDICINE	5873.5	5747.07	97.85%	310.25	260	83.80%	5949.5	5880.5	98.84%	376	368	97.87%
St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	110 - TRAUMA & ORTHOPAEDICS	110 - TRAUMA & ORTHOPAEDICS	1979.6875	1820	91.93%	351.75	333.5	94.81%	1559.6875	1414.5	90.69%	405.5	368	90.75%

APPENDIX 1

July 2014

Monthly planned Nurse/Midwife staffing hours versus Nurse/Midwife hours actually worked

		Main two Specialities on each ward		Day						Night					
				Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Hospital Site Name	Ward Name	S1	S2	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled
Charing Cross Hospital - RYJ02	Marjorie Warren Ward	100 - GENERAL SURGERY	101 - UROLOGY	1237.5	1103	89.13%	540.75	533	98.57%	736	701.5	95.31%	356.5	345	96.77%
St Mary's Hospital (HQ) - RYJ01	Patterson Ward	100 - GENERAL SURGERY	101 - UROLOGY	1563.5	1365.5	87.34%	354	354	100.00%	713	713	100.00%	356.5	356.5	100.00%
Charing Cross Hospital - RYJ02	Riverside	100 - GENERAL SURGERY		2614.5	2456.22	93.95%	556.5	536	96.32%	966	931.5	96.43%	116	115	99.14%
St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	110 - TRAUMA & ORTHOPAEDICS	110 - TRAUMA & ORTHOPAEDICS	2068	1929.5	93.30%	816.5	744.5	91.18%	1286.5	1161.5	90.28%	844	782	92.65%
Hammersmith Hospital - RYJ03	Weston Ward	303 - CLINICAL HAEMATOLOGY	303 - CLINICAL HAEMATOLOGY	1616	1531	94.74%	369	333.5	90.38%	1023	990	96.77%	183	165	90.16%
St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	100 - GENERAL SURGERY		2697.5	2596.5	96.26%	725.5	690	95.11%	2141	2093	97.76%	634.5	621	97.87%
St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	501 - OBSTETRICS		4126	3824.55	92.69%	1227.5	1085	88.39%	3933	3740.5	95.11%	1426.5	1368.5	95.93%
Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	501 - OBSTETRICS		1049.5	1049.5	100.00%	237.5	237.5	100.00%	713	713	100.00%	322	310.5	96.43%
St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	501 - OBSTETRICS		967	953	98.55%	0	0	100.00%	724.5	724.5	100.00%	322	322	100.00%
Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	501 - OBSTETRICS		2344.5	2307	98.40%	1064.75	1049.5	98.57%	1882.5	1874.5	99.58%	690	678.5	98.33%
St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	303 - CLINICAL HAEMATOLOGY	350 - INFECTIOUS DISEASES	2166.5	2014	92.96%	0	0	100.00%	1749	1679	96.00%	0	0	100.00%
St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	300 - GENERAL MEDICINE	110 - TRAUMA & ORTHOPAEDICS	2150.5	2022.5	94.05%	0	0	#DIV/0!	1732	1644.5	94.95%	276	253	91.67%
St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	502 - GYNAECOLOGY	502 - GYNAECOLOGY	1351	1270.5	94.04%	391	379.5	97.06%	713	701.5	98.39%	369	360	97.56%
Queen Charlotte's Hospital - RYJ04	Neo Natal	192 - CRITICAL CARE MEDICINE		4696.83	4689.33	99.84%	211.5	211.5	100.00%	3783.5	3783.5	100.00%	22.5	22.5	100.00%
St Mary's Hospital (HQ) - RYJ01	NICU	192 - CRITICAL CARE MEDICINE		2238	2203.5	98.46%	379.5	379.5	100.00%	1703	1673	98.24%	264.5	253	95.65%
St Mary's Hospital (HQ) - RYJ01	PICU	192 - CRITICAL CARE MEDICINE	350 - INFECTIOUS DISEASES	3436	3357.5	97.72%	0	0	100.00%	2832	2763.75	97.59%	0	0	100.00%
Queen Charlotte's Hospital - RYJ04	QCCH labour	501 - OBSTETRICS		4330.75	4202.5	97.04%	855.75	757.5	88.52%	3933	3783.5	96.20%	713	654.5	91.80%
Hammersmith Hospital - RYJ03	Victor Bonney Ward	502 - GYNAECOLOGY	502 - GYNAECOLOGY	2192.5	2092	95.42%	628.5	588.75	93.68%	1082	1081	99.91%	356.5	356.5	100.00%

APPENDIX 2

August 2014

Monthly planned Nurse/Midwife staffing hours versus Nurse/Midwife hours actually worked

		Day						Night					
		Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Hospital Site Name	Ward Name	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled
Charing Cross Hospital - RYJ02	10 North Ward	1745	1588	91.00%	743	701.5	94.41%	885.5	851	96.10%	733.5	713	97.21%
Charing Cross Hospital - RYJ02	11 South Ward	2564.5	2411.5	94.03%	493	448.5	90.97%	2152.5	2104.5	97.77%	518	506	97.68%
Charing Cross Hospital - RYJ02	4 South Ward	1358	1244.5	91.64%	517.5	506	97.78%	778.5	749.5	96.27%	755.5	701.5	92.85%
Charing Cross Hospital - RYJ02	5 South Ward	1792.5	1792	99.97%	0	0	100.00%	1744.5	1744.5	100.00%	0	0	100.00%
Charing Cross Hospital - RYJ02	5 West Ward	2190	1983	90.55%	633.5	621	98.03%	1844	1793	97.23%	633.5	609.5	96.21%
Charing Cross Hospital - RYJ02	8 South Ward	2018.5	1882.17	93.25%	1445.5	1381	95.54%	1131	1081	95.58%	1077.5	1046.5	97.12%
Charing Cross Hospital - RYJ02	8 West Ward	1550	1499	96.71%	1109	1100.5	99.23%	1069.5	1046.5	97.85%	725.5	723	99.66%
Charing Cross Hospital - RYJ02	9 North Ward	2631.5	2385.5	90.65%	793.5	742	93.51%	2001	1920.5	95.98%	368	368	100.00%
Charing Cross Hospital - RYJ02	9 South Ward	1609.5	1563	97.11%	1023	940.5	91.94%	748.5	747.5	99.87%	1225.5	1173	95.72%
Charing Cross Hospital - RYJ02	9 West Ward	1368.5	1308.5	95.62%	701.5	701.5	100.00%	713	713	100.00%	889	874	98.31%
St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	1116	1116	100.00%	397	383	96.47%	713	713	100.00%	381.5	379.5	99.48%
St Mary's Hospital (HQ) - RYJ01	AMU	1202.2	1130.95	94.07%	427	375.5	87.94%	1094.5	1023.5	93.51%	414	414	100.00%
Hammersmith Hospital - RYJ03	C8 Ward	2489.5	2245.5	90.20%	701	641.5	91.51%	2034.5	1827.5	89.83%	599	575	95.99%
Hammersmith Hospital - RYJ03	Christopher Booth Ward	1955.5	1939	99.16%	716.5	690	96.30%	1244.5	1207.5	97.03%	406.5	402.5	99.02%
St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	1973.5	1935.5	98.07%	0	0	100.00%	1795	1782.5	99.30%	34.5	34.5	100.00%
Hammersmith Hospital - RYJ03	Dewardener Ward	1487	1373.3	92.35%	131.5	121.5	92.40%	1375	1342	97.60%	0	0	100.00%
Hammersmith Hospital - RYJ03	Fraser Gamble Ward	1449	1387.5	95.76%	1128.5	1062.5	94.15%	1092.5	1035	94.74%	754.5	751.5	99.60%
St Mary's Hospital (HQ) - RYJ01	Grafton Ward	1174.5	1128.5	96.08%	762	736	96.59%	925.5	908.5	98.16%	555	552	99.46%
Hammersmith Hospital - RYJ03	Handfield Jones Ward	1472	1339	90.96%	939.5	842.5	89.68%	1030.5	1030.5	100.00%	573.5	573.5	100.00%
Hammersmith Hospital - RYJ03	John Humphrey Ward	1509.25	1347.52	89.28%	921	697.5	75.73%	750.5	736	98.07%	900.5	885.5	98.33%
St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	1375.5	1268.75	92.24%	438.5	392.5	89.51%	1192.5	1126	94.42%	494	471.5	95.45%
Hammersmith Hospital - RYJ03	Kerr Ward	1527.5	1383	90.54%	1006.5	927	92.10%	1065	1019	95.68%	630	620	98.41%
Charing Cross Hospital - RYJ02	Lady Skinner Ward	1144.5	1144.5	100.00%	678.5	621	91.53%	713	701.5	98.39%	1114	1092.5	98.07%
St Mary's Hospital (HQ) - RYJ01	Manvers Ward	1461.5	1391.5	95.21%	773.5	729.83	94.35%	1463.5	1426	97.44%	736	736	100.00%
Hammersmith Hospital - RYJ03	Peters Ward	1184	1128	95.27%	714.5	714	99.93%	722.5	698.5	96.68%	355	355	100.00%
St Mary's Hospital (HQ) - RYJ01	Rodney Porter & Crusaid Ward	794.5	794.5	100.00%	356.5	356.5	100.00%	713	713	100.00%	356.5	356.5	100.00%
St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	1627	1553	95.45%	784	713	90.94%	1108	1081	97.56%	518	506	97.68%
St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	1178	1143.5	97.07%	1001.5	989	98.75%	1046.5	1023.5	97.80%	759	759	100.00%
St Mary's Hospital (HQ) - RYJ01	Witherow Ward	1171.5	1109.5	94.71%	913	839.5	91.95%	725.5	713	98.28%	1203.5	1161.5	96.51%
Charing Cross Hospital - RYJ02	10 South Ward	2232.5	2140.25	95.87%	713	608.16	85.30%	1403	1357	96.72%	0	0	100.00%
Charing Cross Hospital - RYJ02	6 North Ward	1918	1782.5	92.94%	811.5	751	92.54%	1104	1035	93.75%	466	414	88.84%
Charing Cross Hospital - RYJ02	6 South Ward	1546	1491.8	96.49%	1074	982.2	91.45%	954.5	920	96.39%	126.5	126.5	100.00%
Charing Cross Hospital - RYJ02	7 North Ward	2017.5	1914	94.87%	690	662.5	96.01%	1380	1299.5	94.17%	679.5	678.5	99.85%
Charing Cross Hospital - RYJ02	7 South Ward	1790.5	1630	91.04%	713	624.5	87.59%	1069.5	1035	96.77%	356.5	333.5	93.55%
Hammersmith Hospital - RYJ03	A6 CICU	3793.5	3777	99.57%	0	0	100.00%	3463.5	3417.5	98.67%	0	0	100.00%
Hammersmith Hospital - RYJ03	A7 Ward & CCU	2134.5	2134.5	100.00%	359	311	86.63%	1782.5	1713.5	96.13%	365	365	100.00%
Hammersmith Hospital - RYJ03	A8 Ward	1931.3	1748.8	90.55%	773.5	739.5	95.60%	1403.5	1322	94.19%	186.5	161	86.33%
Hammersmith Hospital - RYJ03	A9 Ward	1439.5	1426	99.06%	310.5	310.5	100.00%	1070.5	1069.5	99.91%	345	345	100.00%
St Mary's Hospital (HQ) - RYJ01	Albert Ward	1647	1487.5	90.32%	787	752.5	95.62%	1080.83	1011.83	93.62%	793.5	793.5	100.00%
St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	2393	2334.5	97.56%	644	635.5	98.68%	1782.5	1748	98.06%	645	632.5	98.06%
Hammersmith Hospital - RYJ03	D7 Ward	1266.5	1266.5	100.00%	535.5	521.5	97.39%	682	682	100.00%	629	605	96.18%
Hammersmith Hospital - RYJ03	Dacie Ward	1866.5	1866.5	100.00%	148.5	148.5	100.00%	1022.5	1011.5	98.92%	11	11	100.00%
Charing Cross Hospital - RYJ02	Intensive Care CXH	5014.5	4912	97.96%	983.5	920	93.54%	4867.5	4765	97.89%	354.5	310.5	87.59%
Hammersmith Hospital - RYJ03	Intensive care HH	4038.5	3882.75	96.14%	741	569.5	76.86%	4028	3912	97.12%	275	253	92.00%
St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	5404.5	5383.76	99.62%	679	644	94.85%	5355.5	5309.5	99.14%	495.5	471.5	95.16%
St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	1855	1744.5	94.04%	371.5	310.5	83.58%	1483.5	1437.5	96.90%	356.5	356.5	100.00%
Charing Cross Hospital - RYJ02	Marjorie Warren Ward	850.5	837	98.41%	509.5	482	94.60%	598	575	96.15%	357.5	356.5	99.72%
St Mary's Hospital (HQ) - RYJ01	Patterson Ward	1341.5	1214.5	90.53%	369	368	99.73%	713	713	100.00%	356.5	356.5	100.00%
Charing Cross Hospital - RYJ02	Riverside	2277	2145.5	94.22%	519	502	96.72%	994	954.5	96.03%	226.5	218.5	96.47%
St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	1857	1822	98.12%	758	712	93.93%	1069.5	1012	94.62%	609.5	609.5	100.00%
Hammersmith Hospital - RYJ03	Weston Ward	1614	1554.5	96.31%	291	266	91.41%	1023	1011.33	98.86%	0	0	100.00%
St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	2509	2369	94.42%	713	713	100.00%	2127.5	2047	96.22%	713	552	77.42%
St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	4052.1	3630.4	89.59%	962.7	962.7	100.00%	3887	3623.5	93.22%	1276.5	1253.5	98.20%
Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	951.5	951.5	100.00%	164.5	164.5	100.00%	678.5	678.5	100.00%	299	299	100.00%
St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	1000.5	1000.5	100.00%	0	0	100.00%	793.5	793.5	100.00%	264.5	264.5	100.00%
Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	2313	2313	100.00%	1097	1042	94.99%	1894	1840	97.15%	724.5	713	98.41%
St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	2041	1912	93.68%	0	0	100.00%	1695.5	1690.5	99.71%	0	0	100.00%
St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	1781.75	1780.45	99.93%	387	387	100.00%	1568	1483.5	94.61%	379.5	379.5	100.00%
St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	1248.25	1154.25	92.47%	448.5	448.5	100.00%	725.5	724.5	99.86%	356.5	345	96.77%
Queen Charlotte's Hospital - RYJ04	Neo Natal	4231.5	4231.5	100.00%	165	165	100.00%	4036.5	4036.5	100.00%	184	184	100.00%
St Mary's Hospital (HQ) - RYJ01	NICU	1867.5	1867.5	100.00%	333.5	333.5	100.00%	1817	1817	100.00%	287.5	276	96.00%
St Mary's Hospital (HQ) - RYJ01	PICU	2260.25	2240.5	99.13%	0	0	100.00%	2151.5	2104.5	97.82%	0	0	100.00%
Queen Charlotte's Hospital - RYJ04	QCCH labour	4126.96	4126.96	100.00%	885	832.5	94.07%	3934	3749	95.30%	713	690	96.77%
Hammersmith Hospital - RYJ03	Victor Bonney Ward	2022	1915	94.71%	563.5	495.75	87.98%	1082	1069.5	98.84%	356.5	345	96.77%

Imperial College Healthcare NHS Trust

Trust Board Public

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

EXECUTIVE SUMMARY

1. The Trust's Income & Expenditure (I&E) position at the end of August was a Year-to-Date (YTD) deficit of £1.9m (after adjusting for the impairment of fixed assets and donated assets), an adverse variance against the plan of £6.1m. There was an improvement in the month due to a reduction in Bank & Agency expenditure of £1.6m and Non-Pay of £2.1m when compared to the previous month. The main reasons for the YTD adverse variance are:-
    - Cost Improvement Plans (CIPs) are behind plan by £8.1m (46%);
    - Expenditure on Cerner implementation was much greater than expected and year to date expenditure remains above plan;
    - Temporary staff pay costs are significantly higher than plan but the introduction of new controls has had a significant impact this month.

2. There is on-going dialogue with the TDA about the impact of the proposed Project Diamond funding reductions on the Trust's financial position in both current and future years. Any reductions in funding will mean that the Trust's I&E control total will have to reduce accordingly.

3. Recommendations to the Trust Board: The Board is asked to note:-

- The Year to Date (YTD) deficit of £1.9m represents an adverse variance against the plan of £6.1m;
- Significant improvement in delivery of CIPs is required to achieve the financial plan surplus of £11.2m. This is key as the monthly requirement needs to increase by £2.5m from month six to achieve the forecast target of £46.4m;
- Despite the overspend to date, Cerner expenditure overall, must return to plan;
- Cerner reporting issues need to be resolved before the freeze date for month 4 activity reporting to CCGs and NHS England (NHSE) if further income reductions are to be avoided;
- Controls on the booking of bank and agency staff have been introduced and are impacting the financial position;
- The plan to reduce pay expenditure has been put into action.

4. Trust strategic objectives supported by this paper:-

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

1. Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st August 2014.

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

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

2.1 **Statement of Comprehensive Income (I&E Account)**: The Trust's financial position for the month was a **surplus** of £0.8m; this was a **favourable** variance of £0.2m in month. The Year to Date (YTD) deficit of £1.9m represents an adverse variance against plan of £6.1m.

2.2 **CCGs/NHS England Service Level Agreement (SLA) Income**: The CCG & NHS England SLA contract income for the month was calculated using the month four flexed activity data. It has been assumed that the performance fund of £3.5m will be paid in full.

2.3 **Other Operating Income:** Research income was behind plan, but was matched to expenditure to ensure a net zero impact.

2.4 **Expenditure:** Pay expenditure shows an **adverse** YTD variance of **£13.4m** as a result of under-achievement of CIPs and a failure to reduce bank and agency costs due to lack of effective rostering. New controls have been introduced which has resulted in reduction in total Pay costs of £1.5m in month. Non pay expenditure is showing a **favourable** YTD variance of **£6.5m** due to the under-spend on R&D projects of £2.0m, the inclusion of the contingency and un-utilised funding to support service developments and the release of balance sheet accruals. Overall Non-Pay spend has reduced by £2.1m when compared to the previous month. Mainly on clinical supplies & services of which £1m is PbR excluded drugs & devices which is a pass-through cost and was matched by a similar reduction in income

3. Monthly Performance (Page 4 A to C)

3.1 The Divisions are reporting a year to date overspend against plan of **£11.9m** which was a deterioration in month five of £1.2m. This is a further improvement from the £1.9m overspend reported in month four. The rigorous pay controls imposed on the clinical divisions has significantly improved the run rate however further action is required to reduce costs to levels achieved in 2013/14.

3.2 Medicine was overspent by **£4.3m** YTD which is a £0.5m deterioration in month. This position was driven by under delivery of CIP YTD of £0.4m. Pay costs in month five show significant sign of improvement in line with the new controls in place.

3.3 Women's and Children's was overspent by **£2.6m** YTD which was a deterioration in month five of £0.4m. The year to date position was driven by under delivery of CIP alongside overspends pay costs in Nursing and Admin and Clerical staff despite the new pay controls put in place further improvement is required.

3.4 Investigative Sciences was overspent by **£0.6m** YTD, an improvement in month five of £0.2m. The YTD position was driven by additional weekend theatre lists which ceased in month five.

3.5 Surgery and Cancer was overspent by **£4.4m** YTD which was a deterioration in month of £0.4m, but an improvement in run rate of £1m from the month four position. The rigorous pay controls imposed on the clinical divisions has again significantly improved the run rate from the initial reductions evidenced in month four however further action is required to reduce costs to levels achieved in 2013/14.

3.6 The corporate directorates were reporting a year to date overspend against plan of **£1.4m**. The overspend was driven by the Cerner project and additional expenditure in month relating to preparation for the Care Quality Commission inspection. It is anticipated that in future months Cerner will underspend with forecast expenditure to reduce the total overspend on the project.

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

4. Cost Improvement Plan (Page 5)

4.1 Delivery against the CIP programme currently sits at 54% resulting in a month five year to date position which is £8.2m behind plan. However, most areas are forecasting over achievement in future months with current forecasts showing a year end risk of £2.7m under achievement against the plan, an improvement of £2m from the position reported in month four.

4.2 The improved CIP achievement reflects the recovery plans instigated by the Divisions in some areas these actions have resulting in mitigating CIP schemes to replace those that will no longer deliver. However, to achieve the revised forecast outturn in month, delivery needs to increase to circa £5.2m per month.

4.3 Significant under performance is forecast in three of the clinical divisions, however these are mitigated non recurrently by central schemes. These non-recurrent

savings in addition to those within the divisions will need to be addressed on a recurrent basis in 2015/16 if the Trust is to remain in financial balance.

4.2 From September, the newly established QuEST team will work alongside operational colleagues to identify additional schemes.

5. Statement of Financial Position (Page 6)

5.1 The overall movement in year balance was a decrease of £180m and was, predominately, due to the impairment charge on the value of land by £177m. The variance from plan of £9.4m was due to the impairment loss being less than expected.

6. Capital Expenditure (Page 7)

6.1 The YTD Expenditure was £9.1m, behind plan by £4.8m. Expenditure was behind plan mainly due to slippage on the capital maintenance and ICT programmes. Expenditure is expected to catch up in future months. The Trust's annual Capital Resource Limit (CRL) is £30m.

7. Cash (Page 8)

7.1 The cash balance at the end of the month was £46.8m; £2.8m behind the TDA plan, due to payment being £3.8m ahead of plan. Cash is monitored on a daily basis and surplus cash is invested in the National Loan Fund scheme.

8. Monitor metrics – Financial Risk Rating (Page 9)

8.1 Monitor's Continuity of Service Risk Rating score of 4 is acceptable as the Trust currently has sufficient cash to service debts and liabilities as they fall due.

9. Conclusions & Recommendations

9.1 The Trust Board is asked to note:-

- The Year to Date (YTD) deficit of £1.9m represents an adverse variance against the plan of £6.1m;
- Significant improvement in delivery of CIPs is required to achieve the financial plan surplus of £11.2m. This is key as the monthly requirement needs to increase by £2.5m from month six to achieve the forecast target of £46.4m;
- Despite the overspend to date, Cerner expenditure overall, must return to plan;
- Cerner reporting issues need to be resolved before the freeze date for month 4 activity reporting to CCGs and NHS England (NHSE) if further income reductions are to be avoided;
- Controls on the booking of bank and agency staff have been introduced and are impacting the financial position;

- The plan to reduce pay expenditure has been put into action.

Contents

Finance Performance Report for the month ending 31st August 2014

PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income									
Clinical	63,534	66,293	2,760	319,728	321,933	2,205	773,942	780,319	6,377
Research & Development & Education	10,096	9,740	(356)	50,480	48,490	(1,990)	121,200	119,710	(1,490)
Other	5,843	5,610	(233)	29,147	30,121	974	72,920	72,291	(629)
TOTAL INCOME	**79,473**	**81,644**	**2,171**	**399,355**	**400,544**	**1,189**	**968,062**	**972,319**	**4,258**
Expenditure									
Pay - In post	(40,382)	(40,141)	241	(202,598)	(199,727)	2,871	(485,734)	(477,846)	7,889
Pay - Bank	(1,147)	(2,181)	(1,034)	(5,785)	(12,848)	(7,064)	(13,910)	(26,851)	(12,941)
Pay - Agency	(1,658)	(3,070)	(1,412)	(8,440)	(17,662)	(9,223)	(19,269)	(36,404)	(17,134)
Drugs & Clinical Supplies	(18,989)	(19,210)	(221)	(96,556)	(96,421)	135	(230,055)	(230,410)	(355)
General Supplies	(3,472)	(3,391)	81	(17,490)	(16,045)	1,445	(41,769)	(38,507)	3,262
Other	(9,290)	(8,842)	449	(44,666)	(39,749)	4,917	(118,197)	(103,175)	15,022
TOTAL EXPENDITURE	**(74,938)**	**(76,834)**	**(1,896)**	**(375,534)**	**(382,453)**	**(6,918)**	**(908,935)**	**(913,192)**	**(4,257)**
Earnings Before Interest, Tax, Depreciation & Amortisation	**4,535**	**4,810**	**275**	**23,821**	**18,091**	**(5,730)**	**59,127**	**59,127**	**0**
Financing Costs	(4,041)	(4,074)	(33)	(174,710)	(160,099)	14,611	(203,807)	(155,168)	48,639
SURPLUS / (DEFICIT) including donated asset treatment	**494**	**736**	**242**	**(150,889)**	**(142,007)**	**8,882**	**(144,680)**	**(96,041)**	**68**
Impairment of Assets	0	0	0	154,538	139,570	(14,968)	154,538	105,967	(48,571)
Donated Asset treatment	111	103	(8)	553	538	(15)	1,329	1,261	(68)
SURPLUS / (DEFICIT)	**605**	**839**	**234**	**4,202**	**(1,899)**	**(6,101)**	**11,187**	**11,187**	**0**

Surplus / (Deficit): The Trust's financial performance in Month 5 was a surplus of £839k, a favourable variance of £234k. The Year to Date (YTD) position is a deficit of £1,899k, an adverse variance of £6,101k. The improvement of the financial performance this month can be attributed to:-

1. Pay spend reduced by £1.5m when compared to last month due to the introduction of new pay controls;
2. Overall Non-Pay spend has reduced by £2.1m mainly on clinical supplies & services;
3. Income was ahead plan partly due to catch up of reporting of clinical activity in Cerner .

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

PAGE 2 - INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income from Clinical Activities									
Clinical Commissioning Groups	34,514	34,074	(440)	174,321	169,763	(4,558)	418,032	410,448	(7,584)
NHS England	23,948	26,162	2,214	120,512	121,894	1,381	290,584	294,199	3,615
Other NHS Organisations	409	1,114	705	1,551	5,288	3,737	9,237	12,688	3,451
Sub-Total NHS Income	**58,871**	**61,350**	**2,479**	**296,385**	**296,945**	**560**	**717,852**	**717,335**	**(517)**
Local Authority	866	738	(128)	4,358	4,113	(245)	10,509	9,871	(638)
Private Patients	3,234	3,567	333	16,170	17,522	1,351	38,824	42,565	3,741
Overseas Patients	183	296	112	916	1,321	405	2,200	3,171	972
NHS Injury Cost Scheme	130	181	51	648	762	113	1,557	1,829	272
Non NHS Other	250	162	(88)	1,251	1,270	20	3,000	5,549	2,549
Total - Income from Clinical Activities	**63,534**	**66,293**	**2,760**	**319,728**	**321,933**	**2,205**	**773,942**	**780,319**	**6,377**
Other Operating Income									
Education, Research & Development	10,096	9,740	(356)	50,480	48,490	(1,990)	121,200	119,710	(1,490)
Non patient care activities	2,664	2,521	(143)	13,319	12,419	(901)	31,980	29,804	(2,175)
Income Generation	355	294	(61)	1,776	1,527	(249)	4,264	3,664	(600)
Other Income	2,824	2,796	(29)	14,051	16,176	2,125	36,676	38,822	2,146
Total - Other Operating Income	**15,939**	**15,350**	**(589)**	**79,627**	**78,611**	**(1,016)**	**194,120**	**192,000**	**(2,120)**
TOTAL INCOME	**79,473**	**81,644**	**2,171**	**399,355**	**400,544**	**1,189**	**968,062**	**972,319**	**4,258**

Clinical Income ahead of plan in month due to retrospective adjustments of £1m relating to un-coded activity from prior periods. Actual income includes accrual for the full payment of the performance fund of £3.5m. Private patient activity continues to grow and is £333k ahead of the in-month plan and £1,351k YTD.
Other Operating income was behind plan due to R+D project income which matched by expenditure. which down in the month by £400k.

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

PAGE 3 - EXPENDITURE

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,792)	(13,079)	(287)	(64,356)	(64,614)	(258)	(153,689)	(155,073)	(1,384)
Nursing & Midwifery	(12,580)	(12,377)	203	(63,261)	(62,179)	1,082	(151,724)	(149,230)	2,494
Scientific, Therapeutic & Technical staff	(5,763)	(5,472)	291	(29,066)	(27,519)	1,547	(69,865)	(66,046)	3,820
Healthcare assistants and other support staff	(2,379)	(2,460)	(80)	(11,966)	(12,058)	(92)	(28,596)	(28,938)	(342)
Directors and Senior Managers	(2,499)	(2,545)	(47)	(12,471)	(12,558)	(87)	(30,001)	(30,139)	(138)
Administration and Estates	(4,370)	(4,208)	162	(21,478)	(20,800)	679	(51,860)	(48,420)	3,440
Sub-total - Pay In post	**(40,382)**	**(40,141)**	**241**	**(202,598)**	**(199,727)**	**2,871**	**(485,734)**	**(477,846)**	**7,889**
Pay - Bank/Agency									
Medical Staff	(508)	(900)	(392)	(2,559)	(5,889)	(3,330)	(6,111)	(14,133)	(8,022)
Nursing & Midwifery	(851)	(1,704)	(853)	(4,303)	(10,481)	(6,178)	(10,272)	(21,153)	(10,881)
Scientific, Therapeutic & Technical staff	(537)	(660)	(123)	(2,453)	(3,281)	(828)	(5,753)	(7,875)	(2,122)
Healthcare assistants and other support staff	(161)	(600)	(439)	(811)	(2,971)	(2,160)	(1,878)	(7,131)	(5,252)
Directors and Senior Managers	1	(128)	(129)	(35)	(824)	(790)	(23)	(1,978)	(1,955)
Administration and Estates	(750)	(1,260)	(510)	(4,064)	(7,065)	(3,001)	(9,142)	(10,985)	(1,843)
Sub-total - Pay Bank/Agency	**(2,805)**	**(5,251)**	**(2,446)**	**(14,224)**	**(30,511)**	**(16,286)**	**(33,179)**	**(63,254)**	**(30,075)**
Non Pay									
Drugs	(8,798)	(8,533)	266	(44,283)	(43,348)	935	(106,516)	(104,035)	2,481
Supplies and Services - Clinical	(10,190)	(10,677)	(487)	(52,273)	(53,073)	(800)	(123,539)	(126,375)	(2,836)
Supplies and Services - General	(3,472)	(3,391)	81	(17,490)	(16,045)	1,445	(41,769)	(38,507)	3,262
Consultancy Services	(1,271)	(1,394)	(123)	(6,384)	(6,421)	(37)	(15,269)	(9,921)	5,348
Establishment	(633)	(649)	(16)	(3,213)	(3,334)	(121)	(7,637)	(8,002)	(365)
Transport	(941)	(1,031)	(90)	(4,736)	(4,961)	(225)	(11,317)	(11,906)	(588)
Premises	(3,022)	(3,429)	(407)	(15,256)	(15,764)	(509)	(36,390)	(37,834)	(1,444)
Other Non Pay	(3,423)	(2,339)	1,085	(15,078)	(9,269)	5,809	(47,584)	(35,512)	12,071
Sub-total - Non Pay	**(31,751)**	**(31,442)**	**309**	**(158,712)**	**(152,215)**	**6,497**	**(390,021)**	**(372,092)**	**17,929**
TOTAL EXPENDITURE	**(74,938)**	**(76,834)**	**(1,896)**	**(375,534)**	**(382,453)**	**(6,918)**	**(908,935)**	**(913,192)**	**(4,257)**
Financing Costs									
Interest Receivable	20	20	(0)	100	100	(0)	244	246	2
Receipt of Grants for Capital Acquisitions	0	0	(0)	0	0	(0)	0	0	0
Interest Payable	(0)	(70)	(70)	(0)	(376)	(376)	(810)	(810)	0
Other Gains & Losses	(0)	0	0	(0)	5	5	0	4	4
Impairment on Assets	0	0	0	(154,538)	(139,570)	14,968	(154,538)	(105,967)	48,571
Depreciation	(2,886)	(2,790)	96	(14,397)	(14,087)	310	(34,599)	(33,830)	769
Public Dividend Capital	(1,175)	(1,234)	(59)	(5,875)	(6,171)	(296)	(14,104)	(14,811)	(707)
TOTAL - FINANCING COSTS	**(4,041)**	**(4,074)**	**(33)**	**(174,710)**	**(160,099)**	**14,611**	**(203,807)**	**(155,168)**	**48,639**

Pay: Pay spend was £1,534k less than last month due to a reduction in spend on Bank/Agency staff following introduction of pay controls.
Non Pay: Overall Non-Pay spend has reduced by £2.1m mainly on clinical supplies & services of which £1m is PbR excluded drugs & devices which are pass-through costs and were matched by a similar reduction income.
Finance costs: The revaluation of Trust's property has resulted in asset impairment of £139,570k.

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

PAGE 4 (a) - Clinical & Non Clinical Divisions

		In Month			Year to Date (Cumulative)		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Clinical Divisions	Income	4,012	3,991	(21)	20,211	19,838	(373)
	Pay	(36,937)	(38,248)	(1,311)	(184,596)	(193,696)	(9,100)
	Non Pay	(13,315)	(13,137)	178	(67,194)	(69,662)	(2,468)
Clinical Divisions Total		**(46,240)**	**(47,394)**	**(1,154)**	**(231,579)**	**(243,520)**	**(11,941)**
Corporates	Income	7,287	7,539	252	33,338	33,592	254
	Pay	(5,903)	(5,823)	80	(27,900)	(27,397)	503
	Non Pay	(6,505)	(6,935)	(430)	(32,223)	(34,394)	(2,171)
Corporates Total		**(5,121)**	**(5,219)**	**(98)**	**(26,785)**	**(28,199)**	**(1,414)**
Income	Income	61,982	63,557	1,575	315,262	308,973	(6,289)
	Pay	0	0	0	0	0	0
	Non Pay	(77)	(77)	0	(387)	(387)	0
Income Total		**61,905**	**63,480**	**1,575**	**314,875**	**308,586**	**(6,289)**
Private Patients Directorate	Income	2,757	2,906	149	13,635	13,991	356
	Pay	(908)	(906)	2	(4,541)	(4,433)	108
	Non Pay	(824)	(1,002)	(178)	(4,160)	(4,277)	(117)
Private Patients Directorate Total		**1,025**	**998**	**(27)**	**4,934**	**5,281**	**347**
Research	Income	4,538	3,915	(623)	22,691	19,760	(2,931)
	Pay	(1,024)	(658)	366	(5,119)	(3,318)	1,801
	Non Pay	(1,809)	(1,760)	49	(9,047)	(7,797)	1,250
Research Total		**1,705**	**1,497**	**(208)**	**8,525**	**8,645**	**120**
Reserves, Financing Cost & Other Contingencies	Income	(701)	94	795	(7,409)	2,117	9,526
	Pay	974	(430)	(1,404)	5,421	(1,357)	(6,778)
	Non Pay	(9,004)	(8,207)	797	(44,125)	(33,447)	10,678
Reserves, Financing Cost & Other Contingencies Total		**(8,731)**	**(8,543)**	**188**	**(46,113)**	**(32,687)**	**13,426**
Hosted services	Income	507	581	74	2,535	3,213	678
	Pay	(180)	(182)	(2)	(900)	(915)	(15)
	Non Pay	(334)	(408)	(74)	(1,671)	(2,313)	(642)
Hosted Services Total		**(7)**	**(9)**	**(2)**	**(36)**	**(15)**	**21**
Earnings Before Interest, Tax, Depreciation & Amortisation		**4,536**	**4,810**	**274**	**23,821**	**18,091**	**(5,730)**

Clinical & Non Clinical Divisions	**Risk: R**

Variance: Favourable / (Adverse)

PAGE 4 (b) - Clinical Divisions

		In Month			Year to Date (Cumulative)		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Division Of Medicine	Income	914	989	75	4,759	4,740	(19)
	Pay	(10,667)	(11,324)	(657)	(53,419)	(57,649)	(4,230)
	Non Pay	(4,674)	(4,607)	67	(23,664)	(23,744)	(80)
Division Of Medicine Total		**(14,427)**	**(14,942)**	**(515)**	**(72,324)**	**(76,653)**	**(4,329)**
Division Of Women And Children	Income	581	496	(85)	2,878	2,265	(613)
	Pay	(5,523)	(5,869)	(346)	(27,717)	(29,485)	(1,768)
	Non Pay	(1,587)	(1,605)	(18)	(7,986)	(8,210)	(224)
Division Of Women And Children Total		**(6,529)**	**(6,978)**	**(449)**	**(32,825)**	**(35,430)**	**(2,605)**
Investigative Sciences & C S	Income	2,148	2,169	21	10,730	10,913	183
	Pay	(8,801)	(8,853)	(52)	(43,755)	(44,267)	(512)
	Non Pay	(3,419)	(3,164)	255	(17,230)	(17,470)	(240)
Investigative Sciences & C S Total		**(10,072)**	**(9,848)**	**224**	**(50,255)**	**(50,824)**	**(569)**
Surgery, Cancer & Cardiovasc Div	Income	369	338	(31)	1,843	1,920	77
	Pay	(11,945)	(12,202)	(257)	(59,704)	(62,295)	(2,591)
	Non Pay	(3,635)	(3,761)	(126)	(18,313)	(20,238)	(1,925)
Surg, Canc & Cardiovasc Div Total		**(15,211)**	**(15,625)**	**(414)**	**(76,174)**	**(80,613)**	**(4,439)**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(46,239)**	**(47,393)**	**(1,154)**	**(231,578)**	**(243,520)**	**(11,942)**

Clinical Divisions	**Risk:**	**R**

PAGE 4 (c)- Financial Performance - Non Clinical Divisions

		In Month			Year to Date (Cumulative)		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Corporate Governance	Income	0	0	0	0	1	1
	Pay	(86)	(101)	(15)	(484)	(456)	28
	Non Pay	(20)	(2)	18	(98)	(17)	81
Corporate Governance Total		**(106)**	**(103)**	**3**	**(582)**	**(472)**	**110**
Director Of Operations	Income	176	341	165	878	1,493	615
	Pay	(745)	(693)	52	(3,635)	(3,369)	266
	Non Pay	(67)	(39)	28	(335)	(314)	21
Director Of Operations Total		**(636)**	**(391)**	**245**	**(3,092)**	**(2,190)**	**902**
Estates Directorate	Income	910	947	37	4,633	4,659	26
	Pay	(786)	(850)	(64)	(3,971)	(4,015)	(44)
	Non Pay	(4,906)	(5,339)	(433)	(25,173)	(25,398)	(225)
Estates Directorate Total		**(4,782)**	**(5,242)**	**(460)**	**(24,511)**	**(24,754)**	**(243)**
Finance	Income	(77)	30	107	88	159	71
	Pay	(754)	(766)	(12)	(4,239)	(3,782)	457
	Non Pay	(312)	(377)	(65)	(1,480)	(1,924)	(444)
Finance Total		**(1,143)**	**(1,113)**	**30**	**(5,631)**	**(5,547)**	**84**
Human Resources	Income	280	280	0	1,384	1,483	99
	Pay	(524)	(498)	26	(2,588)	(2,548)	40
	Non Pay	(150)	(166)	(16)	(846)	(892)	(46)
Human Resources Total		**(394)**	**(384)**	**10**	**(2,050)**	**(1,957)**	**93**
Information & Comms Technology	Income	183	154	(29)	916	717	(199)
	Pay	(1,336)	(1,293)	43	(7,874)	(8,037)	(163)
	Non Pay	(716)	(655)	61	(3,106)	(4,582)	(1,476)
Information & Comms Technology Total		**(1,869)**	**(1,794)**	**75**	**(10,064)**	**(11,902)**	**(1,838)**
Medical Director	Income	4,881	4,814	(67)	24,404	23,920	(484)
	Pay	(563)	(447)	116	(2,798)	(2,673)	125
	Non Pay	(168)	(218)	(50)	(840)	(924)	(84)
Medical Director Total		**4,150**	**4,149**	**(1)**	**20,766**	**20,323**	**(443)**
Nursing directorate	Income	25	19	(6)	125	133	8
	Pay	(240)	(289)	(49)	(1,133)	(1,289)	(156)
	Non Pay	(36)	(32)	4	(178)	(167)	11
Nursing directorate Total		**(251)**	**(302)**	**(51)**	**(1,186)**	**(1,323)**	**(137)**
Press & Communications	Income	1	8	7	3	81	78
	Pay	(82)	(35)	47	(391)	(377)	14
	Non Pay	(9)	(12)	(3)	(46)	(82)	(36)
Press & Communications Total		**(90)**	**(39)**	**51**	**(434)**	**(378)**	**56**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(5,121)**	**(5,219)**	**(98)**	**(26,784)**	**(28,200)**	**(1,416)**

Non Clinical Divisions	**Risk: R**

Variance: Favourable / (Adverse)

PAGE 5 - Cost Improvement Programme

		In Month			Year to Date (Cumulative)			Forecast Outturn			
Division / Corporate directorate	Responsible Director	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance %
Medicine	Steve McManus	655	221	(434)	3,338	1,254	(2,084)	8,332	4,450	(3,882)	**-47%**
Surgery	Steve McManus	670	484	(185)	3,104	1,948	(1,156)	8,733	7,584	(1,149)	**-13%**
WAC	Steve McManus	264	103	(161)	1,068	655	(414)	3,657	2,696	(961)	**-26%**
DISCs	Steve McManus	452	1,004	552	2,099	2,010	(89)	5,735	6,422	687	**12%**
Private Patients	Bill Shields	340	414	74	1,667	1,993	326	4,023	4,697	674	**17%**
Corporate Governance	Cheryl Plumridge	14	3	(11)	67	28	(39)	177	150	(28)	**-16%**
Director of Operations	Steve McManus	57	1	(56)	368	1	(367)	768	645	(123)	**-16%**
Estates Directorate	Ian Garlington	195	195	0	1,007	643	(364)	3,887	3,641	(245)	**-6%**
Finance Directorate	Bill Shields	102	102	0	484	426	(59)	1,197	1,236	39	**3%**
Human Resources	Jayne Mee	62	59	(3)	309	287	(22)	746	571	(175)	**-23%**
ICT	Kevin Jarold	95	47	(48)	430	197	(233)	1,182	1,052	(130)	**-11%**
Medical Director	Chris Harrison	27	27	(1)	135	104	(31)	327	205	(122)	**-37%**
Nursing Directorate	Janice Sigsworth	10	5	(5)	36	17	(19)	104	93	(11)	**-10%**
Press & Communications	Michelle Dixon	10	8	(2)	47	38	(9)	117	100	(17)	**-14%**
Central schemes (inc internal phasing adjustment & mitigations)		315		(315)	3,559		(3,559)	10,115	12,864	2,749	**27%**
Total		**3,269**	**2,672**	**(596)**	**17,720**	**9,602**	**(8,118)**	**49,100**	**46,407**	**(2,693)**	**-5%**

COST IMPROVEMENT PROGRAMME: Delivery against the CIP programme improved significantly in month 5 with 83% of the in month plan delivered to report a reduced deficit in month on CIPs of £550k this performance increases the year to date delivery to 54% of plan. The improved CIP achievement reflects the recovery plans instigated by the Divisions in some areas these actions have resulted in mitigating CIP schemes to replace those that will no longer deliver. However to achieve the forecast outturn in month delivery needs to increase to circa £5.2m per month.

Significant under performance is forecast in three of the clinical divisions, however these are mitigated non recurrently by central schemes. These non recurrent savings in addition to those within the divisions will need to be addressed on a recurrent basis in 15/16 if the Trust is to remain in financial balance.

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

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance 1st April 2014 £000s	Plan as at August £000s	Actual Previous Month Balance £000s	Actual Current Month Balance £000s	Actual In Year Movement £000s	Variance to Plan as at August £000s	Actual Monthly Movement £000s
Non Current Assets	Property, Plant & Equipment	595,639	402,576	413,978	413,634	(182,005)	11,058	(344)
	Intangible Assets	1,413	1,749	1,419	1,382	(31)	(367)	(37)
Current Assets	Inventories (Stock)	14,214	15,006	14,427	14,938	724	(68)	511
	Trade & Other Receivables (Debtors)	96,256	90,512	95,302	99,724	3,468	9,212	4,422
	Cash	50,449	49,636	56,521	46,802	(3,647)	(2,834)	(9,719)
Current Liabilities	Trade & Other Payables (Creditors)	(128,280)	(130,030)	(133,713)	(127,622)	658	2,408	6,091
	Borrowings	(2,701)	(2,701)	(2,701)	(2,701)	0	0	0
	Provisions	(25,091)	(15,039)	(24,837)	(25,026)	65	(9,987)	(189)
Non Current Liabilities	Borrowings	(20,709)	(20,709)	(20,709)	(20,709)	0	0	0
	Provisions	(15,888)	(15,888)	(15,888)	(15,888)	0	0	0
	TOTAL ASSETS EMPLOYED	**565,302**	**375,112**	**383,799**	**384,534**	**(180,768)**	**9,422**	**735**

Ratio/Indicators	**Risk Rating**		
	Current Month	**Previous Month**	**Change in month**
Debtor Days	37	34	(3)
Trade Payable Days	50	50	0
Cash Liquidity Days	23	23	0

The Trust had its land valued by an independent RICS Chartered Surveyor, GVA Grimley Ltd, on a modern equivalent asset basis as at 31st July 2014.
This resulted in an impairment of £177m of which £139.5m was charged to the SOCI and the balance of £37.5m to revaluation reserve

The increase in debtors for the month is predominantly due to:

- Increase in NHS Debtor accruals of £4.3m predominately due to additional accruals of £0.6m for over performance, R&D MFF of £0.8m transitional funding of £0.7m, Project Diamond of £0.6m, CQUIN of £0.6m and Consultant Distinction Awards of £0.5m
- Increase in non NHS Trade debtors of £3.4m. This is largely due to month 1 to 5 invoice of £2.6m raised to councils for Sexual Health STI Services and £0.6m for R&D related projects
- Decrease in prepayments of £3.6m mainly due to the release of the final ISS payment in advance of £2.4m, NHL NEPTS Services of £0.6m, Ravenscourt Park Hospital of £0.5m and CNST of £0.3m
- Increase in other debtors of £0.3m

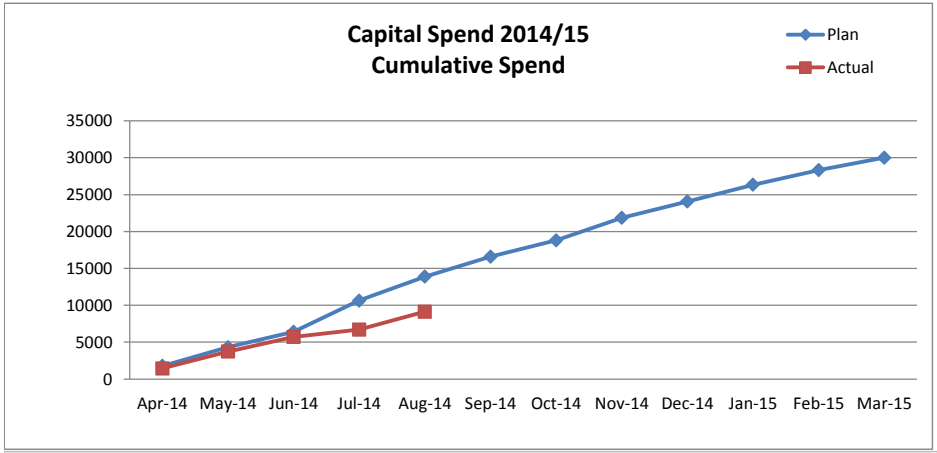
The Increase in creditors for the month is predominantly due to:

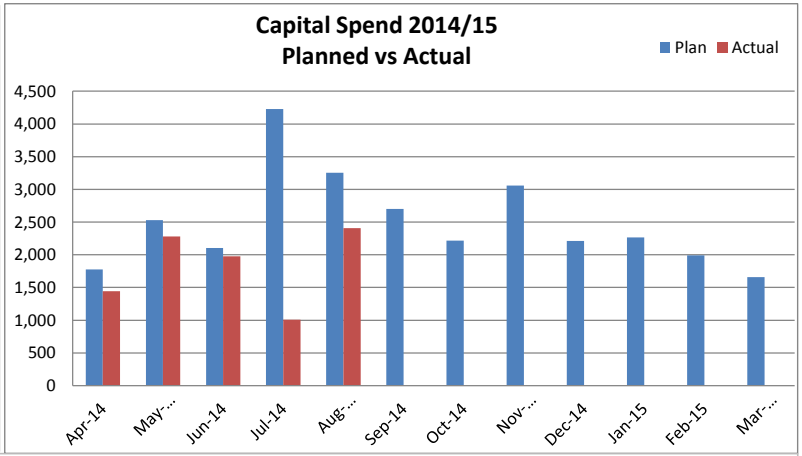
- Decrease in NHS deferred income of £4.8m predominantly due to the release of month 5 LDA and MDECS income of £4.9m
- Decrease in trade creditors of £4m as invoices have fallen due for payment
- Increase in the Imperial College accrual of £1m due to an increase in uninvoiced expenditure for salary recharges and BRC spend
- Increase in the capital accrual of £0.8m
- Increase in PDC accrual of £1.2m
- Decrease in other creditors of £0.3m

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

PAGE 7 - CAPITAL EXPENDITURE

By Scheme	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Endoscopy provision QEQM level 2 (SMH)	0	5	(5)	330	1,064	(734)	330	1,250	(920)
Site Redevelopment	300	191	109	1,330	1,101	229	2,192	3,200	(1,008)
Capital Maintenance (Backlog & Statutory) - CXH	230	77	153	920	188	732	2,520	3,160	(640)
Capital Maintenance (Backlog & Statutory) - HH	170	130	40	830	342	488	2,020	2,540	(520)
Capital Maintenance (Backlog & Statutory) - SMH	190	145	45	760	650	110	2,090	1,950	140
Imaging Review	250	122	128	750	436	314	2,650	2,500	150
Medical Equipment purchases	220	761	(541)	880	1,777	(897)	2,420	4,600	(2,180)
Theatre Refurbishment Programme	100	2	98	400	149	251	1,000	313	687
ICT investment programme	1,110	330	330	6,291	2,413	3,878	7,226	6,500	726
Minor Works (below £50k)	45	43	2	180	243	(63)	500	500	0
Improving the cancer inpatients experience (6 North and 6 South)	200	72	128	350	93	257	700	960	(260)
Private Patients Facility Improvements	50	43	7	250	98	152	250	200	50
Waste compound relocation (HH)	0	0	0	0	0	0	500	0	500
Development of Business Cases/Feasibility Studies	20	18	2	80	123	(43)	220	250	(30)
PICU St Mary's	320	17	303	320	33	287	2,583	232	2,351
Private Patients Refurbishment	8	0	8	58	0	58	878	0	878
Other site developments	0	13	(13)	0	166	(166)	0	312	(312)
Imaging Improvements (HH) - providing expanded Imaging in A-Block	39	1	38	164	11	153	1,921	40	1,881
C Block North (Building 114) refurbishment	0	(1)	1	0	26	(26)	0	1,250	(1,250)
New Linear Accelerators	0	(10)	10	0	208	(208)	0	248	(248)
Total Capital Expenditure	**3,252**	**1,959**	**843**	**13,893**	**9,121**	**4,772**	**30,000**	**30,005**	**(5)**
Donations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(5)	5	0	(5)	5
Total Charge against Capital Resource Limit	**3,252**	**1,959**	**843**	**13,893**	**9,116**	**4,777**	**30,000**	**30,000**	**0**
Capital Resource Limit							**(30,000)**	**(30,000)**	**0**
Over/(Under)spend against CRL							**0**	**0**	**0**



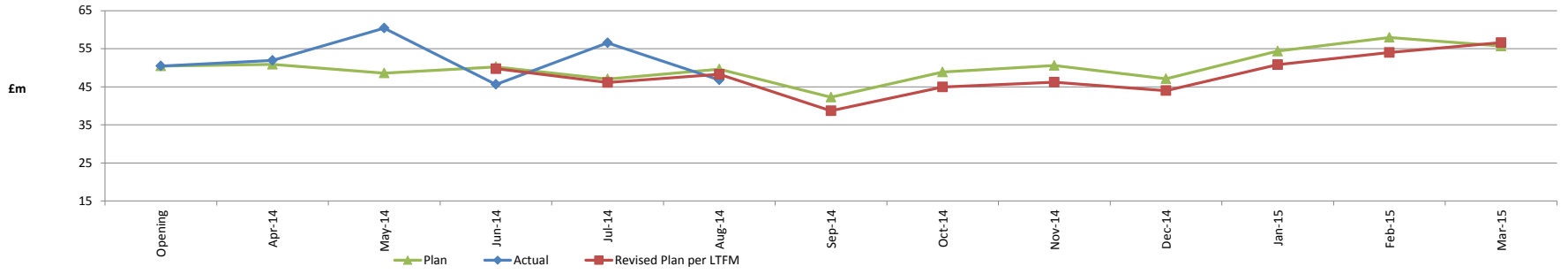


The year to date variance of £4,777k relates predominantly to the ICT investment and capital maintenance programmes both of which are behind year to date plan. It is expected that slippage on these expenditure streams will be recovered. The slippage is in part offset by the medical equipment and endoscopy programmes, both of which are currently ahead of plan.

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

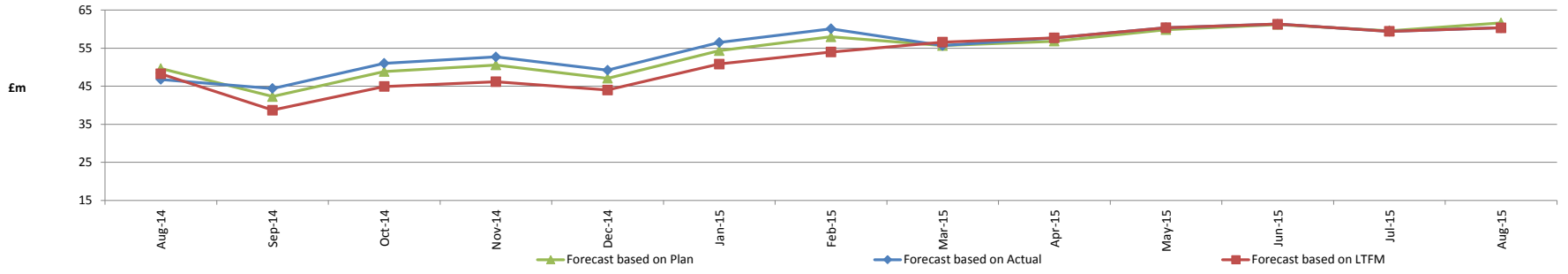
PAGE 8 - CASH

2014/15 monthly forecast versus actual month end cash balances



	Opening	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Plan	50,449	50,914	48,591	50,245	47,044	49,636	42,286	48,863	50,577	47,091	54,358	57,958	55,701
Actual	50,449	51,917	60,421	45,631	56,521	46,802							
Revised Plan per LTFM				49,739	46,109	48,273	38,717	44,943	46,199	43,992	50,825	53,993	56,605

Twelve month rolling cash flow forecast for the period ending 31 August 2015



	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Forecast based on Plan	49,636	42,286	48,863	50,577	47,091	54,358	57,958	55,701	56,834	59,859	61,224	59,589	61,646
Forecast based on Actual	46,802	44,428	51,005	52,719	49,233	56,500	60,100	55,701	57,708	60,367	61,300	59,412	60,336
Forecast based on LTFM	48,273	38,717	44,943	46,199	43,992	50,825	53,993	56,605	57,708	60,367	61,300	59,412	60,336

The cash balance at 31st August 2014 was £2.8m below plan. The variance was made up of income in advance of plan of £1m and payments in excess of plan of £3.8m. The increase in payments reflects the increase in year to date expenditure over plan.

At the end of August the balance of cash invested in the National Loan Fund scheme totalled £45m. This amount was invested fo r 7 days at an average rate of 0.39%. Total accumulated interest receivable at 31 August 2014 was £100k.

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

PAGE 9 - DEBTORS AND CREDITORS

Aged Debtor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
NHS	36,427	4,747	1,422	12,261	10,523	1,322	66,702	62,756
Non-NHS	9,134	1,926	469	2,753	2,962	784	18,028	13,991
Overseas	162	148	188	389	727	1,848	3,462	3,391
Private Patient	2,170	1,750	1,009	2,227	2,037	268	9,461	9,058
Total	**47,893**	**8,571**	**3,088**	**17,630**	**16,249**	**4,222**	97,653	89,196
% of Total Debt	**49.0%**	**8.8%**	**3.2%**	**18.1%**	**16.6%**	**4.3%**	**100.0%**	
Memo - Salary Overpayments	**22**	**6**	**17**	**93**	**42**	**323**	**503**	**551**

Aged Creditor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
NHS	21,678	2,441	529	1,561	515	124	26,848	27,469
Non NHS	3,106	1,047	230	1,984	373	123	6,863	7,679
Total	**24,784**	**3,488**	**759**	**3,545**	**888**	**247**	**33,711**	35,148
% of Total Creditors	**73.5%**	**10.3%**	**2.3%**	**10.5%**	**2.6%**	**0.7%**	**100.0%**	

Aged Debtor Analysis

The aged debtor analysis above includes all sales ledgers, excluding salary overpayments (shown as a memo item), private patients, accruals and work in progress. This is for consistency with the figures reported to the TDA for trade receivables.

The top 2 debtors based on sales ledger only are:

NHS England	£10.4m of which £10.1m is overdue
NHS Hammersmith and Fulham CCG	£4.6m of which £4.1m is overdue

Aged Creditor Analysis

The aged creditor analysis includes the accounts payable ledger, invoice register accruals and other accruals. This is consistent with the figures reported to the TDA for trade payables.

The Trust's largest overdue creditor based on accounts payable ledger and invoice register only is Imperial College £2.3m (total outstanding balance £3.2m). Work with the College continues to be ongoing to resolve outstanding queries and disputes to enable invoices to be processed for payment.

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

Page 10 - FINANCIAL RISK RATINGS (FRR)

Continuity of Service Risk Rating

Metric	Weighting	Metric Description	April	May	June	July	August
Liquidity Ratio	50%	Liquidity ratio (days)	3	3	3	3	3
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	2	3	4	4	4
Overall Continuity of Service Risk Rating			**3**	**3**	**4**	**4**	**4**

Monitor's continuity service risk rating was green due the Trust's current strong cash position.

Financial Risk Ratings	**Risk:**	**G**

PAGE 11 - SLA Activity & Income by POD (Estimate for August 2014)

Point of Delivery	Year to Date (Activity)			Year to Date (Income)			Forecast		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Admitted Patient Care									
- Day Cases	29,389	23,538	(5,851)	24,506	19,969	(4,537)	58,864	55,224	(3,640)
- Regular Day Attenders	1,651	1,931	280	2,995	2,496	(499)	2,971	6,467	3,496
- Elective	8,295	8,989	694	28,396	27,096	(1,300)	68,551	69,247	696
- Non Elective	34,359	38,246	3,887	66,617	70,699	4,082	160,186	162,461	2,275
Accident & Emergency	69,657	68,155	(1,502)	8,241	7,874	(367)	19,699	19,443	(256)
Adult Critical Care	16,580	22,941	6,362	19,638	22,046	2,408	47,359	47,416	57
Renal Dialysis	105,163	99,719	(5,444)	15,702	14,879	(823)	37,864	36,774	(1,090)
Outpatients - New	115,117	102,498	(12,619)	19,272	16,646	(2,626)	53,758	40,923	(12,835)
Outpatients - Follow-up	209,082	191,708	(17,374)	28,894	25,492	(3,402)	68,004	66,282	(1,722)
Ward Attenders	2,153	2,818	665	354	409	55	854	1,050	196
PbR Exclusions			0	38,020	40,249	2,228	91,512	96,715	5,203
Direct Access	936,644	948,069	11,425	6,672	6,710	38	16,088	16,053	(35)
CQUIN			0	6,082	6,055	(27)	14,516	8,771	(5,745)
Others	904,572	910,969	6,396	37,846	41,065	3,219	82,536	100,067	17,531
National Rules			0	(4,449)	(5,191)	(742)	(10,728)	(11,116)	(388)
Contractual Rules			0	(5,751)	(1,757)	3,994	(4,207)	(6,013)	(1,806)
Transformation Fund			0	3,503	3,503	0	8,446	8,446	0
TDA Over performance				4,377	73	(4,304)	10,485		(86)
NWL Balance to Agreed Baseline			0	1,169	0	(1,169)	0	2,789	2,789
SLA Income	**2,432,662**	**2,419,581**	**(13,081)**	**302,085**	**298,311**	**(3,774)**	**726,758**	**720,999**	**(5,759)**
Less Non English Organisations	0	0	0	(1,474)	(1,314)	160	(3,554)	(3,307)	247
Less Foundation Trust Income	0	0	0	(1,517)	(1,226)	290	(3,657)	(2,953)	704
Less Local Authority	0	0	0	(4,261)	(4,113)	148	(10,275)	(10,092)	183
Less Others	0	0	0			0	(657)	0	657
TOTAL	**2,432,662**	**2,419,581**	**(13,081)**	**294,834**	**291,658**	**(3,176)**	**708,615**	**704,647**	**(3,968)**

Income by Sector	Year to Date (Income)			Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
North West - London	141,137	141,137	0	338,018	340,159	2,141
London - Others	17,425	17,313	(111)	40,740	43,634	2,894
Non London	7,735	7,644	(91)	19,718	18,010	(1,708)
NHS England	120,512	121,894	1,381	290,584	294,199	3,615
Non Contracted Activities	3,255	3,206	(49)	8,696	7,699	(997)
Out of Area Treatment	392	391	(1)	946	946	0
TDA Over performance	4,377	73	(4,304)	9,913	0	(9,913)
TOTAL	**294,834**	**291,658**	**(3,176)**	**708,615**	**704,647**	**(3,968)**

The report is an analysis of NHS SLA Income from clinical activities.
Year to Date position was an adverse variance against plan of (£3.2m). The main reasons are : -
- Decrease in Day case activities of (£4.5m) with the key under performing service lines being Clinical Haematology (£0.8m), Gastroenterology (£0.7m),
Reproductive Medicine (£0.7m), Obstetrics (£0.6), Nephrology (£0.6m) and Urology (£0.5m).
- Elective activity was below plan by (£1.3m). The key under performing service lines were Adult BMT (£0.6m) and General Surgery (£0.5m).
- Non Elective work was above plan by £4.0m with the key over performance on Stroke Medicine £1.5m,General Medicine £1.4m, Midwifery Episodes £1.2m, Thoracic Medicine £1.0m and Gastroenterology £0.7m but A&E underperformed (£2.0m)
- Outpatient first appointments were below plan by (£2.6m). A review is being undertaken on Diagnostic Imaging.
- Outpatient follow up appointments have decreased against plan by (£3.4m) which includes OP procedures. The main variances were in Gynaecology (£0.9), Renal Services (£0.7m), Audiological Medicine (£0.4m) Cardiology (£0.3m), Anaesthetics (£0.2) and Reproductive Medici ne (£0.2) .

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

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	3.1
Title	Annual Operating Plan
Report for	Noting
Report Author	Alex Williams, Head of Planning and Business Development
Responsible Executive Director	Bill Shields, Chief Financial Officer
Freedom of Information Status	Report can be made public

Executive Summary: *This is a copy of the Annual Operating Plan, outlining the major projects that are being undertaken in each directorate through FY14/15 to FY15/16. Progress against these projects will be monitored regularly in internal performance meetings.*

Recommendation(s) to the Board: *The Board is asked to note the contents of this paper.*

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Annual Plan

Project Log

Owned by Planning and Business Development Team

v 1.0	15/05/2014
v.2.0	16/07/2014
v. 3.0	18/07/2014
v. 4.0	30/07/2014
v5.0 - v7.0	Internal working versions
v8.0	12/09/2014
v.9.0	19/09/2014

Instructions for completion

This planning document is designed as a simple record of key projects, their value and progress against them.

CEO Office

Completed by (insert name)	**Tracey Batten**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*	*Select date from list*	*Select date from list*	*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Develop Cancer Partnership with AHSC partners	To move the memorandum of understanding (MOU)with the Royal Marsden into an agreed partnership agreement	Chief Executive	N/A	Feb-14	Dec-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Review future leadership structure of the AHSC	Work to continue strengthening the role of the AHSC and to establish multi-professional education and research	Chief Executive	N/A	Sep-14	Mar-15	3	As an Academic Health Science Centre, to generate world leading research which is translated rapidly into exceptional clinical care.
Continuing to develop organisational culture	Work is taking place in a number of areas to develop and strengthen the orgainsational culture. An overall plan will be worked up to ensure all areas have robust action plans in place and that they all align to the overall orgainsational strategy	Chief Executive	N/A	Apr-14	Mar-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Further develop key external relationships	To develop a formalised stakeholder plan and continue to build and strengthen relationships with external partners (for example Tri-Borough colleagues, NHS England (London Region), CCGs, local councils, OSCs and MPs)	Chief Executive	N/A	Apr-14	Dec-14	4	To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Medical Director

Completed by (insert name)	**Chris Harrison**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Development of Medical Education Transformation Programme	A complete transformation of medical education is required following sub-standard performance and an external review which highlighted issues including: persistent poor reviews and survey results, reports of bullying and undermining, and a negative perception of ICHT's performance and commitment to improve medical education. The following will be undertaken: • Divisional Directors will be supported to take responsibility for education in their division • Education roles to be aligned with the Divisions with appropriate time allocated • Improvement strategy with clear statement of intention developed • Education transformation programme to be implemented with focused leadership and Darzi fellow appointments • Junior doctors need to be seen as an integral part of the organization and involved • Junior doctor roles and rotas need to be reviewed with hospital at night implemented • Culture of learning to improve care and safety to be developed • Structures to reflect those in the divisions with clarity on roles and KPIs • Make 2015 a year of "Education and training at ICHT" in collaboration with Imperial College and AHSC . The transformation programme will build on and pull together work currently underway including: • Restructure of education team • Specialty specific actions taken as a result of GMC surveys, quality visits, student feedback • Bullying and undermining project with external support from the postgraduate dean for education development • SPA and educational tariff review	AMD Education	N/A	Apr-14	Apr-16	2	To educate and engage skilled and diverse people committed to continual learning and improvement.

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Development of Clinical Effectiveness, Patient Safety & Audit Programme	A trustwide safety improvement programme and a trustwide clinical effectiveness programme will be developed to deal with a number of issues have been identified since the transfer of clinical governance to the MD's office in 2014, including: • Assurance of compliance with NICE guidance and standards not in place • Safety improvement programme supported by audit is not in place • Local Audits - No centrally approved programme of local audit within divisions. • National Mandatory Audits – no central record to show that the Trust currently participates in all mandatory audits, no process in place to provide assurance of actions to deal with areas of concern. • M&M Meetings – no standardised process for the recording of M&Ms, outcomes of M&Ms not routinely reported at divisional level. • Safety Alerts - Audit of safety alert outcomes have not been historically completed and the policy not clear about their management. • PROMS and VTE have no executive lead.	AMD Safety & Effectiveness	N/A	Apr-14	Apr-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of Public Health Work Programme	Ensure that the expertise in the school of primary care and public health is effectively used in developing and implementing the Trust's strategy	AMD Public Health & Primary Care	N/A	Jul-14	Mar-15	4	To pioneer integrated models of care with our partners to improve the health of the communities we serve.
Maintenance and Reaccreditation of BRC status	To maintain BRC status and achieve reaccrediation in 2017. Maintenance of BRC status is dependent on: • Meeting metric to recruit the first patient within 70 calendar days of a valid research application being received by the R&D office • Meeting performance metric of delivery of the agreed number of patients/participants by the agreed date for each study • Providing adequate facilities and infrastructure to carry out clinical research • Providing adequate support to research teams when setting up or running clinical trials	Research Director	N/A	Apr-14	Apr-17	3	As an Academic Health Science Centre, to generate world leading research which is translated rapidly into exceptional clinical care.
Development of Medical revalidation and appraisal process	To develop the processes around professional development of all doctors, including revalidation and appraisal, job planning, management of concerns, support to doctors in difficulty, which will allow us to ensure all doctors are revalidated within the timeframe required.	AMD Revalidation, Appraisal & Professional Development	N/A	Apr-14	Apr-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Quality Strategy Implementation Action Plan	The Quality Strategy is the Trust's plan by which we focus on the quality of clinical care at Imperial College Healthcare NHS Trust and ensure that we continuously improve our services. It sets out under the following 6 headings what we mean by quality: • Safety • Effectiveness • Patient Centeredness • Equity • Timeliness • Efficiency Each quality goal is outlined, has an objective set and specific actions described which will be taken during the three years covered by the strategy. Each goal has an executive lead, however the Medical Director has overall responsible for delivery and implementation of the Quality Strategy from Board to Ward.	Medical Director	N/A	Dec-14	Apr-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Nursing Directorate

Completed by (insert name)	**Janice Sigsworth**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*	*Select date from list*	*Select date from list*	*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Development of PEX improvement programme (2015/16)	The trust has a number of short term tactical projects to deliver improvements in the patient experience. It is felt that a longer term strategic approach to driving improvements is required. This is currently being explored, for example by visiting the Cleveland Clinic.	Janice Sigsworth	£150k	Apr-14	Apr-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Implementation of E-roster safe care module	*In order to ensure that our nurse/midwife staffing levels meet our patients' needs, a new module has been purchased for eroster. *The safe care module allows staff to enter patient acuity which determines the staffing levels required. *This ensures that the care needs of our patients are met, it helps avoid over or under staffing and makes optimum use of substantive staff. It also allows clinical areas to focus attention on potential staffing issues in advance, allowing resources to be flexed as required. *This project will also extensively support the implementation of the national safe nurse/midwife staffing guidance and requirements and also provide robust evidence and assurance on safe staffing for the CIH visit. *The project has started and the module is currently being piloted in three ward areas. *Project management and administrative resource is required to enable full-roll out across the Trust (NB: the module itself has already been purchased and funded)	Jayne Mee and Janice Sigsworth	£51k	Apr-14	Dec-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Managing CIH visit & ensuring good or outstanding rating	Project management and preparation of the organisation for the September CIH inspection	Janice Sigsworth	£256k	May-14	Dec-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*	*Select date from list*	*Select date from list*	*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Ensuring successful Nurse revalidation	Infrastructure and support will be needed to implement nurse re-validation in partnership with HR. This will require building electronic systems architecture to support validation requirements for our nurses and midwives as revalidation will be a condition of registration every 3 years for each registrant. Education of staff, support and policy work will need to be developed to support the governance and delivery of revalidation	Janice Sigsworth	N/A	Apr-15	Apr-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Operations Directorate

Completed by (insert name)	**Steve McManus**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align*	
Patient Services Centre	A central resource to coordinate outpatient and inpatient scheduling, booking and call centre functions acting as first point of call for patients.	Steve McManus	TBC	Aug-13	Feb-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
NW London Pathology Modernisation	A hub and spoke model to centralise pathology services across NW London, involving Hillingdon, Chelwest, ICHT and West Middx.	Steve McManus	£59.9m contribution over 10.5 yrs	Sep-12	Dec-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Delivery of clinical transformation programme	To develop and deliver a programme of clinical transformation that underpins the clinical strategy across the next 3 years +. To ensure that the CTP supports the 2014/15 contract requirements set out in CQUIN schedules etc	Steve McManus	£23m income via CQUIN and contract incentives	Jul-14	Apr-17	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Hammersmith EU closure	To close the Hammersmith EU in line with the Trust plans and SaHF requirements. To ensure that urgent care services across the Trust remain resilient on all 3 main sites	Steve McManus	N/A	Apr-14	Sep-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Annual Capacity Planning and Seasonal resilience	Develop the annual capacity planning capability in line with the Trust operating annual plan for 2015/16. Ensure that seasonal resilience plans are in place for 2014/15	Steve McManus	TBC	Jul-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Delivery of Macmillan partnership agreement and investment plan	Develop a strategic partnership with Macmillan through the completion of a signed MOU and investment agreement	Steve McManus	£2.7m income over 3 years	Mar-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
MEDICINE DIVISION							
Renal Service Model of Care	Develop strategic plans for the renal service model of care taking account of the outputs from the renal service external review.	Tim Orchard	TBC	Apr-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Urgent Care Pathway	Develop the service model for urgent care with particular emphasis on introduction of ambulatory emergency pathways.	Tim Orchard	£1.1m cost across acute medical model and ED senior staff	Apr-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of Neurosciences Services	Develop the service model for Neurosciences that supports NHSE accreditation as a Neuroscience centre	Tim Orchard	TBC	Apr-14	Sep-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align*	
SURGERY DIVISION							
Delivery of safe and sustainable Emergency Surgical Services	Develop resilient emergency surgery services across the Trust with a particular emphasis on the medium term sustainability of emergency surgery provision at the CXH	Jamil Mayet	Up to £1m full year cost	Sep-13	Jul-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of Critical Care Services	Develop the strategic planning for critical care services across the Trust	Jamil Mayet	TBC	Apr-14	Apr-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
INVESTIGATIVE SCIENCES							
Development of imaging Capability	Deliver sustainable imaging capability across the Trust with particular emphasis on expanding modalities and the upgrade of imaging equipment	Julian Redhead	TBC	Apr-14	Mar-17	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
WOMEN'S AND CHILDREN'S							
Development of PICU service	Develop the expansion plans for the PICU to ensure a safe, effective and sustainable environment for paediatric intensive care patients that also supports the strategic requirements of the paediatric service overall.	TG Teoh	£8.7m capital cost	Sep-13	Sep-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Strategy Directorate

Completed by (insert name)	**Ian Garlington**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Retender of the Soft FM contract	Retender of the £30m soft services contract in place on our 3 main sites which provides portering, cleaning, patient feeding and hydration etc. contract in three parts, Core FM; Retail; Private Patients	Chris O'Boyle	£26m pa	Apr-14	Sep-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Whole Systems Integrated Care (WSIC) & Better Care Fund	Support of the national pioneer for WSIC. Working with up to 12 early adopter sites in supporting new models of care to sample populations of up to 50k	Ian Garlington	unknown	Apr-14	Mar-17	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Site Redevelopment (SAHF) Full Business Case	Developing Investment making (Full) Business Case *** Strategic Objectives - include options 1-4	Ian Garlington	£700m	Jul-14	Mar-19	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Developing Strategic Commercial Partnerships	Identification and discussion with non-NHS entities around future potential to work in alliance to improve competitiveness or effectiveness in the delivery of existing or new services	Ian Garlington	unknown	Feb-14	on-going		1 - 4 inclusive
Developing NWL Healthcare Partnerships	Identification and discussion with NHS entities around future potential to work in alliance to improve competitiveness in the AQP arena and the effectiveness in the delivery of existing or new services	Ian Garlington	unknown	Mar-14	on-going		1 - 4 inclusive
Developing Strategic Relationship with NHSE	Development of key contacts to support service redesign for specialist services and organisational evolution.	Ian Garlington	unknown	Apr-14	on-going		1 - 4 inclusive
Outsourcing of the EBME maintenance contract	Outsourcing of the PPM activity for the Trust fleet of biomedical equipment and imaging.	Chris O'Boyle	£6.51m pa	Nov-14	on-going	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of Transport Strategy	Supporting the Clinical Strategy and FBC, development of a comprehensive Transport strategy	Ian Garlington	£100k	Sep-14	May-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Governance Directorate

Completed by (insert name)	**Cheryl Plumridge**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*	*Select date from list*	*Select date from list*	*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Developing a strategic focus on Health and Safety	A project to offset reduced spend on external HS&E consultancy/support with the creation of a number of internal posts to support the Trust's focus on HS&E. This will be taken forward by the Director of Estates working with the Director of Governance &Assurance as part of the plan to transfer the H&S budget to Governance &Assurance in the next FY.	Chris O'Boyle (supported by Cheryl Plumridge)	£355k (approx)	Jul-14	Apr-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Further development of Corporate Risk Register	Revision of the Corporate Risk Register and the process for its future revision, including arrangements for exec director engagement and wider Board involvement in its production, moderation of risks, and the linkage with the strategic objectives and BAF.	Cheryl Plumridge	Unknown	Jul-14	Apr-15	3	As an Academic Health Science Centre, to generate world leading research which is translated rapidly into exceptional clinical care.
Development of Governor and Membership Strategy	Strategies to ensure the Trust can fulfil its legal obligations to develop and engage potential Governors and Members of the Foundation Trust.	Cheryl Plumridge/Helen Potton	Unknown	Aug-14	Apr-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Finance Directorate

Completed by (insert name)	**Bill Shields**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align*	
Roll-out of World Class Supply Chain	The WCSC programme is designed to transform the way the Trust manages its expenditure with third parties. The traditional approach of generating savings by concentrating on sourcing products at lower unit prices will not be sufficient to generate the level of savings required to deliver the efficiency challenge. This means transforming contract management, product choice and inventory management through building local capacity and capability in people, systems & processes and clinical engagement.	Marcus Thorman	£15,869k net benefit over programme life	Apr-14	Mar-17	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Transformation of Imperial Private Health care - Structural review and commercial growth and marketing strategy	Transformation of Imperial Private Healthcare, encompassing: - restructure of the division and leadership arrangements - incentivisation for the Divisions via private 'dividend' model - growth of income via expansion of capacity, diversification of service portfolio, new referral streams, focus on service quality - development of medium to long term strategy for IPH, including marketing strategy Revenue growth is open-ended, but there is a 50% growth objective over two years to April 2016, and the strategy will need to be set and delivery substantially underway by then to be on target	Kerensa Heffron	Income growth of c. £15m over 2 years to April 2016 (additional contribution est. £10m with additional profit est. £5m)	Apr-14	Apr-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Foundation Trust - IBP	Production of the Trust's IBP for submission to the TDA in accordance with Board approved timescales	Bill Shields	No set cost, part of FT programme using internal resource	Jun-13	Jun-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Foundation Trust - LTFM	Production of the Trust's LTFM for submission to the TDA in accordance with Board approved timescales	Bill Shields	No set cost, part of FT programme using internal resource	Jun-13	Jun-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development, Team selection and launch of QuEST programme	Creation of team to deliver in year CIP programme and support FT programme by producing granular 3 year plan	Bill Shields & Steve McManus	No set cost, part of FT programme using internal resource	Oct-14	Oct-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Investigate Opportunities for outsourcing/partnering of back office services	Options for finance and finance and procurement services to be developed and delivered, subject to business case approval	Bill Shields	Anticipated financial benefits include savings of £875k over the period FY14/15 - FY19/20. This savings is net of one-off revenue costs of £342k, of which £256k is for redundancy costs and £86k is for migration costs.	Apr-14	Mar-20	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Roll-out of granular costing systems with links to dedicated clinical leadership and link to business intelligence	Embed the use of costing and profitability data in performance management, planning and decision-making. Improve the user interface for reporting. Further improve the depth and quality of costing information to enable robust patient level analysis to be completed.	Marcus Thorman	No additional cost	Apr-14	Mar-16	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

ICT Directorate

Completed by (insert name)	**Kevin Jarrold**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Developing organisational ICT strategy	Refresh the ICT strategy to support the clinical strategy and wider corporate agenda	Kevin Jarrold	N/A	Sep-14	Dec-14	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Continued roll-out of Cerner	Complete the transition to stable business as usual operation for the Patient Administration and Maternity functionality and deliver the programme of agreed developments for clinical functionality	Kevin Jarrold	N/A	Apr-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Investing in IT infrastructure to bring this to acceptable standards	Deliver the agreed ICT investment programme which includes upgrading the wireless network, new mobile device management capability, refresh of PCs and our data storage and supporting our community based staff with improved access to clinical systems	Kevin Jarrold	£6.5m	Apr-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of organisational business intelligence strategy	Development of organisational business intelligence strategy to deliver complete, accurate, real-time, Business Intelligence to support performance, education and research. A single version of the truth via a single access point for Trust staff via Qli	Kevin Jarrold	£0.5m	Apr-14	Mar-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Continued development of NIHR collaborative	Continued development of NIHR collaborative involving the largest Biomedical Research Centres (BRC), i.e. Imperial, Oxford, Cambridge, UCLH and GSST, to collaborate and demonstrate how sharing of NHS clinical information, held electronically, can facilitate more effective clinical research, and lead to benefits for patients and the public, researchers and NHS staff.	Kevin Jarrold	£0.1m	Apr-15	Mar-15	3	As an Academic Health Science Centre, to generate world leading research which is translated rapidly into exceptional clinical care.
Continued development of Health information exchange	The objective of the Health Information Exchange project is to build upon the clinical functionality being implemented as part of the Cerner Programme (see above) to enable the sharing of the digital patient record with other parties involved in the delivery of care and with patients. This project is supported by the Imperial College Charity	Kevin Jarrold	£1m	Apr-15	Mar-15	4	To pioneer integrated models of care with our partners to improve the health of the communities we serve.

People & Organisational Development Directorate

Completed by (insert name)	**Jayne Mee**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*	*Select date from list*	*Select date from list*	*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Development of Employer Branding	Develop an Employer Brand that enables the Trust to stand out from its competitors in attracting, recruiting, and retaining talented people	Jayne Mee (Dawn Morris)	£80k	May-14	Dec-14	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Implementation of Health & Wellbeing strategy	Implementation of the Health & Wellbeing Strategy	Jayne Mee (Nicola Bullen)	Unknown	Jun-14	Mar-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Implementation of the Occupational Health review	Implementation of the OH review ensuring change in behaviour to a workability model as a major strand of the Health and Wellbeing Strategy	Jayne Mee (Nicola Bullen)	Unknown	Apr-14	Mar-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Review and refresh Imperial Values and Behaviours	To review and refresh the Imperial Values and Behaviours	Sponsor Jayne Mee Owner Horizons Cohort 2	Unknown	Jul-14	Jun-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Implementation of Talent Management Programme	Implementation of the Talent Management Review, identifying talent for the future through Succession Planning	Jayne Mee (Sue Grange)	Unknown	Sep-14	Feb-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Produce Final workforce plan	Support the Clinical Strategy, and LFTM with a workforce plan that will deliver numbers and appropriate skill mix	Jayne Mee (Karen North)	Unknown	Sep-14	Jun-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.

Communications Directorate

Completed by (insert name)	**Michelle Dixon**
Financial Year (select from list)	**2014/15 - 2015/16**

Project Name	Description	Owner	Value (£000s)	Project Commencement Date	Project Conclusion Date	Strategic Objective	
Insert the name of your project	*Insert a description of the project*	*Who owns it*	*How much is the project worth*			*Which of the Trust's 4 objectives does it best align with? (Select objective number)*	
Development of new Trust website and wider digital strategy	Comprehensive overhaul of current website to include discovery/audience insight phase, redesign of look and feel, new content management system and rebuild. Also includes creation of content strategy and redevelopment of much of our existing content plus folding in of current microsites.	Caroline Weller	£240k capital plus £378k one-off revenue	Sep-14	Jul-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Communications and engagement programme to support clinical transformation	Design and run communications and engagement programme for range of internal and external audiences, in partnership with clinical transformation office and strategy directorate, and co-ordinating with SaHF	Michelle Dixon	N/A	Sep-14	Dec-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Development of corporate branding	Project to produce clear and compelling purpose, organisational boiler plate, 'service'/brand hierarchy and naming strategy, new look and feel, plus an implementation plan	Michelle Dixon	N/A	Jan-15	Dec-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Internal communications and engagement strategy and development plan	Review and development programme to improve internal communications and increase staff engagement	Michelle Dixon	N/A	Oct-14	Feb-15	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Development of social media strategy for staff	Develop access, policy, toolkit and training for staff.	Caroline Weller	N/A	Jun-14	Sep-14	2	To educate and engage skilled and diverse people committed to continual learning and improvement.
Development of communications strategy	Development of overarching communications and engagement strategy	Michelle Dixon	N/A	Nov-14	Feb-15	1	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

Agenda Item	3.2
Title	NHS Trust Development Authority Self-Certifications
Report for	Noting
Report Author	Alex Williams, Head of Planning and Business Development
Responsible Executive Director	Bill Shields, Chief Financial Officer
Freedom of Information Status	Report can be made public

Executive Summary:

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

The Board is asked to retrospectively approve the June 2014 and July 2014 submissions.

Recommendation to the Board:

The Board is asked to note the Trust Development Agency self-certifications.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: June 2014 Submitted 31/07/2014

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

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

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICHT Response: Yes** **Explanation:** All Governors and Directors pass the fit and proper persons test.	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q3. Condition G7 Registration with the Care Quality Commission. **ICHT Response: Yes** **Explanation:**	Janice Sigsworth, Director of Nursing
Q4. Condition G8 Patient eligibility and selection criteria. **ICHT Response: Yes** **Explanation:** This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals or determining the manner in which services are provided. The Trust fulfils this condition through a range of methods including; use of the ICHT access policy which sets out transparently how the Trust manages referrals and access to services, co-design with CCGs and NHSE of the eligibility criteria for access to specialist tertiary services and publication of these criteria to health care professionals and patients, use of specific processes to seek funding approval for those procedures where contractually prior commissioning approval is required, compliance with the standards set out within the NHS Constitution.	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q6. Condition P2 Provision of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q7. Condition P3 Assurance report on submissions to Monitor. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes**	Bill Shields, Chief Financial Officer

Explanation:	
Q10. Condition C1 The right of patients to make choices. **ICHT Response: Yes** **Explanation:** This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have choice of provider. ICHT achieves this condition through a range of initiatives including; publishing waiting times through Choose & Book to support patients and their GP in making informed decisions in the GP surgery, working closely with CCGs and NHSE to draft and implement referral criteria/pathways for access to specialist services.	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q12. Condition IC1 Provision of integrated care. **ICHT Response: Yes** **Explanation:** This condition states that the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. ICHT works in partnership with commissioners to develop integrated care and whole systems approaches to developing patient pathways including; co-design and piloting of a virtual ward, development of joined community and secondary care outpatient services, improvements to electronic communications relating to patient records.	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: June 2014, Submitted 31/07/2014

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

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICHT Response: Yes** **Explanation: Governance arrangements in place to assure quality of care with clear accountability and reporting.**	Chris Harrison, Medical Director
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICHT Response: Yes** **Explanation: Robust process and governance arrangements in place and are part of the preparation and project management of the upcoming Chief Inspector of Hospitals visit, scheduled in early September).**	Janice Sigsworth, Director of Nursing
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICHT Response: Yes** **Explanation: Responsible officer in place with governance arrangements to provide assurance.**	Chris Harrison, Medical director
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICHT Response: Yes** **Explanation: The Trust remains a going concern as defined by the most up to date accounting standards.** **The Board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Bill Shields Chief Financial Officer
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICHT Response: Yes** **Explanation: A review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February this year by Governance/FT Team. In respect of NTDA Accountability Framework, this document sets out how the TDA will work with the Trust on a day to day basis and how it will measure etc. As an aspirant FT, we have regular involvement and meetings with TDA. The review looked at the themes and approval model and concluded the Trust was on track which was in part supported by the work undertaken for the QGF and BGAF. In respect of the NHS Constitution this consists of 7 principles, 6 values and a number of identified rights for public and patients. We reviewed each element and confirmed that appropriate processes or procedures were in place to enable the Trust to confirm that it complies with the NHS Constitution.**	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICHT Response: Yes** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.**	Cheryl Plumridge, Director of Governance and Assurance.
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.*	Cheryl Plumridge, Director of Governance and Assurance.

ICHT Response: Yes **Explanation: The Annual Governance Statement identifies significant issues for the coming year. The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver. In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.**	
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICHT Response: Yes** **Explanation: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, Risk & Governance Committee are followed up on and the actions reported at each Audit, Risk & Governance Committee.**	Cheryl Plumridge, Director of Governance and Assurance.
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICHT Response: Yes** **Explanation: The AGS has gone through a rigorous process, is overseen by the Audit Risk & Governance Committee, and is tested and challenged by internal and external audit.**	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **Methicillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** • There is a national expectation of zero MRSA blood stream infections for all Trusts for 2014/15; • During May 2014 2 cases were allocated to the Trust; • There were no Trust associated cases confirmed during June 2014. **Clostridium difficile infections:** • The Department of Health annual ceiling for the Trust is 65 cases for 2014/15; to date the Trust has reported 25 cases associated with the Trust; • 9 Trust associated cases were reported to Public Health England (PHE) in May, with a further 9 in June 2014; • Actions arising from multidisciplinary review of these cases include a communication programme to raise staff awareness of the isolation policy and a review of PPIs within the community sector. In June, the Trust continued to deliver the 4-hour waiting time standard in our A&E department. The Trust consistently delivers this standard each month. The Trust is currently bidding for money to support resilience over the winter period that is available nationally. Reported Referral to Treatment (RTT) performance was challenged in June and the Trust underperformed on all three standards. Since implementing a new Patient Administration System (PAS) in April, the trust is going through a period of stabilisation and familiarisation. It was expected that there would be a number of data quality issues that would need to be resolved following the switch over. These issues are being managed during weekly meetings with divisional teams. However, there are still some challenges with both ensuring that staff record data correctly onto the system, and the volume of validation that needs to happen to ensure appropriate prospective monitoring of patients waiting for treatment. There was one patient recorded as waiting over 52 weeks for treatment. The patient has now been treated and will be recorded as an under 52 week treatment for July due to patient choice being taken into account (this is not the case for reported incomplete pathways).	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response: Yes** **Explanation: The Trust is compliant and re-submit the toolkit return on 31 March 2014.**	Kevin Jarrold, Chief Information Officer.
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICHT Response: Yes** **Explanation: We update the register of interests continuously. It is taken to every public Trust Board for Board members. We refresh this by requesting a new return every other Board. Responsibility for making declarations for all staff is advertised periodically – the last one took place in March '14 via the Source which included information on the requirement and how to make a declaration. All Board positions are in place. Reviews have been undertaken on the governance structure and continue to be undertaken which in part consider the effectiveness of the governance**	Cheryl Plumridge, Director of Governance and Assurance.

structure.	
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response: Yes** **Explanation: A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.**	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response: Yes** **Explanation: A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.** **A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.**	Jayne Mee, Director of People and Organisational Development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: July 2014 Submitted 29/08/2014

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11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICHT Response: Yes** **Explanation:** All Governors and Directors pass the fit and proper persons test.	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q3. Condition G7 Registration with the Care Quality Commission. **ICHT Response: Yes** **Explanation:**	Janice Sigsworth, Director of Nursing
Q4. Condition G8 Patient eligibility and selection criteria. **ICHT Response: Yes** **Explanation:** This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals or determining the manner in which services are provided. The Trust fulfils this condition through a range of methods including; use of the ICHT access policy which sets out transparently how the Trust manages referrals and access to services, co-design with CCGs and NHSE of the eligibility criteria for access to specialist tertiary services and publication of these criteria to health care professionals and patients, use of specific processes to seek funding approval for those procedures where contractually prior commissioning approval is required, compliance with the standards set out within the NHS Constitution.	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q6. Condition P2 Provision of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q7. Condition P3 Assurance report on submissions to Monitor. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes**	Bill Shields, Chief Financial Officer

Explanation:	
Q10. Condition C1 The right of patients to make choices. **ICHT Response: Yes** **Explanation:** This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have choice of provider. ICHT achieves this condition through a range of initiatives including; publishing waiting times through Choose & Book to support patients and their GP in making informed decisions in the GP surgery, working closely with CCGs and NHSE to draft and implement referral criteria/pathways for access to specialist services.	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q12. Condition IC1 Provision of integrated care. **ICHT Response: Yes** **Explanation:** This condition states that the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. ICHT works in partnership with commissioners to develop integrated care and whole systems approaches to developing patient pathways including; co-design and piloting of a virtual ward, development of joined community and secondary care outpatient services, improvements to electronic communications relating to patient records.	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: July 2014, Submitted 29/08/2014

CLINICAL QUALITY
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In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICHT Response: Yes** **Explanation: Governance arrangements in place to assure quality of care with clear accountability and reporting.**	Chris Harrison, Medical Director
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICHT Response: Yes** **Explanation: Robust process and governance arrangements in place and are part of the preparation and project management of the upcoming Chief Inspector of Hospitals visit, scheduled in early September).**	Janice Sigsworth, Director of Nursing
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICHT Response: Yes** **Explanation: Responsible officer in place with governance arrangements to provide assurance.**	Chris Harrison, Medical director
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICHT Response: Yes** **Explanation: The Trust remains a going concern as defined by the most up to date accounting standards.** **The Board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Bill Shields Chief Financial Officer
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICHT Response: Yes** **Explanation: A review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February this year by Governance/FT Team. In respect of NTDA Accountability Framework, this document sets out how the TDA will work with the Trust on a day to day basis and how it will measure etc. As an aspirant FT, we have regular involvement and meetings with TDA. The review looked at the themes and approval model and concluded the Trust was on track which was in part supported by the work undertaken for the QGF and BGAF. In respect of the NHS Constitution this consists of 7 principles, 6 values and a number of identified rights for public and patients. We reviewed each element and confirmed that appropriate processes or procedures were in place to enable the Trust to confirm that it complies with the NHS Constitution.**	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICHT Response: Yes** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.**	Cheryl Plumridge, Director of Governance and Assurance.
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.*	Cheryl Plumridge, Director of Governance and Assurance.

ICHT Response: Yes **Explanation: The Annual Governance Statement identifies significant issues for the coming year. The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver. In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.**	
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICHT Response: Yes** **Explanation: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, Risk & Governance Committee are followed up on and the actions reported at each Audit, Risk & Governance Committee.**	Cheryl Plumridge, Director of Governance and Assurance.
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICHT Response: Yes** **Explanation: The AGS has gone through a rigorous process, is overseen by the Audit Risk & Governance Committee, and is tested and challenged by internal and external audit.**	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** • There is a national expectation of zero MRSA blood stream infections; • To date 3 cases of MRSA BSI have been allocated to the Trust since April 2014; • There were no Trust associated cases confirmed during July 2014. **Clostridium difficile infections:** • The Department of Health's annual ceiling for the Trust is 65 cases for 2014/15; to date we have reported 31 cases associated with the Trust, in comparison to 29 reported cases in the same period in 2013/14; • 6 Trust associated cases were reported to Public Health England (PHE) in July 2014; • The 12 month rolling total for Trust associated cases is 57; • During quarter one a total of 2045 stool specimens were tested for C. difficile, during July, 668 specimens were tested. • In July, the Trust continued to deliver the 4-hour waiting time standard in our A&E department. The Trust consistently delivers this standard each month. The Trust is currently negotiating with commissioners on how system resilience funding to support winter pressures will be allocated. **Referral to treatment** Reported Referral to Treatment (RTT) performance remains challenged in July. The Trust met the standard for patients treated on a non-admitted pathway but under-delivered on the admitted and incomplete pathway standards. Since implementing a new Patient Administration System (PAS) in April, the Trust has been going through a period of stabilisation and familiarisation. It was expected that there would be a number of data quality issues that would need to be resolved following the switch over. One of the key problems is that the number of patients waiting on our system is showing as higher than the true number of patients. These issues are being managed during weekly meetings with divisional teams. However, there are still some challenges with both ensuring that staff record data correctly onto the system, and the volume of validation that needs to happen to ensure appropriate prospective monitoring of patients waiting for treatment.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response: Yes** **Explanation: The Trust is compliant and re-submit the toolkit return on 31 March 2014.**	Kevin Jarrold, Chief Information Officer.
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICHT Response: Yes** **Explanation: We update the register of interests continuously. It is taken to every public Trust Board for Board members. We refresh this by requesting a new return every other Board. Responsibility for making declarations for all staff is advertised periodically – the last one took place in March '14 via the Source which included information on the requirement and how to make a declaration. All Board positions are in place. Reviews have been undertaken on**	Cheryl Plumridge, Director of Governance and Assurance.

the governance structure and continue to be undertaken which in part consider the effectiveness of the governance structure.	
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response: Yes** **Explanation: A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.**	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response: Yes** **Explanation: A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.** **A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.**	Jayne Mee, Director of People and Organisational Development.

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	3.3
Title	Trust Policies: Health & Safety at Work & Fire Safety Policies
Report for	Decision
Report Author	Christopher G O'Boyle Director of Estates & Facilities
Responsible Executive Director	Cheryl Plumridge Director of Corporate Governance and Assurance
Freedom of Information Status	Report can be made Public

Executive Summary:

The Imperial College Healthcare NHS Trust (henceforth called the "Trust") regards the promotion of health, safety and welfare at work as a mutual objective for management, workers, 'third parties' and employees at all levels. It is, therefore, the Trust's policy to do all that is reasonable and practicable to prevent personal injury, to protect everyone from foreseeable work hazards, including the public in so far as they come into contact with its premises/services and to prevent damage to property. Fire Safety Management is seen as an integral part of delivering that objective.

The corporate H&S and Fire policies for the Trust are attached and are in accordance with the Health and Safety at Work etc. Act 1974, the Regulatory Reform (Fire Safety) Order 2005, the Management of Health and Safety Regulations 1999 and the Health Technical Memorandum 05-01: Managing healthcare fire safety.

- these policies apply to all staff, students, patients, volunteers, contract staff, contractors, agency, visiting workers, visitors and site partners within the trust;
- apply to all buildings occupied by the Trust;
- annually the Trust board should approve the objectives of the Trust H&S committee and receive a report so it can monitor progress.

Only by adopting these policies and monitoring compliance at Board level, can the Trust Board, executives and senior managers demonstrate compliance with statutory legislation, standards and guidance as they affect the Trust. The Chief Executive Officer is required by statute to sign these policies on behalf of the Trust and to widely distribute to all stakeholders.

Trust strategic objectives supported by this paper:

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

Risk:

These policies set out to manage the Trust's responsibility to do all that is reasonable and practicable to prevent personal injury, to protect everyone from foreseeable work hazards, including the public in so far as they come into contact with its premises/services and to prevent damage to property.

Finance issues:

Safe systems of working should have a nil cost implication.

Legal and Compliance issues:

Only by adopting these policies and monitoring them at Board level, can the Trust Board, executives and senior managers demonstrate compliance.

Implications for Equality, Diversity and Human Rights:

The attached polices are the Trust's response to discharge it's duty of care to provide safe, premises/services which are fit for purpose and are critical in directly supporting patient care and protect all staff, patients and visitors.

Engaging People:

These policies are written in accordance with the DH Health Technical Memorandum (HTM) 00 March 2014 guidance, HTM 05-01 dated March 2013 Managing healthcare fire safety and benefit from expert input from the Trust's Health and Safety and Fire experts USC Ltd to ensure our policies are appropriate and fit for purpose.

Recommendation to the Board:

The Trust Health & Safety Committee (H&S) have reviewed, approved and recommended acceptance to ExCo, who have ratified these policies and recommend them for Board approval and signature by the Chief Executive Officer and Designated Person as appropriate.

Trust Policies: Health & Safety at Work & Fire Safety Policies

1. Introduction:

The attached polices have been reviewed by the Trust H&S committee, were ratified by ExCo at the meeting of the 1st September 2014 and are recommended to the board as the Trust's response to discharge its duty of care to do all that is reasonable and practicable to prevent personal injury, to protect everyone from foreseeable work hazards, including the public in so far as they come into contact with its premises/services and to prevent damage to property. Fire Safety Management is seen as an integral part of delivering that objective.

2. Policies for Approval:

2.1. Health and Safety At Work Etc. Act 1974

The Health and Safety at Work Act 1974 also referred to as HASAWA or HSW is the primary piece of legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive (HSE) and Local Authority are responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment.

Statutory instruments are the secondary types of legislation made under specific Acts of Parliament. These cover a wide range of subjects, from control of asbestos at work, ionising, radiation and working at height.

The HSW Act 1974 places the duty on an employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all employees and others who may be affected by its acts or omissions. This includes the provision and maintenance of safe plant, machinery, equipment and safe systems of work. Although the ultimate responsibility for compliance with the Act rests with employers, every employee also has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work.

The Trust responsibilities are clear "ensure so far as reasonably practicable the health and safety and welfare at work of all [their] employees"... and "to conduct [their] undertaking in such a way as to ensure, so far as reasonably practicable, that persons not in … employment who may be affected [by the undertaking] are not exposed to risks to their health and safety".

Compliance with the HSW Act is a legal requirement and the attached policy is the Trusts response to the legislation. The Chief Executive Officer is required to, by statue, to sign this policy on behalf of the Trust.

2.2. The Regulatory Reform (Fire Safety) Order 2005

The new Fire Safety Order simplifies, rationalises and consolidates existing fire safety legislation. It provides for a risk based approach to fire safety allowing more efficient and effective enforcement by the fire and rescue service.

At the core of the legislation lies the fire risk assessment. This is an organised appraisal of the Trust work activities and the workplace to enable to identify potential fire hazards, and to decide who (including employees and visitors) might be in danger in the event of fire, and their location.

The Fire Safety Team evaluates the risks arising from the hazards and decides whether the existing fire precautions are adequate, or whether more needs to be done. They assess the risks from fire with regard to the health, safety and welfare of employees, patients, students, visitors and contractors whilst they are on its premises and maintains a record of its findings which is required under the Regulatory Reform (fire Safety) Order 2005 and the Management of Health and Safety at Work Regulations 1999;

This policy adopts a systematic approach to fire safety throughout the Trust, this includes:

- following the Firecode suite of documents published by the Department of Health which provide guidance and set objectives whereby risks are eliminated or minimised by the correct selection and design of facilities, equipment and processes;
- the provision and maintenance of safe and healthy working conditions, adequate fire prevention arrangements, safe means of access and egress and taking account of all statutory requirements;
- the provision of information, operational policies and procedures, training, instruction and supervision to enable employees to perform their work safely and efficiently;
- maintenance of suitable and sufficient records of training and of testing and maintenance of fire safety systems;
- making available all necessary fire safety devices and fire fighting equipment and provides instruction in their use;
- maintaining suitable reference building plans showing relevant fire safety arrangements;

This Fire Safety Policy sets out the Trust Boards intent not only to comply with their legal obligations, but to clearly set out the roles, responsibilities and management arrangements to ensure minimum impact of fire on life, the delivery of service, the environment and property. The Chief Executive Officer and Designated Person are required to sign this policy.

3.3. By adopting these policies and monitoring compliance at board level, can the Trust board, executives and senior managers demonstrate compliance with statutory legislation, standards and guidance as they affect the Trust and adopt safe systems of working.

4.0 Recommendation to the Board

The ICHT's Health & Safety Committee (H&S) have reviewed, approved and recommended acceptance to ExCo, who have ratified these policies and recommend them for Board approval and signature by the Chief Executive Officer and Designated Person as appropriate.

Appendix A Policies
Health & Safety at Work Policy
Fire Safety Policy

Imperial College Healthcare NHS
NHS Trust

Health and Safety Policy and Procedures

Author/s:	Brian Pender, Head of Security and Safety Sharon Wood, Safety Consultant
Contact Details:	Brian Pender, Head of Security and Safety Brian.pender@imperial.nhs.uk
Date written:	2nd July 2012
Approved by:	Health and Safety Committee/Partnership Committee
Date Approved:	
Ratified by:	Executive Committee
Date Ratified:	Aug 2014
Date Policy becomes Live :	Aug 2014
Next due for revision:	Aug 2015
Target Audience:	All Trust Staff
Location of Policy:	Trust Intranet: http://source/safetyandsecurity/health_and_safety/policies/index.htm http://source/source/policies/index.htm
Related Policies:	Risk Management Strategy Risk Assessment Policy and Procedures Incident Reporting Policy and Procedure Fire Safety Policy and Procedures Security Policy and Procedures Manual Handling Policy Display Screen Equipment Policy Policy for the Control of Substances Hazardous to Health New and Expectant Mothers Policy and Procedure Falls Management and Prevention Policy – Patients (Including Slips and Trips) Slips, Trips and Falls Policy and Guidance Lone Working Policy and Procedure Stress at Work Policy Guidelines Policy for the Management of Violence and Aggression Trust Radiation Safety Policy Waste Management Policy Work Experience Policy Raising Concerns Policy and Procedure (Whistleblowing) 2011

	Bullying and Harassment Policy and Procedure Policy for Hospital Cleaning Dress Code and Uniform Policy An Organisation-wide Policy for the management of inoculation injuries Maternity, Adoption, Paternity (Maternity Support) and Parental Leave and Benefits Policy Policy for Senior Management Risk Awareness Training Statutory and Mandatory Training Policy and Procedure

Version Control Sheet

Version	Updated by	Updated on	Description of Changes
V0.1	Brian Bareham/Sharon Wood	New policy drafted March 2011	Replaces the 2008 Health and Safety Policy
V0.2	Gaynor Pickavance/Sharon Wood	April 2011	Reformatted document, updated policy titles.
V0.3	Gaynor Pickavance/Sharon Wood	June 2011	Incorporating comments from PAG
V0.4	Joint Unions Partnership	24 July 2011	Incorporating comments from JUP H&S Reps
V0.5	Sharon Wood	14 May 2012	Replaced Gene Therapy and Genetic Modification Safety Committee with the Joint Clinical Research Safety Committee Added Joint Safety Group Changed 2 yearly Stat/Man training to 3 yearly
V0.6	Brian Pender / Sharon Wood	2 July 2012 10 August 2012	Replace Head of Safety and Risk with Head of Security and Safety Replace Director of Estates with Interim Director of Estates Services
V0.7	Sharon Wood	February 2014	Change committee name to Health and Safety Committee (HSC) Replace Terms of Reference for HSFSC with HSC Remove reference to PAG Replace JUP (Joint Union Partnership with JSC (Joint Staff Committee) Replace Clinical Programme Groups with Divisions Remove Governance Committee Remove Terms of Reference for the: • Governance Committee • Trust Radiation Safety Committee • Joint Clinical Research Safety Committee • Security Committee • Fire Safety Committee
V0.8	Sharon Wood	July 2014	Replace Director of Estates and facilities with Director of Governance and Assurance (as responsible person for H&S) and add Executive Committee in place of Governance Committee Replace Joint Staff Side Committee with Partnership Committee Replace Director of Occupational Health with Occupational Medicine/ Health and Wellbeing

Contents

1 Introduction

The Trust regards the promotion of health, safety and welfare at work as a mutual objective for management, workers, 'third parties' and employees at all levels. It is, therefore, the Trust's policy to do all that is reasonable and practicable to prevent personal injury, to protect everyone from foreseeable work hazards, including the public in so far as they come into contact with its premises/services and to prevent damage to property.

This document is a corporate policy for the Imperial College Healthcare NHS Trust (henceforth called the "Trust") and is in accordance with the Health and Safety at Work etc. Act 1974.

2 Purpose

2.1 General Policy Statement

The Trust so far as is reasonably practicable:

- assesses the risks to the health, safety and welfare of employees, workers, students and visitors whilst they are on its premises and maintains a record of its findings as required under the Management of Health and Safety at Work Regulations 1999;

- adopts a systematic approach to safety as described in the Healthcare Commission's Core and Developmental Standards and the NHS Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts;

- provides and maintains safe and healthy working conditions, including means of access and egress and takes account of all statutory requirements;

- provides information, operational policies and procedures, training, instruction and supervision to enable employees to perform their work safely and efficiently;

- makes available all necessary safety devices and protective equipment and provides instruction in their use;

- provides adequate welfare facilities;

- maintains a constant and continuing interest in health, safety and welfare matters consulting and involving employees or their representatives wherever possible;

- liaises with all other employers upon its sites in so far as the activities of these employers affect the health, safety and welfare of the Trust's staff, students and visitors; and, insofar as the Trust's business impacts upon the employees of those other employers

- has a planned audit programme to measure the application of the Trust's policies and procedures.

All Trust employees, students, volunteers and visiting workers have a duty while at work:

- to take reasonable care for the health and safety and welfare of themselves and of all other persons who may be affected by their acts or omissions;

- to co-operate with the Trust in ensuring all statutory and other requirements are complied with e.g. risk assessments;

- to observe the provisions of this safety policy and other policies, codes of practice etc. relating to health and safety and welfare;

- to not intentionally interfere with or misuse anything provided for health, safety or welfare.

This policy and statement together with the sub-policies, procedures and guidance describes the Imperial College Healthcare NHS Trust health and safety arrangements.

This policy is endorsed by the Imperial College Healthcare NHS Trust Board via the Chief Executive and will be subject to review on an annual basis.

Signed: …… Date: ……..

Dr Tracey Batten, Chief Executive

of Imperial College Healthcare NHS Trust

3 Duties

3.1 Duties within the Organisation – General

The Trust is a large complex organisation which works closely with its Partner Organisations.

The Chief Executive has overall statutory responsibility for managing health and safety for the Trust. The Director of Governance and Assurance has been allocated executive director responsibility by the Chief Executive for health and safety matters arising on all the Trust's sites.

Divisional and Directorate Directors and Departmental Managers are responsible for ensuring that health and safety requirements are met within their areas. In order to

discharge this responsibility they may appoint suitable, qualified individuals to act as Departmental Safety Co-ordinators, Fire Wardens, Radiation Protection Supervisors and First Aiders.

The Trust has appointed Radiation Protection Advisers to provide specific advice on matters of radiation protection and other matters relating to ionising and non-ionising radiation safety.

As required under the Management of Health and Safety at Work Regulations 1999, the Trust has reviewed the provision of competent safety assistance and has appointed a Head of Security and Safety to provide advice and assistance in-house for the fulfilment of the necessary health, safety and welfare obligations. The Trust has also appointed external Safety Consultants to assist the Head of Security and Safety to fulfil those functions.

A representative Health and Safety Committee has been established with sub-committees: Trust Radiation Safety Committee, Joint Clinical Research Safety Committee and individual Division / Directorate Safety Committees.

Health and safety and welfare issues are also addressed within clinical areas under the auspices of the Trust's Clinical Governance arrangements and these include clinical risk management and control of infection.

3.1.1 Responsibility for Health & Safety Management

3.2.1 The Chief Executive, the Director of Governance and Assurance, Medical Directors and Nurse Director

The **Chief Executive** is responsible and accountable to the Board for ensuring compliance with, so far as is reasonably practicable, Trust policies, codes of practice and local rules.

The **Director of Governance and Assurance** is responsible to the Chief Executive for day to day health and safety and welfare arrangements on all the Trust sites.

The **Medical Director** is responsible for clinical issues across the Trust.

The **Director of Nursing** has general responsibilities for ensuring the quality of nursing and midwifery care across the Trust.

The Duties and responsibilities are:

- to allocate human and physical resources to key tasks;
- to allocate financial resources as appropriate;
- to make detailed arrangements including a prioritised action plan to address issues identified;
- to adopt best practice to ensure that the objectives of the policy are met;
- to allocate clear responsibility to the relevant managers for health and safety across the whole organisation;
- to receive reports and information from senior managers and professional staff and take appropriate action.

3.2.2 Divisional and Directorate Directors and Departmental Managers

Divisional and Directorate Directors, and Departmental Managers are responsible and accountable for all health, safety and welfare matters within their areas affecting staff, workers, patients and visitors. This includes the consideration of the suitability, competence and health of staff and workers, as well as equipment and materials used, accommodation and activities. Managers have a key health and safety role within the Trust and as part of their performance reviews are assessed on their effectiveness at managing health and safety and welfare.

The duties and responsibilities are:

- to act as or appoint a member of staff as Departmental Safety Co-ordinator and where appropriate, in consultation with the Radiation Protection Adviser, a Radiation Protection Supervisor;
- to ensure that this policy and all health, safety and welfare rules and procedures are communicated, understood and implemented by their staff, students and visitors and that staff, students and visitors comply with these in their work practices;
- to undertake health and safety risk assessments of all work activities as required by the Management of Health & Safety at Work Regulations 1999;
- to identify health, safety and welfare training needs within the department, ensure that staff, workers and students receive appropriate training and monitor the effectiveness of safety training and to maintain records in the department;
- to facilitate local induction for new members of staff, workers and students, including temporary and agency staff;
- to allocate sufficient resources, including financial, to meet health, safety and welfare requirements, including the paid time for all to read and ask questions about the Health & Safety Policies and Procedures;
- to investigate, report and record all incidents and hazards in accordance with agreed procedures, taking preventative or remedial action as necessary;
- to hold and document meetings with staff, students and their safety representatives to keep them aware and informed of all developments in health, safety and welfare and to discuss and implement safety requirements in their department;
- to provide information as required to the Departmental Safety Co-ordinator, Head of Security and Safety, Safety Consultants, Safety Representatives and others as appropriate;
- to assist in the regular safety inspections of the department, and initiating action via service departments or other departments as appropriate;
- to liaise with the Estates Department and Clinical Engineering Department as necessary on the installation and usage of machinery and equipment;
- to liaise with the Head of Security and Safety and Safety Consultants on proposed developmental issues;
- to ensure that a decontamination clearance certificate is issued prior to commencement of any maintenance/service work on items of plant or equipment that have been in contact with hazardous substances or refurbishment of areas where such substances have been used;
- to ensure that a "Permit to Work" system is operated where 'dangerous processes' exist (e.g. hot work, entry into confined spaces & work involving medical gases);

- to ensure procurement of appropriate safer devices (e.g. safer needles), protective clothing and equipment and provision of instruction in their use and maintenance;
- to prepare in conjunction with the Departmental Safety Co-ordinator, Head of Security and Safety, Safety Consultants and other appropriate persons, a Departmental Health and Safety Policy, operational policies, procedures and local rules relating to health, safety and welfare in the workplace, in consultation with Health & Safety Representatives.

3.2.3 Departmental Safety Co-ordinators

Departmental Safety Co-ordinators may be appointed by Departmental Managers. Departmental Safety Co-ordinators assist the Manager to meet their health, safety and welfare responsibilities.

The duties and responsibilities are to:

- understand and apply the Trusts Health and Safety Policy, its guidelines and procedures, as well as the Departmental Health and Safety Policy;
- liaise with the Manager, Head of Security and Safety and Safety Consultants and other health & safety representatives;
- maintain a local Safety Manual (which may be electronic);
- review at regular intervals all local health and safety policies, procedures and local rules and advise the manager when changes are necessary;
- monitor plant equipment, processes, working practices, procedures and standards of housekeeping to ensure that they are safe;
- assist the manager in the preparation and review of risk assessments;
- distribute health and safety information and draw to the attention of staff and workers particular areas of relevance to work procedures;
- carry out local safety inspections and maintain records;
- monitor the selection, use, maintenance and replacement of personal protective equipment (PPE);
- refer promptly to the manager and the Head of Security and Safety any health and safety problems which cannot be resolved locally on a timescale appropriate to the risk;
- ensure that staff and workers within their areas are familiar with accident procedures, fire precautions and first aid arrangements;
- ensure that persons in charge of projects/activities are made fully aware of their responsibility for the health, safety and welfare of all staff and workers working for them and report to the managers any apparent shortfalls;
- act as display screen equipment / workstation and manual handling assessors;

- act as fire wardens.

3.2.4 Radiation Protection Supervisors

The Radiation Employer (The Trust) in consultation with local managers appoints Radiation Protection Supervisors (RPS) (See Regulation 17(4) IRR99)

The Duties and Responsibilities are:

- To supervise work within their designated area to ensure that it is carried out in accordance with the Local Rules drawn up under regulation 17(1) of the IRR99.

Reference: IRR99 Part 4 Regulation 17(1):

Local rules and radiation protection supervisors
17. (1) For the purposes of enabling work with ionising radiation to be carried on in accordance with the requirements of IRR99, every radiation employer shall, in respect of any controlled area or, where appropriate having regard to the nature of the work carried out there, any supervised area, make and set down in writing such local rules as are appropriate to the radiation risk and the nature of the operations undertaken in that area.

(2) The radiation employer shall take all reasonable steps to ensure that any local rules made pursuant to paragraph (1) and which are relevant to the work being carried out are observed.

(3) The radiation employer shall ensure that such of those rules made pursuant to paragraph (1) as are relevant are brought to the attention of those employees and other persons who may be affected by them.

(4) The radiation employer shall -

(a) appoint one or more suitable radiation protection supervisors for the purpose of securing compliance with these Regulations in respect of work carried out in any area made subject to local rules pursuant to paragraph (1); and

(b) set down in the local rules the names of such individuals so appointed

3.2.5 Employees, Contractors, Staff, Students, Volunteers and Visiting Workers

All employees and workers, students and visiting workers must take reasonable care for their own health and safety and welfare and that of others who may be affected by their activities.
The duties and responsibilities are:

- comply with all safety rules and instructions and risk assessments relating to their work;
- to attend any training relevant to their work;
- to bring to the attention of the manager any perceived training needs;
- report unsafe conditions or activities to their manager or Departmental Safety Co-ordinator so that remedial action can be initiated;
- make use of any safety measures or devices provided for the work including personal protective clothing or equipment in accordance with instruction or training given;

- not interfere with or misuse anything which is provided in the interests of health and safety and welfare;

- to co-operate with the Trust regarding its safety policy arrangements.

The Trust Work Experience Policy can be found on the Trust Intranet.

3.2.6 Contractors

All contractors working on Trust premises are expected to take reasonable care for their own health, safety and welfare and others who may be affected by their activities, and follow any instruction relating to their health and safety.

The duties and responsibilities are:

- to co-operate with the safety policy arrangements for the Trust;

- comply with any safety rules or local instructions given to them;

- not to enter areas where notices indicate entry is prohibited;

- make use of any safety measures or devices provided for the work including personal protective clothing or equipment in accordance with instruction or training given;

- not interfere with or misuse anything which is provided in the interests of health and safety;

- where contractors have control of discrete areas on or within Trust property, their own policies, codes of practice etc. will apply provided that such policies do not contradict those of the Trust;

- managers of contracts are expected to monitor the performance of contractors while on site to ensure Trust staff, students, visitors and patients are not put at risk;

- the Trust is responsible for nominating a competent CDM Co-ordinator for certain projects as required in the Construction (Design and Management) Regulations 2007.

3.3 Competent Advice

The Trust has appointed the following to provide competent advice:

3.3.1 The Head of Security and Safety

The Trust has appointed a Head of Security and Safety to provide advice on general Health and Safety and Welfare. The role is to support Trust Management and to monitor and advise on safety performance.

The Trust has also appointed Health and Safety Consultants to assist the Head of Security and Safety to fulfil those functions and the Trust to meet its health and safety and welfare obligations.

The Head of Security and Safety has a co-ordinating role in relation to general safety issues including health and safety training, review of risk assessments and audit of the Trust Safety arrangements.

The main tasks and responsibilities are:

- on a day-to-day basis to assist the Trust in ensuring, as far as is possible, that all activities comply with the necessary legislation and to advise the Director of Governance & Assurance on safety matters, so as to ensure that the Trust's procedures for caring for the health, safety and welfare of its staff and students are of the highest standard and that the health, safety and welfare of the general public is not adversely affected by the Trust's activities;

- to attend or arrange for others to attend the Health and Safety Committee, and its sub committees and follow up any recommendations made;

- to appoint a Fire Safety Manager on behalf of the Trust and ensure , training and instruction of staff, workers and students in respect of safety and fire prevention, and to keep them conscious of the problems of safety, and of their responsibility for the safety of those with whom they work and to organise evacuation exercises;

- to arrange for others to carry out audits of each department at appropriate intervals and provide a report to Departmental Managers and relevant Safety Committees;

- to obtain, where appropriate, expert external advice to ensure that the safety procedures in operation are of the highest standard;

- to act directly as adviser to managers and members of staff on safety matters and, where necessary, to obtain expert advice on their behalf;

- to investigate health and safety incidents and advise on remedial action as necessary

- to provide reports to the Health and Safety Committee regarding health and safety performance, trend analysis and benchmarking

- to liaise on behalf of the Trust with the relevant Enforcing Authorities.

The Head of Security and Safety holds a Trust wide responsibility for the coordination and management of security within the Trust. This role is supported by the local site Security Managers. For further detail please see the Security Policy and Procedures.

3.3.2 Occupational Medicine / Health and Wellbeing

The Trust has its own in-house Occupational Medicine / Health and Wellbeing Service whose role is to promote the physical and mental health, safety and welfare of employees. The service is managed by the Associate Director of Occupational Health and Wellbeing and the Consultant in Occupational Medicine. The role includes pre-employment health screening and on-going health surveillance; provision of accident and sickness monitoring, assessment of employees following long periods of absence from work and advising Trust Management accordingly. In addition, an immunisation programme and a confidential counselling service are provided.

The service provides:

- the assessment of working environments and recognition and evaluation of the physical, chemical, biological, design and psycho-social hazards to health in the workplace;

- the taking and recording of general medical histories from individuals and evaluating any implications for fitness for work;

- the assessment of the needs for health surveillance programmes and provision of relevant health information on jobs or processes to protect employees health;

- advise for management regarding the fitness of individuals for work and the suitability of working practices;

- advice on rehabilitation and help with resettlement into appropriate work;

- advice and care to employees after accidents at work (and maintaining effective data systems to monitor risks to health from accidents);

- liaison with others, e.g. Head of Security and Safety and the Health and Safety Committee, to formulate policy and examine working practices;

- development of health promotion practices to help employees and workers meet and address their health needs and assist employers' responsibilities under the Health at Work Initiative;

- the implementation of relevant health care programmes, such as an immunisation service;

- facilitation of treatment for employees and workers becoming ill or who are injured at work.

3.3.3 The Infection Prevention and Control Doctor & Infection Prevention and Control Nurses

The Trust has appointed a Director of Infection Prevention and Control (DIPC). The role is to provide advice on infection control issues such as isolation procedures, management of suspected outbreaks, disposal of waste and linen, preventing infection spread, sterilisation and disinfection.

The Infection Prevention and Control Team (IPCT) consists of the DIPC, Infection Prevention and Control Doctor (IPCD), Consultant Microbiologists, and the Infection and Prevention Control Nurses (IPCNs).

- the DIPC is responsible to the Trust's Medical Director, and takes a lead role in infection control issues and hospital epidemiology and reports directly to the Trust Board as necessary;

- the IPCNs liaise closely with the IPCD, Department of Microbiology laboratory and clinical areas. Part of their role is to provide advice to all grades of staff on infection control issues such as isolation procedures, management of 'infected' patients or suspected outbreaks, disposal of waste and linen, and decontamination of equipment;

- the IPCT also prepares policy documents and the yearly Infection Prevention and Control Annual Report;

- education is an integral part of the IPCT's role in preventing the spread of infection. Targeted surveillance and audit are also essential components of the Infection Prevention and Control Programme.

3.3.4 The Radiation Protection Adviser

The Trust has appointed Radiation Protection Advisors to provide a Radiation Protection Advice service. Their role is to provide advice on all matters relating to radiation protection and radiation safety. The role includes review of working practices involving ionising radiation, advice on accommodation and environmental requirements, on monitoring, on maintenance of records of all acquisitions and disposals of radioactive substances, and liaison with enforcement bodies.

The duties and responsibilities are to:

- assist the Divisional / Directorate Directors and Departmental Managers in drawing up local rules for radiation work
- investigate radiation incidents;
- carry out prior risk assessments on new items of radiation producing equipment and supervise or carry out the appropriate critical examinations;
- report to the appropriate manager all incidents, hazards, potential problems with the radiation work, and on any new training requirements;
- assist the Trust to comply with relevant legislation and enforcing bodies, e.g. Environment Agency and Health and Safety Executive;
- report incidents to government agencies as required by legislation;
- attend safety and radiation protection committee meetings;
- maintain the RPA accreditation on a scheme approved by the HSE.

Reference: IRR99 Schedule 5 Regulation 13(1):

MATTERS IN RESPECT OF WHICH A RADIATION PROTECTION ADVISER MUST BE CONSULTED BY A RADIATION EMPLOYER

1. The implementation of requirements as to controlled and supervised areas.

2. The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.

3. The regular calibration of equipment provided for monitoring levels of ionising radiation and the regular checking that such equipment is serviceable and correctly used.

4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.

3.3.5 Back Care and Manual Handling Adviser

The Trust has appointed a Back Care and Manual Handling Adviser to advise on manual handling issues.

The main duties and responsibilities are to:

- implement, audit, review and develop the Manual Handling and Display Screen Equipment Policies;
- assist managers to undertake workplace ergonomic assessments;
- advise the Trust on appropriate handling equipment to complement safe handling practice;
- develop appropriate codes of practice for safe handling;
- develop appropriate training programmes and deliver to Trust employees.

3.3.6 The Head of Clinical Engineering

The Head of Clinical Engineering advises Trust management on all aspects of medical equipment acquisition, operation, upkeep, replacement and disposal. The role also includes advising Trust management of its regulatory obligations and liabilities with respect to medical devices. The Head of Clinical Engineering is also responsible for the management and performance of the Clinical Engineering Department.

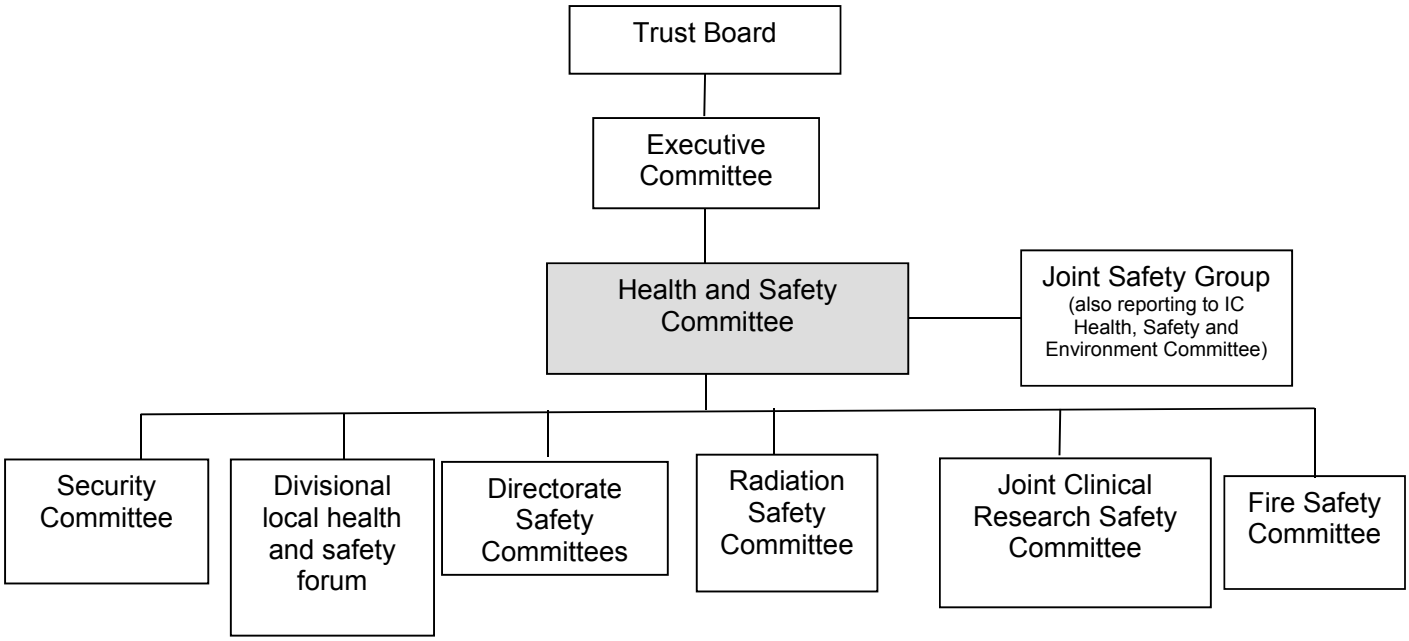
Other responsibilities include:

- assisting Divisional / Directorate Directors and Service Managers, Clinical Directors and Chiefs of Service in establishing and maintaining comprehensive plans for medical equipment acquisition, operation, upkeep and replacement;
- ensuring that programmes are in place to provide adequate training for all users of medical equipment, and that all users have ready access to instructional material and facilities;
- ensuring that all medical equipment is subject to a formal acceptance procedure which includes specification of appropriate maintenance;
- providing Quality Control of all planned maintenance and repair work whether in-house or contracted-out;
- ensuring that the Clinical Engineering staff induction, working and safety procedures are kept up to date and adhered to;
- overseeing the distribution of Medicines and Healthcare products Regulatory Agency (MHRA) Safety Notices, and ensuring that action is taken where appropriate. Clinical Engineering maintains a central register of notices received, distribution, acknowledgements and actions taken;
- ensuring that a system is in place for formally reporting incidents involving medical equipment to the MHRA, reviewing the policy, and keeping a central register of all reports;
- maintaining records of service work carried out on medical equipment;

- liaising with the Safety Office as necessary;
- obtaining advice from external specialists where appropriate.

4 Reporting Structure

The Trust Board is responsible for monitoring the Trust's system of internal control including risk management.



5 The Terms of Reference for the Health and Safety Committee (HSC)

These can be found at Appendix A.

5.1 Terms of Reference – Specialist Committees/Groups

The Terms of Reference for the specialist committees/groups are available from the Safety Office on request.

5.2 Divisional / Directorate Committees/Forum

Each Division / Directorate has its own Safety Committee/Forum. The terms of reference for individual committees should be available on the S drive in Division / Directorate folders – they are also available from the Safety Office. The committees' terms of reference must reflect the HSC terms of reference.

6 Safety Arrangements

6.1 Policies

All corporate safety policies are approved by the Health and Safety Committee and copies are found on the Trust's intranet:

http://source/safetyandsecurity/health_and_safety/policies/index.htm

http://source/source/policies/index.htm

In addition, some departments will have a local Safety Policy outlining that department's arrangements for health and safety and will require staff to follow procedures laid down in local codes of practice. Local codes of practice (COPs) are procedural documents developed within departments in consultation with involved staff and their Trades Unions H&S Representatives. Copies of COPs will be held within departmental safety folders.

6.2 Training

Training is carried out in line with the Trust training needs analysis and non-attendance is followed up in line with the Statutory and Mandatory Training Policy and Procedure. This training assists with the implementation of and compliance monitoring for the Health and Safety Policy and Procedures.

- All staff and workers receive training at Corporate induction;
- All staff and workers receive 3 yearly clinical and non clinical mandatory updates;
- Departmental Safety Coordinator/Risk Assessors receive support and training for appropriate subjects such as risk assessment, inspections etc. as a part of the DSC programme;
- Departmental/ bespoke training is available by arrangement with the Safety Office.

6.3 Safety Audits

Safety Audits are carried out by the Health and Safety Consultants on a rolling programme. Areas of concern are prioritised in terms of their level of risk. Executive Summaries are presented at the Health and Safety Committee for consideration or follow up where required. Follow-up inspections are carried out to monitor progress and implementation. Recommendations are reported back to the Committee.

6.4 Health, Safety & Management of Risk Inspections

Health, Safety & Management of Risk Inspections are carried out on a rolling programme basis. Areas of concern are identified and prioritised in terms of their seriousness of risk. Follow-up inspections are carried out to monitor progress and implementation of recommendations.

6.5 Departmental Safety Inspections and Risk Assessments

Divisional and Directorate Directors and Departmental Managers are required to ensure that areas over which they have control are inspected at six monthly intervals. The Head of Security and Safety provides a safety checklist which Departmental Heads and their Departmental Safety Co-ordinators can use to identify hazards in the workplace. Those hazards that cannot immediately be eliminated will be subject to risk assessment.

The safety checklist requires Departmental Heads to confirm that risk assessments covering substances hazardous to health, manual handling, use of display screens, use of work equipment, and all other work activities including security of staff having been subject to risk assessment.

Risk assessments are to be reviewed annually or sooner if there are any significant changes in legislation, guidance, procedures, location, personnel, etc. and after any incidents/accidents.

Those areas of high risk where control measures have not been put in place are required to be identified and a return made to the Head of Security and Safety for discussion at the Health and Safety Committee.

6.6 Accident/Incident Reporting

All accidents, incidents, near misses and violent occurrences, which occur on Trust premises, are to be reported on the Trust's accident/incident reporting systems.

Accident/incident reports are available online using 'Datix' http://source/source/resource/datix/index.htm. It is the responsibility of the Manager in whose area the accident occurred to ensure that an adequate report is made and followed up where appropriate.

Accidents/Incidents & serious incidents (SIs) involving clinical risk are reviewed under the auspices of the Trust's Clinical Governance arrangements.

The Head of Security and Safety (or an appointed deputy) reviews all other reports on Datix to determine the severity and the risk of the accident occurring again. Accidents that fall under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) are reported by the Head of Security and Safety (or an appointed deputy) on behalf of the Trust and reports via the Director of Governance and Assurance to the Executive Committee and the Trust Board.

6.7 First Aid

The Trust maintains suitable numbers of first aid personnel to deal with minor accidents and emergencies at the workplace.

These personnel have sufficient training and qualifications in accordance with statutory requirements. First Aid is available from the Accident and Emergency Department, Security and by named persons in areas which are in isolated parts of the sites.

6.8 Emergency Procedures

The Emergency Planning Committee plans for incidents which cannot be dealt with within the Trust's normal day to day activities. Emergency procedures are in place to manage external incidents by means of the Trust's Major Incident Policy, and major internal incidents by means of the Internal Disaster Recovery Plan.

Managers are responsible for ensuring that all staff within their area are familiar with these arrangements and have received suitable training. Managers are also responsible for ensuring that other people who are in their area are informed of an emergency and of the arrangements in place to handle it.

6.9 People and Organisational Development

The People and Organisational Development Directorate has overall responsibility for the organisation of the Corporate Welcome. The Safety Office provides a facilitator for the relevant sections of the session.

6.10 Estates Department

The Estates Department have a planned maintenance programme the purpose of which is to ensure that all reasonable steps are taken to maintain both premises and equipment at a high standard. It is a requirement that all equipment and premises are cleared from hazards or where this is not possible the hazards are clearly stated before work commences and a certificate provided.

6.11 Clinical Engineering Department

The Clinical Engineering Department have a planned maintenance programme the purpose of which is to ensure that all reasonable steps are taken to maintain equipment used in patient care to a high standard. It is a requirement that all equipment is cleared from hazards or where this is not possible the hazards are clearly stated before work commences and a certificate provided.

6.12 Building, Engineering or Maintenance Contractors

Where contractors have control of areas on or within Trust property, their own policies, codes of practice etc. will apply. Where there is any interface they are required to co-operate with all other employers on site as well as any statutory rules (e.g. Construction (Design & Management) Regulations), safety standards and local rules that are applicable. This stipulation will be part of the tender document. Managers of contracts (the 'Responsible Person') are expected to monitor the performance of contractors while on site to ensure the Trust's staff, students and visitors are not put at risk.

6.13 Contracted Service Providers

Contracted service providers must have their own policies, codes of practice, local rules, etc. which are complimentary to those of the Trust. In addition, contracted service providers must adhere to all the policies, codes of practice and local rules of the Trust.

6.14 Safety Representatives

Safety Representatives may be appointed by recognised Trades Union and Professional Organisations in accordance with the Safety Representatives and Safety Committees Regulations 1977 as modified by the Management of Health and Safety at Work Regulations 1992 and the Health and Safety (Consultation with Employees) Regulations 1996. Their role and functions under the regulations are recognised by the Imperial College Healthcare NHS Trust and they will be afforded the necessary time off with pay to attend any necessary courses and meetings as laid down in the Trust's Time Off for Trades Union Duties/Activities Policy. A list of currently recognised Trade Unions is maintained and updated as necessary by the Director of People and Organisational Development.

The Recognition Agreement can be found on the People and Organisational Development site on the Trust Intranet.

7 Document Development

7.1 Responsibility for Document Development

The Head of Security and Safety is responsible for the development of this document and for subsequent reviews. This policy will be reviewed annually.

7.2 Identification and Communication with Stakeholders

Imperial College Healthcare NHS Trust and its Partner Organisations – including Imperial College, London, Medical Research Council, ISS Mediclean, West London Mental Health Trust, Dominion Housing Group, Chelsea and Westminster NHS Foundation Trust and Thames Valley Housing Association. Compass Group plc and all other commercial partners. The policy is circulated to all HSC members for consultation. In turn each member circulates the policy to their constituents, such as their Divison/Directorate Safety Committees/groups and the Partnership Committee.

7.3 Equality Impact Assessment

This policy has been equality impact assessed and the findings can be found in Appendix E.

8 Approval and Ratification

8.1 Approval

This policy is approved by the Health and Safety Committee.

8.2 Ratification

This policy is ratified by the Executive Committee.

9 Dissemination and Implementation

9.1 Dissemination

This policy will be sent to all Departmental Safety Co-ordinators to be included with their local safety information. It will also be available on the Trust intranet within the Safety and Security site at:

http://source/safetyandsecurity/health_and_safety/policies/index.htm
http://source/source/policies/index.htm

9.2 Implementation of Procedural Documents

Advice and support on this Policy and procedure can be obtained from the Head of Security and Safety, Safety Consultants, Departmental Safety Co-ordinators and the Trades Union appointed Safety Representatives. The contents of the policy are discussed during corporate and local inductions and during statutory/mandatory update training.

10 Monitoring Compliance

10.1 Process for Monitoring Compliance

The process of monitoring compliance and effectiveness of this policy will be through feedback from local inspections carried out by the Departmental Safety Co-ordinators and from the Health, Safety and Management of Risk Inspections carried out by the Safety Office. A report of findings will be submitted to the Health and Safety Committee on a quarterly basis for discussion and identification of any further action. Annual reports of findings will also be submitted to the Trust Board.

10.2 Standards/Key Performance Indicators

This policy will be reviewed against the requirements outlined in the Health and Safety Executive document “Successful Health and Safety Management” HS(G) 65. A gap analysis will be produced by the Health and Safety Committee and reviewed annually thereafter. Performance

indicators will be developed by the Health and Safety Committee following the initial gap analysis. The first KPIs identified for the next three years, and which will be monitored by the Health & Safety Committee and the Executive Committee are:

- Number of Directors trained in health, safety and welfare (target 80%);
- Percentage of staff attendance at mandatory training events (target 95%);
- Percentage of staff attending 'key topic' training annually e.g. manual handling (target 95%);
- Percentage of attendees at Corporate Welcome within six weeks of appointment (target 95%);
- Attendance at and frequency of Health and Safety meetings - e.g. HSC and its sub-committees – are all areas represented at all meetings by member or their deputy (target 80%);
- Annual number of enforcement notices, convictions and fines (target 0);
- Number of RIDDOR incidents expressed as a percentage of total incidents;
- Number of Management Inspections (to monitor implementation of the Trust's Health and Safety Policy) completed by the Safety Office (target 50 per year);
- Annual notification of non-clinical claims with potential indicative costs where possible;
- Absenteeism rate (indicator of health performance).

11 References

Health and Safety at Work etc. Act, 1974, London, Stationery Office

Safety Representatives and Safety Committees Regulations 1977, London, Stationery Office

National Health Service Litigation Authority Standards for Acute Trusts, 2007, NHSLA

Management of Health & Safety at Work Regulations, 1999, London, Stationery Office

Health and Safety (Display Screen Equipment) Regulations, 1992, as amended by the Health and Safety (Miscellaneous amendments) Regulations 2002, London, Stationery Office

Manual Handling Operations Regulations, 1992, as amended by the Health and Safety (Miscellaneous amendments) Regulations, 2002, London, Stationery Office

Provision and Use of Work Equipment Regulations, 1998, London, Stationery Office

Workplace (Health, Safety and Welfare) Regulations, 1992, London, Stationery Office

Personal Protective Equipment at Work Regulations, 1992, London, Stationery Office

Control of Substances Hazardous to Health Regulations 2002 (as amended), London, Stationery Office

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013, London, Stationery Office

The Health and Safety (First Aid) Regulations 1981, London, Stationery Office

Construction (Design and Management) Regulations 2007, London, Stationery Office

Ionising Radiation Regulations 1999, London, Stationery Office

Genetically Modified Organisms (Contained Use) Regulations 2000, London, Stationery Office

Scientific Advisory Committee on Genetic Modification (SACGM) Compendium of Guidance 2007, Health and Safety Executive

Environmental Protection Act, 1990, London, Stationery Office

Successful Health and Safety Management 2013, HSG Series HS (G) 65, Health and Safety Executive

Appendix A – Health and Safety Committee (HSC) – Terms of Reference

Imperial College Healthcare NHS
NHS Trust

Health and Safety Committee
TERMS OF REFERENCE

July 2014

Executive Summary/Overview

The Imperial College Healthcare NHS Trust (ICHNT) Health and Safety Committee (HSC) is chaired by the Director of Governance and Assurance or in the absence of the Director by the Head of Security and Safety as directed. The committee reports on non-clinical safety issues to the Trust Board as appropriate. The HSC approves and monitors policies, incidents and the progress of subsequent investigations to promote the health, safety and welfare of employees and all other people affected by the work of the Trust, through consultation and communication.

The Terms of Reference for the HSC are as follows:

1 Duties

1.1 The main duties and responsibilities of the Committee are as follows:-

1.1.1. to promote co-operation between management and staff in initiating, developing and carrying out measures to ensure the health,

safety and welfare of Trust staff and all other people affected by the work of the Trust;

1.1.2. to continually monitor and review measures taken to ensure the health, safety and welfare of staff and all other people affected by the work of the Trust;

1.1.3. to consider reports provided by the Safety Consultants, the Inspectorate of the Health and Safety Executive and any other external or regulatory body and to review action plans arising from such reports;

1.1.4. to consider any matters submitted by members of the committee. Such submissions, unless urgent, are to be forwarded at least seven working days prior to the meeting;

1.1.5. to continually review safety training and communications within the Trust;

1.1.6. to identify priority areas for training and development of managers and other staff relating to safety and security functions;

1.1.7. to monitor the effectiveness of the Safety, Fire and Security Policies;

1.1.8. to monitor the effectiveness of the committee's sub-committees;

1.1.9. to review reports of accidents , fire and security incidents (provided by the Security and Safety Department) and other untoward occurrences, and to analyse reporting from Datix, and ensure appropriate action is taken to reduce such accidents and incidents;

1.1.10. to formally recommend priorities for expenditure on measures to improve health, safety and welfare, and monitor progress of the implementation of these recommendations;

1.1.11. to invite such persons as appropriate to attend HSC meetings for the purpose of providing specialist/expert advice on particular topics within their area of expertise;

1.1.12. to establish specialist sub-committees, as appropriate, to advise on specialist hazards and to determine the Terms of Reference and Membership of such committees and to receive action plans and reports from them as required;

1.1.13. as required, to make recommendations to The Chief Executive, relating to the approval of the Trust Safety Policy & Procedures and subsequent amendments as appropriate. As required, other subordinate Policies, Codes of Practice and Local Rules that inform best practice, relating to secure and safe working conditions will be made available to The Chief Executive if required;

1.1.14. to liaise and collaborate with the Safety Committees of the Trust site partners;

1.1.15. to advise on the measures necessary to comply with Fire Code and fire precautions legislation;

1.1.16. to receive reports on fire evacuation exercises, any outbreak of fire or any other fire related incident;

1.1.17. to receive reports regarding security issues that impact on the Trust and/or its staff, site partners and patients, either directly or indirectly;

1.1.18. to conduct an annual review of risk registers relating to health, safety, fire and security and record any revisions/action plans, monitoring the progress of such plans;

1.1.19. to review any risk assessment or outcomes of any safety surveys that have arisen as a result of a serious/high risk incident that may have occurred since the last HSC meeting;

1.1.20. to notify the Trust Board of any risks assessed as 'extreme'. Such risks will be included in the Trust Risk Register;

1.1.21. to approve procedural documents relating to health, safety, fire and security;

1.1.22. to develop and monitor performance against KPIs..

1.2 The Committee will receive the following direct reports:-

1.2.1. A report from each Division and Directorate sub committee

1.2.2. A report from each specialist group/sub-committee including Radiation, and Joint Clinical Research Safety Committees

1.2.3. A report from each of the Site Partner Organisations

1.2.4. A Health and Safety (general) report and Accident/Incident statistics

1.2.5. Fire (general) report and statistics

1.2.6. Security (general) report and statistics

1.2.7. Training – (general) report and statistics

1.2.8. Occupational Health report

1.2.9. Back Care and Manual Handling Team report

2 Membership

2.1 The membership will comprise of (i) competent advisors (ii) representatives of the Trust Divisions and Corporate Directorates (iii) representatives from the HSC's sub-committees and groups (iv) staff representatives and (v) Trust Site Partners.

The structure of the committee:

1. Director of Governance and Assurance (Chair)
2. Head of Security and Safety (Nominated Deputy)
3. Security Manager Operations
4. Fire Safety Manager
5. Representative from the Trust's Safety Consultants
6. Representative from the Office of the Chief Operating Officer (Emergency Planning Manager – Site Operations)
7. Representative from Estates and Facilities (Strategy)
8. Representative from People and Organisational Development
9. Representative from Governance and Assurance
10. Representative from the Medical Directorate (Clinical Governance)
11. Representative from the Nursing Directorate
12. Representative from Finance
13. Representative from Communications
14. Representative from Information Technology
15. Representative from Medicine
16. Representative from Surgery, Cancer and Cardiovascular
17. Representative from Investigative Sciences and Clinical Support
18. Representative from Women's and Children's
19. Partnership Committee two H&S Representatives
20. Representative and/or reports from each of the specialist sub committees
21. Representative from the Back Care and Manual Handling Team
22. Representative from Occupational Medicine / Health and Wellbeing
23. Representative from Statutory and Mandatory Training
24. Representatives from Site Partner Organisations (Imperial College London, MRC/CSC and ISS)
25. Chair of the Medical Device Management Group
26. Head of Estates Ops
27. Head of Legal
28. Member of Infection control team
29. Head of Stat Man Training

Other members of staff may be invited/ requested to attend as required.

3 Quorum

3.1 A quorum will consist of not less than 14 members of which at least one must be a Staff Side H&S Representative.

4 Expected Attendance

4.1 Members of the Committee are expected to attend all meetings.

4.2 If Committee members are unable to attend a meeting they are expected to send a nominated deputy.

5 Frequency of Meetings

5.1 The Committee will meet a minimum of six times per annum, unless exceptional circumstances apply.

5.2 Extraordinary meetings may be called at the request of the Chair of the Committee or in the Chair's absence, the Head of Security and Safety.

6 Authority

6.1 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, including contractor, student and volunteer with relevant responsibility and knowledge of the matter. These personnel are directed to co-operate with any lawful/reasonable request made by the Committee.

6.2 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of any person considered to possess the relevant experience and expertise to assist the committee in its deliberations.

7. Reporting to the Board

7.1 The HSC will produce an annual report that will be published on the Security and Safety Section of the Trust intranet site.

7.2 After each meeting the Executive Committee will receive an executive summary of the meeting.

8. Procedures

8.1 The role of the HSC Secretary and the Minute Secretary will be undertaken by members of the Security & Safety Department.

8.2 Any member of Trust staff including contractor, site partner, volunteer or student may raise an issue with the Chair of the HSC and/or the Head of Security & Safety by written submission. The Chair shall decide whether or not the issue shall be included in the Committee's business (it is expected that all other appropriate channels will have been explored prior to submission). The individual raising the issue may be invited to attend.

9. Terms of Reference

9.1 The HSC will review its Terms of Reference annually.

10. Monitoring the Effectiveness of the Committee

10.1 The HSC will produce annual objectives against which it will report its progress to the Trust Board.

10.2 The Trust Board is required to approve the annual objectives.

10.3 The HSC will monitor and retain records relating to delegate attendance at meetings and will provide attendance figures as part of the annual report.

APPENDIX B EQUALITY IMPACT ASSESSMENT

1.1 Title of Policy/Procedure/Function/Service **Health & Safety Policy and Procedures**	
1.2 Directorate/Department **Estates**	
1.3 Name of Person Responsible for This Equality Impact Assessment **Brian Pender**	
1.4 Date of Completion	**9/2/2014**
1.5 Aims and purpose of Policy/Procedure/Function/Service **To do all that is reasonable and practicable to prevent personal injury and damage to property and ensure compliance with Health & Safety legislation.**	
1.6 Examination of Available Evidence – Tick evidence used:	

Census Data for UK
Census Data for London
Census Data for Local Authority Area
Trust Workforce Data
National Patients Survey
Trust Patients Survey
Trust Staff Survey
Other Internal Research/Survey/Audit (list below)
Other External Research/Survey/Audit (list below)
1.7 What is the summary of the available evidence?

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

	Yes/No/ Not Enough Data	Impact is Justified
Ethnicity/Race	No	
Disability	No	
Gender/Sex	No	
Religion/Belief	No	
Sexual Orientation	No	
Age	No	
Human Rights	No	
Deprivation	No	

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

1.10 No further action required.	x

1.11 Full Equality Impact Assessment required – Please contact Equality and Impact Manager.

Imperial College Healthcare NHS
NHS Trust

The policy named below has been ratified by the Imperial College Healthcare NHS Trust Health and Safety Committee on the date stated.

Health & Safety Policy and Procedures
3RD JULY 2014

Signed:	**Signed:**
C PLUMRIDGE **DIRECTOR OF GOVERNANCE AND ASSURANCE / CHAIR, HEALTH AND SAFETY COMMITTEE**	**N NORTH** **PARTNERSHIP COMMITTEE LEAD H&S REPRESENTATIVE**

Imperial College Healthcare NHS
NHS Trust

Fire Safety Policy

Author/s:	John Jackson, Fire and Safety Manager
Contact Details:	john.jackson@imperial.nhs.uk
Date written:	11th August 2014
Version	2.1
Approved by:	Health & Safety Committee
Date Approved:	27th August 2014
Ratified by:	ExCo
Date Ratified:	1st September 2014
Date Policy becomes Live :	24th September 2014
Next due for revision:	1st September 2015
Target Audience:	Trust staff and contractors
Location of Policy:	Trust Intranet (The Source) under Policies and Procedures
Related Policies:	Emergency Planning Major Incident Plan Risk Management Strategy Risk Assessment Policy and Procedure Security Policy and Procedures Health and Safety Policy and Procedures Trust Contractors' Security Policy Statutory and Mandatory Training Policy and Procedure Estates Health and Safety Policy Lone Worker Policy and Procedures No Smoking Policy

Version Control Sheet

Version No.	Updated by	Updated on	Description of Changes
1.0	John Jackson	01/09/2008	Re-write of separate hospital policies
2.0	John Jackson	11/08/2014	Full revision of policy
2.1	John Jackson	28/08/2014	Minor changes following quality review by the Health & Safety Committee

Contents

STATEMENT OF POLICY

This document is a corporate policy for the Imperial College Healthcare NHS Trust (henceforth called the "Trust") and is in accordance with the Regulatory Reform (Fire Safety) Order 2005(1), the Health and Safety at Work etc. Act 1974(2), the Management of Health and Safety Regulations 1999(3) and the Health Technical Memorandum 05-01: Managing healthcare fire safety(4).

Application and review

- This policy applies to all staff, students, patients, volunteers, contract staff, contractors, agency, visiting workers, visitors and site partners within the Trust.
- This policy applies to all buildings occupied by the Trust.
- This policy and statement will be reviewed on an annual basis.

The Trust regards the promotion of health, safety and welfare at work as a mutual objective for management and employees at all levels.

Fire Safety Management is seen as an integral part of that objective.

It is, therefore, the Trust's policy to do all that is reasonable and practicable to prevent personal injury and damage to property, and to protect everyone from foreseeable work hazards, including the public, where they come into contact with its premises or services.

The Trust as far as is reasonably practical:

- Assesses the risks from fire with regard to the health, safety and welfare of employees, students, visitors and patients whilst they are on its premises and maintains a record of its findings as required under the Regulatory Reform (Fire Safety) Order 2005[1] and the Management of Health and Safety at Work Regulations 1999[3]
- Adopts a systematic approach to fire safety. This includes following the Firecode[5] suite of documents published by the Department of Health which provide guidance and set objectives whereby risks are eliminated or minimised by the correct selection and design of facilities, equipment and processes
- Provides and maintains safe and healthy working conditions, adequate fire prevention arrangements, safe means of access and egress and takes account of all statutory requirements
- Provides information, operational policies and procedures, training, instruction and supervision to enable employees to perform their work safely and efficiently
- Maintains suitable and sufficient records of training and of testing and maintenance of fire safety systems
- Makes available all necessary fire safety devices and fire fighting equipment and provides instruction in their use

[1] (Regulatory Reform, 2005)
[2] (Health & Safety Executive, 1974)
[3] (Health & Safety Executive, 1999)
[4] (Department of Health, 2013)
[5] (Department of Health, 2013)

- Provides and maintains suitable reference building plans showing relevant fire safety arrangements
- Maintains a constant and continuing interest in fire safety matters by consulting and involving employees or their representatives wherever possible
- Liaises with facilities management providers and all site partners upon its sites where the activities of these employers affect the fire safety of the Trust's staff, students visitors and patients; and where the activities of the Trust may affect the activities of the other employers
- Audits the application of the Trust's policies and procedures

All persons working on Trust premises

All staff, students, volunteers, contract staff, contractors, agency, visiting workers, visitors and site partners within Imperial College Healthcare NHS Trust have a duty while at work on the Trust's sites:

- to take reasonable care for the health and safety of themselves and of all other persons who may be affected by their acts or omissions
- to co-operate with the Trust in ensuring all statutory and other requirements are complied with
- to observe the provisions of this Fire Safety Policy and other policies, codes of practice etc. relating to fire, health and safety
- to not intentionally interfere with or misuse anything provided for fire safety

This policy and statement together with the sub-policies, procedures and guidance approved from time to time by the Health & Safety Committee who reports to the Governance Committee and published via the Trust's systems describe the Imperial College Healthcare NHS Trust Fire Safety arrangements.

The Imperial College Healthcare NHS Trust Board endorses this policy.

Signed: **Date:**

(Chief Executive Officer)

(Director of Strategy)

1. Introduction

Fire in Hospitals

1.1. A fire in a hospital can have catastrophic consequences causing death and injury, widespread damage to buildings and disruption of hospital services. It is vitally important that all possible measures are taken to prevent fires and where a fire does occur, that its effects are minimised by early detection and from rapid and effective response by staff.

1.2. Business continuity can be seriously affected by any significant fire and the Trust strives to have arrangements in place to ensure that services to patients, staff and the public are maintained.

Definition of a major fire incident

1.3. The definition of a major fire incident is when one or more areas are being affected by fire/smoke, or where wards or departments have to be evacuated.

Application

1.4. This Fire Policy applies to all staff in premises of the Trust.

1.5. The Trust has undertaken to ensure that all statutory requirements relating to fire precautions and fire safety are observed on the sites for which they are responsible. The main statutory provisions are to be found in the Regulatory Reform (Fire Safety) Order 2005[(6)] and the Health and Safety at Work etc. Act 1974.[(7)]

1.6. The Trust also undertakes to comply with the guidance given in the Firecode suite of documents as required by the Secretary of State for the Department of Health.

Relationship with other policies and procedures

1.7. This policy has been written to reflect the requirements of national legislation and the Health Technical Memorandum 05-01: Managing healthcare fire safety[(8)].

1.8. This policy should also be read in conjunction with other Trust relevant policies. The following is a non-exhaustive list:

- Health & Safety Policy
- Risk Management Strategy
- Security Policy
- Risk Assessment Policy
- No-smoking Policy
- Major Incident Policy
- Business Continuity

[6] (Regulatory Reform, 2005)
[7] (Health & Safety Executive, 1974)
[8] (Department of Health, 2013)

- Training Policy

Fire Risk Assessments

1.9. It is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005[6] and Department of Health Firecode[9] that Fire Risk assessments are carried out for all areas and for the building as a whole.

1.10. The risk assessments identify the management systems and physical fire precautions within the hospital which must be maintained, in addition to requirements for fire systems maintenance and staff training.

1.11. Fire risk assessments are completed or existing ones amended where there are any new building works or refurbishments. Building plans associated with the fire risk assessment process must be kept up to date.

1.12. It is also a requirement of the Department of Health Firecode[9] that such Assessments are completed. This is carried out by a Fire Safety Advisor on an annual rolling programme.

1.13. Copies of fire risk assessments are held:

- by the Estates Operations department - complete portfolio of all areas assessed
- by each department or ward for their local records - record relevant to that area only
- by the Fire and Safety Manager - complete portfolio of all areas assessed

1.14. The Fire Authorities have the right to come and inspect such assessments at any reasonable time or in the event of any fire related incident.

2. Fire Prevention

General

2.1. The Chief Executive has overall statutory responsibility for managing Fire Safety for the Imperial College Healthcare NHS Trust. The Director of Strategy has been delegated responsibility by the Chief Executive for fire safety matters arising within the Trust.

2.2. Heads of Divisions and General Managers (Divisions) are responsible for ensuring that fire and safety requirements are met within the areas which they manage. In order to discharge this responsibility they should appoint one or more Fire Wardens and ensure there is at least

[9] (Department of Health, 2013)

one such fire warden on duty at all times that the department or ward is occupied, as appropriate.

2.3. As required under the Management of Health and Safety at Work Regulations 1999[10] and the Regulatory Reform (Fire Safety) Order 2005[6] the Trust has reviewed the provision of competent advice and ensured there are measures in place to provide assistance to meet the necessary fire safety obligations. This may be provided by directly employed staff, consultants or a mixture as appropriate.

2.4. A Health & Safety Committee has been established which considers fire safety matters. This Committee reports to the Governance Committee which in turn reports directly to the Trust Board. These committees, and others that are formed as appropriate, have been established to facilitate consultation on all fire safety matters.

Responsibility for Fire Safety

The Chief Executive Officer, Director of Nursing and Medical Director

2.5. The Chief Executive is responsible and accountable to the Board for ensuring, so far as is reasonably practicable, that Trust Policies, Codes of Practice and operational procedures are complied with.

2.6. The Director of Nursing has general responsibilities for ensuring the quality of nursing and midwifery care across the Trust and their staff's completion of training in fire safety

2.7. The Medical Director is responsible for clinical issues across the Trust and for liaising with others to ensure that fire safety is taken into account with regard to patient safety.

2.8. The Board's duties and responsibilities are:

- To appoint a Board level director to take formal responsibility for fire safety. Fire Safety Structure Appendix A
- To ensure there is access to a competent Fire Safety Manager
- To allocate human and physical resources to key fire safety tasks
- To allocate financial resources as appropriate
- To make detailed arrangements for a prioritised Fire safety action plan as part of a corporate risk register
- To adopt best practice to ensure that the objectives of this policy are met
- To allocate clear responsibility to relevant managers for fire safety across the whole organisation
- To receive reports and information from senior managers and professional staff and take appropriate action
- The Trust to appoint a Fire Safety Committee to monitor arrangements for Fire Safety Appendix B.

[10] (Health & Safety Executive, 1999)

Executive Directors and Department & Ward Managers

2.9. Executive Directors and Department & Ward Managers are responsible and accountable for all fire safety matters within their areas affecting staff, patients and visitors.

2.10. This includes ensuring the suitability, competence and training of staff and that all equipment and materials used for their activities are fit for purpose. Managers have a key fire safety role within the Trust and as part of their performance reviews should be assessed on their effectiveness at managing fire safety. They must be aware that prior to the Fire Brigade taking control, and in the event of a need to evacuate, they are the responsible person until the Trust's emergency planning procedures are formally deployed.

2.11. Those duties and responsibilities are:

- To act as or appoint sufficient appropriate members of departmental staff as Fire Wardens
- To ensure that this policy and all fire safety rules and procedures are communicated, understood and implemented by their staff, students and visitors and that staff, students and visitors comply with these in their work practices
- To assist the Fire and Safety Manager or representative to undertake fire risk assessments as required by the Regulatory Reform (Fire Safety) Order 2005[6]
- To identify fire safety training needs within the department, to ensure that appropriate training is provided, to monitor the effectiveness of the training, and to maintain records in the department
- To facilitate local induction for new members of staff, including temporary and agency staff
- To allocate sufficient resources, human, material and financial, to meet fire safety requirements
- To investigate, report and record all incidents and hazards in accordance with agreed procedures, taking preventative or remedial action as necessary
- To undertake regular safety inspections of the department, and initiating action through service departments or other departments as appropriate
- To liaise with the Estates Operations department, Fire and Safety Manager and Partner Contractors as necessary on the installation of new machinery, particularly where that equipment may have a fire safety implication
- To consult with staff, students and their safety representatives to keep them aware and informed of all developments in fire safety and to discuss and implement fire safety requirements in their department
- To ensure that flammable and combustible materials are kept to a minimum, correctly stored and staff are trained in their use

- To liaise with the Estates Operations Department to ensure that a "Permit to Work" system is operated where 'dangerous processes' exist (e.g. hot work & work involving medical gases)
- To provide information as required to the Fire Wardens, Safety Office, Safety Representatives and others as appropriate
- To prepare in conjunction with the Fire Wardens, Fire and Safety Manager, Safety Office and other appropriate persons, a departmental Emergency Plan, operational policies and procedures relating to fire safety in the workplace
- To ensure that persons in charge of projects/activities are made fully aware of their responsibility for the fire safety of all staff working for them and report to the managers any apparent shortfalls

Fire and Safety Manager and Fire Safety Advisors

2.12. The Director of Strategy has been delegated as having formal responsibility at Board level for fire safety within the Trust.

2.13. The Director of Strategy in turn delegates responsibility to the Director of Estates & Facilities.

2.14. The Fire and Safety Manager has been appointed in accordance with Firecode and the Regulatory Reform (Fire Safety) Order 2005(6)

2.15. The responsibilities of the Fire and Safety Manager are:

- To have an awareness of all fire safety features and their purpose
- To have knowledge of the fire safety risks particular to the organisation
- To be aware of requirements for disabled staff and patients (related to fire procedures)
- To ensure appropriate levels of management are always available
- To ensure decisions can be made regardless of the time of day ensuring compliance with legislation
- To develop and implement the organisation's fire safety policy
- To develop an effective training programme
- To cooperate between site partners on fire safety management where two or more share the same premises
- To report fire incidents in accordance with current practice
- To monitor and mitigate unwanted fire incidents
- To liaise with enforcing authorities
- To liaise with other managers
- To monitor, inspect and maintain fire safety systems.

2.16. It is intended that the Fire Safety Advisors should be capable of assisting and provide technical expertise to the Fire and Safety Manager in their discharge of his/her role and responsibilities.

2.17. The Fire Safety Advisors are responsible for the following:

- Providing expert advice on the application and interpretation of fire legislation and fire safety guidance, including Firecode
- Advising on the content of the organisation's Fire Safety Policy
- Helping with the development of a suitable training programme, including delivery of the training
- Liaising with enforcing authorities on technical issues
- Liaising with managers and staff on fire safety issues
- Liaising with the other competent professional specialists

Fire Wardens

2.18. Fire Wardens are appointed by Department Managers. Fire Wardens assist the Manager to meet their fire safety responsibilities.

2.19. The duties and responsibilities are:

- To inform and liaise with the manager to identify training needs, organise training where appropriate, and maintain training records within the department
- To ensure that members of staff, long term visitors and visiting employees are aware of the location of break glass alarm points, extinguishers and fire exits
- To know precisely what to do in the event of a fire in his/her area of responsibility
- To be responsible, on a day-to-day basis, for the maintenance of fire precautions in their area of responsibility
- To keep the Fire and Safety Manager informed of any developments in their area(s) of responsibility that might affect fire precautions
- To maintain any local Emergency Plan, and other related policies
- To monitor plant equipment, processes, working practices, procedures and standards of housekeeping to ensure that they are safe
- To distribute fire safety information and draw to the attention of staff particular areas of relevance to work procedures
- To carry out local safety inspections and maintain records
- To refer promptly to their Manager and the Fire and Safety Manager, any fire safety problems which cannot be resolved locally on a timescale appropriate to the risk
- To attend refresher training every three years

Employees

2.20. All employees and others with a contractual arrangement with the Trust must take reasonable care for their own health and safety including fire safety, and that of others who may be affected by their activities.

2.21. The duties and responsibilities are:

- To comply with all safety policies and operational procedures relating to their work
- To attend any training relevant to their work
- To bring any need for training to the attention of the manager
- To comply with any existing risk assessments, and to bring to the notice of their manager any hazard not already covered in the risk assessment procedure
- To report unsafe conditions or activities to their manager or safety supervisor so that remedial action can be carried out
- To make use of any fire safety measures or devices provided in accordance with instruction or training given
- Not to interfere with or misuse anything which is provided in the interests of fire safety

Young Persons

2.22. Young persons will be subject to a specific Trust Health & Safety risk assessment that incorporates fire safety.

2.23. Young persons in the Trust, excluding patients and patient visitors, will typically include:

- Nursing & healthcare students
- Work experience students
- Students on “Observation days”
- School parties
- Children at various organised functions

2.24. Young persons are subject to the Trust’s health and safety risk assessment process that includes fire safety. Young person’s working for or studying in the Trust will normally be supervised until they are deemed by their managers or tutors to be competent.

Patients and Visitors

2.25. All patients and visitors are expected to take reasonable care for their own health and safety and that of others who may be affected by their activities, and follow any instruction or information provided. Where appropriate patients, or their representatives will be given relevant information on admittance to hospital.

2.26. All patients and visitors are expected to:

- Comply with any fire safety rules or instructions given to them
- Not enter any area where a notice indicates entry is prohibited
- Not interfere with or misuse anything which is provided in the interests of fire safety

Contractors

2.27. All contractors working on the Trust premises are expected to take reasonable care for their own fire safety and that of others who may be

affected by their activities, and follow any instruction relating to their health and safety, including fire.

2.28. Contractors working on Trust premises will be required to liaise and co-operate with all other employers on site and comply with all statutory rules and other safety standards as well as any local fire procedures which are applicable. This stipulation will be part of the tender document.

2.29. Where contractors have control of discrete areas on or within Trust property, their own Policies, Codes of Practice etc. may apply.

2.30. Managers of Contracts are expected to monitor the performance of contractors while on site to ensure Trust staff, students, visitors and patients are not put at risk. The Trust is responsible for nominating a competent CDM Co-ordinator for certain projects as required in the Construction (Design and Management) Regulations 2007(11)

Estates & Facilities Management

2.31. The Trust and the Estates & Facilities Department will undertake to liaise closely to ensure that all aspects of fire safety are met. This includes general fire precautions, maintenance to current standards, response to alarms and training needs with in-house contractors.

Head of Estates Operations

2.32. The Head of Estates Operations is responsible for the maintenance of all physical fire systems which fall under the direct control of the Trust in accordance with legislation, British Standards, Firecode and other relevant guidance.

2.33. The duties and responsibilities are:

- to understand and apply the Trust's Fire Safety Policy, its guidelines and procedures, as well as the departmental Emergency Plan;
- to liaise with the Fire and Safety Manager and other health and safety representatives.
- to liaise with representatives for those areas managed by the Estates & Facilities Department.

2.34. All fire systems are serviced & maintained by the Estates Operations Department, dependant on locality, and records are maintained by the department. These systems include:

- Fire Alarm System – in accordance with British Standards series BS 5839 (12) and Firecode
- Emergency Lighting – in accordance with British Standards series BS 5266(13) and Health Technical Memorandum series HTM-06(14)

[11] (Health & Safety Executive, 2007)
[12] (British Standards Institution, 2013)

- Fire Extinguishers & Hose reels – in accordance with British Standards BS EN3-7[15] & BS 5306
- Emergency Power – in accordance with HTM-06[14]
- Electrical Supply Installation HTM-06[14]
- Portable Appliance Testing (PAT)
- Fire Doors
- Fire Dampers & Ventilation Systems
- Lightning Protection

2.35. All plans for major refurbishment or any new building must be approved by the Building Control office of the Local Authority, or Approved Inspector. The Estates & Facilities Directorate liaises with local authorities in this respect on behalf of the Trust. Where such work will affect, or is originated by the Trust or a Partner Contractor then full consultation must take place and suitable records maintained.

2.36. Liaison also takes places with the London Fire & Emergency Planning Authority where necessary.

Fire Response Team (FRT)

2.37. The Trust has a number of nominated staff who act as a Fire Response Team.

2.38. The Senior Security Officer on duty leads the Fire Response Team and is the person in charge at any fire alarm activation.

2.39. They will be supported by other Security officers and, during “normal” office hours, Estates Operations staff, and where appropriate a representative of the Trust.

2.40. In the event of a fire alarm, the duties and responsibilities of the FRT are:

- To respond to fire alarm notifications
- To attend the scene of the alarm and investigate further as necessary
- To liaise with local staff and the Fire Brigade as appropriate
- To assist and liaise with the Fire Brigade on its arrival
- To be the initial controller of the situation, until the arrival of a Fire Brigade Officer
- To determine if there is a fire of significant size, and to contact the Switchboard to call Senior Management
- To understand and apply the Trust’s Fire Safety Policy, its guidelines and procedures
- To liaise with the Fire and Safety Manager and other Health & Safety Representatives

[13] (British Standards Institution, various)
[14] (Department of Health, 2006)
[15] (British Standards Institution, various)

- To provide the Fire Brigade with information e.g. fire & safety systems; utilities & environmental systems; hazardous contents of the affected area and information regarding valuable or specialist equipment (e.g. MRI scanners)

Training

2.41. It is mandatory that every member of staff attends an appropriate Fire Training Course on a regular basis (annually).

2.42. The frequency of the training will vary according to the person's role and is identified by means of a Training Needs Analysis. Training will be provided to all levels of staff on a regular basis and will include induction training, appropriate refresher training and specialist training to relevant groups, e.g. Fire Response Team, Fire Wardens, estates operations staff, critical care units etc.

2.43. Training is facilitated by the Health and Safety Department and records of attendees are kept. Reports are provided as appropriate to relevant committees and groups.

2.44. If e-Learning is used it must be stressed that this is not normally accepted as the only means of training; other training will also be required in order to monitor compliance.

2.45. It is the responsibility of Managers to ensure that they and their staff comply, and that a record of attendance is maintained.

2.46. Fire Safety training should comply with the Imperial College Healthcare NHS Trust Training Policy.

Fire Brigade Attendance

2.47. At St Mary's, Western Eye, Charing Cross and Hammersmith and Queen Charlotte's Hospitals the Fire Response Team carry out an initial response and call the Fire Brigade only on confirmed or suspected fire.

Evacuation Plans

2.48. The Trust has systems in place for Evacuation Planning and Business Continuity.

2.49. Local Evacuation Plans give details about the evacuation strategy for each area, depending upon factors as building type, occupancy, patient numbers etc.

2.50. These plans normally include reference as appropriate to:

- evacuation of the occupants of the area or building
- refuges and places of relative safety
- use of lifts
- communications during the evacuation process
- how persons are accounted for

- arrangements for the mobility impaired
- re-occupation of the affected area.

2.51. These plans will differ from area to area but are intended to give guidance to ensure that all persons are included in identifying suitable means of escape.

2.52. All members of staff should make themselves aware of the emergency plan for the area where they work.

General Fire Precautions

2.53. Routine fire precautions are critical to ensure the risk of fire starting is kept as low as possible.

2.54. All members of staff have a responsibility to reduce the risk of fire starting and to maintain general fire precautions.

2.55. General fire precautions will be audited each year as part of the Annual Fire, Risk Assessment programme. A summary fire safety audit report will be submitted to the Trust's Health & Safety Committee

2.56. Further guidance is given in Fire Guidance Notes(16)

3. Fire Alarms and Evacuation

Fire Alarm System

3.1. Fire alarm systems are provided in all Trust managed buildings. These systems are designed and maintained to current standards and records kept of such maintenance with the Estates & Facilities Management team.

3.2. Further information about what action to take in the event of actual or suspected fire is contained in Fire Guidance Notes(16) with the Estates & Facilities Management team.

Progressive Horizontal Evacuation & Local Emergency Plans

3.3. The Trust deploys a technique known as Progressive Horizontal Evacuation. This would involve the movement of staff and patients horizontally to the next fire compartment. There could be vertical evacuation from the building if required.

Reporting of fires to the Department of Health

3.4. It is a requirement to report all actual fires to which the fire brigade have been called to the Department of Health.

3.5. Fires involving death, injury, large-scale evacuation or large-scale damage are reported immediately via telephone or email.

[16] (Department for Communities and Local Government, 2012)

3.6. Fires involving death or injury must also be reported to the Health & Safety Executive under the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR)[17]

4. Fire-fighting Equipment

Fire Equipment

4.1. Fire fighting equipment is available throughout the Trust for use by persons who have been trained in its use.

4.2. This equipment consists of fire extinguishers, fire blankets with some hose reels. In addition there are fire hydrants and dry rising mains for use by the fire brigade.

4.3. It is the responsibility of all staff not to interfere with or obstruct any fire fighting equipment. Any identified problems must be reported to the Estates Operations Department as soon as possible.

5. Procurement

Furniture and Textiles

5.1. All furniture & textiles bought officially must comply with furniture fire safety regulations and codes of practice, e.g. Health Technical Memorandum 05-03 Part C: Textile and furnishings[18]

5.2. Any furniture that is offered to or donated to the organisation by third parties must be checked that for compliance with current regulations. Advice on this matter may be obtained from the Safety Office.

5.3. In addition no furniture or fittings should be brought from home without first obtaining approval. Advice may be sought from the Safety Office.

Electrical Equipment

5.4. All electrical equipment that is brought into the Trust, either through the normal supplies channels or through any other route, e.g. donation, must be suitable for the purpose it is to be used for.

5.5. In addition all electrical equipment must be portable appliance tested for electrical safety before it is first put into use.

5.6. Portable electrical equipment is subject to regular inspection known as Portable Appliance Testing (PAT). Refer to the Trust Portable

[17] (Health & Safety Executive, 2013)
[18] (Department of Health, 2007)

Appliance Testing Policy and Procedure[19] for appliance testing frequencies.

6. Monitoring and Review

6.1. This Policy will be monitored and reviewed as part of the annual fire safety audit and changes made. Any changes deemed necessary at any other time will be incorporated as appropriate.

7. Document Development

7.1. The Fire and Safety Manager or nominated deputy will be responsible for the development, implementation, review and upkeep of this document.

7.2. The Health and Safety Committee is responsible for identifying and communicating with stakeholders.

7.3. All public bodies have a statutory duty under equality legislation covering race, disability and gender to undertake equality impact assessments on all policies/guidelines and practices. The Trust equality impact assessment tool also includes religion/belief, sexual orientation, age, deprivation and human rights.

7.4. An Equality Impact Assessment (EIA) has been carried out on this policy and the results are shown in Appendix C.

8. Approval and Ratification

8.1. This policy has been approved by the Health and Safety Committee

8.2. This policy has been ratified by ExCo.

9. Dissemination and Implementation

9.1. This policy document will be available on the Trust's Intranet and copies will also be distributed to all staff in the Estates & Facilities Directorate and other relevant Trust staff and contractors.

9.2. Staff training on the implications and requirements of this policy will be undertaken as required.

[19] (Imperial College Healthcare NHS Trust, 2013)

10. Document Control

10.1. The author of the procedural document is responsible for updating documents onto the appropriate site on the Trust's intranet.

10.2. Each author has an account and can only publish according to the security on each account. Where there is no active author the web team can load new documents or change existing documents where required.

10.3. A register/library of procedural documents and the library of Clinical Guidelines is maintained on the Intranet. Ownership of the original procedure document (together with supporting documents such as the Dissemination Plan) will remain with the author/s. Members of staff will be trained locally to upload documents on to the Intranet. Where no local member of staff has been trained, the communications team will upload documents.

11. Monitoring Compliance

11.1. The table below outlines the Trust's monitoring arrangements for this policy

Table 1: Compliance monitoring activities for Fire Policy

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring and receipt of findings/reports	Frequency of the monitoring activity	Group/ individual responsible for ensuring that actions are completed
Operations and maintenance of Fire Alarm system BS 5839 Emergency Lighting BS 5266 Fire Fighting Equipment BS 5306 accordance with statutory, mandatory requirements	Estates Department Weekly, Monthly Quarterly and yearly Management Review Meetings	Professional Estates Managers Fire and safety Manager	Annual	Professional Director of Estates and Facilities, Head of Estates Operations and various professional Trust Groups.
Management Review Meetings	Manager	Professional Estates Managers Fire and Safety	Annual	Director and Head of Operations Estates

12. References

- British Standards Institution, 2013. *BS 5839-1:2013 Fire detection and fire alarm systems for buildings. Code of practice for design, installation, commissioning and maintenance of systems in non-domestic premises.* UK: BSI.
- British Standards Institution, various. *BS 5266 series: emergency lighting.* UK: BSI.
- British Standards Institution, various. *BS 5306 series: fire protection.* UK: BSI.
- Department for Communities and Local Government, 2012. *Fire safety law and guidance documents for business.* [Online]
  Available at: https://www.gov.uk/government/collections/fire-safety-law-and-guidance-documents-for-business
- Department of Health, 2006. *HTM06: electrical services series.* UK: DoH.
- Department of Health, 2007. *Firecode HTM 05-03:Part C -Textiles & finishings.* UK: DoH.
- Department of Health, 2013. *Fire safety 05-01: Managing healthcare fire safety.* Second edition ed. UK: DoH.
- Department of Health, 2013. *HTM05: fire safety series.* UK: DoH.
- Health & Safety Executive, 1974. *(The) Health & Safety at Work Act.* UK: HMSO.
- Health & Safety Executive, 1999. *Management of Health & Safety Regulations 1999.* UK: HMSO.
- Health & Safety Executive, 2007. *Construction (Design and Management) Regulations 2007.* UK: HSE.
- Health & Safety Executive, 2013. *RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.* UK: HMSO.
- Imperial College Healthcare NHS Trust, 2013. *Portable Applicance Testing(PAT) Policy*
- Regulatory Reform, 2005. *Fire Safety Order.* ed. UK:

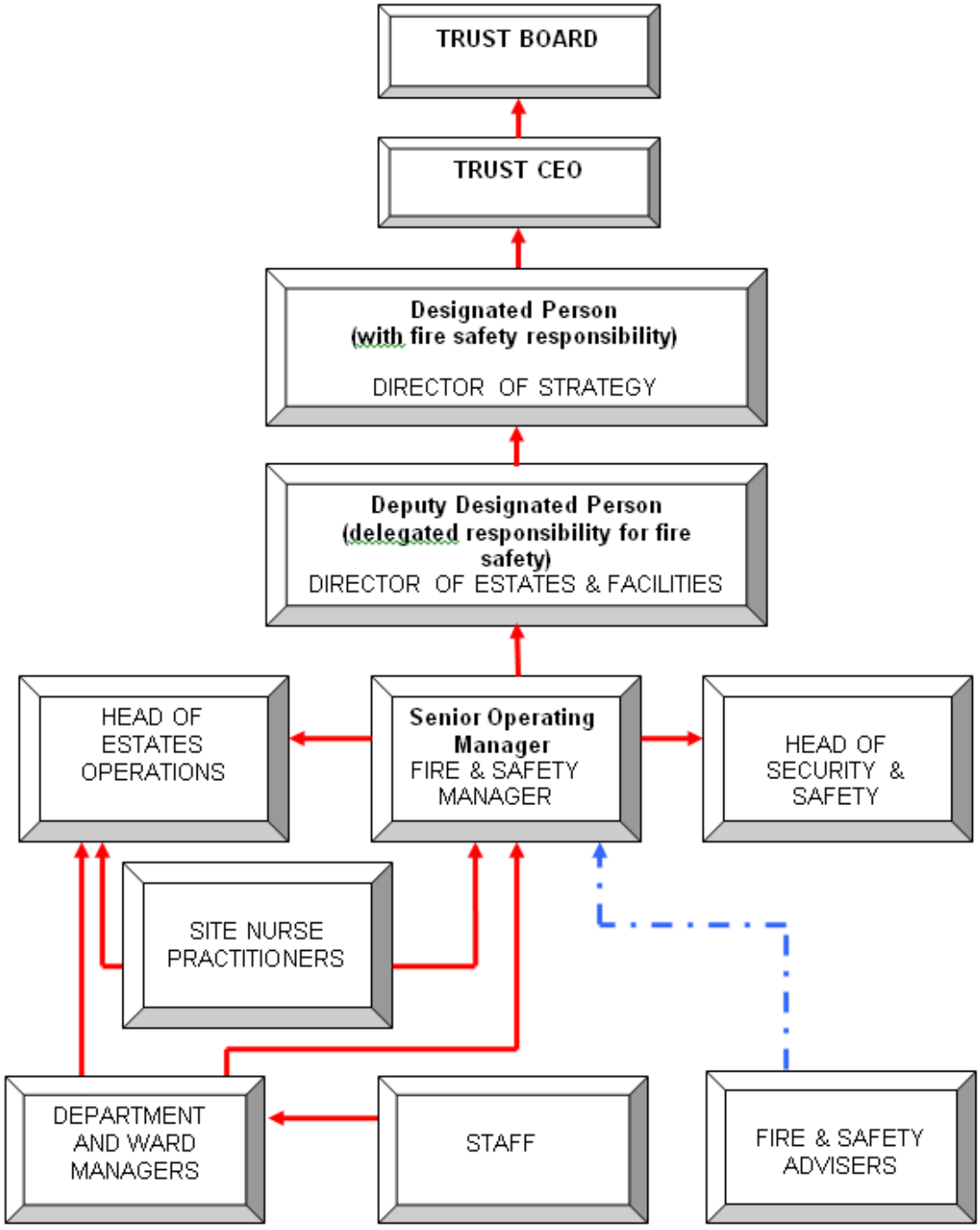
13. Appendices

13.1. Appendix A: Fire Safety Structure

13.2. Appendix B: Fire Safety Committee Terms of Reference

13.3. Appendix C: Quality Impact Assessment for Fire Policy

Appendix A: Fire Safety Structure



Appendix B: Fire Safety Committee Terms of Reference

FIRE SAFETY COMMITTEE

TERMS OF REFERENCE

September 2014

1. Duties

1.1. The Imperial College Healthcare NHS Trust (henceforth called the "Trust") Fire Safety Committee is a group of professional Fire Safety, Health and Safety and Allied professionals. The Trust Fire Safety Committee is therefore constituted to act as a forum for Fire Safety leads from the Trust, with representation from Imperial College and other allied professionals for network sharing discussion, information, best practice, advice, learning and assistance to other group's members. This includes commissioning and provider organisations.

1.2. To gain knowledge through the sharing of best practice and learning.

1.3. To discuss national standards, directives or applicable legislation and where possible identify and agree common principles on approach.

1.4. To receive presentations from other bodies such as the National Patient Safety Agency (NPSA); NHS Litigation Authority (NHSLA); Department of Health (DH); Health and Safety Executive (HSE); NHS Counter Fraud and Security Management Service (CFSMS); London Fire Brigade (LFB).

1.5. To work with bodies external to the NHS in project management where there is a benefit to the Trust.

1.6. To identify and discuss changes or further information that affects the Trust e.g. Regulatory Reform (Fire Safety) Order 2005, NHS Firecode.

1.7. To discuss and review the Trust Fire Risk Assessments and actions arising from them.

1.8. To identify and advise on fire training needs.

1.9. The Trust's Fire Safety Committee's main aim will be to provide assurance and recommendations to the HSFSC regarding the Trust's compliance with relevant fire safety legislation.

2. Membership

2.1. The Fire Safety Committee will comprise the following:-

- Head of Security and Safety (Chair)
- Fire and Safety Manager (Deputy)
- Head of Estates Operations (Deputy)

Imperial College Healthcare NHS Trust staff, Imperial College staff responsible for:

- Risk Management
- Health & Safety
- Fire
- Security
- Estates
- Allied Professionals
- Nursing
- Site Operations

In Attendance

- As applicable

By Invitation (if applicable):

- The members will have the option to invite specified persons to attend meetings where specialised knowledge, experience or skill is necessary for the terms under discussion.

3. Quorum

3.1. The quorum for meetings will be 5 Members.

4. Expected Attendance (75% of meetings)

4.1. Members are expected to attend all meetings or send a nominated deputy when they cannot attend.

5. Frequency of Meetings

5.1. Meetings of the Fire Safety Committee will be held at least every 3 months.

5.2. An emergency meeting may be called by any two members where an urgent issue is identified and requires immediate action.

6. Authority

6.1. The Committee is authorised by the Health & Safety Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or worker with relevant responsibility and knowledge of the matter and all employees and workers are directed to co-operate with any lawful request made by the Committee.

6.2. The Committee is authorised by the Health & Safety Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Reporting (to Board/High Level Committees)

7.1. The Committee reports to the Health & Safety Committee after each meeting. The reports will include:

- actions arising from Fire Risk Assessments
- inspections
- audits

- training
- fire incidents – e.g. actual fires, and unwanted fire signals

8. Procedures

8.1. The Fire Safety Committee will normally issue an agenda for each meeting at least one week in advance to enable members to identify issues requiring discussion or consultation prior to the meeting.

8.2. The agenda will include the following standing items:

- Fire Risk Assessments
- Inspections and audits
- Training
- Fire incidents
- Members Exchange

8.3. Normally the minutes will be issued within 4 weeks of the meeting.

9. Review of Terms of Reference

9.1 The terms of reference will be reviewed annually.

10. Effectiveness of the Committee

10.1. The Committee will prepare an annual report for presentation to the Health & Safety Committee.

10.2. The Committee will produce annual objectives against which it will report its progress to the Health & Safety Committee.

These will include:

- Progress on actions arising from Fire Risk Assessments
- Progress on actions arising from internal/external inspections
- Increase attendance at fire training
- Reduction in unwanted fire signals

10.3. The Health & Safety Committee is required to approve the annual objectives.

Appendix C: Equality Impact Assessment

Equality Impact Screening

1.1 Title of Policy Fire Policy		
1.2 Directorate/Department Estates and Facilities		
1.3 Name of Person Responsible for This Equality Impact Assessment John Jackson – Fire and Safety Manager		
1.4 Date of Completion	1/09/2014	
1.5 Aims and purpose of Policy To ensure a safe environment for patients, staff, contractors, visitors and students and comply with statutory legislation.		
1.6 Examination of Available Evidence – Tick evidence used:		
Census Data for UK		x
Census Data for London		x
Census Data for Local Authority Area		x
Trust Workforce Data		
National Patients Survey		
Trust Patients Survey		
Trust Staff Survey		
Other Internal Research/Survey/Audit The London fire and Emergency Planning Authority Audits.		
Other External Research/Survey/Audit Incident Statistics.		

1.7 What is the summary of the available evidence?

The policy is applicable all staff and all areas of the ICHT's estate and as such there does not appear be any significant impact arising from the implementation of this policy to any particular group.

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

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

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

1.10 No further action required. ☒

1.11 Full Equality Impact Assessment required – Please contact Paul Carswell, Equality Impact Manager. ☐

5 Monitoring Arrangements

This Policy will be monitored for equality impact when the Policy is next reviewed or updated.

6 Other Notes/Comments

N/A

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	3.4
Title	Standing Order – SFIs updates for Procurement
Report for	Decision
Report Author	Denis Kelliher, Head of Procurement
Responsible Executive Director	Marcus Thorman, Director of Operational Finance
Freedom of Information Status	Report can be made public

Executive Summary:

This report covers changes to the Standing Financial Instructions (SFIs) within the Trust's Standing Orders (SOs). These changes are being presented to the Trust Board for approval. The changes have been agreed by ExCo and the Audit, Risk & Governance Committee. These changes primarily affect the sections covering Tendering and Contracting (SFI 16) to bring the Trust's processes into line with modern procurement practices and technology developments, specifically within e-Commerce (including e-Tendering). The use of e-Commerce (selected provider: Due North) automates a number of requirements on the Trust with regards to opening tenders. For tenders managed electronically, no physical opening and logging is required of senior trust staff to prevent allegations of bribery arising. The system manages this through secure logins preventing access to tender prior to the opening time with a full audit trail. For tenders not managed via e-Commerce the process for opening remains unchanged.

The Board is asked to ratify these changes to the SFIs. The board is also asked to note that a fully revised set of Standing Orders and Standing Financial Instructions will be submitted to the December Audit, Governance and Risk Committee.

Trust strategic objectives supported by this paper:

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

Standing Order – SFIs updates for Procurement

This report covers changes to the Standing Financial Instructions (SFIs) within the Trust's Standing Orders (SOs). These changes are being presented to the Trust board for approval. The changes have been agreed by ExCo and the Audit, Risk & Governance Committee. The required software and processes are in place and a trial has been undertaken of functionality, the ARGC's ratification is requested to amend the SFIs to reflect new practice.

Background

In the Department of Health's recently published the NHS e-Procurement Strategy it stated:

"The European Commission strategy for e-procurement24 (April 2012) requires all contracting authorities to undertake OJEU-compliant procurement procedures using electronic means by mid-2016. Progress is in hand within the European Commission to take this requirement through the legislative process."

To comply with this forthcoming requirement, NHS providers and their procurement partners will need to manage above-threshold OJEU procurement procedures, including contract notices, tendering processes, reverse auctions and contract awards by electronic means.

e-procurement can significantly simplify the way procurement is conducted, reduce waste and deliver better procurement outcomes (lower price, better quality) by stimulating greater competition across the Single European Market. It can also contribute to addressing two of the main challenges the European economy is facing today: the need to maximise the efficiency of public expenditure in a context of fiscal constraints and the need to find new sources of economic growth.

To meet these recommendations the Trust (through the London Procurement Partnership) has recently acquired access to an e-Commerce portal delivered by Due North

Tender Management and Receipt of Tender Responses

Tenders returned through the Electronic portal are place within a "Lockbox" and has a full audit trail both supplier and Trust side. This controls the process and ensures adherence to the SFI principles to avoid the potential for accusations of malpractice to made. Arguably this is more secure than the current manual process tender access and security is touchless and tracked for audit purposes.

Suppliers can access their submission until the hour/date of tenders closing. Tenders received before this time/date cannot be accessed prior to the closing date by the Trust ensuring the Trust cannot alter any supplier submission before the closing date. Once the closing date/time has expired suppliers cannot enter the system and change their

submission once more providing a robust audit trail.

Changes to the Standing Financial Instructions:

Section 16 of the SFIs covers the Tendering and Contracting procedures. The following section includes the amended SFIs using track changes highlighted in red.

16.6.1 Invitation to tender

(i) All invitations to tender shall state the ~~date and time as being the~~ latest date and time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

i. If the Invitation to Tender was via the Due North e-Commerce system, then responses must be made via the system. The document title or the subject of any response must not bear any names or marks indicating the sender both individually or corporately. Or;

ii. If the Invitation to Tender was issued on paper then any responses must be submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates and the tender number) and the latest date and time for the receipt of such tender addressed to the Chief Executive ~~or nominated Manager.;~~ The tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

<Section iii and iv are unaltered>

16.6.2 Receipt and safe custody of tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of paper / physical tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

Where responses are received via an e-Commerce system the system will be capable of recording the date and time of receipt for audit purposes and prevent opening prior to the agreed time.

16.6.3 Opening tenders and Register of tenders

Where tenders are managed via an e-Commerce system and submissions are received electronically through this system, the system will prevent breech of process by preventing access in advance of the deadline and logging access and

opening of tender submissions. Any member of staff with a login can open a tender on behalf of the trust (provided the deadline is past and the system allows access). No further action is required. However where a paper / physical tender is received:

<requirements (i) through (viii) relating to physical tenders remain unchanged>

Minor amendments have been made to make reference to the e-Commerce system in the remainder of 16.6 to ensure clarity and consistency of the processes required.

Other changes to the SFI

- Decisions reserved for the board – amended approval of contracts
- Amended powers reserved for the Board for contract approval from £9m to £5m to ensure consistency with Scheme of Delegation.
- For quotations above £25k the preference that any local tender be undertaken in the e-Commerce system – currently some Estates and ICT quotations are undertaken locally and outside of procurement.
- Update of Scheme of Delegation to reflect organisation structure changes in 13/14;
- SFIs updated to reference the correct external bodies (Crown Commercial Service and NHS Supply Chain) as they refer to old / defunct bodies;
- Acceptance of tenders these will be on the principles of 'Most Economically Advantageous Tender' which replaces lowest value/cost;
- List or Approved Suppliers amended to include reference to the engagement of new suppliers; and
- Amendments to formatting to ensure consistency and clarity.

Risk, Financial and Compliance considerations

The e-Commerce system in conjunction with the revised SFIs will reduce the risks associated with tender opening (ie challenge on the grounds of malpractice, human fallibility) through automation and ensuring that processes are reflected in the Trust's SOs/SFIs.

There are no financial issues or impacts (other than details) arising from this paper.

Action

The Board is asked to ratify these changes to the SFIs. The board is also asked to note that a fully revised set of Standing Orders and Standing Financial Instructions will be submitted to the December Audit, Governance and Risk Committee.

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	4.1
Title	Update on the closure of the Emergency Unit at Hammersmith Hospital
Report for	Noting
Report Author	Professor Tim Orchard, Divisional Director – Medicine
Responsible Executive Director	Mr Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made Public

Executive Summary: The purpose of this paper is to update the Trust Board following the closure of the Emergency Unit at Hammersmith Hospital on 10th September 2014.

Capacity has been enhanced at St Mary's and Charing Cross hospitals to support the closure as planned, and the new pathways and operating procedures associated with it are in place.

Recommendation to the Board: The Trust Board is asked to note the closure of the Hammersmith EU on 10th September 2014 and the assurance process put into place to monitor the impact of this change.

Trust strategic objectives supported by this paper:

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

Update on the closure of the Emergency Unit at Hammersmith Hospital

Purpose of the Paper

The purpose of this paper is to update the Trust Board following the closure of the Emergency Unit (EU) at Hammersmith Hospital (HH) on 10th September 2014.

Introduction

The vision for modernising and improving healthcare in North West London described in Shaping a Healthier Future (SaHF) includes closure of the emergency units at HH and Central Middlesex (CMX) hospitals during the early phase of implementation. The Secretary of State for Health announced on 30th October 2013 that the departments would close 'as soon as practicable'.

These changes, put forward by clinicians, are needed to:

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

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

It was recommended that the two emergency departments (HH and CMX) closed on the same day. This was to avoid the potential impact of one department closing and patients being diverted to the remaining one as it prepares to close. As such, both units closed as planned on 10th September 2014.

Current position

Following several months of planning and preparation the Hammersmith EU was successfully closed on Wednesday 10th September 2014. The London Ambulance service stopped relaying patients at 7pm on the previous evening and at 9am on the 10th September the EU doors were closed to walk-in patients.

The Urgent Care Centre (UCC) at HH is now operating as a self-contained unit and clinical pathways are in place for any patients that require more acute intervention. The UCC extended its hours of operation to 24 hours a day, seven days a week on 23rd June 2014.

The Specialist Medicine Assessment Centre that is based on B1 Ward has opened and is receiving medical GP referrals, ambulatory care patients and known Renal or Haematology patients. There is also a discharge lounge located there that can be used by any of the medical wards based on the Hammersmith site.

The medical referral telephone line is now open between 9am and 8pm, seven days a week, for all urgent medical GP referrals. It is also able to connect the GP with either the Consultant or Registrar based at the Hammersmith for clinical advice. The feedback from

GPs has been positive, especially as it has reduced the time required to refer medical patients to ICHT.

Work has been completed at HH, St Mary's (SMH) and Charing Cross (CXH) to accommodate the new pathways and to create extra capacity for additional activity resulting from the Hammersmith EU closure. This includes:

- An additional majors and resuscitation cubicle in the SMH Emergency Department;
- Opening of 15 Lewis Lloyd beds for inpatient care at SMH;
- Relocation of ambulatory Care at CXH and creation of additional trolley assessment space;
- Development of an Older Persons Rapid Assessment Clinic and Frailty Unit on 4 South ward at CXH, which will be accessible by Emergency Department;
- Installation of patient monitoring on C8 Ward at HH to enable sick level 1 patients to be managed there;
- Cosmetic improvements to B1 ward at HH to enable it to be opened as the Specialist Medicine Assessment Centre;
- Additional assessment space created in the Heart Attack Centre;

The Pickering Unit, which will offer more space for Ambulatory Care at SMH, will be completed by 21st September 2014. This will also allow more patients to be managed away from the Emergency Department therefore improving patient flow.

In addition, the following changes to staffing levels have been made:

- 3 additional Core Medical Trainees added to the acute medical teams at SMH and CXH;
- 6 additional Band 5 nurses added to the Emergency Department establishment at SMH and 3 additional Band 5 nurses added to the Emergency Department establishment at CXH;
- An additional 8A Senior Nurse for Elderly Medicine has been appointed to provide leadership on Lewis Lloyd ward at SMH;
- 2 additional clerical posts have been created to enable weekend and evening working on the admission wards at SMH and a new role of Pathway Co-ordinator has been established to help patient flow both in and out of the hospital at CXH.

Maintaining Performance

The actual changes in activity following the Hammersmith EU closure require careful monitoring to ensure the additional capacity at SMH and CHX is sufficient to meet need. As well as a daily conference call between sites, the following performance indicators are being monitored on a daily and weekly basis:

- Postcode drift – the postcodes of attenders are being monitored and compared to pre-closure levels to gauge any drift in where people are travelling from;
- Daily attendance numbers compared to six week averages – attendance levels from all sites including the UCCs are monitored daily and compared to six week averages;

- Ambulance arrivals and waits – daily monitoring of numbers of ambulances that have arrived at either the CXH or SMH Emergency Departments compared with historic averages on those days;
- Waiting Times to initial assessment by a doctor, time to having some form of treatment and total time in the emergency department – these measurements give an indication of the issues increased volumes can cause especially if there is an influx of attenders;
- Red stream numbers to the Emergency Departments – the number of patients who are seen in the UCC and then are assessed as needing a more acute level of care is being monitored to ensure correct streaming processes remain in place and that the GPs are seeing appropriate patients;
- Admissions from the Emergency Departments – the number of attendances that have resulted in an admission and the conversion ratio;
- Treat and transfer – patients who have been transferred to another site due to capacity issues rather than clinical need;
- Ambulatory care – the number of patients who have been managed in the ambulatory care unit rather than the Emergency Department compared with historical averages.

In addition the following elements will be added to the monitoring dashboard as more data becomes available:

- Delayed transfers of care;
- Complaints related to the new pathways of care;
- Incidents related to the new pathways of care.

The key KPIs will be tabled at the Trust Board meeting to ensure directors are able to review the first week's performance data

Governance Structure

The weekly Hammersmith EU Closure Committee, attended by the ICHT Senior Responsible Officer, Programme Director, key Executive Directors and members of the Division of Medicine management team, that was established to oversee and coordinate delivery of the EU closure, will continue to meet to address any issues arising from the closure and to formally monitor the performance metrics outlined above.

In addition, the Closure Committee will continue to report into the following forums:

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

Legal and Compliance issues

None

Implications for Equality, Diversity and Human Rights

None

Recommendation(s) to the Board

The Trust Board is asked to note the closure of the Hammersmith EU on 10th September 2014 and the assurance process put into place to monitor the impact of this change.

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

Agenda Item	4.2
Title	CQC Chief Inspector of Hospitals' Visit, September 2014
Report for	Discussion
Report Author	Kara Firth, Regulation Manager
Responsible Executive Director	Professor Janice Sigsworth Director of Nursing
Freedom of Information Status	Report can be made Public

This paper provides an overview of the activities and outcomes of the recent Care Quality Commission inspection of the Trust.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

CQC Chief Inspector of Hospitals' Visit, September 2014

1 Background

1.1 CQC Inspection Methodology and Ratings

The Care Quality Commission (CQC)'s current inspection methodology is significantly different from the approach used during previous inspections of the Trust. Using their inspection findings, the CQC are assessing whether our services are:

- Safe,
- Effective;
- Caring;
- Responsive to people's needs;
- Well led.

By services, the CQC means what it calls the eight core services it has identified for NHS acute trusts:

- A&E;
- Medicine (including older peoples' care);
- Surgery;
- Intensive / Critical Care;
- Services for children and young people;
- Maternity and family planning;
- End of life care;
- Outpatients.

Based on the inspection findings, the CQC will rate our services, sites and the Trust overall for each of these five 'domains'. Ratings categories are:

- Outstanding;
- Good;
- Requires improvement;
- Inadequate.

2 Inspection Activities at Imperial

2.1 Announced and Unannounced Visits

CQC inspections include both announced and unannounced components. Announced visits of all areas across our three main sites took place between 2nd and 5th September. A number of unannounced visits have taken place during 6 – 21 September across all our sites.

2.2 Inspection Team

Approximately 50 inspectors attended our announced component of the inspection. Smaller teams carried out inspections of individual services / areas: these teams had one or two CQC inspectors, one clinician or specialist (e.g. Pharmacist) and one 'expert by experience' (these are laypersons who support CQC inspections where they have experience with particular types of services, e.g. a specialty. They will not be patients of the service being inspected).

3 Inspection feedback

3.1 Feedback from staff

The CQC held a listening event for people who use Imperial's services, on 2 September in White City. They reported that the event ran smoothly and people came to share their views. No feedback was received from the CQC after the event.

Our staff have reported that there were no surprises in terms of services and areas visited, areas of focus or questions during staff focus groups and interviews.

3.2 Feedback from the CQC

Following the conclusion of the announced component of the inspection, on 5 September the CQC gave brief feedback to the CEO and Executive Team. They said that all the staff they met were helpful, open and honest and thanked us for the welcome they had received.

The CQC will take all the information about us and work through the findings. These will be set out in their inspection reports.

4 Next steps

4.1 Inspection Reports

In eight to ten weeks (mid-November) we will receive five draft inspection reports: one report for each hospital (St. Mary's, Charing Cross, Hammersmith, and Queen Charlotte's and Chelsea) and an overall report for the Trust.

4.2 Factual Accuracy Check by the Trust

When the draft inspection reports arrive, we will have 10 working days to carry out a factual accuracy check (i.e. to identify and correct any factual inaccuracies in the report).

Following the factual accuracy check, the CQC process allows for compliance and / or enforcement actions to be issued as part of the finalisation of the inspection reports, if any aspects of the inspection fell consistently below the regulatory standards.

4.3 Quality Summit

The CQC will respond to our factual accuracy check to advise which changes they accept and will make them before the report is finalised. Approximately five days after we receive our final inspection reports, a Quality Summit will be held with representatives of the Trust and our partners in the local health economy. During the summit, a high level action plan will be proposed to address areas requiring improvement. Our inspection reports will be published on the CQC website within 48 hours after the summit.

We anticipate that our Quality Summit will be held towards the end of November or early December. Monitor's published position states that to proceed with an application for foundation trust status, trusts need to achieve a CQC rating of 'good' overall.

4.4 Lessons Learned and On-going Compliance

We will run a debrief exercise to learn lessons from the inspection. These will be folded into a proposal to refresh the Trust's approach to:

- Ensuring requirements relating to the Trust's CQC registration are met across the organisation;
- Providing mechanisms of assurance which allow the Trust to demonstrate that the requirements are being met; and
- Driving improvements in our performance with an emphasis on the quality and safety of care we deliver.

A separate paper on this will be brought to the Executive Committee in the new year for sign off, and then taken to the Quality Committee.

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	4.3
Title	Infection Prevention and Control Report.
Report for	Noting
Report Author	Professor Alison Holmes – Director of Infection Prevention and Control
Responsible Executive Director	Professor Chris Harrison – Medical Director
Freedom of Information Status	Report can be made public

Executive Summary: It is a requirement of the health and social care act (2008) that Trust Boards are fully appraised on the incidence of healthcare associated infections (HCAIs). This paper provides current data on HCAIs at the Trust and includes analysis of themes and trends which will inform further programmes of work focusing on reducing HCAIs at the Trust. Additional infection prevention and control (IP&C) activity is also presented, which includes the actions and process that are in place to ensure the Trust is fully prepared for the management of infection in the overseas patient and returning travellers to the UK.

Recommendation(s) to the Board/Committee: The Board is asked to note the Trusts HCAI figures to date and other IP&C service activity.

Infection Rates	Apr-14	Ceiling	May-14	Ceiling	Jun-14	Ceiling	Jul-14	Ceiling	Aug-14	Ceiling	Year to Date	Year (Ceiling)
MRSA Bacteraemia Episodes	1	0	2	0	0	0	0	0	0	0	3	0
C.difficile Episodes (Toxin EIA Positive)	7	6	9	6	9	5	6	5	10	5	41	65
E.coli Bacteraemia Episodes	6		4		2		2		9		23	
MSSA Bacteraemia Episodes	2		3		2		5		1		13	

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Infection Prevention and Control Report.

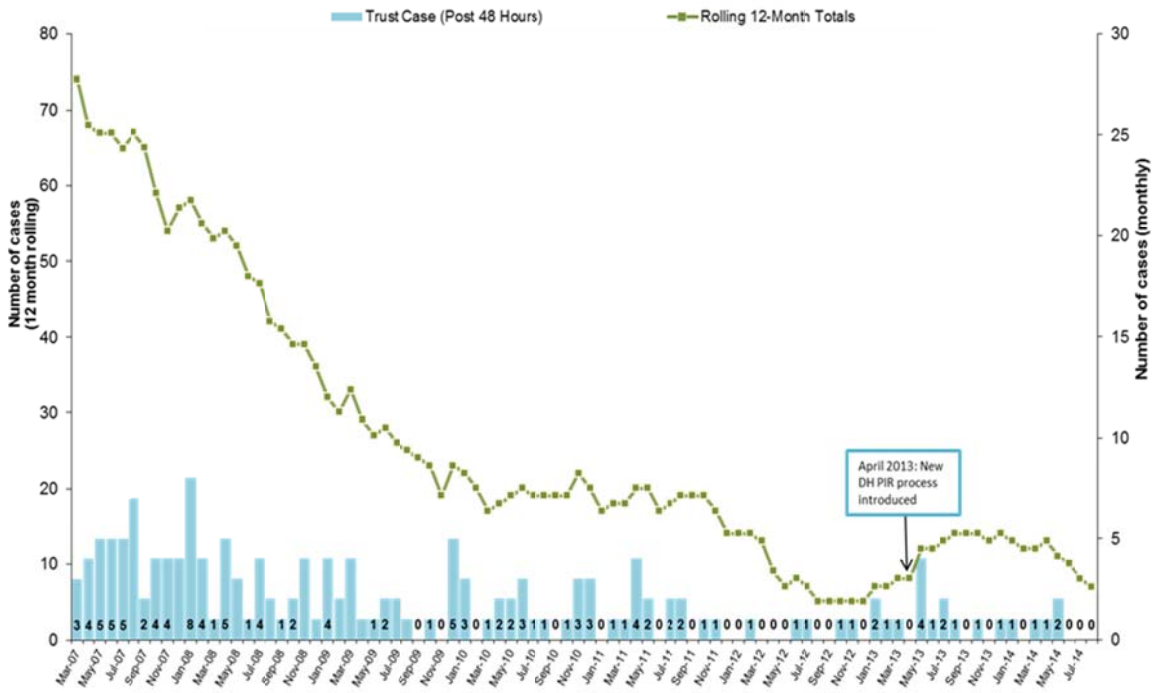
Purpose of the report: This paper provides current data on HCAIs at the Trust and includes analysis of themes and trends which will inform further programmes of work focusing on reducing HCAI at the Trust. Additional IP&C activity is also presented, which includes the actions and process that are in place to ensure the Trust is fully prepared for the management of infection in the overseas patient and returning travellers.

1.0 Healthcare associated infection (HCAI) report

1.1 Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

There is a national expectation of zero MRSA BSIs for all Trusts for 2014/15.
To date there has been three Trust attributable cases (one case in April and two in May). 11,344 blood cultures have been taken in this time. The first case was a pre-48 hour blood culture identified as a possible contaminant. The second case was a gentleman receiving chemotherapy at the Trust who then presented in A&E with facial cellulitis secondary to a shaving cut. Both the investigating organisation and the Trust agreed that the allocation should be attributed to a third party, however the final allocation following arbitration allocated the case to the Trust. The allocation of this case is being jointly challenged by the Trust and the CWHHE CCGs Commissioning Collaborative. The third case was a pre-48 hour blood culture which was identified as a contaminant. The blood culture procedure was technically difficult and the patient had very poor venous access. There were no Trust attributable cases during August 2014, when 2289 blood cultures were taken. The current rate of MRSA incidence per 100,000 bed days is 2.11

Figure 1: Rolling 12 month and monthly number of Trust attributed MRSA BSI cases, (March 2007 - August 2014)



1.2 *Clostridium difficile (C. difficile)* infections

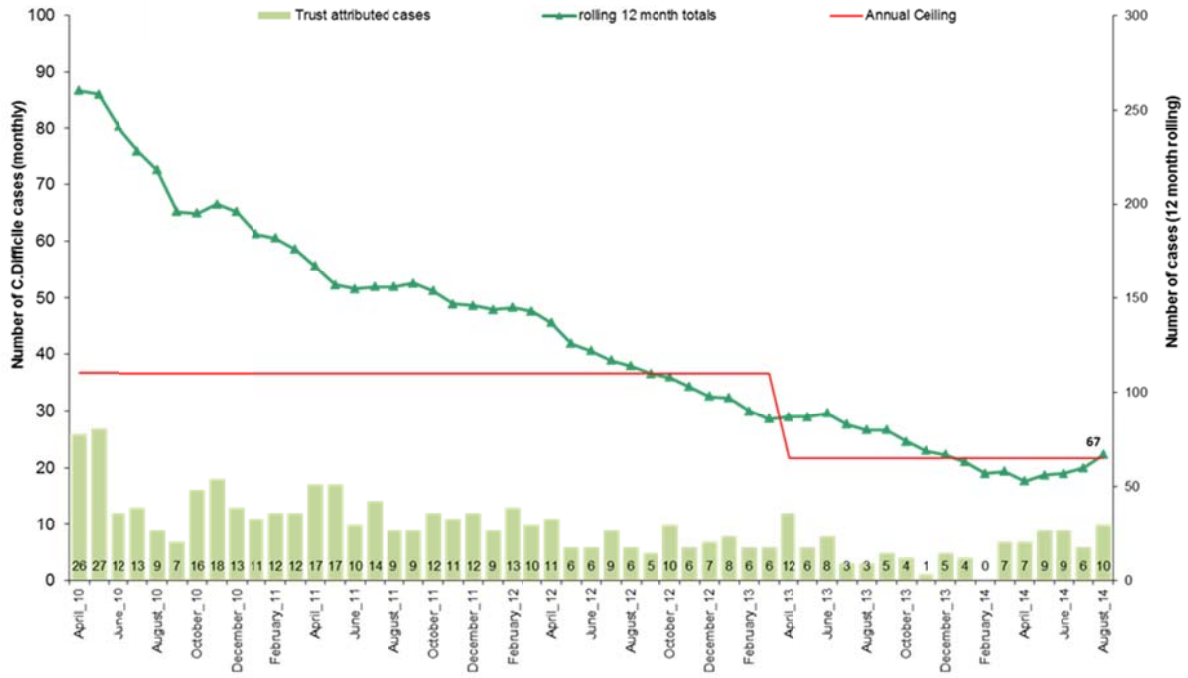
The Department of Health's annual ceiling for the Trust is 65 cases for 2014/15. To date we have reported 41 cases associated with the Trust with 10 Trust associated cases reported to Public Health England (PHE) for August 2014. There were no outbreaks or cases that were epidemiologically linked. Year to date 32122 specimens were tested for *C. difficile,* with a total of 596 specimens tested in August 2014.

The Trust has a comprehensive and rolling action plan based on PHE guidance. This focuses on our systems and processes around surveillance, testing and the isolation and management of *C. difficile* patients. The plan has multidisciplinary involvement of medical, nursing and pharmacy staff together with management, estate and facilities and primary care. For each case, a multidisciplinary clinical and case review is undertaken to identify patient risk factors and themes in which the organisation can learn. Should any risk factor or common theme be identified, these are escalated via clinical and managerial structures within the appropriate division and discussed at the weekly taskforce meeting.

If risk factors or themes are identified from primary care these are discussed at the Clinical Quality Group. To date we have identified antibiotic prescribing and proton pump inhibitor use as a risk factor for patients coming into our organisation and have informed primary care to review this with GP's. Prof Azeem Majid, Professor of Primary Care and Head of the Department of Primary Care & Public Health at Imperial College London will also now be working with us to engage primary care in minimising risk.

Working alongside the *C. difficile* action plan is a comprehensive antibiotic stewardship programme. This includes evidence based guidelines, clinical teams, surveillance and quality indicator reporting governed by a specific antimicrobial group.

Figure 2: Trust attributable *C. difficile* infection and 12 month rolling totals (April 2010 – August 2014)



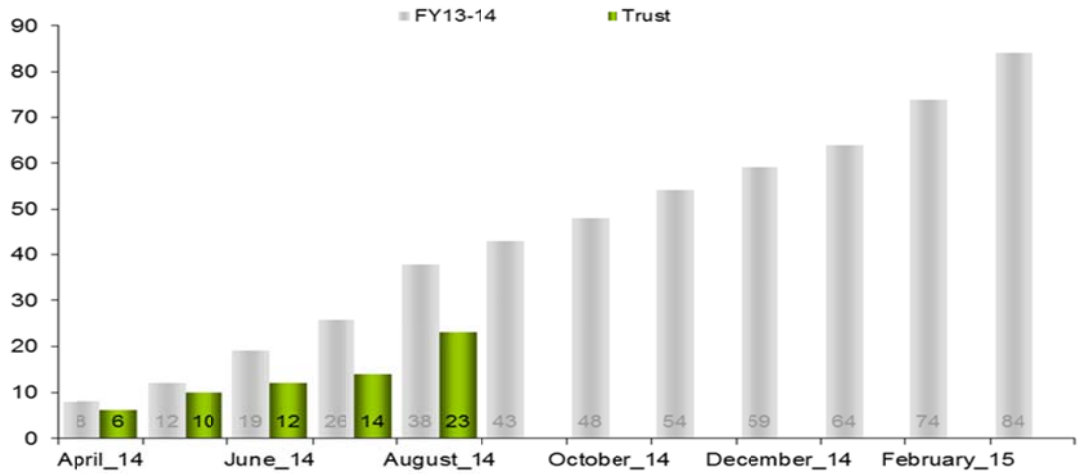
Monthly incidence from April 2012 does not show any clear seasonality.

1.3 Meticillin sensitive Staphylococcus aureus bloodstream infections (MSSA BSI)
There is no threshold for this indicator at present. In August 2014 there were ten cases reported of which one case was attributed to the Trust. This case was associated with a long term central venous catheter in a post-partum renal dialysis patient.
The cumulative figure for this financial year (April to August 2014) is 13 Trust-attributable cases compared to 23 this time last year (FY 2013/14). The IP&C team undertake a review of all Trust attributable cases and the findings and subsequent learning is discussed with divisional and clinical teams. All vascular access device related BSIs are discussed at the line safety committee.

Figure 3: Cumulative Trust attributable MSSA incidence April to August 14, vs FY 13-14

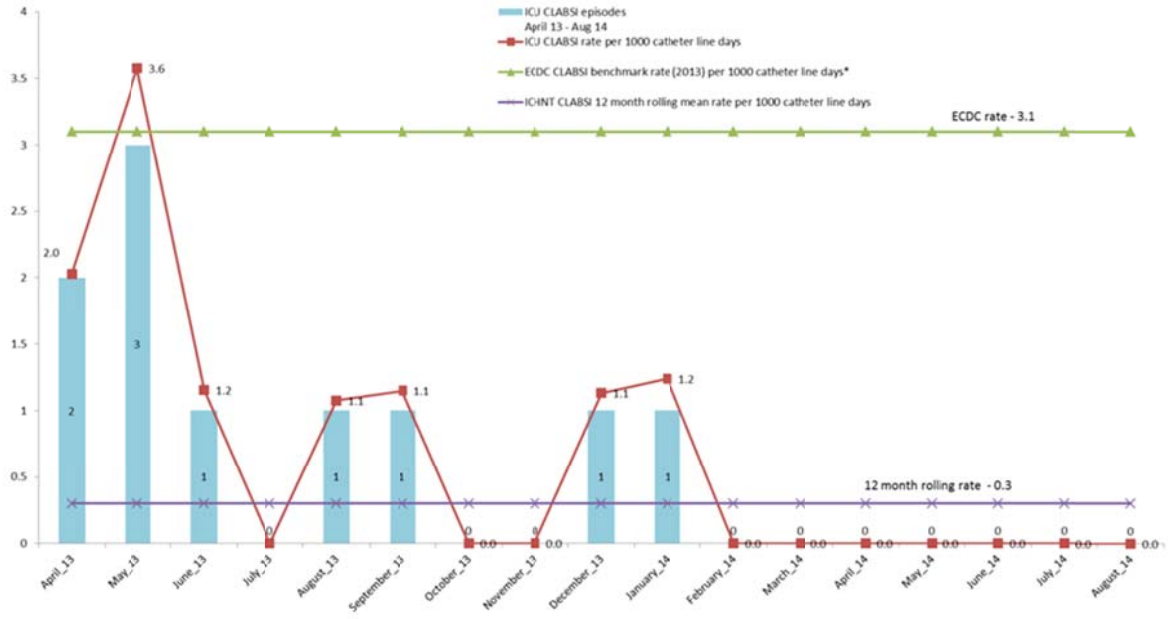
1.4 *Escherichia coli* bloodstream infections (*E. coli* BSI)
There is no threshold for this indicator at present. In August 2014 there were 46 cases of which nine were attributed to the Trust. Of these, two were due to biliary sepsis and two had intra-abdominal sepsis as the source of infection. A further two had chorioamnionitis as the source and one had a catheter related urinary source. One case was related to an ischaemic bowel following surgery abroad and the final case was related to a community-associated pneumonia.
The cumulative figure since the beginning of April to August 2014 is 23 Trust-attributable cases compared to 38 this time last year (FY 2013/14).

Figure 4: Cumulative Trust attributable *E.coli* BSI incidence April-August 14 vs FY 13-14



1.5 Level 3 Critical care central line bacteraemia surveillance.
There have been no cases of central line associated blood stream infections (CLABSI) in any of the adult intensive care units since April 2014 and the paediatric intensive care unit (PICU) have not identified a catheter related blood stream infection for the past 18 months.

Figure 5: CLABSI episodes and rate per 1000 catheter line days by month (April 2013 – August 2014) in adult critical care



1.6 Carbapenemase Producing Organisms
The Trust identified one case in August. The total for 2014/15 so far is 12.
In line with the guidance issued by PHE and NHS England, an action plan is in place to ensure that the tool kit is embedded into practice.

1.7 Fungal Infection Surveillance
We continue to collect Candida blood stream infection surveillance data and in August 2014 we identified 4 cases. The rolling total for 2014/15 is 8.

2.0 Other IP&C activity

2.1 Hand Hygiene
In August 2014, 86.2% of clinical areas submitted a total of 4980 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week). Hand hygiene was 91.1% and compliance with bare below elbows was 98.2%. A hand hygiene strategy has been developed which focusing on the provision of an appropriate infrastructure and facilities for hand hygiene. In addition, training and education, and specifically on the audit, feedback and evaluation process will be addressed. As part of this strategy a hand hygiene facilities audit was undertaken in August 2014. The findings of this audit will be reported at the end of September 2014.

2.2 Aseptic Non Touch Technique (ANTT)
Since the introduction of the ANTT competency assessment framework in January 2012, 12830 staff who have worked or are still working at Imperial have undertaken the assessment. Completion of assessments was 74% at the end of August. This figure represents the large number of staff who have now reached their two yearly reassessment point and are currently undergoing reassessment for ANTT competency. Junior doctors are now ANTT assessed on the day of induction in a skills lab setting by medical assessors from the Divisions and the IPC team.

2.3 Addressing infection risks in the recently overseas patient.
The Trust has up to date patient management pathways for patients with suspected Middle Eastern Respiratory Syndrome (MERS) and viral haemorrhagic fever (VHF), linked to the latest information from PHE.
Ebola is of public health importance because it has a high case-fatality rate, is difficult to recognise rapidly and has no effective treatment. In view of the on-going outbreak of Ebola in Sierra Leone, Liberia and Guinea, early recognition and assessment of patients presenting at the trust is critical. Updated guidance has been produced and made widely available to all front line staff. Protecting staff by providing appropriate PPE is critical in managing patients with this infection and a Filtering Face Piece (FFP3) respirator is required to be worn by staff and a robust Fit Testing programme is required which complies with the FFP3 guidance from the Health and Safety Executive (HSE). This programme is being undertaken by the Trusts Emergency Planning Team. General training on use of PPE is being undertaken by the IPC team. Visual information has been made available to all staff regarding PPE.
Isolation facilities with ante rooms (for the safe donning and removal of personal protective equipment) is required in the accident and emergency and admitting areas. Site specific admission pathways have been agreed with frontline staff to minimise risk.

2.4 Antibiotic Stewardship
Antibiotic stewardship optimises patient outcomes from infection while minimising negative consequences of bacterial resistance and HCAI. It is a key aspect of quality care and patient safety.

- The latest point prevalence study was completed on 15th August. The report is due shortly and will be circulated to divisional directors with key messages.
- NHS England has issued a Patient Safety Alert on resources to support the prompt recognition of sepsis and the rapid initiation of treatment. The Trust is going to be re-launching a multidisciplinary sepsis management initiative led by Dr Bill Oldfield.
- European Antibiotic Awareness Day 18 November 2014: The CMO, the Director for Health Protection and Medical Director for PHE and the Director of Patient Safety at NHS England have urged Trusts to register their commitment and their planned activities. A Trust wide programme is under development with the support of the communications department.
- Prof Azeem Majid will be involved in supporting joint work with primary care.

Legal and Compliance issues: It is a requirement of the health and social care act (2008) that Trust Boards are fully appraised on the incidence of healthcare associated infections (HCAIs).

Recommendations to the Board: The Board is asked to note the Trusts HCAI figures to date and other IP&C service activity.

Imperial College Healthcare NHS Trust

Trust Board Public

Agenda Item	4.4
Title	Trust Board Calendar
Report for	Decision
Report Author	Cheryl Plumridge Director Governance & Assurance
Responsible Executive Director	Cheryl Plumridge Director Governance & Assurance
Freedom of Information Status	Report can be made public

The Trust Board Calendar was circulated 17 September for comments. The Director of Governance & Assurance will provide an update at the meeting.

Trust strategic objectives supported by this paper:

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

Recommendation(s) to the Board: The Board is asked to approve the Trust Board calendar for 2015-16.

Imperial College Healthcare NHS
NHS Trust

DRAFT IMPERIAL COLLEGE HEALTHCARE NHS TRUST BOARD & COMMITTEE SCHEDULE 2015 – 2016 v0.4

MONTH	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
TRUST BOARD MEETING		Wed 27 May 10.00 – 13.30 Oak Suite, W12		Wed 29 July 10.00 – 13:30 Oak Suite, W12		Wed 30 Sept 10.00 – 13:30 Oak Suite, W12		Wed 25 Nov 10.00 – 13:30 Oak Suite, W12		Wed 27 January 10.00 – 13:30 Oak Suite, W12		Wed 30 March 10.00 – 13:30 Oak Suite, W12
AGM						September Date, Time and Venue tbc						
TRUST BOARD SEMINAR	Wed 29 April 9.30 – 12.00 New Boardroom Charing Cross		Wed 24 June 9.30 – 12.00 New Boardroom Charing Cross				Wed 28 Oct 9.30 – 12.00 New Boardroom Charing Cross		Wed 16 Dec 9.30 – 12.00 New Boardroom Charing Cross		Wed 24 Feb 9.30 – 12.00 New Boardroom Charing Cross	
TRUST BOARD DEVELOPMENT MEETINGS	Wed 29 April 12.30 – 14.30 New Boardroom Charing Cross		Wed 24 June 12.30 – 14.30 New Boardroom Charing Cross				Wed 28 Oct 12.30 – 14.30 New Boardroom Charing Cross		Wed 16 Dec 12.30 – 14.30 New Boardroom Charing Cross		Wed 24 Feb 12.30 – 14.30 New Boardroom Charing Cross	
PROPOSED COUNCIL OF GOVERNORS												
AUDIT, RISK & GOVERNANCE COMMITTEE	Wed 8 April 10.00 – 12.30 CWB		Wed 3 June 10.00 – 12.30 CWB				Wed 7 Oct 10.00 – 12.30 CWB		Wed 2 Dec 10.00 – 12.30 CWB			Wed 9 Mar 10.00 – 12.30 CWB
FOUNDATION TRUST PROGRAMME BOARD	Tues 21 April 15.00 – 17.00 CWB	Tues 19 May 15.00 – 17.00 CWB	Tues 23 June 15.00 – 17.00 CWB	Tues 21 July 15.00 – 17.00 CWB		Tues 22 Sept 15.00 – 17.00 CWB	Tues 20 Oct 15.00 – 17.00 CWB	Tues 17 Nov 15.00 – 17.00 CWB	Tues 15 Dec 15.00 – 17.00 CWB	Tues 19 Jan 15.00 – 17.00 CWB	Tues 16 Feb 15.00 – 17.00 CWB	Tues 22 Mar 15.00 – 17.00 CWB
QUALITY COMMITTEE		Wed 13 May 10.00 – 13.00 CWB		Wed 15 July 10.00 – 13.00 CWB		Wed 16 Sept 10.00 – 13.00 CWB		Wed 11 Nov 10.00 – 13.00 CWB		Wed 13 Jan 10.00 – 13.00 CWB		Wed 16 Mar 10.00 – 13.00 CWB
FINANCE & INVESTMENT COMMITTEE		Wed 20 May 16.00 – 18.00 CWB		Wed 22 July 16.00 – 18.00 CWB		Wed 23 Sept 16.00 – 18.00 CWB		Wed 18 Nov 16.00 – 18.00 CWB		Wed 20 Jan 16.00 – 18.00 CWB		Wed 23 Mar 16.00-18.00 CWB
REMUNERATION & APPOINTMENTS COMMITTEE			Wed 10 June 10.00 – 11.30 CWB						Wed 9 Dec 10.00 – 11.30 CWB			

V2.0

Imperial College Healthcare NHS
NHS Trust

CONFIRMED MINUTES OF THE QUALITY COMMITTEE

Wednesday 9 July 2014
Clarence Wing Boardroom
St Mary's Hospital
10.00am – 1pm

Present:	
Prof Sir Anthony Newman Taylor	Chairman
Dr Rodney Eastwood	Non-Executive Director
Dr Tracey Batten	Chief Executive
Prof Alison Holmes	Director of Infection Prevention and Control
Prof Jamil Mayet	Divisional Director: Surgery & Cancer (except Agenda Item 3.2.1)
Steve McManus	Chief Operating Officer (from Agenda Item 1.6 but not for 3.2.1)
Jayne Mee	Director of People and Organisational Development
Cheryl Plumridge	Director of Governance & Assurance (from Agenda Item3.1.5)
Dr Julian Redhead	Divisional Director: Investigate Sciences & Clinical Support
TG Teoh	Divisional Director: Women & Children (from Agenda Item 3.1.1)
In attendance:	
Dr Ruth Brown	Chief of Service for Emergency Medicine
Carolyn Cullen	Interim Corporate Governance Manager (Minute taker)
Priya Rathod	Associate Director – Chief of staff (for Agenda Items 3.1.2 – 3.2.1)
Dr Senga Steel	Deputy Director of Nursing
Guy Young	Deputy Director of Patient Experience (for Agenda Items 3.1.2 – 3.1.5)

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Prof Sir Anthony Newman Taylor welcomed all present to the meeting.
1.2	**Apologies for Absence**
	Apologies had been received from: Sir Gerald Archer, Sir Thomas Legg, Prof Janice Sigsworth, Prof Tim Orchard and Prof Chris Harrison.
1.3	**Declarations of Interest or conflicts of interest** There were no conflicts of interest declared.
1.4	**Minutes of the Committee's meeting on 11 June 2014** The minutes of the meeting held on 11 June 2014 were approved as a true record.
1.5	**Matters Arising and Action Log** Prof Sir Anthony Newman Taylor commended the Committee on having completed so many of the outstanding actions. The Committee noted the updates to the action log.
1.6.1	**Chief Executive's Introduction** Dr Tracey Batten reported that the visit to the Oxford Radcliffe had been helpful for

	the preparation for the forthcoming Chief Inspector of Hospitals (CIH) visit. Particular lessons learnt had been to ensure that all responses to the inspection team should be a team effort, to expect the unexpected, and to ensure that the data the inspection team used was correct and up to date. A visit to St Georges at Tooting was also being arranged.
2.	**CLINICAL RISK**
2.1	**Update on key risks from Divisional Directors** Steve McManus provided a short overview of divisional risks including: • Hammersmith Emergency Unit closure • Level 2 capacity • Screening of patients having travelled or receiving care overseas.
2.1.1	**Surgery & Cancer**
2.1.1.1	Prof Jamil Mayet reported that risks in his division also remained unchanged; the short term solution for Charing Cross was proving to be effective. Dr Tracey Batten advised that an additional £750Kwas being sought from the CCGs in to support emergency services at Charing Cross until the Chelsea and Westminster Hospital had increased its capacity; which is currently estimated to be in early 2016.
2.1.2	**Investigative Sciences & Clinical Support**
2.1.2.1	Dr Julian Redhead reported that risks in his division remained stable and unchanged. Temporary MRI machines had been sourced and would be in place in July and August to enable the works to be undertaken on the chiller units without any reduction in MRI capacity.
2.1.3	**Medicine**
2.1.3.1	Dr Ruth Brown identified three specific risks for the division: Hammersmith Emergency Unit Closure Level 2 Capacity at Hammersmith Hospital Screening of patients who had travelled, or received care from overseas. In point three: it was reported that an increased number of isolation beds were already in operation and this had been achieved by making better use of existing side rooms and the re-establishment of Alpha Ward, and also investigating producing test results in a 24-48 hours timeslot thereby removing the necessity for isolation. Prof Sir Anthony Newman Taylor requested a paper for the October Quality Committee outlining the Trust's approach to patient screening. **Action:** Prof Tim Orchard to provide an update on the Trust's screening of patients who have travelled or have been in receipt of care overseas.
2.1.4	**Women & Children**
2.1.4.1	In the absence of TG Teoh, Steve McManus updated the Committee and noted that the division's risks had been discussed at the performance review the previous week. He highlighted that in respect of the Paediatrics Intensive Care Unit (PICU) risk; a business case to improve capacity was being presented to the Strategic Investment Committee (SIG) later in the month.
3.	**QUALITY OVERSIGHT**
3.1	**Quality**
3.1.1	**Our People: Experience and Engagement** Jayne Mee presented a summary report on the first three quarter's engagement surveys which highlighted trends in how staff attitudes had changed over the three quarterly surveys. Overall, Survey Three had fewer positive ratings than Survey Two, with the engagement score remaining on a downward trajectory. The Friends and Family Test questions, as required by the Department of Health (DoH), had been included for the first time in Survey Three with 78% of staff recommending the Trust to friends and family if they needed care or treatment and 57% of staff recommending the Trust as a place to work. Ways of improving the response rate for Survey Four were discussed. Prof Sir Anthony Newman Taylor asked if staff were sufficiently assured of the confidentiality of their responses and Dr Rodney Eastwood

	commented on the imbalance in response rates between occupational groups. It was agreed that a covering letter from Dr Tracey Batten would accompany Survey Four to reiterate how confidentiality was maintained, the importance of the survey in shaping working practice in the future and identifying changes that had taken place as a result of previous surveys. **Action:** Jayne Mee to draft a letter from Dr Tracey Batten to accompany Survey Four.
3.1.2	**CQC Chief Inspector of Hospitals Assessment September 2014** Dr Senga Steel updated the Committee on plans for the CQC Chief Inspector of Hospitals (CiH) visit. The visit was scheduled for 2 - 5 September 2014 and there were five key lines of enquiry covering eight domains which would be carried out site by site and trust-wide. Rolling briefs were being used to prepare key respondents for the inspection and action plans to address known hot spots, such as patient's experience of cancer services, were being prepared. A data pack would be submitted eight weeks before the inspection. Dr Tracey Batten advised the Committee that the self- assessment was currently being drafted and would be considered at the August Quality Committee together with any potential problem areas which needed to be addressed. **Action:** Prof Janice Sigsworth to present the Trust's self-assessment to the August Quality Committee together with any potential problem areas which needed to be addressed.
3.1.3	**Patient experience work plan 2014-15** Guy Young advised that actions to support the work plan had been identified from feedback from patient surveys, real time feedback, the Friends and Family Test, NHS Choices, complaints, PALs enquiries and collaborative work with outside organisations including Healthwatch. A separate plan, following the Trust's poor standing in the National Cancer Patient Experience Survey, had been drawn up to improve the experience of cancer patients. The Trust was also working with the cancer charity, Macmillan, on how patient experience could be improved and a Memorandum of Understanding for an on-going collaborative partnership was being drawn up. Prof Sir Anthony Newman Taylor suggested that Macmillan should be able to contribute to the CiH inspection to indicate to inspectors how the Trust was improving cancer patient experience. **Action**: Steve McManus to discuss with MacMillan their willingness to engage with CiH inspectors.
3.1.4	**Proposal for the use of patient stories at the ICHT Board** Guy Young summarised the advantages and disadvantages of the various methods available for presenting patient stories to the Board. It was noted that a patient's willingness to address a Board in person varied and some may be more comfortable presenting their experience via video. After discussion the Committee decided that no one method would be appropriate and a combination of methods, depending on the patient and the issue under discussion, could be used. Guy Young informed the Committee that a patient would present their story to the next Board meeting and Prof Sir Anthony Newman Taylor would provide a verbal précis of the Committee's discussion at the Trust Board meeting in July as part of his report of the Committee's meeting.
3.1.5.1	**Quarterly update report on quality impact assessments (QIA) for the Trust cost improvement programmes (CIP)** Priya Rathod reported that the Medical Director and the Director of Nursing had met with all four divisions and the ICT directorate in June to discuss and approve quarterly impact assessments (QIAs) for the 2014/15 Cost Improvement Programmes (CIPs). No schemes had a risk score above nine and where a risk had been identified, mitigating actions were in place. Revised guidance on the Trust's process of undertaking impact assessment (including guidance on the Stratpro system) for the

	CIPs had been approved by the Executive Committee (Quality and Safety) on the 8th of July.
3.1.5.2	The Committee noted that Jonathan Webster, Director of Quality, Nursing and Patient Safety (Central, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs) had written to the Trust requesting information about the Trust's QIA process for CIPs. Prof Sir Anthony Newman Taylor asked that a short update be prepared giving examples of how QIA had informed recent CIP schemes. **Action:** Chris Harrison to provide examples on how the QIA process had informed recent CIP schemes.
3.1.6.1	**Monthly report on safe Nurse/Midwife staffing levels at the Trust** Priya Rathod reported that the Trust had achieved above 95% for the average fill rate for registered and unregistered nursing/midwife staff both day and night for May and above 90% for June. In May, there were ten wards across the divisions of medicine and surgery where a fill rate of 80-90% had been reported although there had been no concern regarding patient safety and mitigating actions had been put in place. From July, the fill rate data will be recorded in the Trust's integrated performance scorecard.
3.6.1.2	Internal Audit will be asked later this year to review the data collection methodology to provide assurance on the robustness of the data. Dr Rodney Eastwood asked if monitoring averages distorted the real position as there could be inter-day and inter-week variances. Priya Rathod advised that staffing fill rates are monitored daily and weekly so any issues are regularly picked up. Priya Rathod also updated the Committee that the Trust was piloting the "Safe Care" acuity module on eroster which reviews acuity and dependency in real time and therefore provides robust staffing information on a daily basis. Prof Sir Anthony Newman Taylor asked whether adverse incidents were looked at in relation to lower staffing levels and Priya Rathod confirmed that this happens through the review of the harm free care report alongside a range of other quality and safety measures. He requested that this information, summarised by division, be brought back to the Quality Committee in August, **Action:** Prof Janice Sigsworth to provide a divisional summary of staffing data alongside quality and safety measures, to the Quality Committee in August.
3.2	**SAFETY**
3.2.1.1	**Safety and Effectiveness Report** Dr Tracey Batten commended the Medical Directorate team and particularly Louise Fleming, for the work undertaken to produce the Safety and Effectiveness Report which provided the Trust with an excellent overview on patient safety in the Trust. Prof Sir Anthony Newman Taylor suggested the need for a focussed approach to medicines optimisation and was advised that a medicines optimisation working group had been set up. The Committee asked that a paper on medicines optimisation be prepared for the October Quality Committee to consider. **Action:** Dr Julian Redhead to provide a paper on medicines optimisation to the October Quality Committee.
3.2.1.2	Dr Rodney Eastwood noted that only 2.24% of outpatients letter sent electronically had met the five working days of the appointment target in Q4 2013/14 and it was agreed that should be investigated and an update given to the next Quality Committee. **Action**: Steve McManus to provide a report in respect to outpatient letters and improvements required.
3.2.2	**Update on emergency cover at Hammersmith Hospital** The Committee discussed the presentation given to NHS England and the TDA on 1 July 2014 on progress on the planned closure of the Emergency Unit (EU) at Hammersmith Hospital. It was noted that NHS England and the TDA had been

	advised of the effective management and governance of this complex project. Dr Tracey Batten confirmed that the Safety at Night project had helped shape decisions on staffing complements and support to staff working at night at the Hammersmith site. Prof Alison Holmes raised the occupational health concern of staff in respect of treatment for needle stick injuries after the Emergency Unit had closed. Cheryl Plumridge confirmed this had also been discussed at the recent Health & Safety Committee and Dr Ruth Brown said that these concerns were being taken into account and that there was an agreement in principle with Partnership for Health that GPs at the Urgent Care Centre would be trained to deal with these injuries in the future.
3.2.3	**A review of winter pressures organisational learning and early preparation for Q3/Q4** The Trust had achieved top quartile success for the four hour A&E wait, the most used measure of performance for effective management of winter pressures. Daily Sitrep analysis had helped target staff and other resources to improve patient flows. The Winter Office had provided an effective point of contact for all external agencies and ensured that patient discharge was robustly managed. Steve McManus reported the Trust was currently bidding for winter pressures funding to make improvements to the Referral to Treatment pathways. In preparation for winter 2014/15 the Urgent Care Centre was now opening 24 hours a day and plans were in place for the Assessment Unit and the Single Point of Access to work alongside the Site Nurse Practitioner. The Division of Medicine was preparing plans to open additional capacity at the St Mary's site with an ambulatory care facility.
4	**Any other business** There were no items of any other business.
5	**Items for future meetings & Committee work plan**
6	**Date of the next meeting**
6.1	Wednesday 20 August 10am to 1pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS Trust

Report Title: Quality Committee Chairman's Report

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

1. Introduction

The Quality Committee met on 20 August 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

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

- The committee received an update on Investigative Sciences & Clinical Support Scan and x-ray reporting times noting the remarkable turnaround in a very short period of time.
- The committee received an update on End of Life Care noting that a steering group had also been established, chaired by Dr Katie Urch. Current priorities for the steering group were training and communication.
- The committee received an update on safe Nurse/Midwife staffing levels noting a positive improvement in the ward data indicators and that one of the triggers in the Harm Free Care Report was staffing levels.
- The committee received a review of the actions put in place to reduce failure to rescue (FTR) incidents on the St. Mary's site noting that dramatic improvements had been made in the 'out of hours' period (at night and over the weekends) particularly at St Mary's.

3. Key risks discussed

The following risks were discussed:

- The committee received an update on the Infection prevention and control risks in patients from overseas and returning travellers to the UK noting that there was a procedure in place to recognise signs on first sight which A&E staff had been made aware of.

4. Key decisions taken

The following key decisions were made:

- None

5. Agreed Key Actions

The committee agreed actions in relation to:

- Professor Alison Holmes would provide a report on the capacity to screen and isolate

patients as recommended by the Department of Health to the Quality Committee in October.

- A six monthly report on End of Life Care including an action plan to be submitted by Prof Janice Sigsworth.
- Steve McManus and Prof Chris Harrison to bring an audit of failure to rescue (FTR) incidents to the Committee.
- Analysis of the SIs in the Maternity Service to be provided by TG Teoh for the October meeting.
- Detailed report on Medication Incidents to be provided by Dr Julien redhead/Divisional Director for Investigative Sciences.

6. Recommendation

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

Imperial College Healthcare NHS Trust

Report Title: Audit, Risk & Governance Committee Chairman's Report

To be presented by: Sir Gerald Archer, Chairman

1. Introduction

The Audit, Risk and Governance Committee met on 10 September 2014. The main issues discussed were as follows.

2. Significant issues of interest to the Board

The following matters of interest are highlighted to the Trust Board:

- A do not resuscitate (DNR) Procedure and Policy had been produced in line with the End of Life work stream and Executive Committee had signed off the interim DNR approach.
- The report on Pharmacy Performance showed 70-75% of patients were being discharged within one hour in line with The Association of Teaching Hospital Pharmacists recommendation of 70%) and 90-95% within two hours.
- The committee considered a revised Corporate Risk Register noting the Board Risk workshop due to take place on 29 October.
- The Internal Audit and Counter Fraud progress report was discussed. It was noted that the control levels in relation to Bank and Agency payments were to be reviewed.
- The committee received the latest view of the Out-turn for the year noting that Rotas were to be reviewed as when looking at the activity evidence suggested that extra Bank and Agency staff were not required.
- The Committee approved the changes to the Standing Financial Instructions within the Trust's Standing Orders which related to etendering.

3. Key risks discussed

The main areas of concern that arose from the internal audit work during the year related to:

- Medical Devices

4. Decisions and actions

The following decisions and action were agreed:

- DNR Do Not resuscitate Report and Action plan to Quality Committee in 3 months
- Cerner: Roll out dates and cost controls would come to the December meeting. A Post Implementation review report would come to the Committee in March
- Pharmacy Peformance - an update would come to the March 2015 meeting
- The first deep dive from the Corporate Risk Register would take place at the December meeting
- External audit - Land valuation report to be submitted to the Finance and Investment Committee

- Internal audit – a report on the three priorities that were still outstanding would come to the December meeting

5. Recommendation

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

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE

Wednesday 18 June 2014
9.45am – 12.30pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sir Gerald Acher (Chair)	Non-Executive Director
Prof Sir Anthony Newman Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Andreas Raffel	Non-Executive Director Designate
In Attendance:	
Dr Tracey Batten	Chief Executive
Claire Broster	Risk/Project Manager Designate
John Cryer	Director of Estates & Facilities (not for part of 2.7 and all of 2.8 and 4.1)
Jonathon Gooding	Deloitte
Prof Chris Harrison	Medical Director
Kevin Jarrold	Chief Information Officer (until part way through agenda item 2.8)
Philip Lazenby	Director of Audit TIAA
Steve McManus	Chief Operating Officer (not for part of 2.7 and all of 2.8 and 4.1)
Arti Patel	Senior Counter Fraud Specialist TIAA
Cheryl Plumridge	Director of Governance & Assurance
Helen Potton	Interim Corporate Governance Manager (minutes)
Prof Janice Sigsworth	Director of Nursing (from agenda item 1.5 and for part of 2.7,4.1 and not for 2.8)
Ian Sharp	Regional Managing Director TIAA
Bill Shields	Chief Financial Officer
Sir Richard Sykes	Chairman

1	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Sir Gerald Acher welcomed members to the meeting and introduced Claire Broster who would be starting with the Trust in August as the new Risk/Project Manager for the Trust. He advised the committee that a pre-meeting had taken place with non-executive committee members and internal and external audit which would occur twice a year going forward. He said that nothing had been discussed at the private meeting which needed discussing at the full meeting
1.2	**Apologies for Absence**
	Apologies for absence were received from Sir Thomas Legg, Marcus Thorman and Heather Bygrave.

1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared at the meeting.
1.4	**Minutes of the Committee's meeting on 28 May 2014** The minutes of the meeting held on 28 May 2014 were approved as a true record except for the removal of the last seven words in minute 3.2.1.
1.5.1	**Matters Arising from the Minutes and Action Log** The committee noted the updates which completed the following outstanding actions: 4.3 The current arrangements for providing clinical advice on safeguarding issues were good but a substantive appointment to the role needed to be made. The issue would be brought back to the committee as required.
1.5.2	2.2.1 The Staff Survey would be dealt with by the Quality Committee.
1.5.3	2.3.1 Prof Sir Anthony Newman Taylor advised the Committee of the information reported to the Quality Committee noting that cancer experience was an important issue upon which considerable work had been undertaken by the Trust including setting up a cancer steering group. Reported experience was worse for those who had had cancer for more than five years and for those for whom English was not their natural tongue. There had been a redesign of pathways in some areas giving rapid access to some services, for example, in prostate cancer. He referenced the 'Smile' campaign that the Trust was running which highlighted patient experience related issues such as what a patient preferred to be called.
1.5.4	The Trust repeated the survey quarterly to understand the effectiveness of the plans in place. Steve McManus advised that eighteen months ago the Trust had entered into a strategic partnership with MacMillan which had culminated in a Memorandum of Understanding being prepared which would result in funding of £3M for the Trust on patient navigation due to start in September 2014. Prof Janice Sigsworth noted that the friends and family test reported patient experience on a real time basis which was an effective tool for the Trust and that the Trust would be holding a 100 day event in June which would bring together some of the work being done and highlighted the progress the Trust had made.
1.5.5	Sir Richard Sykes suggested that the Trust needed to look at the fragmentation of neurology which resulted in significant inefficiencies impacting upon patient experience. Prof Chris Harrison advised this was being tackled by having single teams in place but would take time to achieve.
2	**GOVERNANCE & RISK BUSINESS**
2.1.1	**eTendering – A proposed update to the Standing Financial Instructions** Bill Shields presented a paper to amend the tendering provisions to an eTendering solution which would enable the Trust to have a better understanding of its procurement which, amongst many benefits, would reduce the level of stock required impacting on the level of stock destroyed at a cost to the Trust. There was no additional cost as the eTendering module was part of a package that the Trust already subscribes to and was in line with financial rules on procurement and recommended by the Department of Health.
2.1.2	The Standing Financial Instructions (SFIs) would require amendment in line with the changes. Sir Gerald Acher asked if Internal and External Audit were happy with the proposal which they confirmed that they were. The Committee discussed the benefits of an organisation that achieved 100% procurement compliance and Sarika Patel noted that the Trust would need a well defined exception policy to assist this. **Action**: Update report on progress to March meeting

	The Committee **noted** the increased controls delivered through the eTendering system and the proposed changes to Standing Financial Instructions to be submitted to the September 2014 meeting. In addition, the Committee **approved** the use of eTendering for a number of tenders between now and the formal update to test system functionality.
2.2.1	**Cerner: Update** Kevin Jarrold presented the Cerner update noting that the Trust was in its eighth week of live operation and that user confidence was growing following exceptional staff engagement and a successful implementation using the floorwalker model and utilising gateways with a set of criteria before the project moved forward. The Committee discussed using the lessons learned from the implementation for other large projects including the Chief Inspector of Hospitals visit.
2.2.2	Bill Shields noted that it had come at a price but Sir Richard Sykes suggested that had it gone wrong the cost would have been greater. Sarika Patel advised that a project evaluation would be presented to the Finance and Investment Committee later in the year.
2.2.3	Kevin Jarrold advised that plans were in place to move to the next phase which needed to see the project move back to expected expenditure although noting that there were a couple of constraints including that currently there were two different emergency department systems being used at different sites, which created a cumbersome workflow. Sir Richard Sykes asked if it could link to other organisation's systems including the London Ambulance Service. He was told it could. Dr Tracey Batten noted the huge clinical benefits of electronic prescribing which was also part of the next phase. The Full Business Case would go to ExCo in July and come back to the Committee in September. **Action**: Update on next stage of Cerner to next meeting. The Committee **noted** the progress being made, the approach being taken to stabilisation and the planning for the next phase.
2.3	**Safeguarding Adults Progress Report** Prof Janice Sigsworth presented the Safeguarding Adults Progress Report which showed that the Trust was doing what it should. She would bring an annual report to the Committee in due course. **Action**: Annual Safeguarding Adults Report to be presented to the Committee (at a future date). The Committee **noted** the contents of the report.
2.4	**Quality Accounts** Prof Chris Harrison presented the Quality Accounts noting that sign off was required as they needed to be live on the NHS Choices website on 30 June and that they had been taken on a number of different Committee agendas. Dr Tracey Batten advised that Bill Shields was coordinating a debrief of the accounts sign off process and that this would be covered in that work. Prof Sir Anthony Newman Taylor noted that the Committee had seen these Accounts at least twice previously and that the comments made had been addressed. Andreas Raffel suggested that they formed a large document and asked if this was prescribed to which Prof Chris Harrison advised that in part they were prescribed but that he would be looking to reduce the volume for next year and that the process to develop these Accounts needed to be

	refined. The Committee noted that the responses to stakeholders comments required review to ensure that they were as full as possible. The Committee **approved** the Trust's response to the stakeholder's comments on the basis that more detail was required in some responses which would be signed off by the Chief Executive and Chairman.
2.5	**Trust Data Quality** Kevin Jarrold presented the Trust Data Quality report, the purpose of which was to ascertain whether or not the Trust was right to have assurance on the quality of the Trust's elective waiting time performance. Internal Audit confirmed that the work that they had undertaken had indicated that the quality was appropriate and External Audit noted that their work had been limited as they had only taken two indicators so were not in a position to comment substantively. Steve McManus advised that a rolling brief would be provided to ExCo and then the Audit, Risk & Governance Committee with a view to including it within the scorecard. Sarika Patel asked for consideration to be given to writing the information in plain English as she had struggled to understand the current paper. **Action**: Timetable for audits to go to September meeting The Committee **considered** the recommendation to implement a rolling programme of reporting performance data quality reports and **noted** the paper on elective waiting times performance data quality. .
2.6.1	**Summary of the Critical Care Staffing restructure and Failure to Rescue final trend report** Steve McManus presented an oral update on critical care staff and would bring back information on trends in failure to rescue to either the Committee or the Quality Committee. **Action**: Report on trends in failure to rescue to Quality or Audit, Risk & Governance Committee
2.6.2	He noted that the critical care vacancy rate had been at 30% and was particularly challenging at Hammersmith but that since the reorganisation to divisions and the introduction of a Director of Critical Care and his programme of change, this was expected to be down to less than 5% at the end of June early July. A critical care steering committee had also been set up which looked at longer term strategy together with short term improvements for acuity and how to deliver integration which had delivered real improvement so he was confident that the Trust was in a more stable position.
2.6.3	Prof Sir Anthony Newman Taylor asked how stable staffing was given the traditional high proportion of staff from abroad and was advised that the manner in which the Trust inducts it new staff and made them want to stay, has resulted in many instances of staff from overseas becoming a core part of the Trust's workforce. Prof Janice Sigsworth suggested that it would be important to work with newly qualified trainees and feed them through into the critical care route as a part of their career development within a rotational programme. Sir Gerald Acher noted that it was also important to understand the reasons for leaving. The Committee **noted** the oral update.

2.7.1	**Corporate Risk Register** Cheryl Plumridge presented the Corporate Risk Register (CRR) noting that discussions had taken place with the Executive Team to develop it and that a workshop was due to take place on 23 July, which would be externally facilitated by experts, and which would develop both the CRR and the Board Assurance Framework (BAF) further in conjunction with the revised vision and objectives. The current register was an amalgam of the previous register and a fresh look at the risks that the Trust currently faced, noting that there were new risks in relation to Medical Education, the issue of closure of the Emergency Unit at Hammersmith Hospital and out of hours surgery at Charing Cross.
2.7.2	She suggested that the Trust was currently better at articulating risks using a bottom up process but that it was important to take a strategic top down approach as well linking this with the Trust's strategic objectives. . Sir Gerald Acher suggested that it was essential that staff appreciated that this was important and that the Board would do something with information obtained. Cheryl Plumridge explained that as part of the new role as Risk/Project Manager, Claire Broster would be getting out and about the Trust to ensure that staff were aware of the process of managing risk and the importance that the Trust Board placed on it.
2.7.3	Sarika Patel, whilst noting that this was work in progress, suggested that the PICU risk should form part of the HCAI risk and suggested that a better understanding of where risks fed into one another and where they were important enough to be a risk in their own right was required.
2.7.4	Dr Tracey Batten stated that the workshop could be repeated involving the Non-Executive Directors and that this could be undertaken during one of the currently planned Strategy Seminars if there was an appetite for this.
2.7.5	Andreas Raffel asked about the do not resuscitate (DNR) judgement that had been reported nationally the previous day and how the Trust was going to approach it. Cheryl Plumridge advised that the position appeared to be that a DNR would be deemed to be illegal if it had not been consulted upon. However, she was asking for clarification on how the ruling would affect the Trust and Trust policy. Prof Chris Harrison stressed the importance of this and the potential impact and implications as it was a practical issue on the wards and needed to be considered in line with best interest and legal capacity assessments. The Committee **noted** the plans to revise the way risk management was conducted in the Trust and **considered** the current CRR which represented work in progress.
2.8.1	**Junior Doctors Local Induction** Prof Chris Harrison presented the Junior Doctors Local Induction report noting that this was a very specific issue around induction on the wards which formed part of the risk on education. He suggested that it could be reported in a more positive way going forward which would be particularly helpful as this was in the public domain and that he was planning to take it through ExCo. Andreas Raffel suggested that it was important to record what people thought about the induction and not just whether it took place.
2.8.2	Prof Chris Harrison noted that the Trust had recently had two senior visits, one from the Deanery and the other from the College which had gone well and it was important to try and maintain that feedback through to the General Medical Council doctor feedback. Sir Gerald Acher requested a deep dive into education at the end of the year. **Action**: Junior Doctor Local Induction deep dive to December meeting

	The Committee **approved** the Medical Director's review of the junior doctor induction process.
3	**EXTERNAL AUDIT BUSINESS**
	There were no External Audit agenda items
4	**INTERNAL AUDIT BUSINESS**
4.1.1	**Internal Audit Report** Ian Sharp presented the Internal Audit Report noting that the plan had been approved by the committee and delivered in accordance with agreed changes. There had been significant assurance stated in the Head of Internal Audit Opinion and there were plans in place to follow up issues that had been identified as having only limited assurance.
4.1.2	The Committee discussed the ongoing issue regarding recovery of patient transport costs that had also been discussed at the Finance & Investment Committee (FIC) and Bill Shields confirmed that this has been taken into account as part of the discussions on the fixed income agreement however a more specific discussion would be required if this moved to a payment by results (PBR) model. The Committee agreed that a more in-depth look at this would be appropriate and a review would take place on transport as a complete process together with the effectiveness of the controls in place which would be dealt with at FIC. **Action**: The FIC to take a paper on patient transport costs The Committee **considered** the 2013/14 Annual Report in conjunction with the Internal Audit Annual plan.
4.2.1	**Internal Audit Strategy Audit Plan** Ian Sharp presented the Internal Audit Strategy Audit Plan which had been developed together with other trusts. The additional work on the risk register would inevitably inform the plan so it may be necessary to flex, it although this would not be the only driver for changes.
4.2.2	The plan contained an Executive lead for each area although Prof Chris Harrison suggested that these required further refinement but the Committee noted that what was important was to ensure that the recommendations were taken on board. Dr Tracey Batten noted that whilst she was happy with the plan for this time going forward she would want to have a more detailed discussion with the Executive team first. The Committee discussed to whom Internal Audit should report on a day to day basis. It was noted there was no prescribed model but that it was essential that, where necessary, there was a clear route to the Chief Executive.
4.2.3	Sarika Patel noted that the Trust had exceeded its budget for consultancy and agency spend and asked Internal Audit to review. Sir Richard Sykes noted that 75% of invoices were currently being signed off by staff, above their level of authority which needed to be addressed. The Committee **approved** 2014 / 15 Internal Audit Strategy Audit Plan with minor changes to the Executive leads.
4.3.1	**Outstanding actions arising from Internal Audit reports – Deep Dive** Philip Lazenby presented a report which looked at outstanding actions arising from Internal Audit recommendations and advised that going forward TIAA would be more robust about challenging Executives as to why the recommendations had not been implemented and escalated where necessary. He suggested that all outstanding actions should be achieved by July/August time. However, Prof Janice Sigsworth suggested that this would be challenging for her and it was agreed that a discussion outside of the meeting on realistic timeframes would take place.

	Action: Revised timelines to be agreed
4.3.2	Ian Sharpe suggested that it was important that the Executive Directors were involved in the sign off of the reports. It was agreed that a further update would be presented to the next meeting. **Action**: A review of outstanding actions to be brought to the Audit, Risk & Governance committee in September. The Committee **noted** the report.
4.4	**Counter Fraud Annual Report** Arti Patel presented the Counter Fraud Annual Report which reflected a similar number of investigations to the previous year. The Committee discussed the issue of illegal contract workers and whether or not the Trust could do more than it currently did. It was noted that the onus was on the contractor's agency but that the Trust was considering purchasing new technology which would enable it to undertake passport and driving licence checks at a cost of £10,000. The Committee **noted** the contents of the Annual Report.
4.5	**Counter Fraud Progress Report** Arti Patel presented the Counter Fraud Progress Report highlighting an investigation into two payments to a false bank account which was currently being investigated by the police after the money had been removed. There was a suggestion that there could be some internal involvement which was being investigated further. The Committee **noted** the contents of the progress report.
5	**FINANCIAL & OTHER BUSINESS**
5.1	**Tender Waivers Report** Bill Shields presented the Tender Waivers Report which was split in accordance with the Standing Financial Instructions (SFIs). The Committee discussed whether or not the classification was too tight and noted that it may be necessary to review the SFIs to provide to create a little more flexibility. The Committee **noted** and **approved** the Tender Waivers Report
5.2.1	**Losses and Special Payments Register** Bill Shields presented the Losses and Special Payments Register which was a standing agenda item and highlighted the level of private patient write offs which related to historical issues. He noted that there had been some changes in the control environment and this together with a new management structure which included staff with previous NHS private patient experience provided confidence that issues would not arise in the future and that the new staff would be confident to challenge existing rules where appropriate. The Committee noted that a review on private patients was due to go to FIC and it was agreed that analysis of the figures would be included in this. **Action**: Private Patient update to include analysis of the figures to FIC.
5.2.2	In respect of overseas visitors the write off was particularly high due to accounting procedures and the lack of regular review which was being addressed going forward. Steve McManus noted that over half of the write off value related to 14 patients and suggested that each should be reviewed to understand the themes and issues that they identified. Dr Tracey Batten suggested that it would be useful to

	understand where the other Trusts were within the Shelford Group and agreed that this would be discussed further by the Executive Team. Bill Shields confirmed that the ex gratia payment related to a significant individual payment. The committee **reviewed** the schedule of losses and special payments in accordance with SFIs
6.1	**ANY OTHER BUSINESS** The Committee noted the Chief Inspector of Hospitals (CIH) visit scheduled for September which would be discussed at the Strategy Seminar the following week.
6.2	Prof Chris Harrison agreed to provide a progress report on the work being done with the Royal Marsden in September.
7	**DATE OF NEXT MEETING** Wednesday 10 September 2014, 10.00am – 1.00pm, Clarence Wing Boardroom, St Mary's Hospital