Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
29 July 2015
11.20 – 13.00
New Boardroom, Charing Cross Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Deputy chairman	11.20	Oral
1.2	Board member's declarations of interests	Deputy chairman		1
1.3	Minutes of the meeting held on 27 May 2015	Deputy chairman		2
1.4	Record of items discussed at Part II board meeting 27 May 2015	Deputy chairman		3
1.5	Action Log	Deputy chairman		4
2	**Operational items**			
2.1	Patient Story	Director of nursing	11.30	5
2.2	Chief Executive's Report	Chief executive		6
2.3	Operational Report & Integrated Performance Scorecard	Chief ops officer		7
2.4	Finance report	Chief financial officer		8
3	**Items for decision or approval**			
3.1	Proposal for co-location of stroke services	Chief ops officer	11.55	9
3.2	Values and behaviours project	Director of comms		10
3.3	Quality Strategy	Medical director		11
3.4	Quality Improvement Programme implementation plan	Medical director		12
3.5	NHS TDA self-certifications – May/June 2015	Trust co secretary		13
3.6	Annual Reference costs submission	Chief financial officer		14
4	**Items for discussion**			
4.1	2014 National adult inpatient survey results	Director of nursing	12.30	15
4.2	CQC update report	Director of nursing		16
4.3	Clinical strategy implementation and estates redevelopment	Director of strategy		17
4.4	2015/16 Clean Sheet Review to set Nursing and Midwifery Establishments	Director of nursing		18
4.5	Research update	AHSC director		19
5	**Board committee reports**			
5.1	Audit, risk & governance committee report (8 July); minutes of the meetings (22 April/27 May); and annual report	Committee chair	12.45	20
5.2	Quality committee report (15 July); minutes of the meeting (13 May); and annual report	Deputy chairman		21
5.3	Finance and investment committee report (22 July); minutes of the meetings (20 May/ 22 May/15 June)	Committee chair		22
5.4	Remuneration committee report (24 June)	Committee chair		23
6	**Items for information**			
6.1	Emergency Preparedness assurance report	Chief ops officer	12.50	24
6.2	Local Supervising Authority (LSA) report of standards of supervision of midwives'	Director of nursing		25
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			12.55	

9	**Annual general meeting**	
	Wednesday 9 September, Porchester Hall, London, W2 5HS 17:30 - 19:00 (doors open 17:00 and close at 19.30)	
10	**Date of next meeting**	
	30 September 2015, Clarence Wing Boardroom, St Mary's Hospital	

NB: will release annual report this day too

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Board Members' Register of Interests

Sir Richard Sykes Chairman

- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Non-Executive Chairman of NetScientific plc since 2008
- Chairman of Royal Institution of Great Britain since 2010
- Chancellor Brunel University since 2013
- Chairman PDS Biotechnology Corporation since 2014

Sir Gerald Acher Non-Executive Director

- Deputy Chairman of Camelot UK Lotteries Ltd (until the end of August 2015)
- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Trustee of KPMG Foundation
- President of Young Epilepsy
- Chairman Brooklands Museum Trust
- Chairman Cobham Community Bus CIC

Dr Rodney Eastwood Non-Executive Director

- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy [Secondary school]
- 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
- Chairman, Audit Committee, Society of Biology

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
- Designated member of JRJ Ventures LLP
- Limited Partner of JRJ Partner 2 LP
- Member of LSBI LLP
- Director of Elljay Limited
- Member of Bridges Ventures Advisory Board

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
- Chairman, Work Health Expert Committee, Health and Safety Executive

Sarika Patel Non-Executive Director

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

Dr Andreas Raffel Non-Executive Director

- Senior Adviser at Rothschild
- Deputy Chair 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

- Trustee of The Point of Care Foundation

Alan Goldsman Interim Chief Financial Officer

- Alan Goldsman Ltd

Steve McManus Chief Operating Officer

- Chair – National Neurosciences Managers Forum
- NHS Providers 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 General Nursing Council Trust

Dr Chris Harrison Medical Director

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

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

11.15am – 1.00pm
Wednesday 27 May 2015
Oak Suite, W12 Conference Centre, Hammersmith Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy chairman
Dr Rodney Eastwood	Non-executive director
Jeremy Isaacs	Non-executive director
Sir Anthony Newman Taylor	Non-executive director
Sarika Patel	Non-executive director
Andreas Raffel	Non-executive director designate
Dr Tracey Batten	Chief executive officer
Alan Goldsman	Interim chief financial officer
Prof Chris Harrison	Medical director
Steve McManus	Chief operating officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Jan Aps	Trust company secretary (minutes)
Ian Garlington	Director of strategy
Jayne Mee	Director of people and organisation development
Prof Gavin Screaton	Dean of the Faculty of Medicine, Imperial College
Louisa Thompson	Patient
Prof TG Teoh	Divisional director, Women's and children's services
Prof Jamil Mayet	Divisional director, Cancer and surgery
Dr Roland Veltcamp	Chair of stroke medicine
Claire Braithwaite	Divisional director of operations, Medicine

1	**General business**	**Action**
1.1	**Chairman's opening remarks and apologies** The chairman welcomed Board members, staff and members of the public to the meeting. Apologies for absence were received from Michelle Dixon and Kevin Jarrold.	
1.2	**Board members' declarations of interest and conflicts of interest** There were no additional conflicts of interests declared at the meeting.	
1.3	**Minutes of the meeting held on 25 March 2015** The minutes were agreed as an accurate record.	
1.4	**Record of items discussed at Part II board meetings 25 March, 8 April, 13 May** The report was noted.	
1.5	**Matters arising and action log** Dr Batten noted that all items were either completed or were on future agendas. The Board noted the updates to the action log. Prof Harrison provided a verbal update on use of Troponin.	
1.6	**Record of the use of the Trust seal** Jan Aps confirmed that all use of the Trust seal complied with the requirements of the Trust Standing Orders. The Board noted the report.	

2	**Operational items**	
2.1	**Patient story** The chairman welcomed Louisa Thompson to the meeting. Ms Thompson is a sickle cell disease patient, a condition which means she experiences debilitating periods of pain when in crisis. She considered that the Trust provided much better care than she had received where she had been previously treated. In particular, the day unit, with fantastic care and support from the nursing staff, enabled her to cope with continuing at home at times when she would otherwise be treated as an in-patient, giving her back control of her life. Ms Thompson explained that she often has prodromal symptoms that warned her of a crisis attack. Steve McManus commented that it was a pleasure to hear that that the service was working well for Ms Thompson, but asked if there were further improvements that could be made, to which she responded that, at times, it would be helpful if greater privacy could be provided, and adjustments available to lighting and temperature levels. She again stressed that, overall, the service had made a real difference to her ability to manage her condition. In responding to Ms Thompson's comments on GP relationships, Dr Batten noted that improved information to GPs may help with the prescribing of pain relief; this would be followed up. Sir Gerald Acher commented this was an area where development of home care services from the Trust could benefit patient care. The chairman thanks Ms Thompson for coming to the Trust board to share her experience.	
2.2	**Chief Executive's report** Dr Tracey Batten particularly highlighted the following items: • Cerner: with the patient administration system now embedded and data quality issues largely addressed, the pilot of clinical documentation and electronic prescribing was underway, with a plan to complete on all sites by the end of 2015/16. Clinical feedback thus far had been positive. • Inpatient survey results: these had been received, and early review showed a slight improvement in scores, with similar results to other Trusts in London. • Royal birth: there had been extensive media interest, and all arrangements had worked smoothly, thanks to the hard work of staff, volunteers and partners (including Metropolitan Police and the Royal Household); positive feedback had been received from the family. • Staff engagement survey: results from the seventh survey showed that response rates continued to increase, with 57% of staff sent the survey having completed it. The engagement index also showed improvement – 3% increase to 44%; this showed that actions to improve staff satisfaction, including reward and recognition, were having a positive impact. The non-executive directors commended the executive team for their efforts in achieving these improvements. The Trust board noted the report.	
2.3	**Operational report and Integrated Performance Scorecard** Steve McManus presented the operational report and integrated performance scorecard together, particularly highlighting the following items: • There were a number of gaps in month 1 data, and a further version of the scorecard would be circulated when a complete set of data was available. • A&E performance had shown steady improvement, with an increasing number of days achieving the target of 95% of patients treated within four hours, demonstrating that the changes were becoming embedded. • Whilst one of the Cancer standards (patients waiting 62 days) had not been achieved in January and February (affecting the quarter 4 performance), all eight standards had been achieved in March and it was expected that this would continue in future months. Dr Raffel noted the small number of RIDDOR injuries (staff injuries reportable to the Health and Safety Executive); Mr McManus confirmed that patient trips and falls were	

	recorded as untoward incidents in the Datix system and reviewed via the quality report at executive committee and quality committee. The standards and data behind the cardiac patient indicators would be checked for accuracy, as would those for elective length of stay; this would be reported to the audit, risk and governance committee (and reported to the board in the committee report). Data quality was subject to a series of controls including internal audit, and overseen at the audit, risk and governance committee. Work continued with Cerner and the data teams to ensure that remaining issues were resolved; it was acknowledged it was essential to be confident in the Trust's data quality. Dr Raffel asked for clarity as to the total number of never events during 2014/15; the data appeared contradictory [post-meeting note: the annual report provided data for 2014/15, and the scorecard a rolling 12 month period, May14 to April 15, hence the difference]. Ms Patel requested detail on how effectiveness and efficiency of outsourcing activity to reduce referral to treatment (RTT) was being assured. Mr McManus outlined that MRI and CT quality was overseen and reported by Trust clinicians, with incidents reported through Trust systems. The Trust was working with CCGs to explore options for outsourcing additional capacity; Ms Patel requested that further information on patient safety and experience be reported to a board committee when available. Prof Harrison would report back if any of the April C difficile cases were due to lapses of care. He would also bring a report to the July Trust board on the CRE infection issues. The Trust board noted the report.	KJ SMcM CH
2.4	**Finance Performance Report** Alan Goldsman noted that the Trust had met all financial targets at 2014/15 year end and reported a £15.4m surplus, but this did not diminish the underlying issues for 2015/16 including loss of project diamond income, increased CNST costs, the tariff arrangements, and lack of CQUIN funding. The annual plan, approved by the Trust board at its extra-ordinary meeting on 13 May, contained an efficiency programme (assessed for quality impact) of £36.4m, but this was not sufficient to deal with all pressures, and the plan demonstrated an £18.5m deficit. The Trust board has not taken this decision without due regard to its impact, and noted this could only be a one year position, and the underlying financial position must improve. The Trust had sufficient cash to support the deficit for one year and a tight capital programme (£49m, including Charity contributions). Noting the risks to the plan, the Trust board noted the need for focus on executing an improvement in efficiency. Early review of the April position appeared positive, with pay costs encouragingly within control totals. Progress on cost improvement programmes would be reported to the finance and investment committee. Contract had yet to be signed but good progress had been made, with local incentive payments, RTT funding and demand capacity yet to be agreed. It had been agreed that an independent review of the tariff would be undertaken nationally prior to the setting of the 2016/17 tariff. The Trust board noted the finance performance report.	
3	**Items for decision or approval**	
3.1	**Proposal for co-location of stroke services** Prof Veltcamp presented the report, noting the strong clinical consensus for the proposal to provide an interim co-location of stroke services on the Charing Cross site prior to their final move co-located on the St Mary's site following the re-development. It was considered that this would bring about improvement in patient experience as well as clinical outcomes and efficiency. Dr Batten advised the Trust board that she had discussed the proposal with individual members of the Westminster oversight and scrutiny committee (OSC) seeking advice as to the appropriate way of moving forward on this. Advice was expected week commencing 1 June, and if no significant issues were highlighted, community engagement would commence. The plan would be to co-locate the services by the end of	

	the calendar year if no major barriers were identified during the community and staff engagement process. The Trust board approved the outlined engagement and communication for the proposed stroke service co-location, noting the shape of the engagement would be informed by the outcome of the Westminster overview and scrutiny committee discussions.	
3.2	**Responsible Officer's Annual report – Revalidation & Appraisal** Dr Redhead noted that revalidation via the General Medical Council (GMC) was a statutory requirement for all doctors registered with a licence to practice. He particularly highlighted that two-thirds of doctors had completed re-validation, and that 92% of doctor had received an appraisal. The Trust board noted the report and confirmed it was satisfied that "the organisation, as a designated body, was in compliance with the FQA regulations", and approved submission of the statement of compliance to NHS England. It also approved the appointment of Dr Redhead as Responsible Officer, replacing Prof Harrison in that role.	
3.3	**NHS Trust Development Authority self-certifications** Mrs Aps outlined the strengthened in governance arrangements in relation to the self-certifications. As 'comply or explain' returns, a detailed description was required where the trust was not in a position to answer yes to individual statements. The Trust board ratified the March submission and approved the April submission, noting there would be further minor changes.	
3.4	**Annual safeguarding reports** Prof Sigsworth, in presenting the adult and children's reports, particularly noted: • good improvement in training compliance • positive feedback from CQC and internal audit reviews of policies and practicalities of application • a focus on female genital mutilation, domestic violence and gang violence. Ms Patel Sarika was pleased to note guidelines in relation to placing of young adults, and asked that the same consideration could be given to the 14-16 age group, acknowledging that this would always depend on clinical need and the maturity of the child. The Trust board noted the reports, including the Annual Safeguarding Children declaration (having been approved by the executive committee and presented to the quality committee) which would be published on the website.	
3.5	**J Savile and the Kate Lampard Lessons learned report** Mrs Aps presented the report on the Kate Lampard lessons learned review of the Savile investigation, highlighting the list of recommendations made. The Trust had taken a number of actions during previous reviews, which was reflected in the responses recorded on the proposed TDA return. The Trust board noted the lessons learned report and approved the TDA submission.	
4	**Items for Discussion**	
4.1	**Corporate risk register** Prof Sigsworth introduced the register, noting it was the first time it had been brought to the public board. Sir Gerald Acher complimented her and her team for the real improvement in the way that risks were being recorded, managed and escalated. An amendment was suggested to risk 65, where the risk would be extended to undergraduate medical education, and would include: that the number of students reducing; changes being introduced in training approach, and location of training; and mobility of students. The Trust board noted the report.	JS/ CH
4.2	**Board assurance framework** Mrs Aps noted that the report was as had been presented to the confidential board in March 2015, other than updating for changes to the corporate risk register. She noted the	

	addition of a range of indicators which would form the basing of a RAG rating for each of the strategic objectives. It was felt that an independent review of the board assurance and governance framework would be appropriate in 2016/17 when the new 'well-led' framework had bedded in. Minor amendments were agreed to in the key controls to objective 1b and 1c (patient experience and outcomes, delivered efficiently): pages 3/4 – 'quality / finance and investment (as appropriate) committee and report to the Trust board' would be added. The Trust board noted the report.	JA
5	**Board Committee Items**	
5.1	**Audit, Risk & Governance Committee** Sir Gerald Acher particularly highlighted the committee's review of the internal audit and counter-fraud plan, and review of documents being prepared for the annual report and accounts, and quality account. The Trust board noted the report of the meeting on 22 April and the minutes of the meeting on 11 March 2015.	
5.2	**Quality Committee** Professor Sir Anthony Newman Taylor noted that much of the committee's business had been discussed at the meeting, but highlighted that the revised quality strategy would be aligned to the CQC quality domains, rather than the Berwick quality domains as previously. The Trust board noted the report of the meeting on 13 May 2015.	
5.3	**Finance & Investment Committee** Sarika Patel noted that the items discussed at the meeting had been covered in the finance review. The committee had also reviewed the paediatric intensive care unit business case, and a further tender document. The Trust board noted the report of the meeting on 20 May 2015.	
6	**Items for information**	
6.1	**Ealing maternity transfer** Dr Batten highlighted the following points from the report: • Ealing CCG had formally decided (on 20 May 2015) to move maternity services from Ealing Hospital, and 1,000 of these births would transfer to the Trust as of 1 July 2015; it was anticipated that paediatric services would transfer to the Trust and other trusts 12 months later. • A significant amount of work had been undertaken to ensure that appropriate arrangements were in place (staffing, infrastructure, financial) at both Queen Charlotte & Chelsea and St Mary's hospitals. • Midwife ratios were being enhanced to 1:30 mothers. The Trust board noted the report, and confirmed that they were assured of the Trust's operational readiness.	
6.2	**Annual Caldicott report** The report sought to provide assurance that it is in compliance with the information governance (IG) legislative requirements and NHS IG standards as part of the DH IG toolkit. Dr Batten, in noting the key points from the report, confirmed that the Trust had maintained level 2 status, allowing other organisations to have confidence in the way that the Trust handles both patient and staff personal information. She also highlighted that 97% of staff had completed the mandatory IG training. The Trust board noted the report.	
6.3	**Annual Complaints report** Prof Sigsworth particularly noted that the Trust was seeking to improve the timeliness of responses, recognising that patients wanted rapid resolution to concerns. A further focus for the coming year would be to demonstrate how the Trust learned from patient experiences to improve the quality of services.	

	The Trust board noted the report.	
6.4	**CQC update report** The Trust continues to be registered at each site without any conditions. The CQC intelligent monitoring report had identified the Trust as an outlier for mortality rates for acute myocardial infarction patients; this had been investigated and no issue found, the CQC had closed the alert, and this had been reported to the quality committee. The Trust board noted the report.	
7	**Any other business**	
	There were no items of any other business.	
8	**Questions from the public relating to Agenda items** In response to questions from the public the following points were made: • Dr Batten explained that the decision to co-locate hyper-acute and stroke services with major trauma services at St Mary's had been made in 2008, and that this remained the appropriate long-term clinical location; this was reflected in the Trust's clinical strategy. The interim co-location at Charing Cross Hospital would provide our patients with an improved level of care and experience. • Further information on the patient post-breast surgery pathway (in relation to bone scans) would be made available at the next Trust board. • Professor Harrison confirmed that the introduction of the responsible officer role and strengthening of consultant appraisals would ensure that doctors were behaving in an appropriate manner, and that the Trust would take action in the rare occasions where this was not the case. • Steve McManus noted that the plan for further MRI equipment would reduce the need for commercially provided mobile scanners, which were, by their nature, a less positive environment for patients. • Dr Batten confirmed that public consultation had been undertaken as part of Shaping a Healthier Future, and that the Trust continued to plan on the basis of this strategy, noting that service planning was not static and would be influenced by the many discussions that continued with stakeholders and partners. • When undertaking specific activity to reduce waiting times for elective patients, the Trust would always: first, extend hours within the Trust (as had been done in March and April); second, work through CCGs to identify other NHS facilities that may have appropriate capacity; and then third, work through CCGs to identify commercial organisations that may have relevant capacity and capability, and offer this to appropriate patients (mainly specific procedures in ENT, orthopaedics, general surgery and urology).	**SMcM**
9	**Date and time of next meeting** The next meeting would be held on Wednesday 29 July 2015, New Boardroom, Charing Cross Hospital.	

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	1.4
Title	Record of items discussed at the confidential Trust Board on 27 May
Report for	Noting
Report Author	Jan Aps, Trust company secretary
Responsible Executive Director	Tracey Batten, Chief executive

Executive Summary:

Decisions taken, and key briefings, during the confidential sessions of a trust board are reported (where appropriate) at the next trust board held in public. Those issues of note and decisions taken at the Trust board's confidential meetings held on 27 May:

- **Co-location of stroke services**: the Trust board noted the progress towards public engagement in relation to moving, pro tempore, stroke services from St Mary's Hospital to Charing Cross Hospital. (Post meeting note – engagement commenced on 15 June 2015 for a period of four weeks)
- **Paediatric intensive care unit (PICU) full business case**: the Board approved the business case which would upgrade and develop the paediatric intensive care unit (PICU) with the provision of co-located high dependency unit (HDU). Total cost would be £9.6million, of which £4.3m would be funded by the Imperial College Healthcare Charity and COSMIC.
- **Community ophthalmology bid**: the Trust board noted the report on the development plans and associated planning application and stakeholder and public engagement requirements.
- **Annual report and accounts:** the Board confirmed that the Trust was a going concern, approved the accounts in principle, based on the opinions of the external and internal auditors, and agreed to the delegation of signing of the management representation letter to the chairman and chief executive. They also reviewed and approved the annual report, including the annual governance statement.
- **Quality accounts**: the Board approved the quality accounts in principle, and delegated the signing of the quality account document to the chairman and chief executive.
- **External auditor**: the Trust board extended thanks to Deloitte LLP for their commitment over the period as the Trust's external auditors (BDO LLP have been appointed as the Trust's auditors from the 2015/16 financial year; an appointment made by the Audit Commission).

Recommendation to the Board:

The Trust Board is asked to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
Performance Scorecard: To develop further out-patient performance metrics	25 March 2015 2.3	Steve McManus	Completed – revised scorecard at July meeting	
Integrated performance scorecard To review scorecard, including board members, and implement revised scorecard for May Trust Board	28 January 2015 2.3	Steve McManus	Completed – revised scorecard at July meeting	
Theatres efficiency To provide a presentation to AR&G Committee in July (update to Trust Board in AR&G report). on the actions to improve theatre efficiency	28 January 2015 2.3	Steve McManus	Completed - reported to July AR&G committee, update in AR&G report to the board	
Cardiac patient indicators Standards and data behind the cardiac patient indicators would be checked for accuracy, as would those for elective length of stay; this would be reported to the audit, risk and governance committee (and reported to the board in the committee report).	27 May 2015 2.3	Kevin Jarrold	Completed – reported to July AR&G, update in AR&G report to the board	
Patient safety and experience The Trust was working with CCGs to explore options for outsourcing additional capacity; Ms Patel requested that further information on patient safety and experience be reported to a board committee when available	27 May 2015 2.3	Steve McManus		Small number of gender reassignment patients, with involvement of representative groups and NHS England, have

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
				been outsourced. Safety and experience reporting aligned to Trust systems.
April C difficile cases Any cases due to lapses of care would be reported to the board	27 May 2015 2.3	Prof Chris Harrison	Completed – all cases due to lapses of care would now be included in the operational report	
Corporate risk register Risk 65 to be amended.	27 May 2015 4.1	Prof Janice Sigsworth	Completed	
Board assurance framework Minor amendments to be made	27 May 2015 4.2	Jan Aps	Completed - revised BAF will be presented at the September private, and then November public, board meetings	
Post breast surgery pathway Further information to be provided on the post-breast surgery pathway (in relation to bone scans)	27 May 2015 8	Steve Mcmanus	Completed - there has been no change of practice in relation to the breast cancer pathway; guidelines for post-operative breast cancer patients state that patients should have an annual mammogram for five years (but no further diagnostics). Bone density measurement is a test offered to some patients on Tamoxifen to help identify osteoporosis. This has never been part of the patient pathway; rather, where patients are identified as possibly benefiting from this, our practice is that the Consultant Oncologist will write to the patient's GP to make the necessary arrangements.	

Imperial College Healthcare NHS Trust

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible
July 2015	**Emergency preparedness, resilience and response (EPRR)** To present progress against action plan to address 'amber' ratings	28 January 2015 3.2	Steve McManus
July 2015	**CRE infection issues** Quality committee report to include update on CRE	27 May 2015 2.3	Prof Chris Harrison
September 2015	**Leadership development** Consideration to be given to implementing a Trust-based graduate training scheme	27 November 2013 3.4.2	Jayne Mee

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	2.1
Title	Patient Story
Report for	Noting
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:

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

John's campaign aims to champion the ability of carers of patients with dementia to stay with them during acute hospital stays. ICHT has collaborated with the campaign and aims to become a dementia friendly organisation.

Julia Jones, co-founder of the campaign and Jo James, lead nurse for dementia at ICHT will tell the Board about the campaign and how ICHT is supporting it.

Recommendation to the Board:

The Board is asked to note the patient story

Trust strategic objectives supported by this paper:

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

Background

The use of patient stories at board and committee level is increasingly seen as positive way of reducing the "ward to board" gap, by regularly connecting the organisation's core business with its most senior leaders. There is an expectation from both commissioners and the Trust Development Authority that ICHT will use this approach. Thus far, the Board has received ten patient stories. The first seven were presented by the Director of Nursing and the last three were presented by patients in person.

The perceived benefits of patient stories are:

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

John's Campaign

John's Campaign was founded after the death of Dr John Gerrard in November 2014. John Gerrard had been diagnosed with Alzheimer's in his mid-70s but was managing to live a good, if limited, life at home, caring for his wife and supported by his family. He was admitted to hospital in February 2014, aged 86, to receive treatment for infected leg ulcers.

During his five-week stay, visits from his family were severely restricted due to an infection outbreak and his decline was catastrophic. His daughter Nicci said "My father went into hospital articulate and able: he emerged a broken man." These words, published in an Observer article in November 2014 sparked an outpouring of public sympathy and many similar accounts.

John's Campaign takes its inspiration from the campaigns of the 1960s which secured the acceptance of parents' rights to remain with their children in hospital and children's rights to the uninterrupted support of their parents.

The ICHT lead dementia nurse, Jo James, and her team read the Observer article and made contact with Nicci Gerard. They have been big supporters of the campaign and have made real changes at ICHT and the trust actively welcomes carers; demonstrated by signs outside the wards and the introduction of a "carer's passport.

Julia Jones, co-founder of the campaign and Jo James, lead nurse for dementia at ICHT will tell the Board about the campaign and how ICHT are supporting it.

The original article featuring Nicci Gerrard's comments, a further article that references the ICHT dementia team and their work and a link to the campaign website can be found below:

http://www.theguardian.com/society/2014/nov/29/nicci-gerrard-father-dementia-hospital-care-elderly

http://www.theguardian.com/society/2015/feb/14/dementia-voice-sufferers-campaign-awareness

http://www.johnscampaign.org.uk/index.html

Imperial College Healthcare NHS Trust

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

Executive Summary:

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

Recommendation to the Board:

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. Financial performance and sustainability

After three months the Trust is reporting a deficit of £11.0m; an adverse variance to plan of £1.9m. This represents deterioration in the position for June of £0.9m. A successful recovery from this position will be achieved by delivery of the planned and funded patient care volumes (both NHS and private care), urgently addressing the invoicing queries issued by CCGs, and by significantly improving cost control in key service areas, notably patient specialty.

It is anticipated that the contracts with the CCGs and NHS England will be finalised by the end of this month. Over the first quarter, £4.6m (69%) of planned Cost Improvement Programmes (CIPs) have been delivered. As divisions work to gain traction on schemes agreed during the latter stages of the business planning process, in-month delivery is forecast to improve from July (to 88%).

2. Operational performance

The Trust achieved the four hour access standard for patients attending Accident and Emergency in June. This was the first time the Trust had achieved the standard in a number of months and was the result of a number of initiatives to improve flow within the organisation. For patients who are discharged, there has been an increased focus on discharging before noon, to allow increased capacity for any new emergency admissions and free up capacity within the emergency departments.

Referral to treatment (RTT) performance has considerably improved over recent months. The primary measure of RTT performance is that 92% of patients should be waiting under 18 weeks at the end of each month. In June the Trust met this standard for the first time since May 2014. Further work over the coming months to increase capacity, particularly in surgical specialities, will result in patient waiting times reducing further and a reduced number of patients waiting over 18 weeks.

In July, performance is reported for the cancer waiting times standards in May. In May the Trust achieved six of the eight cancer standards. The Trust did not meet the 62-day GP referral to treatment standard and the 62-day screening standard. This was due to delays in access to diagnostic services, late referrals from other Trusts in North West London resulting in insufficient time to treat the patient in target, and patient choice reasons.

The Trust has had significant challenges with diagnostic capacity in recent months. This is particularly affecting our imaging services and is due to high staff turnover, diagnostic equipment downtime as well as insufficient equipment capacity. Steps are in hand to ensure we return to achieving the standard in the third quarter of 2015/16.

3. Carbapenem-resistant Enterobacteriaceae (CRE) update

Carbapenem-resistant Enterobacteriaceae (CRE) is an emerging pathogen worldwide, which is highly resistant to antibiotics. A total of 30 patients at the Trust have been affected since July 2014. Additional control measures have been introduced with the support of Public Health England (PHE), which include improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene,

environmental cleaning and disinfection, and antimicrobial usage and stewardship. There have been some operational implications with short term bay and ward closures for cleaning when necessary. The control programme was discussed in detail at the Quality Committee and will be the subject of a further report to the Board. There has been a month-on-month decline in the number of new cases identified since April 2015, with 2 new cases reported to date in July 2015.

4. Ealing maternity transfer

The transfer of Ealing hospital maternity services to other north west London hospitals successfully took place on 1 July 2015. All women who had been booked in at Ealing Hospital have now been mapped and booked in to receiving NWL hospitals. The Trust has received 211 women to date and there is an increase in the number of women booking directly with the Trust. Improved and expanded service areas will all be fully operational by Monday 27 July when the final area, the Lewis Suite at QCCH opens as an antenatal ward. There is focused engagement work taking place with staff across the maternity services and the remaining recruitment is underway.

5. Cerner Implementation

The detailed plans for the roll out of the Cerner functionality for clinical documentation and electronic prescribing have now been developed and reviewed by the Executive Committee and signed off. The implementation across the whole trust will be delivered in nine tranches between September 2015 and March 2016 and the approach using gateway criteria that has been applied successfully across previous phases will be utilised again. The move out of the BT data centre and into the Cerner data centre is tracking to plan for early September.

6. Equality Delivery System 2

The NHS Equality Delivery System (EDS) provides a framework and toolkit with which organisations can assess and improve the services they provide to patients in regard to the protected characteristics identified in the 2010 Equality Act. Use of the EDS ensures that the Trust fulfils the requirements of the public sector Equality Duty. The Trust is undertaking a review of compliance with selected EDS outcomes at a grading event in July. At the event three patient focused outcomes relating to safety, experience and involvement in decisions will be reviewed. The results will be reported to the Board in September.

7. Stakeholder Engagement

In relation to the stroke service proposal we have had regular contact with councillors from Westminster City Council which were beneficial especially in planning the engagement process. Westminster Council has established a Health Policy & Scrutiny Urgency Sub-Committee with the purpose of specifically considering any matter in respect of the statutory functions relating to consultation with health partners. Further discussions and meetings focusing on the stroke service proposal include those held with Healthwatch Central West London, Hammersmith & Fulham CCG Governing Body and a local stroke survivors' support group in the same borough.

In addition, we have attended formal local authority health overview & scrutiny committee meetings in June: with Hammersmith & Fulham Council to discuss our actions and improvements following the Francis Report; and, with Westminster City Council to discuss our progress on the issues of staffing levels and vacancy rates as a result of our actions taken after the CQC inspection report.

Since the General Election, we have also resumed our programme of discussions and meetings with local Members of Parliament representing constituencies in Hammersmith and Westminster.

8. Annual report and AGM

The 2014/15 annual report and accounts were approved by the Trust board in May and submitted to the Department of Health. Today, we are publishing them on our website and making hard copies available on request. We will also include a link to the report and accounts in our newsletters to stakeholders, members and GPs that will follow the July Trust board meeting. The report and accounts will be presented at this year's annual general meeting which will take place at Porchester Hall, W2 on Wednesday 9 September. Invitations to the AGM will begin to go out shortly.

9. Trust named as one of the best places to work in 2015

The Trust has been named as one of the Health Service Journal's (HSJ) best places to work in 2015. The Trust is one of 40 trusts included in the acute trust category. The list is a celebration of NHS organisations that have worked hard to promote staff engagement and create an environment where people can enjoy their work.

The Trust's national staff survey, completed between September and December 2014, reported that the Trust's engagement score of 3.76 was above average when compared with trusts of a similar type. The engagement score is calculated from three key questions; staff ability to contribute towards improvements at work, staff recommendation of the Trust as a place to work or receive treatment and staff motivation at work.

Areas in which the Trust rated above average include:

- staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department
- staff reporting good communication between senior management and staff
- staff agreeing that they would feel secure raising concerns about unsafe clinical practice
- staff having well-structured appraisals in the last 12 months

10. Nursery Ofsted inspection

The Charing Cross Nursery underwent an announced Ofsted (the office for standards in education, children's services and skills) visit this month. We were very pleased to be informed verbally that the Nursery maintained its Good rating and there were some areas which could be recognised as Outstanding, although this would not change the overall rating. Staff worked as a team, including returning to site from annual leave, to ensure a professional and successful inspection.

11. HPMA Awards

In June, the talent and organisation development team within our people and organisation development department were recognised for their role in leading the Trust Leadership programmes by being named Winner in the national Healthcare People Management Awards (HPMA) in the leadership development category. This is a significant achievement to be recognised nationally for the quality of the programmes and the contribution they make to our Trust strategic objectives. The Trust was also recognised by the HPMA for the work that has taken place on engagement and the Trust was named as a finalist in the category on engagement initiatives.

12. Executive team

Alan Goldsman, Interim Chief Financial Officer is leaving the Trust at the end of this month when he will take up his new interim role as Chief Financial Officer at Kings College Hospital NHS Foundation Trust. Alan has made an extensive and significant contribution since he joined the Trust at the beginning of this year.

Richard Alexander will join the Trust as the substantive Chief Financial Officer on Monday 3 August 2015 from University College London NHS Foundation Trust (UCLH) where he has been the Finance Director. Richard's strong values and deep understanding of the NHS make him an ideal fit for the executive team and Trust board – as well as a great leader for the finance team.

Key Strategic Issues

1. Chancellors budget 2015

The Chancellor of the Exchequer, George Osbourne, delivered the first budget for the majority conservative government on 8 July 2015. The budget reaffirmed the Government's commitment for funding the five year forward view (5YFV) through £8bn per annum by 2020, in addition to the £2bn announced in the autumn statement. The Chancellor also reiterated the commitment to a seven day NHS and said that the Government would continue to expand this programme.

2. Health devolution package for London

The Greater Manchester health and social care devolution MOU has set the stage for devolution in other cities. Following the publication of London's joint vision for public sector reform, a number of discussions have taken place to assess the appetite for devolution in London. NHS England is working with the Mayor of London and borough leaders to explore proposals to redesign London's £93 billion public services, which would include the devolution of health and social care responsibility to London boroughs. The key objective is to deliver against underpinning principles for better health and care in London. London councils, the GLA and London CCGs are continuing to explore the potential benefits of devolution and discussions with providers of healthcare in London will be crucial. NHS England are meeting with London leaders to consider the devolution proposals ahead of meetings with the Treasury.

3. "25 year vision" for health and social care

On Thursday 16 July 2015, Jeremy Hunt, Secretary of State for Health, set out the government's 25 year vision for a patients-led, transparent and safer NHS at the Kings Fund. Key announcements included:

- A drive towards greater devolution of responsibility and decision-making from the centre, facilitated by greater transparency of outcomes
- Changes to consultant contracts to enable 7-day services in the NHS.
- The Rose Report on leadership capacity in the NHS, which was also published on Thursday 16 July 2015, and includes the proposal to merge Monitor and the NTDA and a suggestion that the functions of the Leadership Academy come under the purview of Health Education England (HEE)
- Changes to the regulation architecture with a renewed focus on improvement. The new operating name for Monitor and the NHS Trust Development Authority (NTDA) will be NHS Improvement. Ed Smith, current NHS England Deputy Chairman, will Chair the new body, and Lord Ara Darzi will be a non-Executive Director
- The safety function will be moved from NHS England to NHS Improvement, and focus on two areas in the first instance, safe staffing and the Independent Patient Safety Investigation Service
- Introduction of an international buddying system. Virginia Mason Hospital in Seattle will be buddied with five NHS trusts with an expectation to develop further international partnerships in the future
- NHS England will develop proposals for introducing meaningful patient choice and control over their care offered in services for maternity, end of life care and long term conditions.

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	2.3
Title	Operational Report and Scorecard
Report for	For noting
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary: This is a regular report to the Trust Board and outlines the key operational headlines that relate to the reporting month of June 2015. This report has been updated to reflect feedback from both Executive and Non-Executive Board members.

Recommendation(s) to the Trust board:

The Trust board is 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

Trust Board Performance Report

Report Period Month 3 (to end June 2015)

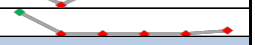
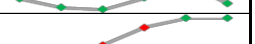
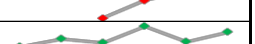
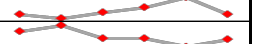
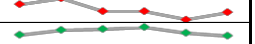
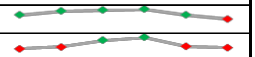
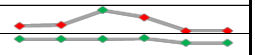
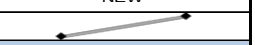
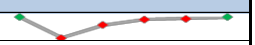
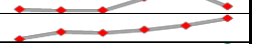
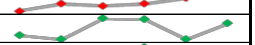
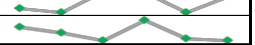
Trust Board, Wednesday 29th July 2015

Imperial College Healthcare NHS
NHS Trust

1 Table of Contents

Imperial College Healthcare NHS Trust

2 Scorecard Summary

Pg	Metric	Period	Standard	Performance	Direction of Travel
	Safe				
5	Serious Incidents (S.I.s)	Jun-15	0	14	
6	Staffing fill rates		tbc	96.75%	
7	MRSA		0	0	
7	Clostridium difficile		5	7	
	Effective				
8	Hospital Standardised Mortality Ratio (HSMR)	Qtr 3 14/15	100	67.06	
8	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	Qtr 3 14/15	70%	71.20%	
9	Harm Free Care (Safety Thermometer)	Jun-15	90%	97.0%	
9	30 day readmissions		tbc	6.43%	
10	Average length of Stay (elective)		3.4	3.66	
11	Average length of stay (non-elective)		4.5	4.8	
11	Activity: First Outpatient	May-15	27,337	27,776	
11	Activity: Follow-up Outpatient		45,300	44,830	
12	Activity: Daycase		6,433	6,001	
12	Activity: Elective Inpatient		1,752	1,335	
12	Activity: Non-elective Inpatient		8,286	8,895	
12	Activity: Adult Critical Care		3,561	3,227	
12	Activity: Regular Day Attender		270	1,099	
	Caring				
14	Mixed-Sex Accommodation	Jun-15	0	0	
15	Friends and Family Test - Inpatients		95%	97.00%	
15	Friends and Family Test - A&E		85%	91.00%	
16	Complaints (total number received)		100	106	
	Well Led				
16	Vacancy rate (%)	Jun-15	10.0%	11.6%	
16	Sickness absence rate (%)		3.4%	3.0%	
17	Statutory and mandatory training excl. doctors in training / Trust grades (%)		95.0%	82.0%	
17	Statutory and mandatory training - doctors in training / Trust grades (%)		95.0%	63.0%	
18	Consultant appraisal rate (%)		95.0%	86.0%	
18	Band 2-9 & VSM PDR rate		95.0%	27.0%	
19	Health and Safety RIDDOR		0	3	
19	Open actions relating to GMC surveys, quality and monitoring visits		tbc	No Data	NEW
20	Staff engagement score		tbc	44	
	Responsive		0		
22	18 Weeks Incomplete (%)	Jun-15	92.0%	92.1%	
22	18 weeks Incomplete (number)		tbc	4,367	
22	52 Weeks Waits (Number)		0	2	
23	Number of diagnostic tests waiting longer than 6 weeks (%)		1.0%	2.0%	
24	A&E Type 1 Performance (%)		95.0%	89.0%	
24	A&E All Types Performance (%)		95.0%	95.4%	
25	Two week GP referral to 1st outpatient, cancer (%)	May-15	93.0%	94.1%	
25	Two week GP referral to 1st outpatient – breast symptoms (%)		93.0%	93.1%	
25	31 day wait from diagnosis to first treatment (%)		96.0%	97.4%	
25	31 day second or subsequent treatment (surgery) (%)		94.0%	97.3%	
25	31 day second or subsequent treatment (drug) (%)		98.0%	98.8%	
25	31 day second or subsequent treatment (radiotherapy) (%)		94.0%	98.7%	
25	62 day urgent GP referral to treatment for all cancers (%)		85.0%	76.4%	
25	62 day urgent GP referral to treatment from screening (%)		90.0%	88.0%	
26	New Outpatient DNA rate (%)	Jun-15	12.3%	13.9%	
26	Follow-up Outpatient DNA rate (%)		11.3%	12.6%	
27	Hospital initiated outpatient cancellation rate (%)		tbc	6.7%	

3 Indicator Overviews

3.1 Safety

3.1.1 Safety: Serious Incidents (SIs)

14 serious incidents were reported in June 2015. The year to date total is 24, compared to 18 for Q1 last year. The average number of SIs per month in 2014/15 was 12. We continue to review each case.

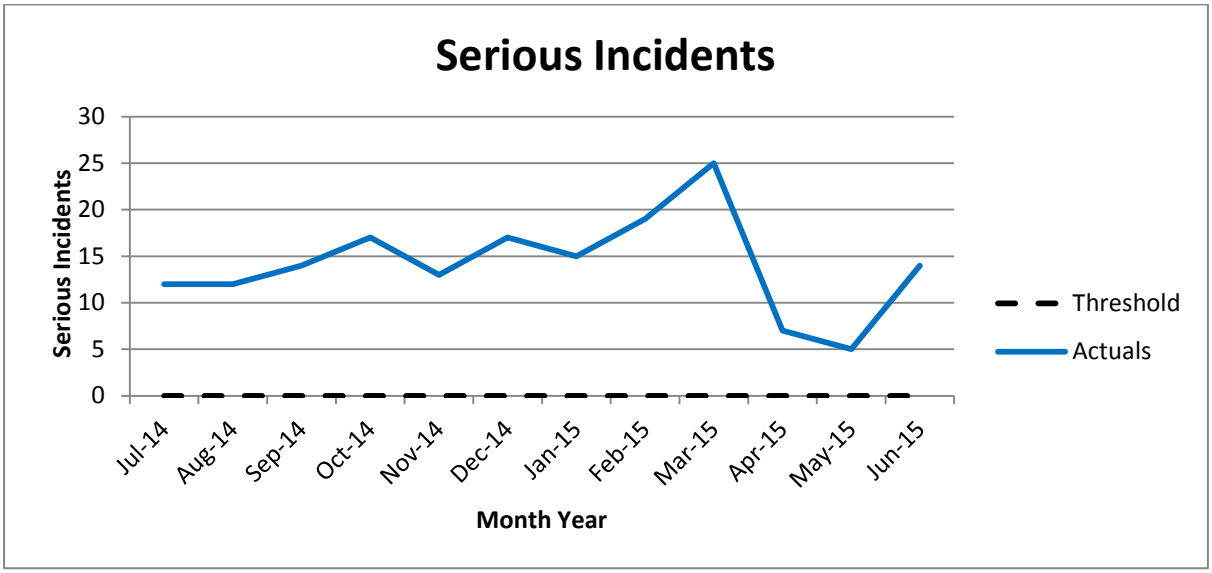


Figure 1 - Number of Serious Incidents (SIs) by month for the period July 2014 – June 2015

3.1.2 Safety: Nurse / Midwife staffing levels

In June the Trust reported the following for the average staffing fill rate:

- Above 95 per cent for registered nursing/midwifery and care staff during the day and night.

Please refer to Appendix 1 for ward level detail.

The month of June saw a sustained improvement in performance. This is due to a reduction in vacancies and an increase in the bank fill rate. There were a very small number of ward areas where the fill rate was below 85 per cent for care staff. Key reasons for this are:

- Small numbers of unfilled shifts in some areas e.g. A8 and Douglas ward which has shown a bigger impact on the overall fill rate for that area; &
- The acuity of patients particularly on medical wards such as AMU which has resulted in requesting additional staff for patients who require specialling. Where additional shifts have not been filled, this has impacted on the fill rates for these areas

On these occasions senior nurses have made decisions to mitigate any risk to patient safety by undertaking the following:

- The ward manager/sister working clinically within the numbers;
- Increasing the compliment of registered staff where there has been a reduced fill rate for care staff;
- Monitoring progress against recruitment and vacancy reduction plans
- Reviewing staffing on a daily basis;
- Adjusting the occupancy to ensure patient needs are met by the staff that are available; &
- Redeploying staff from other areas, where possible.

Divisional Directors of Nursing have confirmed that the levels of care provided during June were safe.

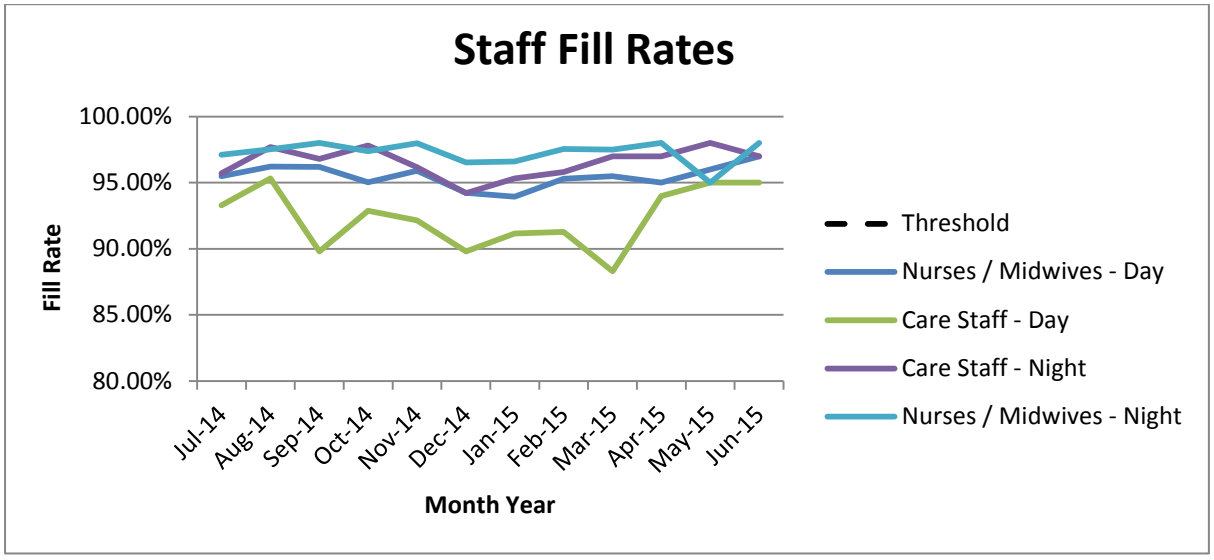


Figure 2 – Staff fill rates by month for the period July 2014 – June 2015

3.1.3 Safety: Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI)

No Trust-attributable cases of MRSA BSI occurred in June 2015.

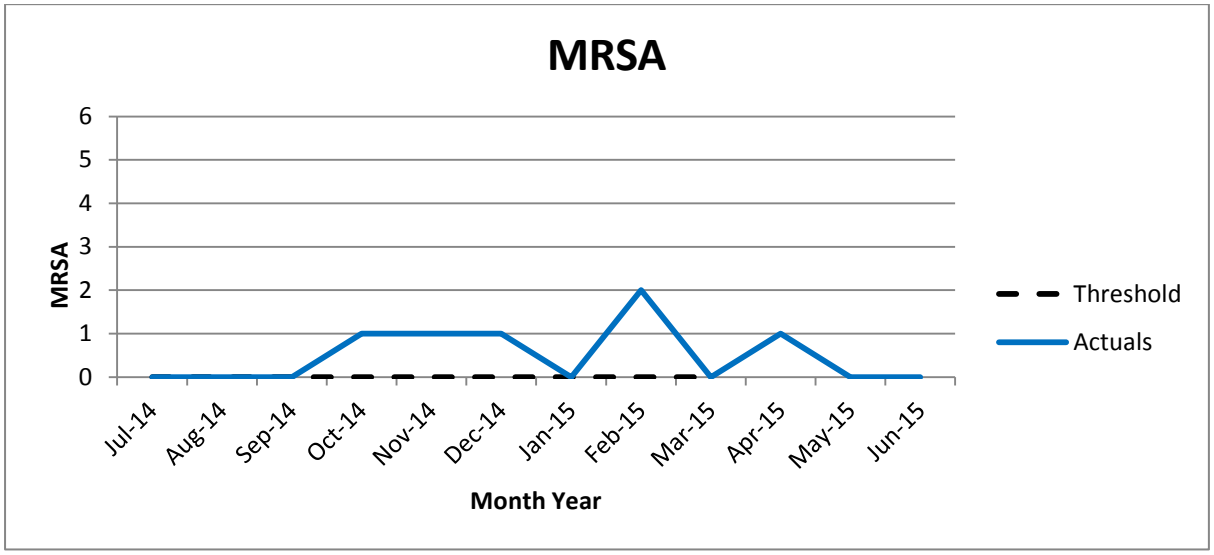


Figure 3 - Number of MRSA (b) infections by month for the period July 2014 – June 2015

3.1.4 Safety: Clostridium difficile

Seven cases of C. Difficile were allocated to the Trust for June 2015. One of these has been identified as a potential lapse of care because two cases had crossing pathways. In another one the ribotype was untypable so we are unable to determine whether transmission took place.

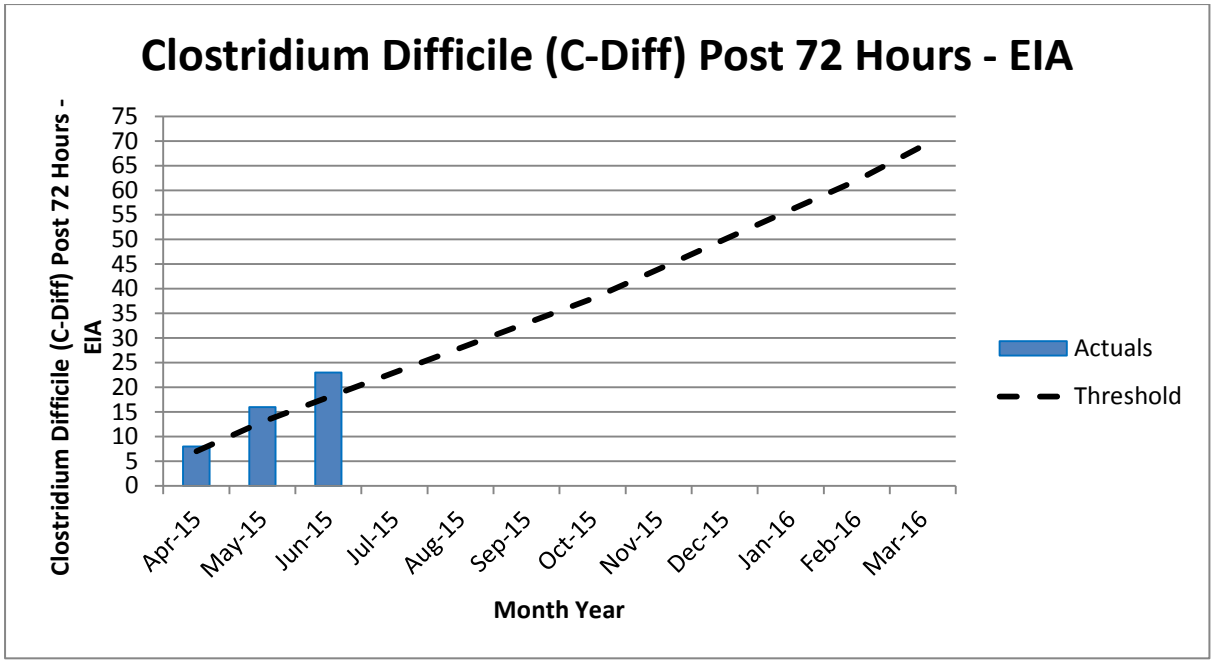


Figure 4 - Number of Clostridium Difficile infections above cumulative plan by month for the period April 2015 – March 2016

3.2 Effectiveness

3.2.1 Effectiveness: Mortality Data

As described in our quality strategy, we are introducing a standardised system to ensure a multi-disciplinary review of all deaths that occur in our hospitals. This will be reported on Datix and will be reviewed at the Medical Director's Incident Review panel. We anticipate that the process will be in place by December 2015; however, we will begin to report initial baseline data relating to the percentage of deaths currently reviewed by a multi-disciplinary team from next month.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures the number of deaths in the Trust, that occur during the patients' stay at the Trust, and is adjusted for a variety of factors (i.e. age, poverty, treatments offered).

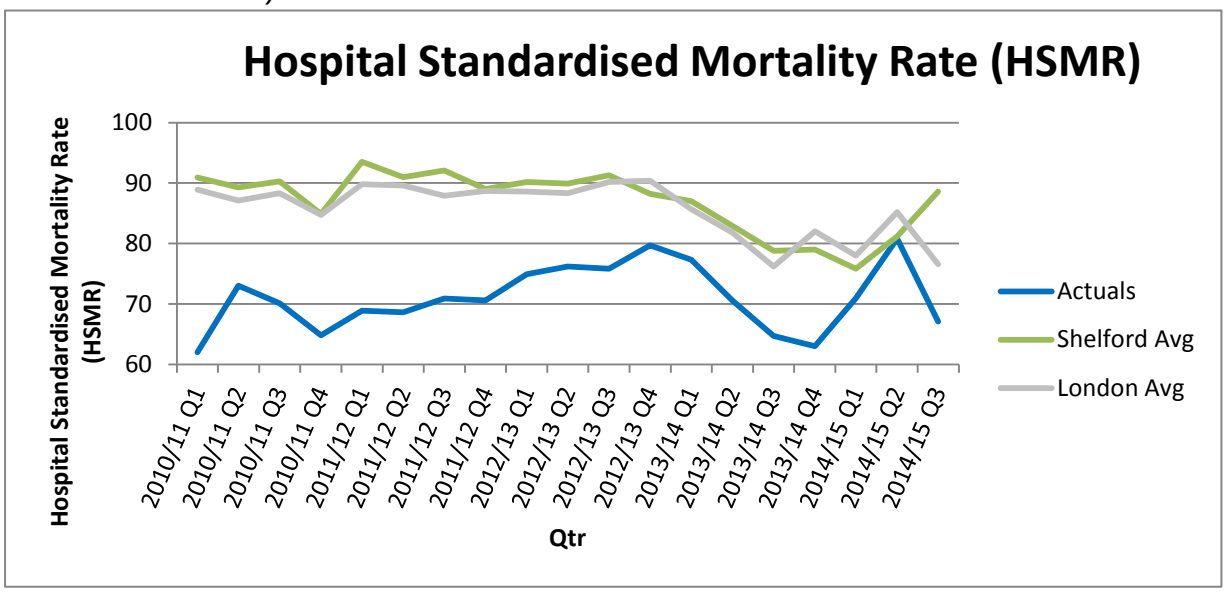


Figure 5 - Hospital Standardised Mortality Ratios for the period Q1 2010/11 to Q3 2014/15

3.2.2 Effectiveness: Recruitment of patients into interventional studies

Finalised data for Q4 will be available in August 2015. Preview data suggests that the Trust performance agains the 70-day benchmark is close to 80 per cent.

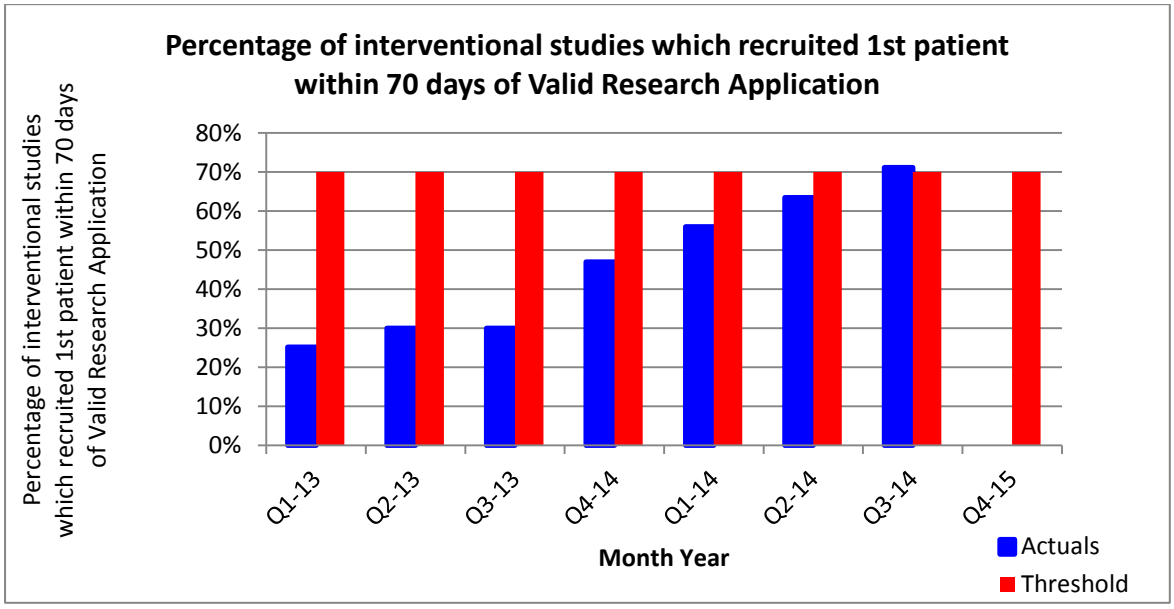


Figure 6 - Interventional studies which recruited First patient within 70 days of Valid Application Q1 2013/14 – Q4 2014/15

3.2.3 Effectiveness: Harm Free Care (Safety Thermometer)

The Trust continues to excel in ensuring our patients experience Harm Free Care during their inpatient stays, with uninterruptedly higher scores than both the London and Shelford average.

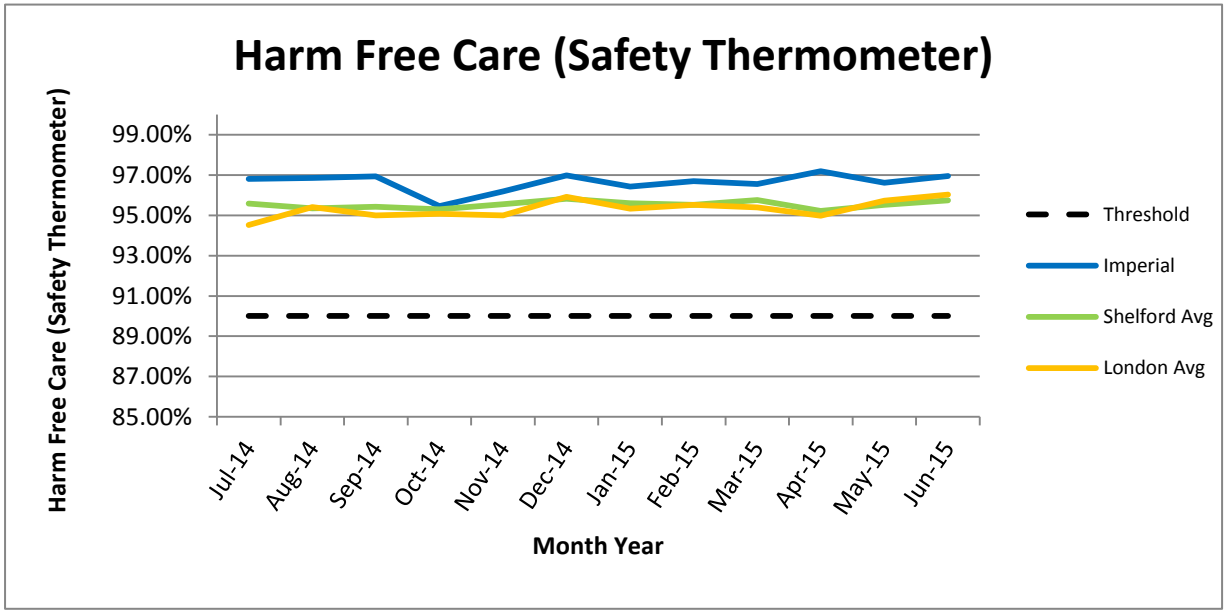


Figure 7 – Harm Free Care (Safety Thermometer) July 2014 – June 2015

3.2.4 Effectiveness: 30 Day Readmissions

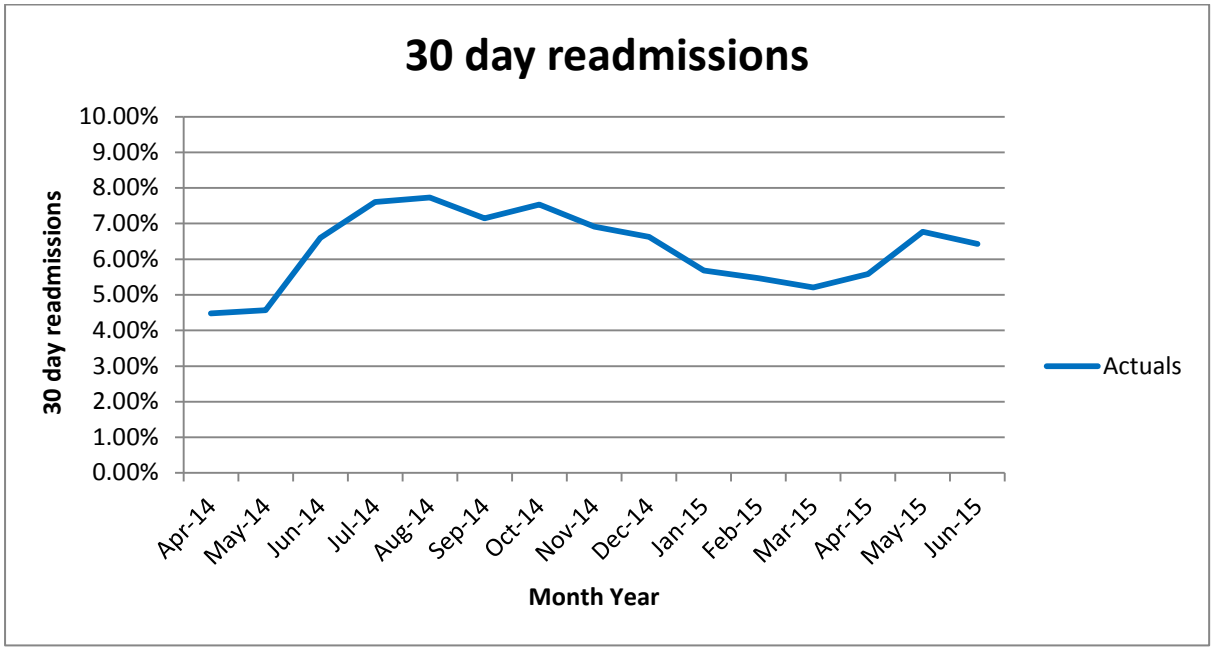


Figure 8 - 30 day readmissions for the period April 2014 - June 2015

3.2.5 Effectiveness: Average Length of Stay

An initial analysis into the increase in the length stay for patients on an elective pathway has highlighted various data quality issues that were artificially inflating the reported position. For example:

i) Historic incorrect entry of day case activity as zero day length of stay. Improvements in reporting has decreased the denominator for this indicator, which is thus reflected as an increase in the overall length of stay;

ii) Focus on correcting data regarding extreme outliers (e.g. a 290 day stay within Endoscopy). The Discharge team is leading this work and working with the Divisions to rectify this information on a live basis;

iii) A number of patients' admission date were recorded with the previous year. It is proving difficult to retrospectively amend this data, although options are currently being explored; &

iv) The split of the length of stay data into elective and non-elective has contributed to the increase in the reported position for the elective length of stay. This has now improved.

A working collective has been formed between the site, information, and performance teams in order to rectify these issues.

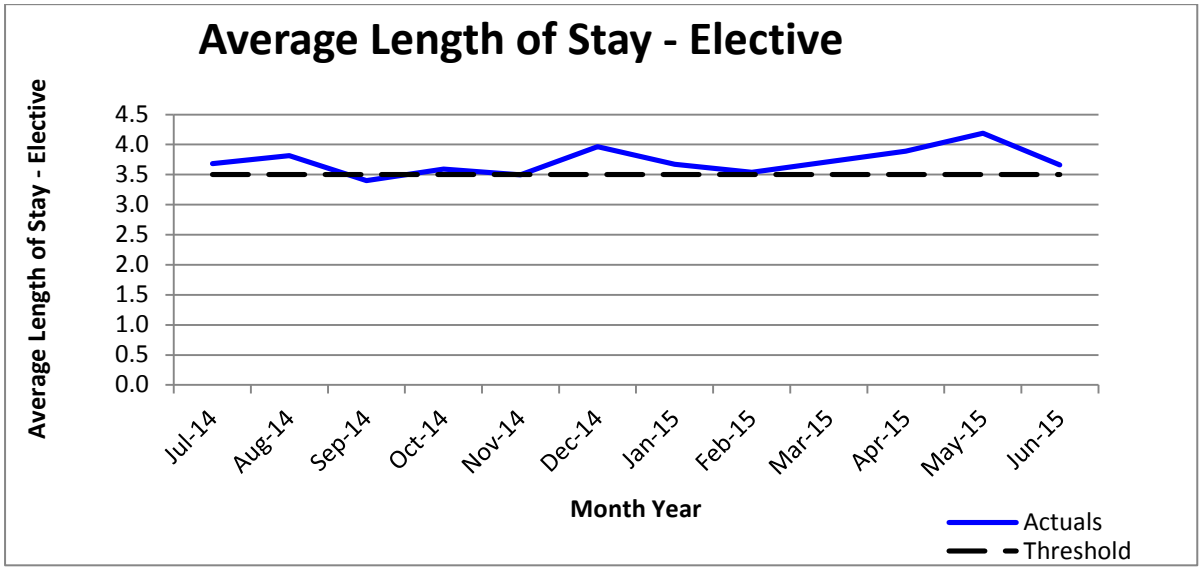


Figure 9 – Average Length of Stay – Elective for the period July 2014 – June 2015

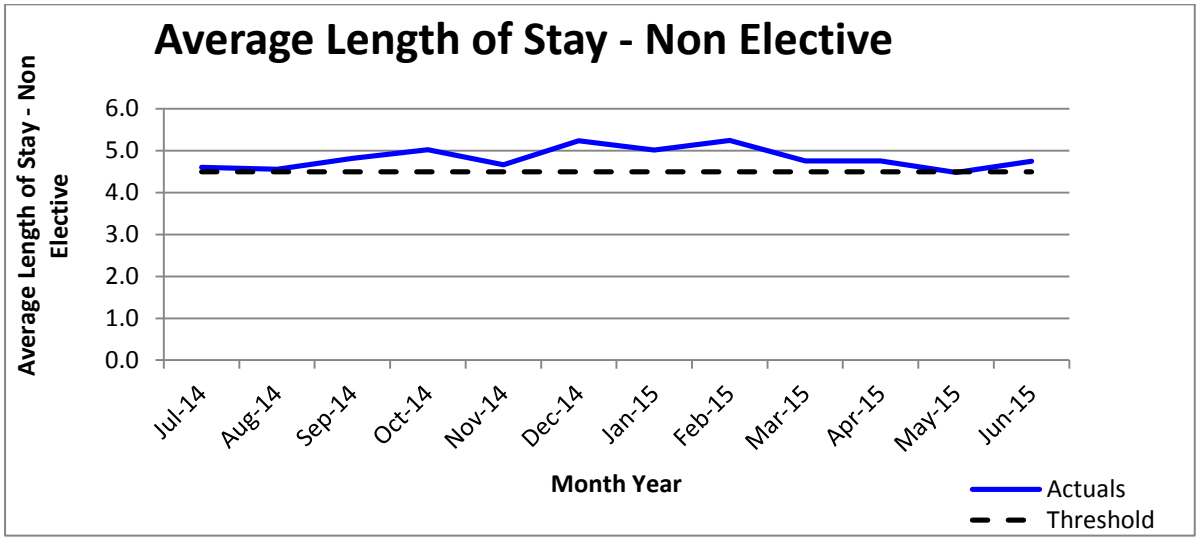


Figure 10 – Average Length of Stay – Non-Elective for the period July 2014 – June 2015

3.2.6 Effectiveness: Activity data

This is the first time that this activity data has been presented in the Operational Report to the Trust Board. Plans are in place to operationalise a regular review with the Finance, Operational, and Corporate teams. The analysis of these indicators will drive data quality improvement to ensure the correct depth of coding.

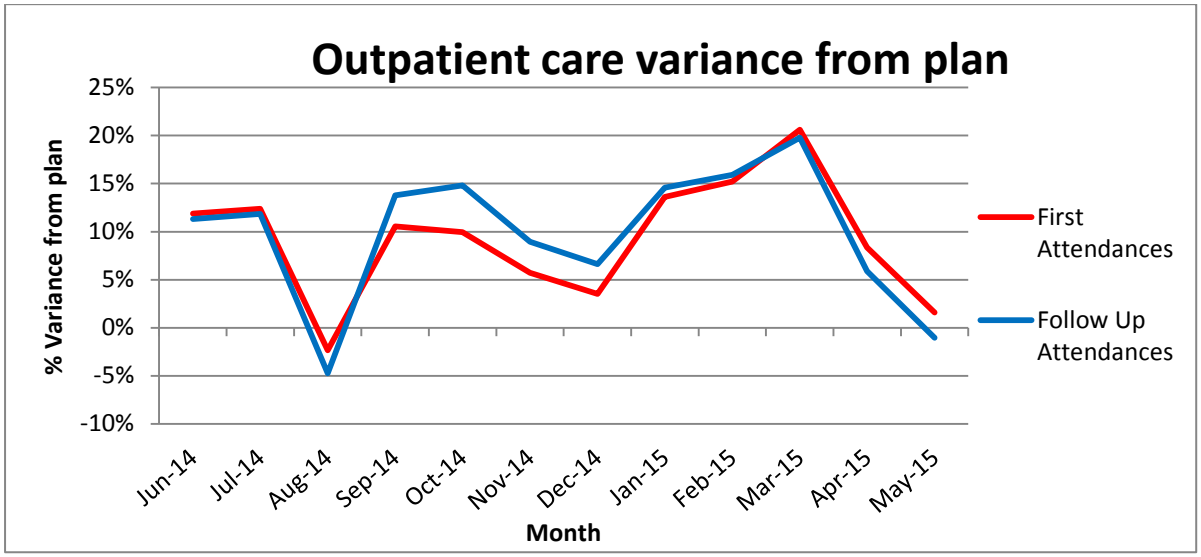


Figure 11 – Outpatient Care Variance from Plan for the period June 2014 – May 2015

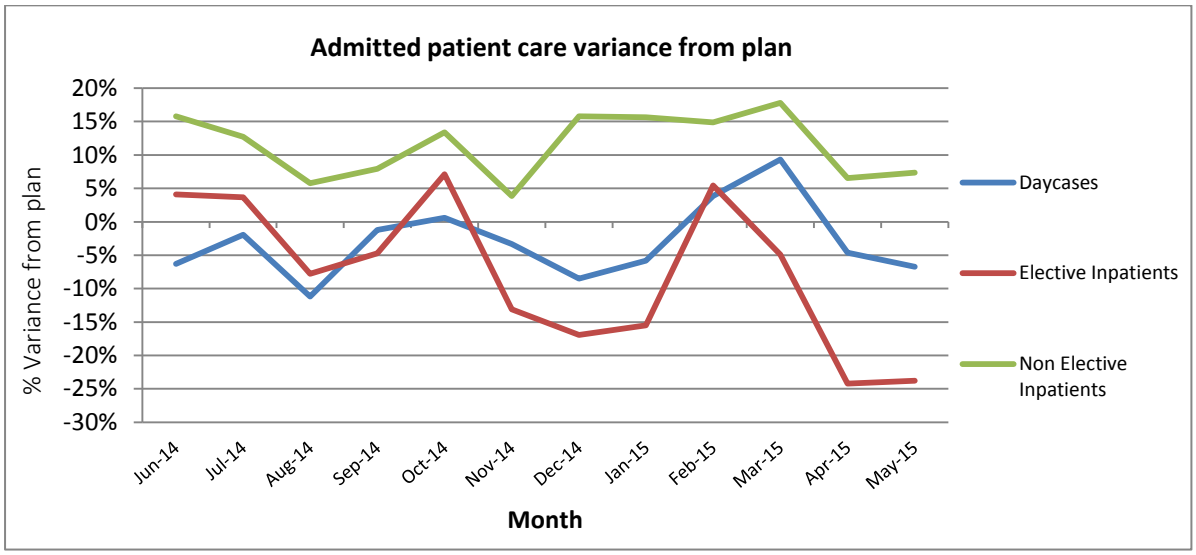


Figure 12 – Admitted Patient Care Variance from Plan for the period June 2014 – May 2015

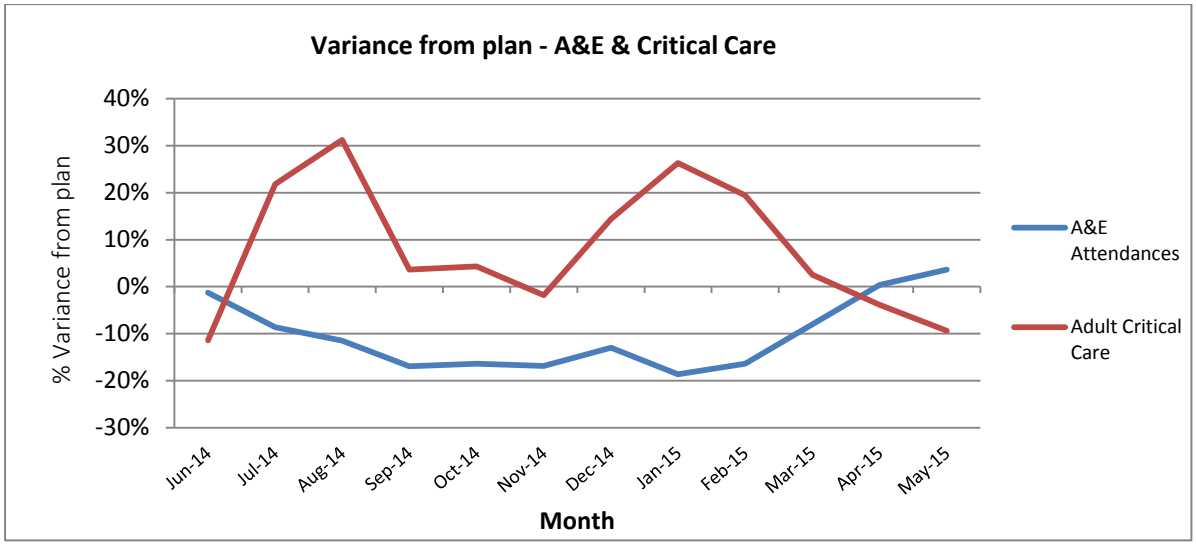


Figure 13 – A&E and Critical Care Variance from Plan for the period June 2014 – May 2015

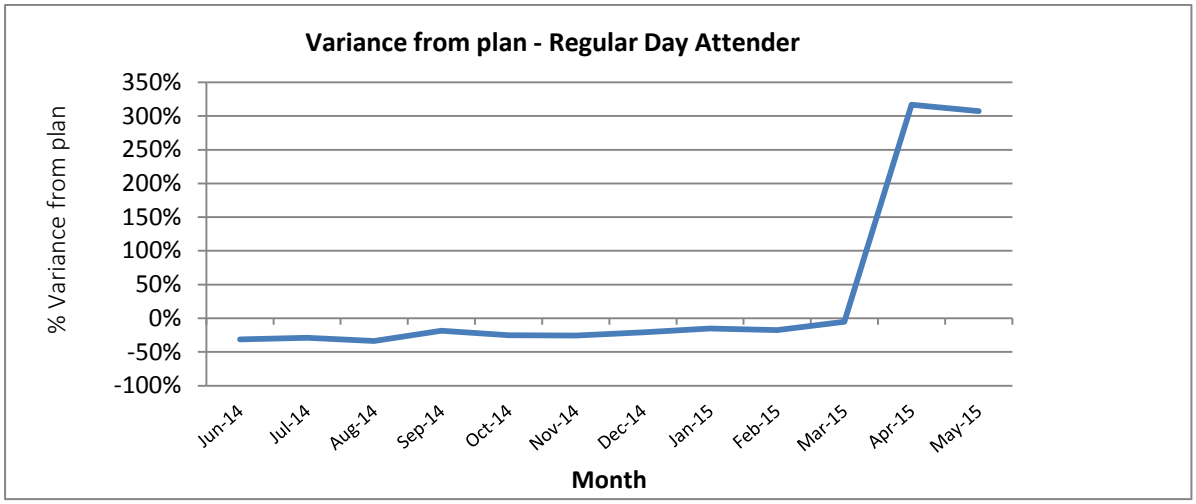


Figure 14 – Regular Day Attender (RDA) Variance from Plan for the period June 2014 – May 2015

3.3 Caring

3.3.1 Caring: Eliminating mixed sex accommodation

No mixed-sex accommodation breaches were reported during June 2015.

Being in mixed-sex 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 all 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.

This rating highlights the total number of times that the same-sex accommodation guidance was breached during the reporting period.

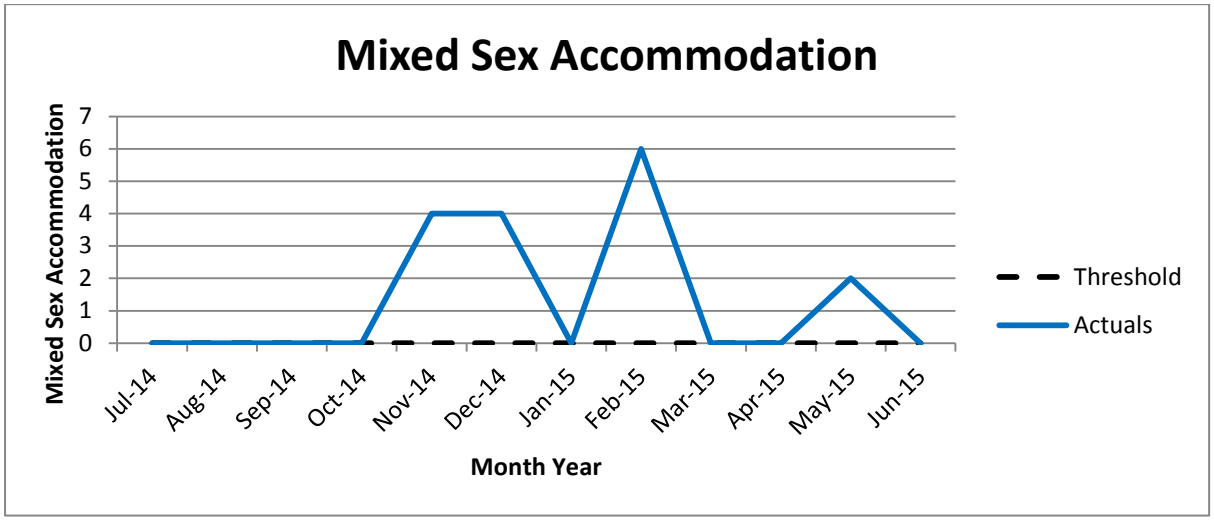


Figure 15 - Mixed Sex Accommodation breaches by month for the period July 2014 – June 2015

3.3.2 Caring: Friends and Family Test

Following the introduction of the new real-time collection system in April, there has been a month on month improvement in the response rates. With levels now approaching those achieved at the end of 14/15. The percentage of patients who would recommend is also increasing. Overall, the trust FFT scores are good and in line with national levels.

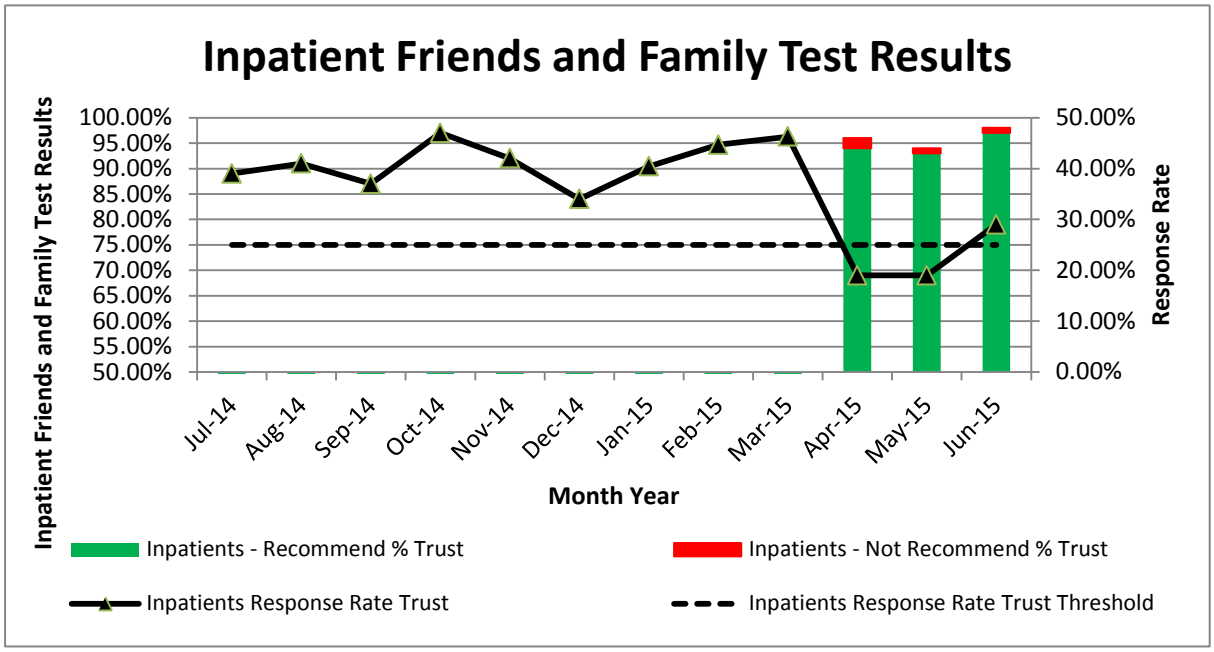


Figure 16 - Friends and Family: Percentage who would recommend ICHT Inpatients for the period April 2015 – June 2015

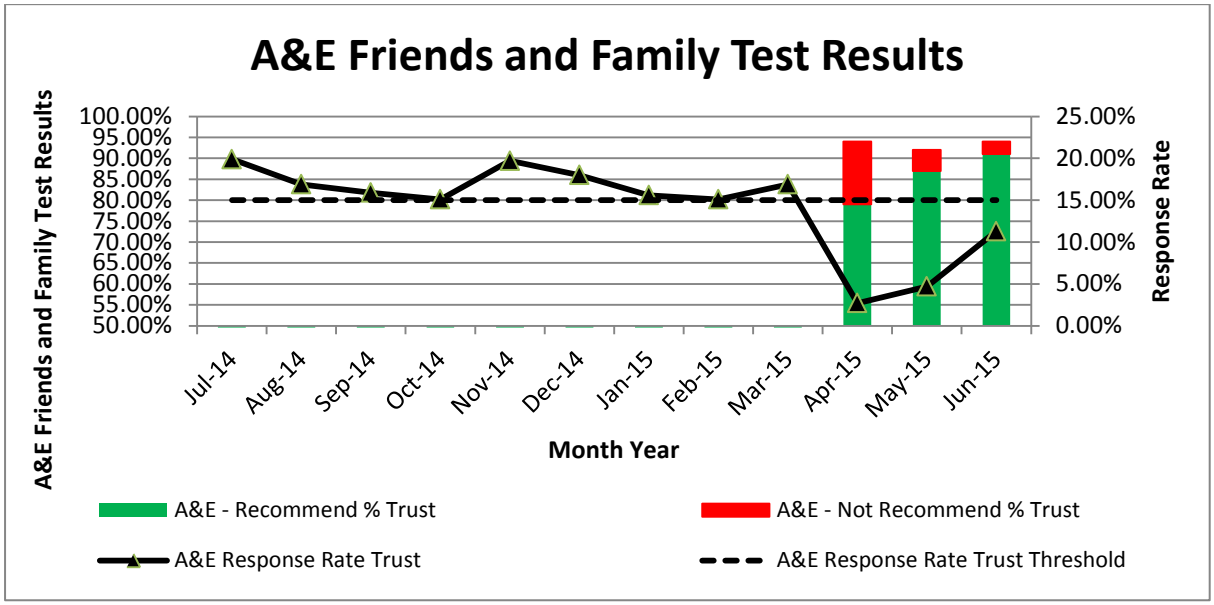


Figure 17 - Friends and Family: Percentage who would recommend ICHT Accident and Emergency for the period April 2015 – June 2015

3.3.3 Caring: Complaints

There has been an increase in the number of complaints in June although there is no obvious reason for this. It was noted last month that the volume of complaints in May was particularly low which may have been related to the two bank holidays. The June volume is more consistent with previous months. The response rate to complaints remains lower than it should be, but this will be addressed by the centralisation of the complaints function. The consultation process for this is well underway and the majority of changes should be in place by the end of August.

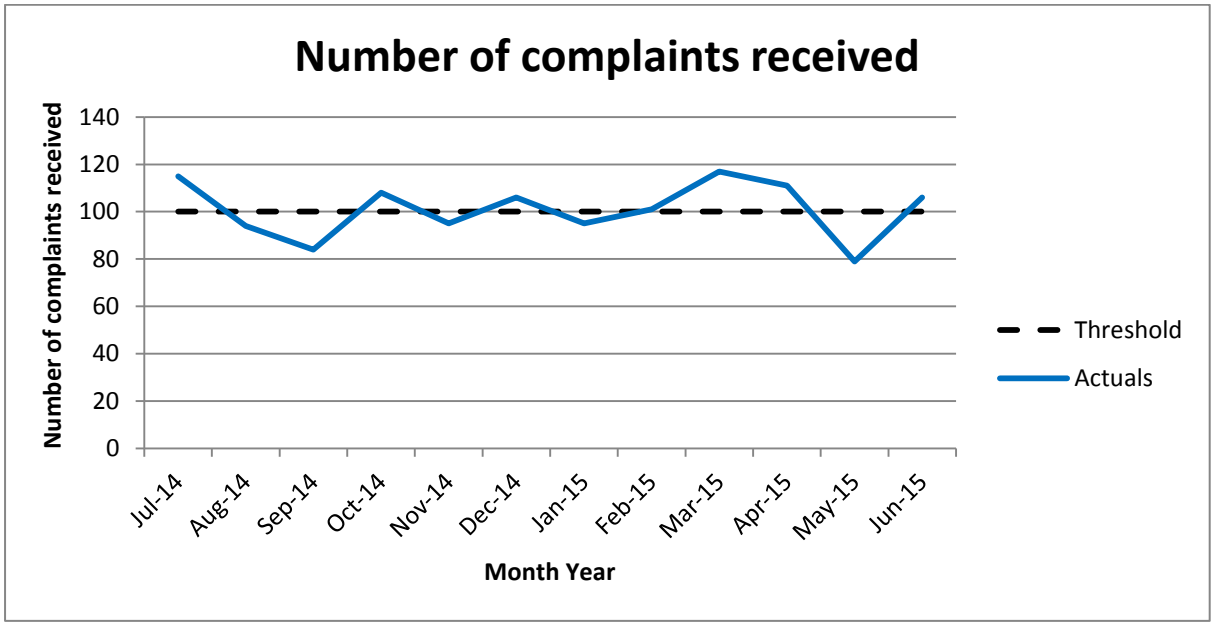


Figure 18 – Number of complaints received for the period July 2014 – June 2015

3.4 Well-Led

3.4.1 Well-Led: Vacancy Rate

- **All roles**

At the end of June, we directly employed 9,231 WTE (37 WTE greater than end of May) with a further 1,257 WTE worked through bank and agency staffing. This reflects the 11.64 per cent vacancy rate (1,216 WTE vacant) and was 41 WTE over the ESR post establishment. The 15/16 plan has been input into ESR for the five Divisions and the Corporate Directorates are in the process of being aligned through partnership working with the Finance and People Planning Teams.

There are 531 WTE pipeline candidates waiting to join (46 WTE more than at the end of May) giving a non-recruited to vacancy rate of 6.55 per cent. Monitoring of vacancies across all departments is supported through monthly reporting, performance reviews and bespoke KPI meetings within the Divisions. Hard to recruit specialties and staffing groups are discussed and targeted recruitment plans agreed at the monthly strategic people planning meetings with the Divisional and Resourcing leads.

- **Bands 2~6 Nursing & Midwifery on Wards**

Within the wards, the band 2-6 vacancy rate was 13.44 per cent (325 WTE vacant) marginally lower than the 13.64 per cent seen at the end of May; A further 166 WTE are waiting to fill these ward vacancies, giving a non-recruited vacancy rate of 6.55 per cent.

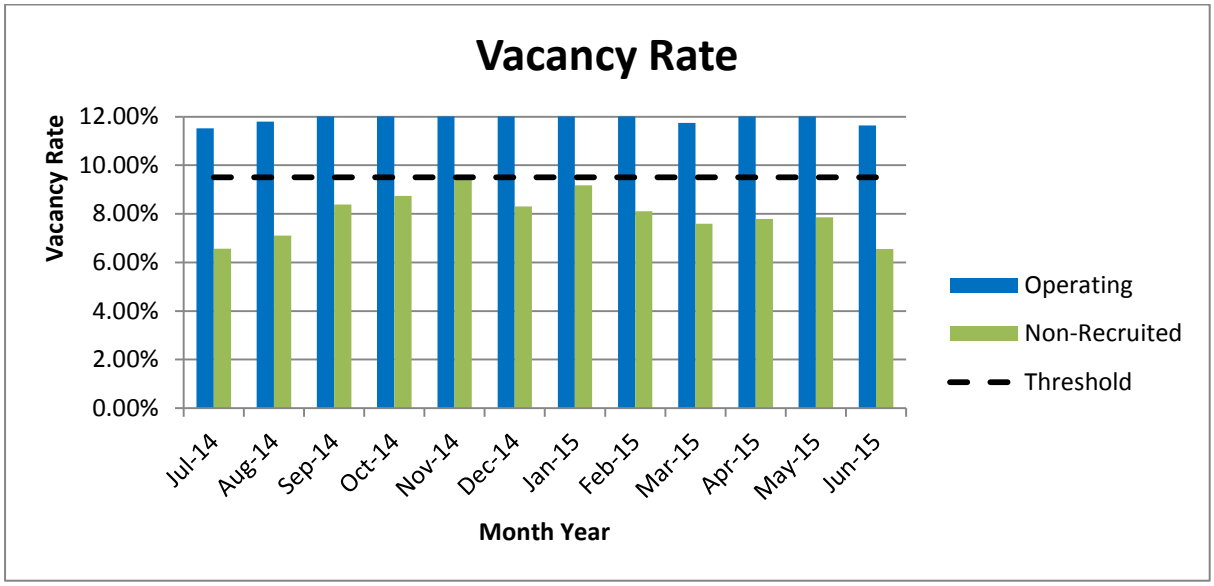


Figure 19 - Vacancy rates for the period July 2014 – June 2015

3.4.2 Well-Led: Sickness absence rate

Recorded sickness absence reduced by 2 per cent in month from 3.08 per cent to 3.01 per cent and is significantly lower than the 3.47 per cent recorded in June 2014

(13 per cent less). Overall, this brings the rolling 12-month position to 3.39 per cent which is now below the 15/16 target of 3.40 per cent.

New managers continue to attend the Understanding Workforce Policies training, as well as refresher training for existing managers, ensuring they are confident and supported in the pro-active management of sickness absence. Absence levels are monitored via daily reviews with GMs and the Site team, as well as monthly divisional and corporate meetings to ensure proactive management.

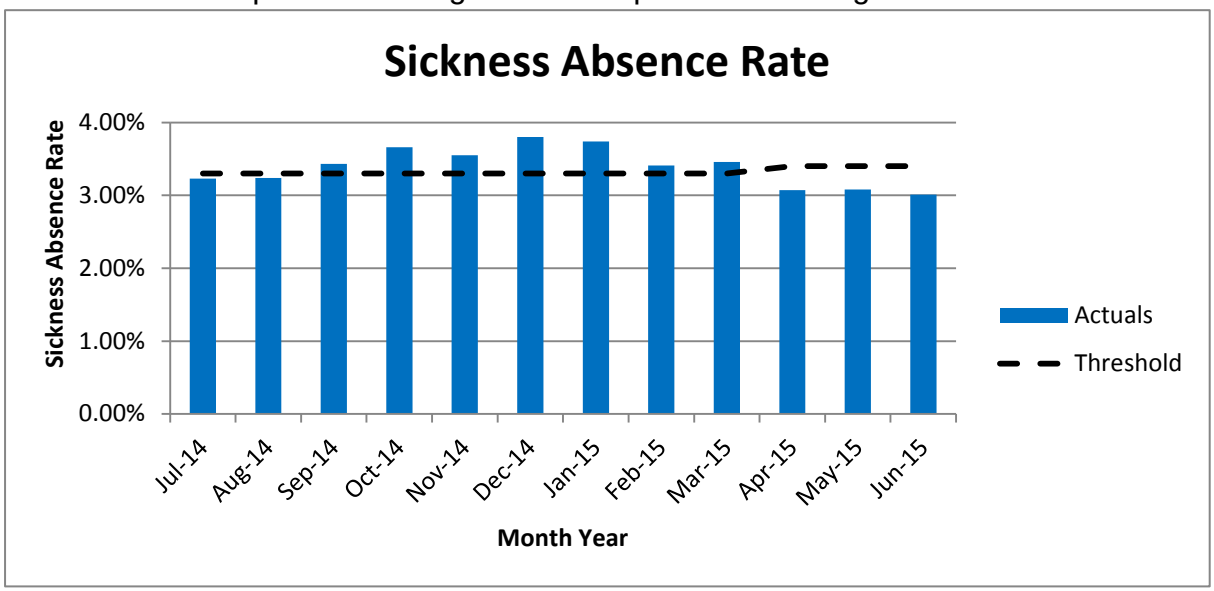


Figure 20 - Sickness absence rates for the period July 2014 – June 2015

3.4.3 Well-Led: Statutory and mandatory training

- **Excl. doctors in training / trust grade**

WIRED 2 was launched on 13 March 2015 to enhance our ability to report on topic level compliance rates for the Trust's ten core skills training topics. Compliance rates have improved significantly from 69 per cent in April 2014 to 82 per cent currently.

A campaign has been launched to increase compliance in Fire Training, with Loop day sessions and targeted communications across the Trust. Compliance has increased from 45 per cent in March to 65 per cent to date with further campaigns in August.

- **Doctors in training / trust grade**

Reports for doctors in training mirror those of other staff groups and shows an overall compliance rate of 63 per cent. Individualised training profiles produced by WIRED are prompting the steady increase in compliance as the group have clarity around which courses they are required to complete from induction onwards.

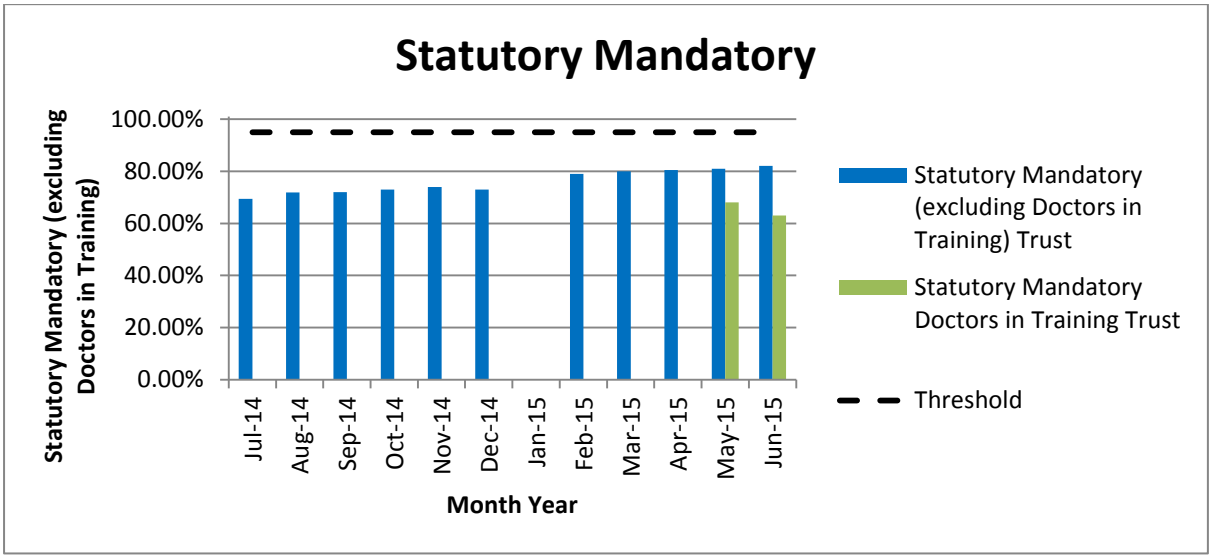


Figure 21 - Statutory and mandatory training for the period July 2014 – June 2015

3.4.4 Well-Led: Non-training Grade Doctor Appraisals

We have changed the way we report doctor appraisal rates this month to ensure we review a more complete measure of compliance. This includes incorporation of career grade doctor appraisal rates, rather than just consultant appraisal rates, and reporting by completed sign off or 'output' of appraisal rather than date of appraisal meeting. Both of these factors have contributed to a lower rate of 85.6 per cent this month; however this does not represent a decline in individual compliance.

All doctors who are 6 months overdue from their appraisal date are being escalated to the Responsible Officer. Non-compliance continues to be managed against the Revalidation & Appraisal Policy. Appraisal compliance is also reviewed at the Divisional Performance Reviews.

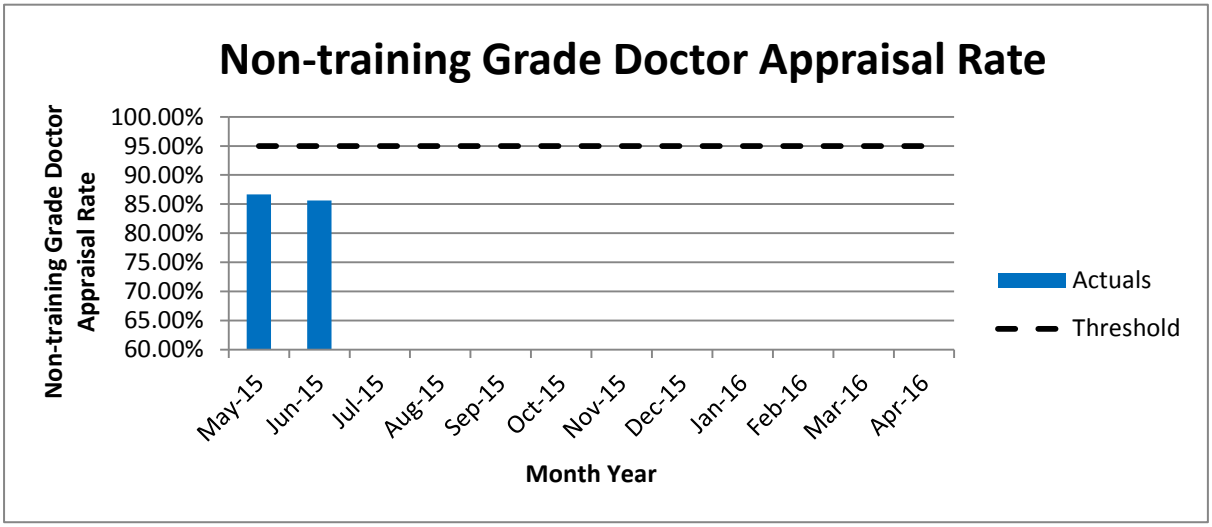


Figure 22 - Non-training Grade Doctor Appraisal Raterates for the period May 2015 – April 2016

3.4.5 Well-Led: Performance Development Reviews (band 2 – 9)

The end of June saw the first PDR completion window close with the expectation that all of our people at bands 7-9 will have had a completed PDR by the end of the first quarter. The PDR compliance rate for staff at bands 7 ~ 9, at the end of June was 85.59 per cent with 257 members of staff within this group still requiring a PDR with their line manager. The Divisional and Corporate leads, with the support of the HR Business Partners, are working to ensure that these remaining PDR's are scheduled and completed as soon as possible.

Our staff, within the band 2-6 group (6,255 headcount), are required to have had a PDR with their line Manager by the end of September and the PDR compliance rate for this group of staff is currently at 10.81 per cent. Overall, at the end of June, the Trust PDR compliance rate for all bands of staff was 27 per cent. Monitoring of all PDR's is supported by weekly reports detailing PDR completion progress to all Divisions and Corporate Directorates. Managers can also monitor PDR compliance at line manager and employee level within the Your People application on Qlikview.

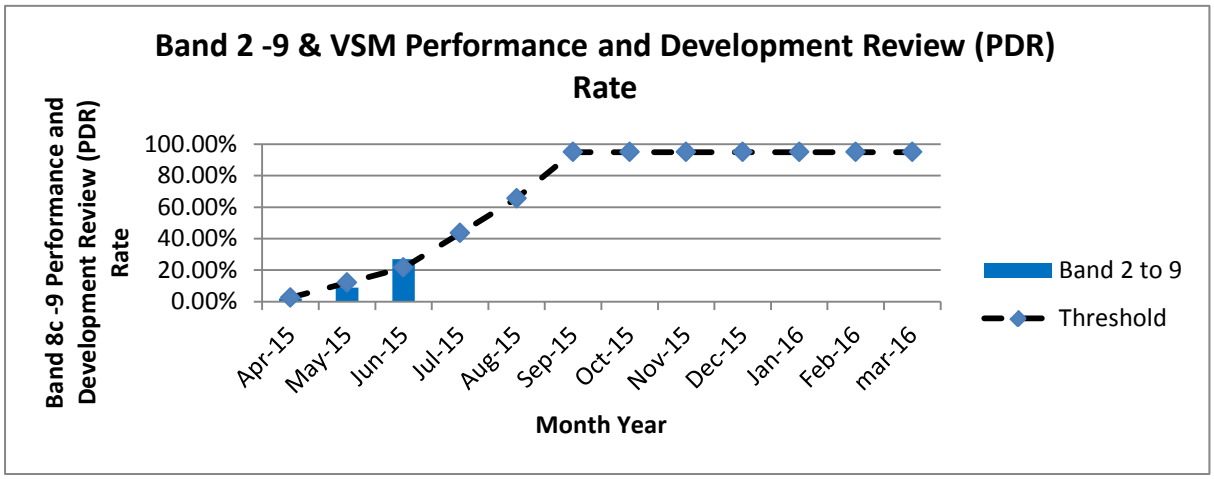


Figure 23 - Band 2 - 9 performance development review rates for the period April 2015 to June 2015

3.4.6 Well-Led: Health and Safety RIDDOR

Three RIDDOR reportable accidents took place during June 2015. Firstly, a member of staff had a 'slip, trip and fall' on a wet floor in Charing Cross Hospital CT Scanning Unit, which resulted in a fractured ankle, leading to an absence of more than seven days from work. Secondly, a member of staff was assisting a fainting patient to the floor but got trapped between the patient and wall and was unable to stand. Whilst being assisted up by another member of staff, the member of staff sustained an injury to her left shoulder. She was off for more than 7 days. Thirdly, a member of staff was struck by a tea trolley at Hammersmith Hospital, leading to right knee injury. The member of staff was off work for more than 7 days.

There were 19 RIDDOR reportable accidents in the 12 months to 30 June 2015. There were no RIDDOR reportable dangerous occurrences during June with a

total of four reportable dangerous occurrences in the 12 months to 30 June 2015. The majority of RIDDOR accidents relate to slips, trips and falls. The health and safety service has introduced a more robust quarterly workplace inspection form to enable DSCs/Managers to report slip/trip hazards and controls.

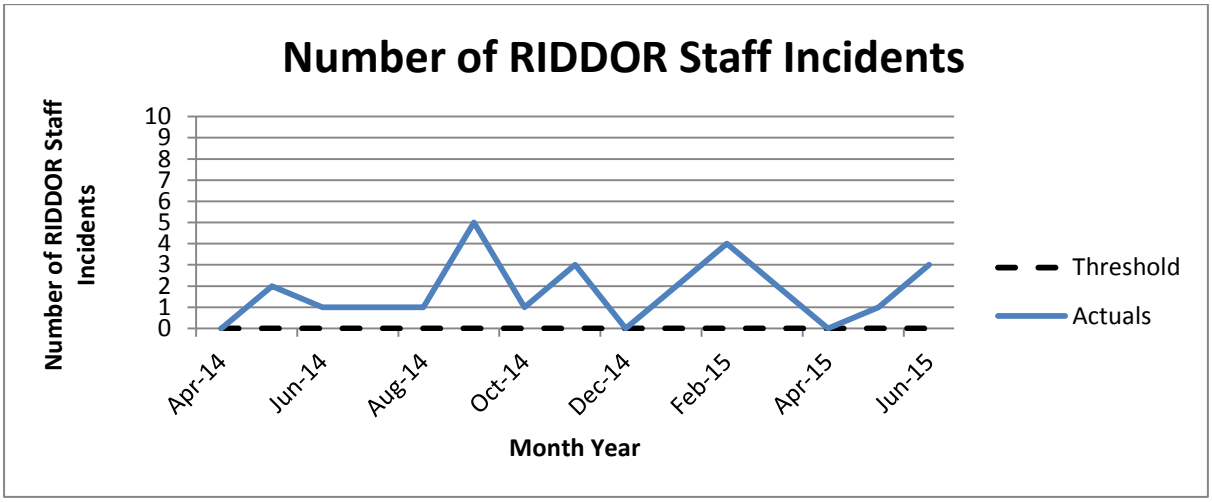


Figure 24 – RIDDOR Staff Incidents for the period July 2014 – Apr 2015 (May and June data whilst the Health and Safety dashboard is revised)

3.4.7 Well-Led: GMC NTS Actions

The GMC National Training survey was published in June 2015. 24 of our programmes have at least one red flag (negative outliers), with the total number of red flags being 50. We are required to produce an action plan by 31st July in response to 46 of these red flags. The actions are currently being drawn up by the Directors of Medical Education with the service in question for submission to HENWL. Once the plan is submitted, we will report the numbers of open and completed actions each month through the scorecard.

The full results of the GMC Survey will be reported to the Board Quality Committee in September.

3.4.8 Well-Led: Staff Engagement

The results of the 7th Quarterly Engagement Survey are being communicated across the Trust. The Survey was open between March and April 2015 and the results show the best results to date.

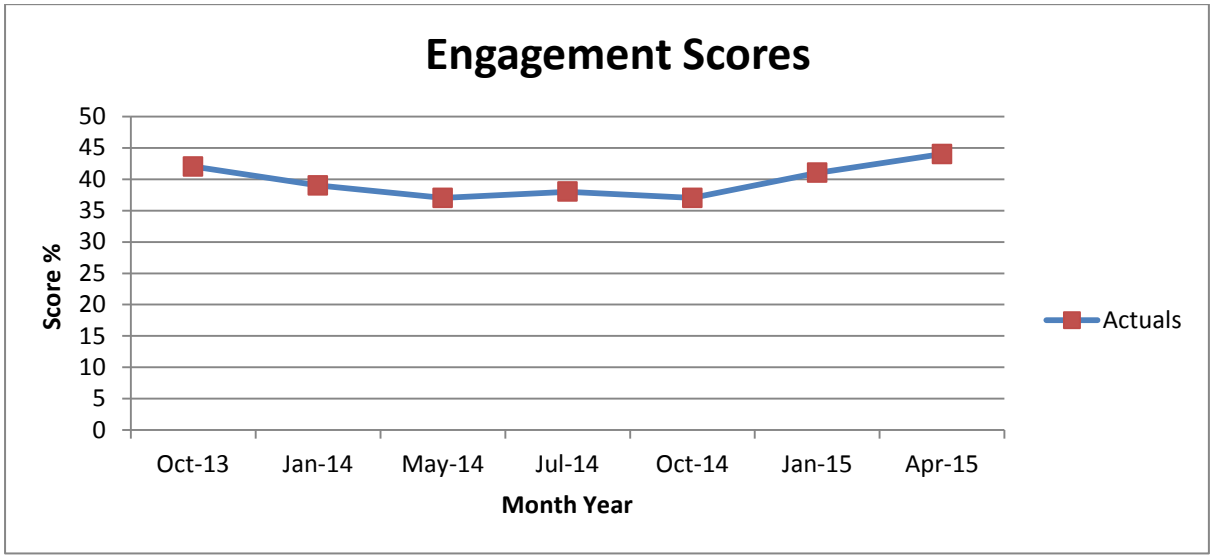


Figure 25 – Engagement scores for the period October 2013 – April 2015

- The total response rate was the highest to date at 57 per cent having increased from 27 per cent in Survey 1;
- The Trust Engagement Score rose by 3 per cent to 44 per cent, again the highest score to date;
- All individual questions show slight improvements since Survey 6; &
- The Friends and Family test questions have both increased since Survey 6. 77 per cent would recommend the Trust for care and treatment, an increase of 1 per cent and 60 per cent would recommend the Trust as a place to work, an increase of 4 per cent since Survey 6.

The next Survey launches on 20th July.

Senior nurses and General Managers helped facilitate a variety of sessions all with the aim of listening to this key frontline group of staff. The question as to "how can we make your working life better?" produced some genuinely interesting responses, for example a simple "hello" in the morning appears not be as common as we might expect; indeed "thank you" still appears thin on the ground. These responses, amongst others, were presented to the Divisional Management Committee and a plan to address these is being worked up.

3.5 Responsive

3.5.1 Responsive: Referral to Treatment (RTT)

The NHS Constitution enshrines the right of patients to be treated within 18 weeks of referral to a consultant-led service. Performance is assessed against two primary performance standards;

- Incomplete Pathways (92 per cent)
- Number of over 52 week waits (zero tolerance).

Referral to treatment performance has considerably improved over recent months. The primary measure of RTT performance is that 92 per cent of patients should be waiting under 18 weeks at the end of each month. In June the Trust met this standard and submitted a performance of 92.12 per cent of patients waiting under 18 weeks. This was the first time since May 2014 that the Trust had achieved the standard.

Further work over the coming months in increasing capacity, particularly in surgical specialities, will result in patient waiting times reducing further and a reduced number of patients waiting over 18 weeks.

Two patients were reported as having waited over 52 weeks in June's submission, which represents a month-on-month decrease of 9 patients.

There are a number of on-going initiatives to further reduce the number of patients on the Trust waiting lists for treatment. These include:

- Clinical validation of referrals
    - Will support referral back to GP earlier for those patients who do not need hospital treatment and support application of access policy for patients who DNA
- Additional outpatient activity
    - Will reduce time to first outpatient appointment to support shorter pathway time for admitted and non-admitted pathways
- Outsourcing of diagnostic work
    - Trust has capacity constraints in several diagnostic modalities
    - Reducing waiting times will support delivery of 6 week standard as well as reducing overall pathway times for RTT and cancer patients
- Additional inpatient activity
    - This will support clearance of a backlog of admitted activity in challenged specialties

Underperformance in activity during the first three months of 2015/16 is a risk to RTT delivery and this is being managed directly with divisional teams.

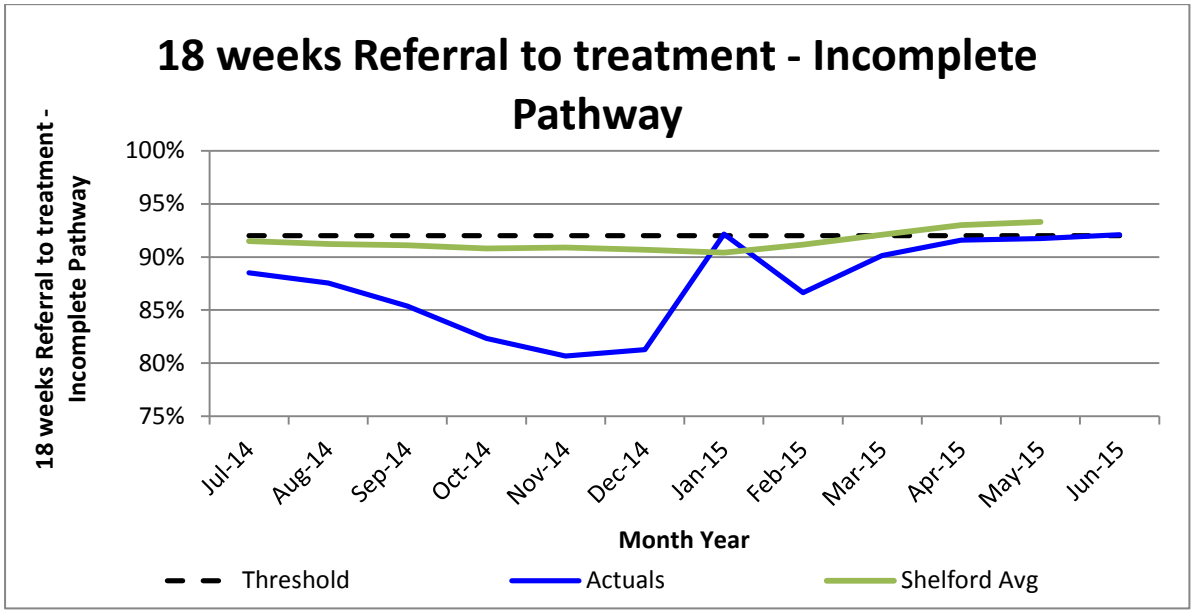


Figure 26 - RTT Incomplete Pathways for the period July 2014 – June 2015

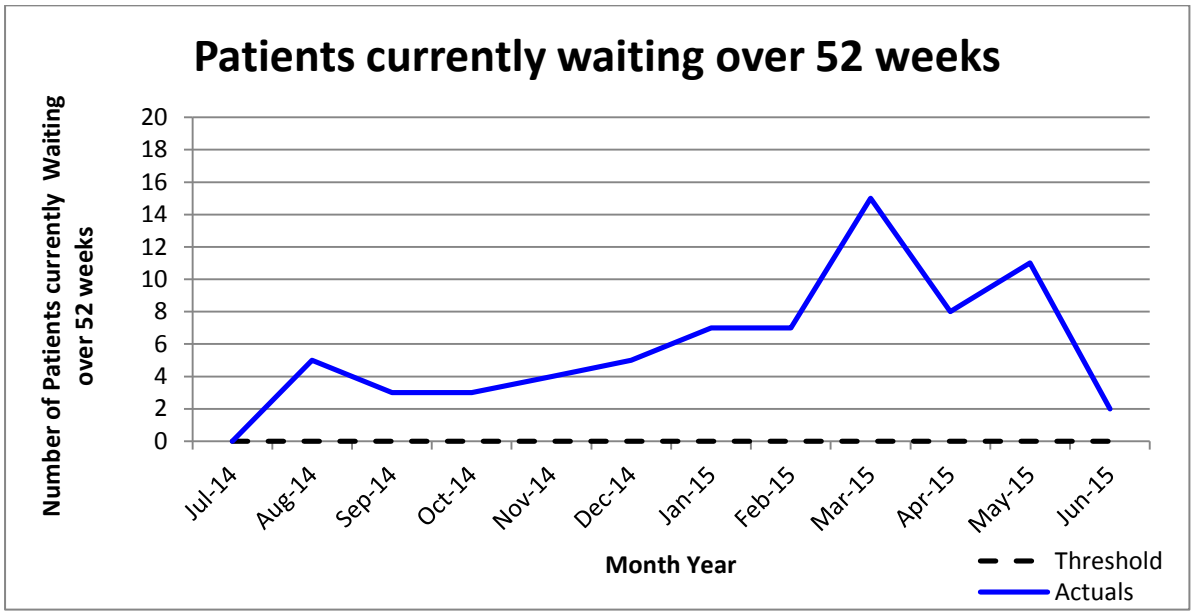


Figure 27 - Number of patients waiting over 52 weeks for the period July 2014 – June 2015

3.5.2 Responsive: Diagnostics

The Trust has had significant challenges with diagnostic capacity in recent months. This is particularly affecting our imaging services and is as a result of insufficient staff and high staff turnover, break down of old diagnostic equipment, and additional equipment needed to increase capacity. The Trust has not met the 6-week diagnostic standard since May 2014 and does not expect to achieve until the third quarter of 2015/16.

There is a recovery plan in place for improving imaging capacity and reducing the time that patients wait for their diagnostic test. This includes recruitment of additional staff to accommodate longer working hours and access to additional scanning machines.

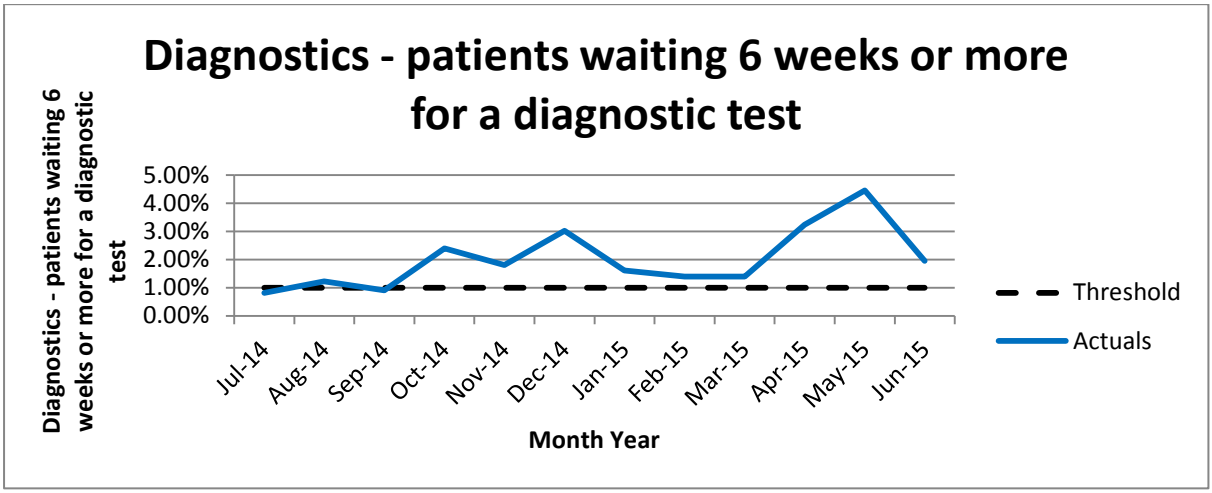


Figure 28 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period July 2014 – June 2015

3.5.3 Responsive: Accident and Emergency

The Trust achieved the four hour access standard for patients attending Accident and Emergency in June. This was the first time the Trust had achieved the standard in a number of months and was as the result of a number of initiatives to improve flow within the organisation. For patients who are discharged, there has been an increased focus on discharging before noon, to allow increased capacity for any new emergency admissions and free up capacity within the Emergency Department.

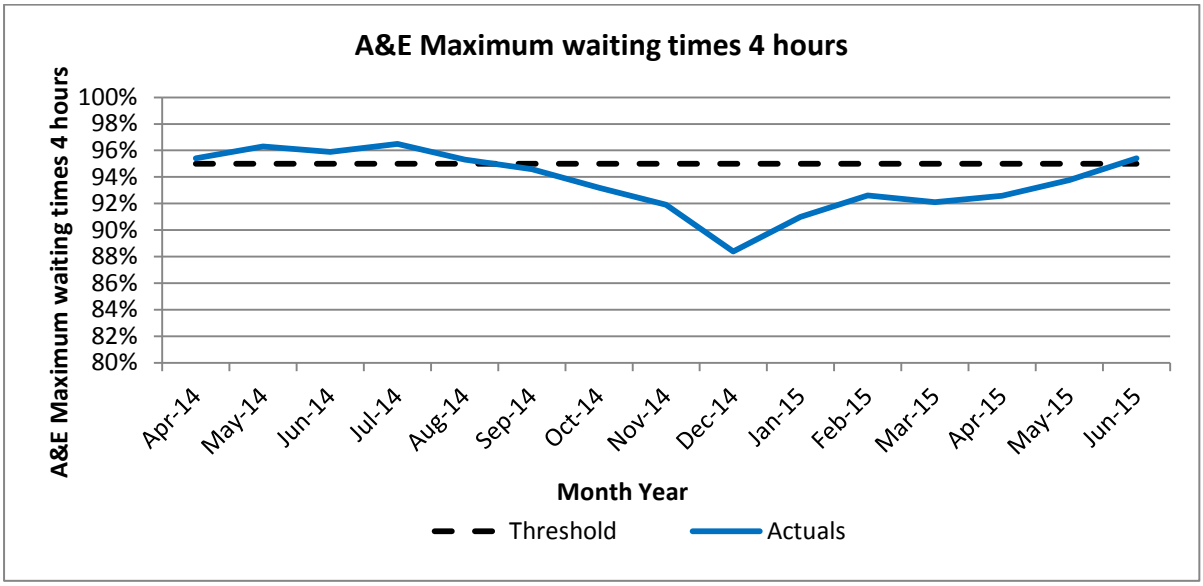


Figure 29 – A&E Maximum waiting times 4 hours for the period April 2014 – June 2015

3.5.4 Responsive: Cancer

In July, performance is reported for the cancer waiting times standards in May. In May the Trust achieved six of the eight cancer standards. The Trust failed to meet the 62-day GP referral to treatment standard in May. This was due to:

- Delays in access to diagnostic services, specifically in imaging and endoscopy; &
- Late referrals from other NWL trusts with insufficient time remaining on the pathway to treat patients within target.

The Cancer Performance Team has agreed a revised escalation process with the Imaging department to prioritise the diagnostic investigations for patients on open cancer pathways in the context of wider capacity challenges within the department. Additional tracking resource has been allocated to the diagnostic phase of the cancer pathways in response to this to support the work of the diagnostics teams. The Trust has also invited the IST to review the colorectal diagnostic pathway in order to establish a more efficient patient flow from GP referral to treatment. The CWHHE commissioning team has continued to support the Trust in the development of improved referral routes into our treating services from local DGHs. A quality schedule has been included in the 2015/16 contract which formally monitors the transfer point between trusts on shared patient pathways to allow the commissioners to drive improvements in local hospitals to ensure that patients are referred to us earlier for treatment.

The Trust also failed to meet the 62-day screening standard in May. This was due to:

- Significant patient choice delays (over 100 days); &
- Delays in scheduling treatment at other NWL sites after patients have been repatriated from the screening service.

Screening guidelines do not correlate neatly with CWT guidelines as patients are given a 6 month window to attend their first assessment clinic after the identification of a screen-detected lesion. This results in very large patient choice breaches against the standard. To counter-balance this, the west London screening team have agreed to increase the level of clinical contact with patients who are not attending, and the point of escalation has been brought forward from two months to day 31. We will be reviewing progress against this in late July.

There are three scenarios in which screening activity can be attributed to ICHT in CWT reporting:

- **Patients screened in the West London Screening Service, hosted at CXH, who are treated at ICHT**. Because CXH hosts the screening service the CWT clock starts for patients screened there are all attributed to ICHT. If screen detected cancers are referred into the surgery or oncology services at ICHT for treatment, a full treatment is reflected in our reported CWT position

as we are responsible for both the clock start and the clock stop. If these patients breach the 62-day screening standard we report a full breach against the Trust. In some scenarios patients are repatriated from the screening service to other local trusts for simple surgery, before returning to us after later opting for more complex surgery instead. In these scenarios ICHT still report a full treatment or breach as the clock start and clock stop are still both recorded against an ICHT site.

- **Patients screened in the West London Screening Service who are treated at another trust**. As above, the clock start for these pathways is attributed to ICHT because we host the screening service. When patients are repatriated to other trusts for treatment, half a treatment is reflected in our reported CWT position because the clock starts and clock stops are at different trusts. If these patients breach the standard, even where any delays are the fault of the recipient trust, we also incur half a breach in our reported CWT position.
- **Patients screened in other screening services treated at ICHT**. Patients screened in other screening services will have their clock starts attributed to the hospital site that hosts that service. When we receive those patients for treatment, we record ICHT as the treating site which means half a treatment is reflected in our reported CWT position because the clock starts and clock stops are at different trusts. As above, if these patients breach the standard, even where any delays are the fault of the referring trust or screening service, we also incur half a breach in our reported CWT position.

Indicator	Standard	May-15	Q4 14/15
Two week GP referral to 1st outpatient, cancer (%)	93.0%	94.1%	93.9%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.1%	94.4%
31 day wait from diagnosis to first treatment (%)	96.0%	97.4%	96.7%
31 day second or subsequent treatment (surgery) (%)	94.0%	97.3%	100.0%
31 day second or subsequent treatment (drug) (%)	98.0%	98.8%	99.6%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	98.7%	96.8%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	76.4%	79.1%
62 day urgent GP referral to treatment from screening (%)	90.0%	88.0%	92.5%

Table 1 - Performance against national cancer standards for the period 1st May to 31st May 2015

3.5.5 Responsive: Outpatient DNA rates

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, or two follow-up appointments, they may be discharged back to their GP.

DNA rates have reduced since September following increased rates of use of text messaging reminders to patients prior to their outpatient appointment.

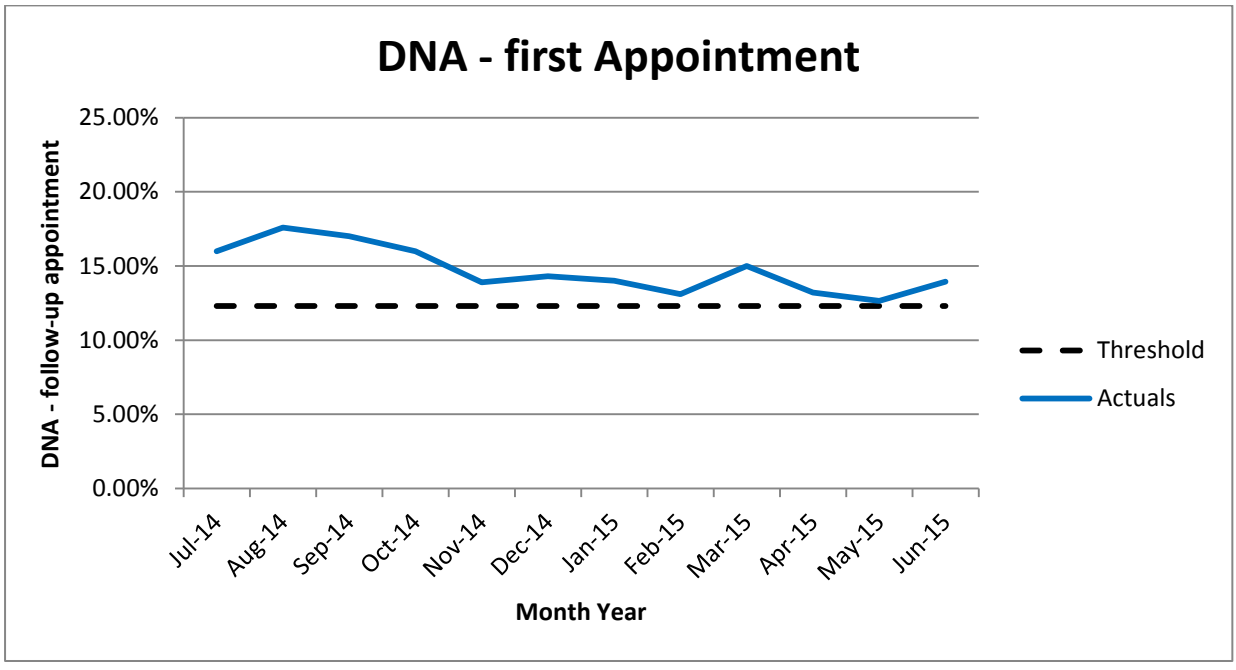


Figure 30 – First outpatient DNA rate for the period July 2014 – June 2015

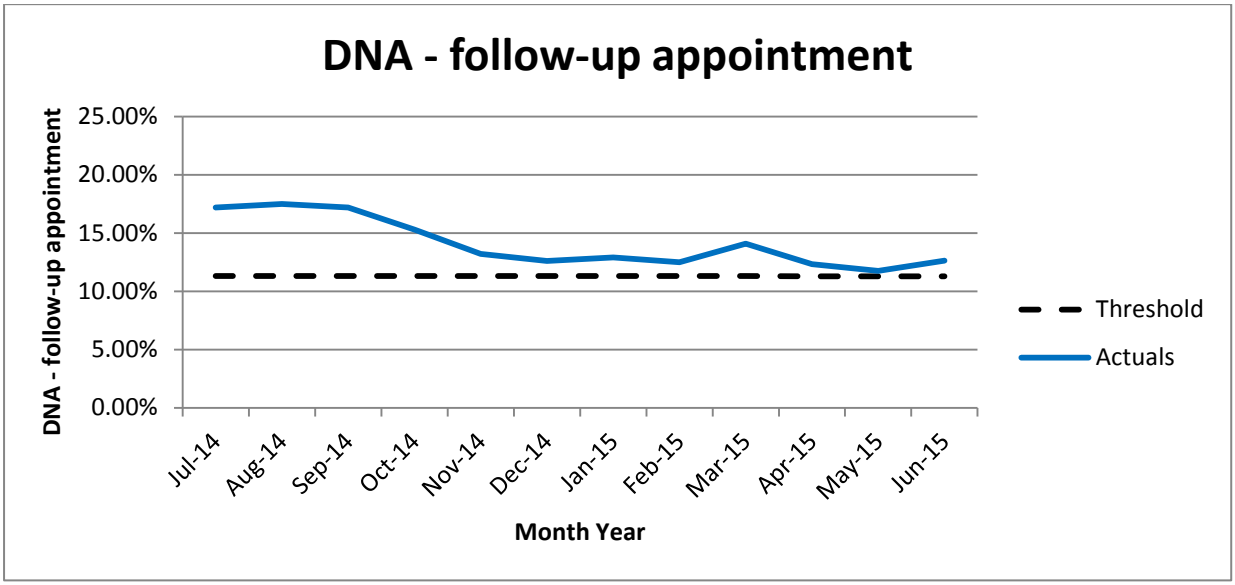


Figure 31 – Follow up outpatient DNA rate for the period July 2014 – June 2015

3.5.6 Responsive: 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 impact on the hospital's efficiency and potentially delays treatment for our patients.

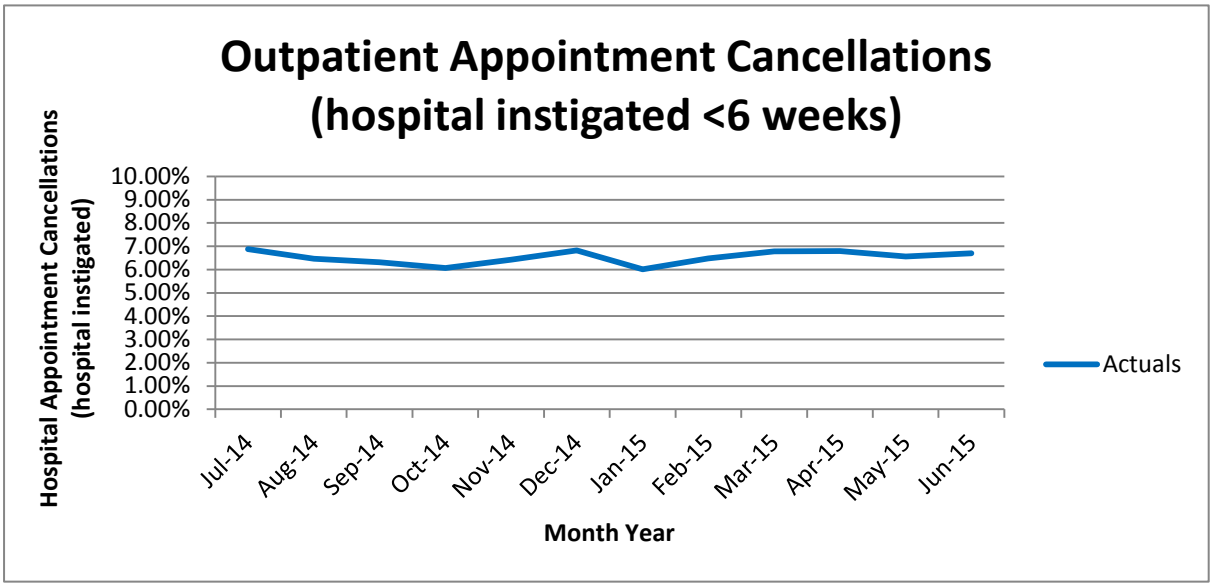


Figure 32 – Outpatient Hospital instigated cancellation rate for the period July 2014 – June 2015

4 Finance

Please refer to the Monthly Finance Report for the Finance narrative.

Imperial College Healthcare NHS
NHS Trust

Page 10 - CONTINUITY OF SERVICES RISK RATING (CoSRR)

Continuity of Service Risk Rating (CoSRR)	Weight	2015/16 Actual M1	Actual M2	Actual Q1	Forecast Q2	Forecast Q3	Forecast Q4	Trend (Actuals)
Liquidity	50%	(1.3)	(2.7)	(4.0)	(6.0)	(9.9)	(13.4)	
Liquidity Risk Rating		3	3	3	3	2	2	YTD
Capital Servicing Capacity	50%	0.39	(0.01)	0.40	1.54	1.96	1.87	
Capital Servicing Capacity Risk Rating		1	1	1	2	3	3	YTD
Overall CoSRR		2	2	2	3	3	3	

Monitor's continuity service risk rating was red due the Trust's deteriorating liquidity position.
Overall this is in line with plan.

Continuity of Services Risk Ratings (CoSRR)	Risk:	R

Table 2 - Continuity of Service Risk Rating (CoSrr) actual and forecast 2015/16

Appendix 1

JUNE 2015

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

			Day						Night					
			Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Division	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
Medicine	Charing Cross Hospital - RYJ02	10 North Ward	1833	1761.12	96.08%	561	543	96.79%	897	884.83	98.64%	540.5	540.5	100.00%
Medicine	Charing Cross Hospital - RYJ02	11 South Ward	2592.5	2563	98.86%	506	448.5	88.64%	2058.5	2012.5	97.77%	563.5	540.5	95.92%
Medicine	Charing Cross Hospital - RYJ02	4 South Ward	1714.5	1680	97.99%	1070	978	91.40%	1184.5	1150	97.09%	828.5	782	94.39%
Medicine	Charing Cross Hospital - RYJ02	5 South Ward	1839	1837	99.89%	11.5	11.5	100.00%	1713.5	1713.5	100.00%	46	46	100.00%
Medicine	Charing Cross Hospital - RYJ02	5 West Ward	2468	2407.5	97.55%	805	725	90.06%	2037.5	1968.5	96.61%	770.5	759	98.51%
Medicine	Charing Cross Hospital - RYJ02	8 South Ward	1859.5	1824.25	98.10%	1247.5	1207.5	96.79%	1035	989	95.56%	1023.5	1012	98.88%
Medicine	Charing Cross Hospital - RYJ02	8 West Ward	1394.5	1387	99.46%	1091	1088.5	99.77%	1035	1035	100.00%	690	682.5	98.91%
Medicine	Charing Cross Hospital - RYJ02	9 North Ward	2568.5	2430	94.61%	977.5	887	90.74%	2024	1932.5	95.48%	322	322	100.00%
Medicine	Charing Cross Hospital - RYJ02	9 South Ward	2236.67	2145.33	95.92%	977.5	954.5	97.65%	1311	1288	98.25%	977.5	977.5	100.00%
Medicine	Charing Cross Hospital - RYJ02	9 West Ward	1380	1352.5	98.01%	1034.166667	988.17	95.55%	690	690	100.00%	1046.5	1035	98.90%
Medicine	St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	2149.25	2003.75	93.23%	977.5	884.67	90.50%	1700.583333	1689.08	99.32%	644	598	92.86%
Medicine	St Mary's Hospital (HQ) - RYJ01	AMU	1276.75	1266.75	99.22%	651	526.25	80.84%	1104	1092.5	98.96%	379.5	379.5	100.00%
Medicine	Hammersmith Hospital - RYJ03	C8 Ward	1898	1817.5	95.76%	701.5	667	95.08%	1748	1656	94.74%	701.5	678	96.65%
Medicine	Hammersmith Hospital - RYJ03	Christopher Booth Ward	2028	1947.5	96.03%	708.5	667	94.14%	1068.5	1034	96.77%	575	563.5	98.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	1876	1770	94.35%	23.5	23.5	100.00%	1818	1760.5	96.84%	57.5	46	80.00%
Medicine	Hammersmith Hospital - RYJ03	Dewardener Ward	1497.5	1424.25	95.11%	0	0	100.00%	1449	1380	95.24%	0	0	100.00%
Medicine	Hammersmith Hospital - RYJ03	Fraser Gamble Ward	1421.5	1401	98.56%	1311	1264.17	96.43%	1081	1069.5	98.94%	872.1666667	860.67	98.68%
Medicine	St Mary's Hospital (HQ) - RYJ01	Grafton Ward	1185	1181	99.66%	701.5	663	94.51%	1035	1013.5	97.92%	368	368	100.00%
Medicine	Hammersmith Hospital - RYJ03	Handfield Jones Ward	1440	1392.75	96.72%	1077.5	823	76.38%	1035	1023.5	98.89%	701.5	679.25	96.83%
Medicine	Hammersmith Hospital - RYJ03	John Humphrey Ward	1415	1351	95.48%	860.5	807.5	93.84%	690	690	100.00%	839.5	839.5	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	1179.5	1160	98.35%	543	466.5	85.91%	1044.5	1021.5	97.80%	540.5	529	97.87%
Medicine	Hammersmith Hospital - RYJ03	Kerr Ward	1545	1424	92.17%	1127.5	1017.5	90.24%	1035	1012	97.78%	770.5	759	98.51%
Medicine	Charing Cross Hospital - RYJ02	Lady Skinner Ward	1155	1101.5	95.37%	414	402.5	97.22%	690	690	100.00%	679.5	668	98.31%
Medicine	St Mary's Hospital (HQ) - RYJ01	Manvers Ward	1447.5	1424.5	98.41%	837.5	826	98.63%	1472	1449	98.44%	828	828	100.00%
Medicine	Hammersmith Hospital - RYJ03	Peters Ward	1310.5	1220.92	93.16%	706.5	665.5	94.20%	747.5	739.5	98.93%	345	345	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Lewis Lloyd	1252	1220	97.44%	1046.5	948.5	90.64%	782	723.5	92.52%	1000.5	977.5	97.70%
Medicine	St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	1535	1532	99.80%	1006	913	90.76%	1089.5	1078	98.94%	690	690	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	1451	1386.88	95.58%	952.9166667	869.92	91.29%	1035	1035	100.00%	586.5	552	94.12%
Medicine	St Mary's Hospital (HQ) - RYJ01	Witherow Ward	1192.5	1182.75	99.18%	742.33	723.83	97.51%	690	690	100.00%	759	747.5	98.48%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	10 South Ward	2348.75	2217	94.39%	726.5	688.42	94.76%	1532.5	1475	96.25%	11.5	11.5	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 North Ward	2192	2110.5	96.28%	1092.5	938	85.86%	1047.5	1001.5	95.61%	1021.5	998.5	97.75%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 South Ward	1299.5	1173	90.27%	852.5	841	98.65%	931.5	886.5	95.17%	137	137	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 North Ward	2206.5	2173	98.48%	674.5	637.5	94.51%	1540.5	1517.5	98.51%	758.5	758.5	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 South Ward	2004.5	1811.26	90.36%	820.5	752	91.65%	1058	1046.5	98.91%	345	333.5	96.67%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A6 CICU	3338.5	3285.5	98.41%	445	445	100.00%	3170.25	3170.25	100.00%	230	207	90.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A7 Ward & CCU	2207.5	2116	95.86%	703.75	604.25	85.86%	1759.5	1727	98.15%	644	609.5	94.64%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A8 Ward	1932	1838.5	95.16%	720	662.17	91.97%	1276.5	1207.5	94.59%	69	23	33.33%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A9 Ward	1367	1355.5	99.16%	414	414	100.00%	1035	1035	100.00%	379.5	379.5	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Albert Ward	1829	1795.5	98.17%	849	833.5	98.17%	1069.5	1035	96.77%	862.5	862.5	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	2395	2346	97.95%	766	676	88.25%	1782.5	1782.5	100.00%	713	713	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	D7 Ward	1360.5	1360.5	100.00%	241.5	241.5	100.00%	701.5	701.5	100.00%	333.5	333.5	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Dacie Ward	1665.5	1571.25	94.34%	231	211.5	91.56%	1033	1021.5	98.89%	92	92	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Intensive Care CXH	4596.5	4565.36	99.32%	1166	1158.75	99.38%	4554	4539	99.67%	632.5	632.5	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Intensive care HH	4634.5	4593.5	99.12%	575	517.5	90.00%	4554	4531	99.49%	184	184	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	5590.75	5444.18	97.38%	1084.5	1084.5	100.00%	5718	5454	95.38%	1092.5	1092.5	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	2161	2055	95.09%	425.5	425.5	100.00%	1759.5	1725	98.04%	425.5	414	97.30%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Patterson Ward	1384.5	1361.5	98.34%	345	333.5	96.67%	724.5	713	98.41%	345	345	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Riverside	2909.5	2619	90.02%	1498.5	1376.5	91.86%	1391.5	1299.5	93.39%	644	586.5	91.07%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	2360	2274.5	96.38%	767	668	87.09%	1658	1600.5	96.53%	414	414	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Weston Ward	1371	1320	96.28%	263.5	259	98.29%	1030	1008	97.86%	145.5	145.5	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	2734	2722.5	99.58%	834.5	731	87.60%	2288.5	2231	97.49%	862.5	828	96.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	4348.5	4252.03	97.78%	1573.5	1436.5	91.29%	3772	3689.5	97.81%	1334	1276.33	95.68%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	239.5	239.5	100.00%	23	23	100.00%	161	161	100.00%	57.5	57.5	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	1035	1035	100.00%	0	0	100.00%	828	816.5	98.61%	218.5	207	94.74%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	2153	2093	97.21%	1298	1270.5	97.88%	1748	1736.5	99.34%	690	690	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	2074.5	2033	98.00%	0	0	100.00%	1805.5	1794	99.36%	0	0	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	2221.5	2196.5	98.87%	356.5	345	96.77%	2013.5	1990.5	98.86%	333.5	333.5	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	1067.5	1044.42	97.84%	435.5	435.5	100.00%	690	655.83	95.05%	345	336.08	97.41%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Neo Natal	3928.1	3928.1	100.00%	174	174	100.00%	3636	3600.5	99.02%	80.5	80.5	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	NICU	1994.75	1963.5	98.43%	287.5	287.5	100.00%	1840	1828.5	99.38%	322	322	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	PICU	3260	3109	95.37%	0	0	100.00%	3369.5	3213.5	95.37%	0	0	100.00%
Women and Children's	Queen Charlotte's Hospital - RYJ04	QCCH labour	4568.17	4320.67	94.58%	869.5	832	95.69%	3806.5	3747	98.44%	690	678.5	98.33%
Women and Children's	Hammersmith Hospital - RYJ03	Victor Bonney Ward	1830	1774.02	96.94%	522.75	513.9	98.31%	977.5	966	98.82%	322	322	100.00%
Private Healthcare Group	Charing Cross Hospital - RYJ02	15th Floor PP	2639	2512.5	95.21%	742.5	662	89.16%	1566	1509	96.36%	715.5	646.5	90.36%
Private Healthcare Group	St Mary's Hospital (HQ) - RYJ01	Lindo 3 & 4	1921.5	1910.75	99.44%	1319	1314	99.62%	1599.25	1599.25	100.00%	1105.25	1105.25	100.00%
Private Healthcare Group	St Mary's Hospital (HQ) - RYJ01	Lindo Nursing	2705.49	2674.99	98.87%	540.5	540.5	100.00%	1119.5	1094.5	97.77%	356.5	356.5	100.00%
Private Healthcare Group	Hammersmith Hospital - RYJ03	Sainsbury Wings	2058	2058	100.00%	368	365	99.18%	702	702	100.00%	299	299	100.00%

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	2.4
Title	Financial report - 3 months ended 30 June 2015
Report for	Noting
Report Author	Alan Goldsman, Chief financial officer
Responsible Executive Director	Alan Goldsman, Chief financial officer

Executive Summary:

This report provides details of the Trust's financial results for the 3 months ended 30 June 2015.

Recommendation:

The Trust board is asked to note this paper.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and in the appropriate environment.

IMPERIAL COLLEGE NHS TRUST

FINANCE REPORT – 3 MONTHS ENDED 30 June 2015

1) Introduction

This report provides a brief summary of the Trust's financial results for the 3 months ended 30 June 2015. The Trust board is asked to note this paper and the actions proposed to mitigate and recover the position going forward.

2) Summary

After three months the Trust is reporting a deficit of £11.0m; an adverse variance to plan of £1.9m. This represents deterioration in the position for June of £0.9m. The table below provides a summary of the income and expenditure position.

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Total Income	83,985	83,091	(894)	247,619	241,200	(6,419)
Total Expenditure	(82,191)	(82,208)	(17)	(245,136)	(240,669)	4,467
Earnings Before Interest, Tax, Depreciation & Amortisation	1,794	883	(911)	2,483	531	(1,952)
SURPLUS / (DEFICIT) including donated asset treatment	(1,789)	(3,035)	(1,246)	(8,966)	(11,207)	(2,241)
SURPLUS / (DEFICIT)	**(2,057)**	**(2,959)**	**(902)**	**(9,069)**	**(10,994)**	**(1,925)**

A successful recovery from this position will be achieved by delivery of the planned and funded patient care volumes (both NHS and Private care), urgently addressing the invoicing challenges issued by CCGs, and by significantly improving cost control in key service areas.

3) Revenue

The Appendix provides a summary of the position after 3 months.

3.1) NHS Activity and Income

The summary table shows the position by division.

Divions	Year to Date (Activity)			Year to Date (Income)		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s
A - Medicine	490,414	491,966	1,552	73,279	73,980	701
B - Surgery and Cancer	353,763	364,104	10,342	75,797	73,840	(1,957)
C - Investigative Sciences and Clinical Support	528,673	598,542	69,870	8,089	8,410	322
D - Womens and Childrens	72,174	76,135	3,961	26,733	26,317	(416)
X/Z - Central Division Total	30,658	27,837	(2,821)	3,393	1,929	(1,464)
YTD JUNE's FORECAST ACTIVITY & INCOME	1,475,682	1,558,585	82,903	187,291	184,476	(2,815)

[Note: Division X/Z represents those revenue streams from NHS commissioners that are not for direct patient care or managed through patient care facilities controlled by the clinical divisions (such as for patient transport); or items that have a 'contra' impact on expenditure. The variance shown has no impact on the Trust bottom line surplus]

Underperformance in Surgery and Cancer and in Women and Children is to a large degree mitigated by releasing the funds held in reserves to meet the cost of the service developments

agreed as part of the annual plan. The medicine position might be overstated once commissioner challenges are considered (see below).

3.2) Private Care income

Private care income is underperforming by just under £2m; of which £1m represents new work with costs held in reserves to undertake it (so an underlying variance of £1m).

This is mostly for Surgery and Cancer (£0.5m) and Women and Children (£0.6m). A detailed appraisal and action plan is being prepared to recover the position.

3.3) Expenditure

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

		In Month			Year to Date (Cumulative)		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Division of Medicine	Income	906	1,023	117	3,122	3,266	144
	Pay	(11,752)	(12,315)	(563)	(35,324)	(36,557)	(1,233)
	Non Pay	(4,757)	(5,538)	(781)	(14,278)	(15,039)	(761)
Division Of Medicine Total		**(15,603)**	**(16,830)**	**(1,227)**	**(46,480)**	**(48,330)**	**(1,850)**
Division of Women and Children	Income	587	476	(111)	1,716	1,225	(491)
	Pay	(6,159)	(6,091)	68	(18,388)	(18,112)	276
	Non Pay	(1,169)	(1,290)	(121)	(3,538)	(3,214)	324
Division Of Women And Children Total		**(6,741)**	**(6,905)**	**(164)**	**(20,210)**	**(20,101)**	**108**
Investigative Sciences & C S	Income	2,254	2,334	81	6,784	6,555	(229)
	Pay	(8,908)	(8,811)	97	(26,696)	(26,518)	178
	Non Pay	(3,584)	(3,731)	(147)	(10,744)	(10,724)	20
Investigative Sciences & C S Total		**(10,238)**	**(10,207)**	**31**	**(30,655)**	**(30,686)**	**(31)**
Surg, Canc & Cardiovasc Div	Income	422	424	2	1,455	1,210	(245)
	Pay	(12,795)	(12,624)	171	(38,177)	(38,012)	165
	Non Pay	(4,287)	(4,277)	10	(12,723)	(11,894)	829
Surg, Canc & Cardiovasc Div Total		**(16,660)**	**(16,477)**	**183**	**(49,445)**	**(48,696)**	**749**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(49,242)**	**(50,419)**	**(1,177)**	**(146,789)**	**(147,813)**	**(1,024)**

The Division of Medicine has seen a very significant growth in the requirement for nurse 'specialling'; for patients requiring one-to-one nursing care (£0.5m YTD). Elsewhere the Division has work to do in managing to the agreed and funded establishments. There is some evidence that non-pay costs (£0.7m adverse) relate to activity and that the variance will be reduced once the adjustment for income is made.

4) Contract

Contracts have not yet been signed with CCGs or NHSE. These are imminent and there is no reason to believe that any of the performance to the end of June would be materially worse or better than reported. A realistic view has been taken with regard to data challenges using prior year outcomes as a guide.

5) Efficiency programme

Over the first quarter, £4.6m (69%) of planned CIPs have been delivered. As divisions work to gain traction on schemes agreed during the latter stages of the business planning process, in-month delivery is forecast to improve from July (to 88%). The QuEST team has begun work with divisions to ensure mitigations are identified with sufficient time to give confidence about delivery in order to bridge what, if projected forward at the same level of delivery, would result in a £4m year-end gap.

Deep dive meetings with each division are scheduled in the second half of July; they are also being organised with those corporate directorates with larger CIP programmes or where there is currently significant slippage in delivery.

The largest area of CIP underperformance to-date has been in non-pay expenditure, leading to a projected £1m year-end variance in corporate areas largely attributable to delays in concluding a contact for managed maintenance services (anticipated for sign off imminently) and to the attribution of World Class Supply Chain (procurement) savings.

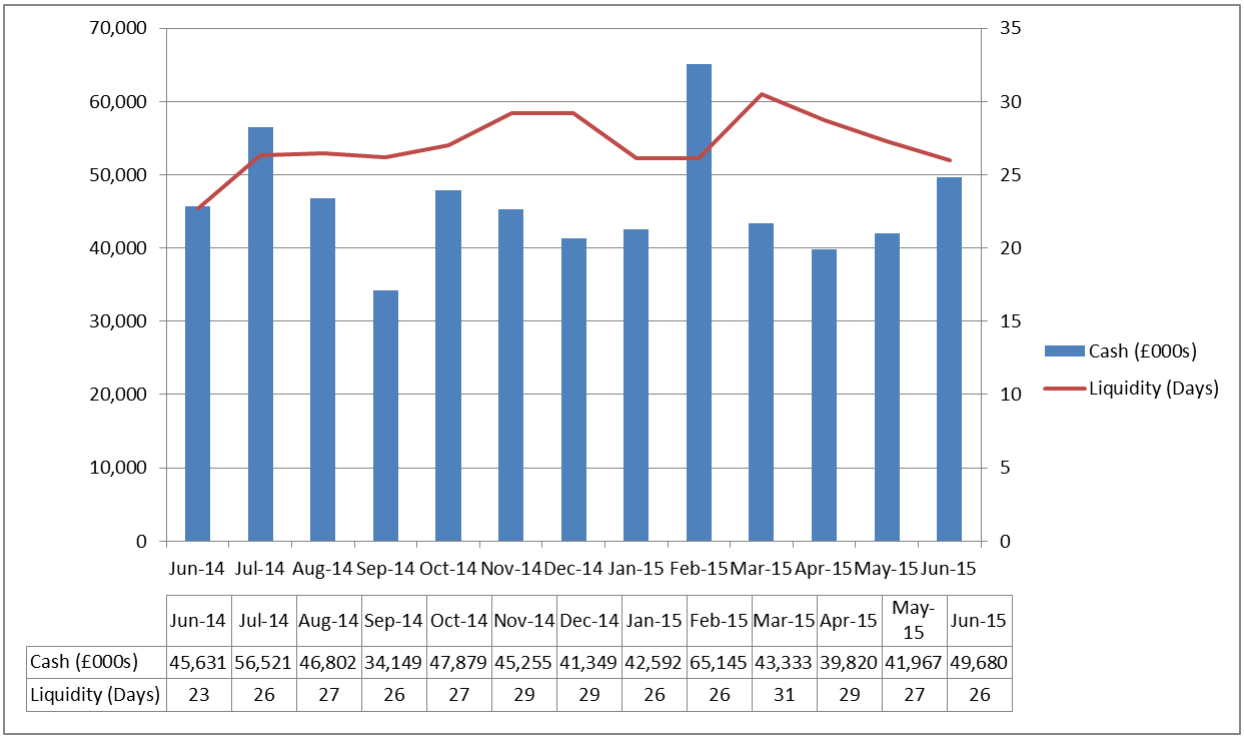
The other main areas of underperformance over the year to-date relate to:

- additional contribution from private patients income;
- a number of areas where NHS income was anticipated to increase have also underperformed against plan - for example, a contract for agreed growth in the gender reassignment service has only recently been finalised which led to a delay in undertaking additional work, but the service is anticipated to be delivered in full by year-end;
- slippage in actions taken to ensure the Trust incurs fewer contract fines and penalties has resulted in failure to deliver the associated CIPs;
- delayed implementation of a new Theatre efficiency programme. This has now been established under the leadership of the COO and plans are being drawn up to accelerate delivery over the second half of the year.

The Chief Operating Officer and Chief Financial Officer hold weekly Programme Oversight meetings about CIP and business plan delivery, with fortnightly meetings with each division. These will be used to maintain focus on CIP delivery and ensure that, where required, robust mitigations are signed off and implemented to support delivery of the full value of the CIP programme required by the 2015/16 business plan – starting with deep dive meetings planned to start in the second half of July.

6) Cash

The chart below shows the cash balance at the end of June (£49.7m) using the scale on the left hand axis and the liquidity days for the Trust, using the scale on the right. The balances over the last 12 months are shown for reference:



	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Cash (£000s)	45,631	56,521	46,802	34,149	47,879	45,255	41,349	42,592	65,145	43,333	39,820	41,967	49,680
Liquidity (Days)	23	26	27	26	27	29	29	26	26	31	29	27	26

There is no evidence that the current performance is having a detrimental effect on the cash position; this is most likely because of slow capital spend uptake. Payment of the £10.2m performance bond in July will further improve the position.

7) Capital

The capital programme is subject to detailed review elsewhere on this agenda. The Trust's annual Capital Resource Limit (CRL) has been formally approved at £38.8m, an increase of £0.8m due to the receipt of capital funding for ICHTs participation in the national Genomes Project.

Discussions with ICHT Charity mean an expected £12.2m is expected to fund projects in year, with £9.0m assumed in the original plan. Charitable funding does not impact on the CRL.

8) Conclusion

The rate of performance improvement required in both activity performance and productivity is planned to increase across the year. A difficult first quarter increases this challenge further over the remaining three quarters and a successful recovery from this position will focus on delivery of the planned and funded patient care volumes (both NHS and Private care), urgently addressing the invoicing challenges issued by CCGs, and by significantly improving cost control in key service areas.

Appendix

Statement of Comprehensive Income – 3 months to 30th June 2015

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	65,489	67,199	1,710	192,431	189,408	(3,023)
Private Patients	3,874	3,366	(508)	11,322	9,353	(1,969)
Research & Development & Education	8,998	9,147	149	26,994	27,176	182
Other	5,624	3,379	(2,245)	16,872	15,263	(1,609)
TOTAL INCOME	**83,985**	**83,091**	**(894)**	**247,619**	**241,200**	**(6,419)**
Expenditure						
Pay - In post	(42,751)	(41,486)	1,265	(126,959)	(123,411)	3,548
Pay - Bank	(2,295)	(2,158)	137	(6,548)	(7,471)	(923)
Pay - Agency	(2,564)	(4,584)	(2,020)	(8,953)	(12,081)	(3,128)
Drugs & Clinical Supplies	(21,396)	(22,866)	(1,470)	(63,128)	(63,362)	(234)
General Supplies	(2,887)	(2,918)	(31)	(8,660)	(8,662)	(2)
Other	(10,298)	(8,196)	2,102	(30,888)	(25,682)	5,206
TOTAL EXPENDITURE	**(82,191)**	**(82,208)**	**(17)**	**(245,136)**	**(240,669)**	**4,467**
Earnings Before Interest, Tax, Depreciation & Amortisation	**1,794**	**883**	**(911)**	**2,483**	**531**	**(1,952)**
Financing Costs	(3,583)	(3,918)	(335)	(11,449)	(11,738)	(289)
SURPLUS / (DEFICIT) including donated asset treatment	**(1,789)**	**(3,035)**	**(1,246)**	**(8,966)**	**(11,207)**	**(2,241)**
Impairment of Assets	0	0	0	0	0	0
Donated Asset treatment	(268)	76	344	(103)	213	316
SURPLUS / (DEFICIT)	**(2,057)**	**(2,959)**	**(902)**	**(9,069)**	**(10,994)**	**(1,925)**

Imperial College Healthcare NHS
NHS Trust

Trust board - public

Agenda Item	3.1
Title	Proposal for co-location of stroke services
Report for	Decision
Report Author	Prof Tim Orchard, Divisional Director, Medicine
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary

At its meeting held on 27 May 2015, the Trust Board considered a report on the proposed co-location of stroke services on one site and took the decision that engagement and communications on the proposal should proceed followed by this further report for consideration by the Board on the outcomes of the process.

Currently, Imperial College Healthcare NHS Trust provides two stroke units – at Charing Cross Hospital in Hammersmith and St Mary's Hospital in Paddington - as well as a hyper acute stroke unit (HASU) at Charing Cross Hospital.

The Trust wants to deliver the best outcomes and experience for all our stroke patients. We believe that the proposed change would enable us to meet fully best practice standards seven days a week, enabling patients to have the fullest and speediest recovery possible.

There is a strong clinical consensus within the Trust that providing stroke services across two hospital sites is not sustainable in terms of quality or efficiency. We believe there are significant benefits in creating a fully integrated service on one site in terms of seven-day access to senior specialist clinicians, therapists and MRI scanning services.

To support best practice, we propose moving the St Mary's Hospital stroke unit to Charing Cross Hospital to create a fully integrated service on one site. This would be an interim model for approximately the next five years, until St Mary's Hospital, the Trust's major acute site, is redeveloped. It was agreed as part of the 2009/10 London-wide stroke service re-organisation that ultimately the Trust should run an integrated stroke service out of St Mary's Hospital so that patients can benefit further from co-location with the major trauma centre there.

The co-located service would be provided across one floor of Charing Cross Hospital and would include:

- Hyper acute stroke unit (HASU) with 20 beds at Charing Cross Hospital
- A stroke unit at Charing Cross Hospital with 34 beds, an expanded gym, and day room
- TIA (transient ischaemic attack) investigation service at Charing Cross Hospital
- In addition, there would be outpatient follow-up clinics at Charing Cross and St Mary's hospitals

Under the proposal, the total number of stroke inpatient beds and staff would remain unchanged. The pathway for our stroke patients who require further rehabilitation in their local community will also remain the same.

The main reasons for the proposal to change our current stroke services are to:

- provide the best outcomes and experience for patients, their families and carers
- improve access to therapy services
- provide 7-day, 24-hour consultant cover for all our patients, in line with best practice guidelines set out by the Royal College of Physicians
- co-locate stroke and neurosurgical services
- provide 24-hour availability of MRI scanning services
- reduce the average length of stay for all stroke patients
- have the best trained stroke specialist teams

The public and stakeholder engagement process began on Monday 15 June and was extended from the original planned four-week period to run up to Wednesday 22 July in order to gather as much feedback as possible. Separately and concurrently, a formal consultation process was undertaken with the directly-affected Trust staff currently working in the stroke unit at St Mary's Hospital.

A single, integrated stroke unit at Charing Cross Hospital could mean a potentially longer journey for visitors of patients who would currently be cared for in the St Mary's Hospital stroke unit – particularly, those from the boroughs of Brent and Westminster which are the two main sources for patients. There would still be outpatient stroke services at both Charing Cross and St Mary's hospitals so there would be no travel impact for patients once they were discharged from hospital. As this is a particularly important issue, a specific piece of transport analysis was commissioned to understand the potential impact on patients, visitors and staff and to use the findings to develop information and identify possible approaches to address travel issues.

Recommendation to the Board

The Board is asked to approve that the proposed stroke service co-location proceeds as outlined, along with immediate improvements to information on transport options and support for visitors and further consideration of longer-term improvements as part of the developing Trust-wide transport strategy.

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
NHS Trust

Proposal for co-location of stroke services

Purpose of the report

At its public meeting held on 27 May 2015, the Trust's Board approved a recommendation that engagement and communications on the proposed stroke service co-location should proceed followed by a further report for consideration by the Board on the outcomes of this process.

Further to the decision taken by the Trust Board on 27 May, this report provides updates and further information on: the activities and outcomes of the engagement process undertaken on the stroke service proposal; the formal consultation with directly-affected staff; the transport analysis study; and, the current plans for refurbishment of the area designated for the additional capacity required at Charing Cross Hospital.

The Board is asked to approve that the proposed stroke service co-location proceeds as outlined, along with immediate improvements to information on transport options and support for visitors and further consideration of longer-term improvements as part of the developing Trust-wide transport strategy.

Background

Patient journey through the stroke service
Suspected stroke patients will normally enter the health system via their nearest A&E department with a hyper acute stroke unit – 'HASU'. These designated HASUs have a range of clinical professionals who are specifically trained and experienced in stroke care. There are eight HASUs in London – including the Charing Cross Hospital HASU in our Trust.

The following London hospitals have HASUs:

- Charing Cross Hospital, Hammersmith
- King's College Hospital, Denmark Hill
- Northwick Park Hospital, Harrow
- Princess Royal University Hospital
- Queen's Hospital, Romford
- St George's Hospital, Tooting
- The Royal London Hospital, Whitechapel
- University College Hospital, Euston

For the first few days following a stroke, a patient in the HASU will receive intensive care from a specialist team of doctors, nurses and therapists. After about three days, as soon as the patient is well enough, they will be transferred to one of 24 stroke units across London as they do not need such intensive care and where the focus is on rehabilitation. There is currently a stroke unit at both Charing Cross Hospital and St Mary's Hospital.

The 24 rehabilitation stroke units in London are located at:

Barnet Hospital, Charing Cross Hospital, Chelsea and Westminster Hospital, Croydon University Hospital, Hillingdon Hospital, Homerton Hospital, King's College Hospital, Kingston Hospital, National Hospital for Neurology and Neurosurgery, Newham Hospital, North Middlesex Hospital, Northwick Park Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital, Queen's Hospital, Royal Free Hospital, St George's Hospital, St Helier Hospital, St Mary's Hospital, St Thomas' Hospital, The Royal London Hospital, University Hospital Lewisham, West Middlesex Hospital, Whipps Cross Hospital.

In the rehabilitation stroke unit, a specialist team will continue to care for each stroke patients often complex needs, setting out the best medication and treatment, providing therapy and helping plan for life after stroke, until the patient is well enough to go home.

The duration of the inpatient stay will depend on the severity of the impact of the stroke and the subsequent symptoms.

In 2008, as part of the London-wide improvement of stroke services, the Trust successfully bid to run a HASU as well as two stroke units.

Subsequently, the Trust's HASU opened at Charing Cross Hospital in December 2009. The public consultation that informed the London stroke services improvement project showed a preference for co-locating HASUs on the same site as major trauma centres, as they need similar back-up and support. The longer term agreement was therefore to move the HASU to St Mary's Hospital, which runs the major trauma centre for north west London, as part of the future redevelopment of the St Mary's site.

Our two stroke units are based at Charing Cross Hospital, next to the HASU, and at St Mary's Hospital.

We provide outpatient follow-up services at both Charing Cross and St Mary's hospitals.

TIA patients

London has also improved its response to transient ischaemic attack – 'TIA' or a 'warning stroke' - and now has 24 TIA services across the capital. These services make a fast diagnosis and provide access to a specialist within 24 hours for people at high risk of a more severe stroke or within seven days for those at low risk.

Until March 2015 there was a TIA service at both Charing Cross Hospital and St Mary's Hospital, when the service temporarily moved over to Charing Cross Hospital due to staffing resource issues. This was an interim measure due to maternity leave.

On-going care after discharge

We estimate that about 55-60 per cent of all stroke survivor patients admitted to our stroke units are able to go home, or to a nursing home, with community support, which may include nursing care and a range of therapy services (see discharge profile chart for St Mary's Hospital stroke unit below). When discussing the patient's discharge home, we will ask about the facilities they have available. We will also talk to the patient about their circumstances, for instance whether they have some relatives or friends who can provide support. We will continue to refer patients to their local social services, where their needs will be assessed and relevant support arranged.

Of the other discharged stroke survivor patients about 40-45 per cent will need further rehabilitation in local centres, including rehabilitation units in the community and specialist neuro-rehabilitation centres. This can be for a few weeks or months, or an ongoing process, depending on the severity of the stroke, the patient's needs, general health and their previous abilities. We will discuss the options with the patient as they near the time of their discharge. Staff at the Trust stroke unit will continue to ensure that all the arrangements for the patient's care are organised for them when they leave hospital.

The current proposal is for any follow up appointments resulting from an inpatient admission to take place at outpatient clinics at both Charing Cross Hospital and at S. Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

Information on Trust stroke services guiding changes

Patient profile and pathway through the Trust's stroke service

The average age of a typical patient is **72yrs**.

Age	17-30	31-45	46-55	56-65	66-75	76-85	86-95	96-105
%	1.4	4.7	10.3	12.0	23.0	29.3	17.2	2.1

Mode of admission to HASU

Referred from	A&E	Other Hospitals	SMH	TIA Clinic	Other (e.g. theatres,wards)
%	76.0	2.0	2.3	0.8	18.0

Discharge profile

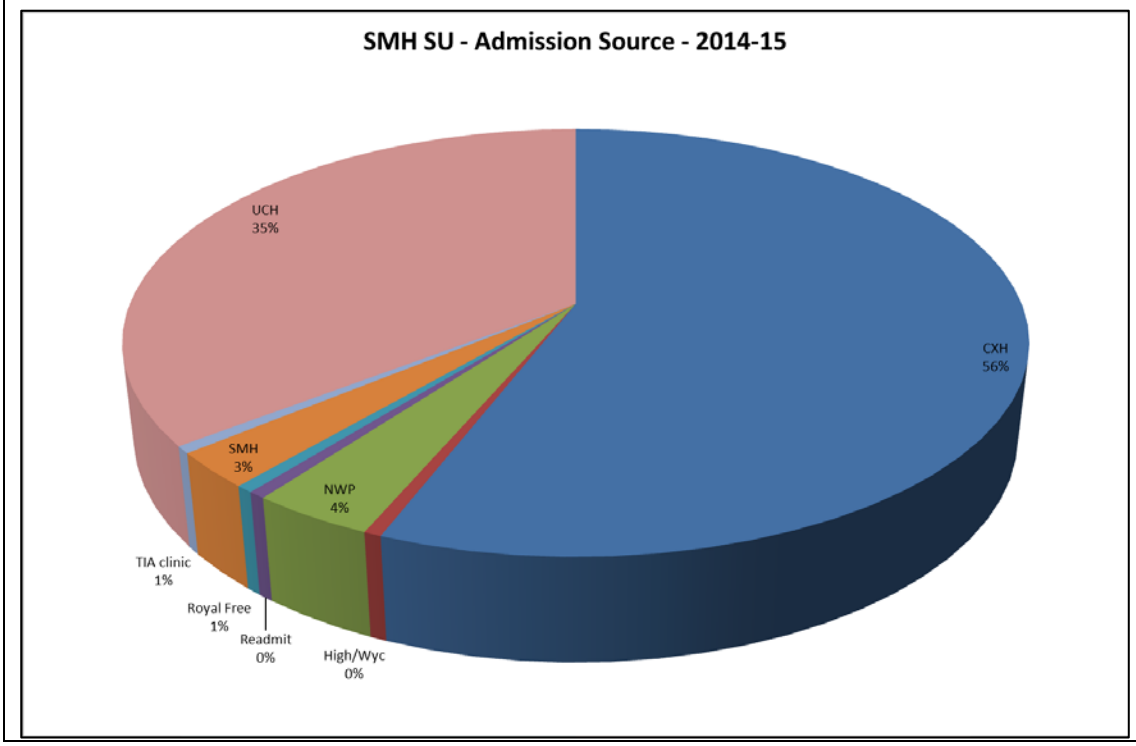
Discharge outcome	CXH SU	SMH SU	Repatriation to local SU	Internal transfer to CX Ward	Home	Self-Discharge
%	27	10.7	21.9	7.4	32.2	0.8

Patient admissions 2014/15

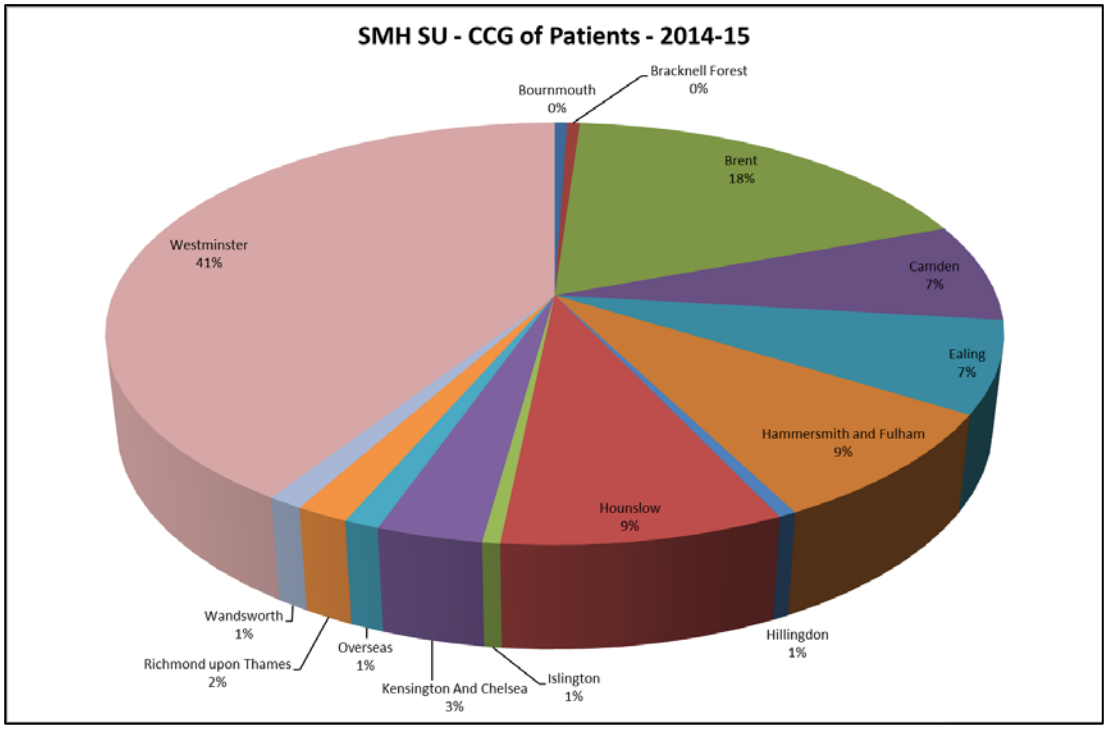
Site	**Stroke**	**TIA**	**Other (**eg.Seizure/Migraine**)**	***Average LOS Hrs.**	***Average LOS Days**
CXH HASU	1111	162	472	103.06	-
CXH SU	343	7	26	-	18.1
SMH SU	186	-	-	-	26.2

**LOS: Are measured in hours for HASU and Days in SU*

Mode of admission to St Mary's Hospital (SMH) stroke unit



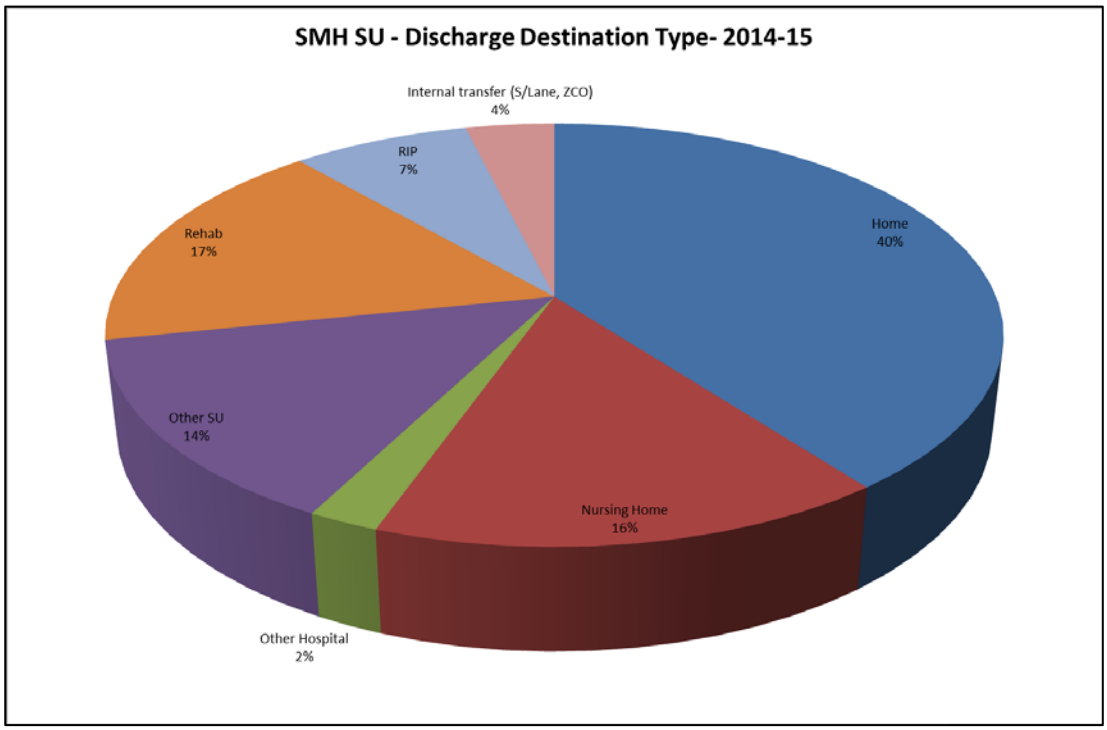
CCG of patients admitted to St Mary's Hospital (SMH) stroke unit



For St Mary's Hospital stroke unit total 186 patient admissions in 2014/15, two largest sources:

- 41 per cent of total from Westminster/Central London = 76.26 patients (6.35 per month)
- 18 per cent of total from Brent = 33.48 patients (2.79 per month)

Discharge profile for St Mary's Hospital (SMH) stroke unit



The case for change

There is a strong clinical consensus within the Trust that providing stroke services across two hospital sites is not sustainable in terms of quality or efficiency. The main benefit of the proposed co-location would be better patient outcomes and experience with improved continuity of care. The entire stroke specialist team would be on one site and would be better equipped to deliver the quality of service for all stroke patients within the recommendations of the Royal Colleges for working seven days per week.

The proposal is in line with the Trust's clinical strategy, approved by the Trust Board in July 2014, which set out the case for co-locating stroke services. The strategy states:

"4.2.4 Stroke and neurosciences
There is strong clinical consensus that providing inpatient stroke and neurosciences services across three sites is not sustainable from a safety and quality perspective. There are critical clinical adjacencies with A&E, major trauma and the hyper acute stroke unit and so all stroke services plus a neurosurgical elective spinal service will be based alongside those services on the St Mary's major acute site. Remaining elective neurosciences services will be based at Hammersmith Hospital alongside related specialties, particularly head and neck/base of skull surgery."

The main reasons underlying the proposal to change our current stroke services are to:

- **Provide the best outcomes and experience for patients, their families and carers.** The current stroke unit at St Mary's Hospital is based in old and outdated facilities. There is no prospect of significantly improving these facilities in advance of the planned major redevelopment of the St Mary's estate which is at least five years away. The current facilities are cramped, reducing privacy for patients, and do not include a day room where patients can spend time with visitors during their recovery period in hospital. There is an opportunity to re-provide this service in larger, modern facilities at Charing Cross Hospital in the interim.
- **Improve access to therapy services.** Having all specialist therapy staff on one site, with an expanded and improved gym, would enable us to provide high-quality, seven day services to all stroke patients. The more therapy stroke patients receive, the better their potential outcome.
- **Provide seven-day consultant review for all our patients, in line with best practice guidelines set out by the Royal College of Physicians.** As there is a much smaller service at St Mary's Hospital, there have not been enough patients to support the workload for a specialist consultant to be on duty for routine work at the weekends. Instead, there is daily consultant review from Monday to Friday only. Integrating the two stroke units and co-locating them with the HASU, would enable us to have seven day access to a stroke consultant on site for all stroke patients.
- **Co-locate of stroke and neurosurgical services**
  Charing Cross Hospital has neuro-surgeons on-site and bringing together specialist services will mean better clinical outcomes and safer services for patients.
- **Ensure 24-hour availability of MRI scanning service**
  Linked to the HASU and neuro-surgery services, Charing Cross has 24-hour availability of MRI scanning services, unlike St Mary's Hospital which currently provides a limited service. With a co-located stroke service at Charing Cross, all stroke patients would have access to 24-hour MRI if their condition should deteriorate.
- **Reduce the average length of stay for all stroke patients.** The average length of stay for a stroke patient at Charing Cross is 18 days compared with 26 days at St Mary's. This is partly linked to increased access to specialist consultants and other specialist clinicians and greater availability of therapy services.
- **Have the best trained stroke specialist teams.** By creating an integrated stroke service on one

site, rather than being split over two sites, we would be able to deploy our doctors, nurses and therapists more effectively. This would improve rota cover, training opportunities, communication and shared learning.

Current and Proposed Stroke Services at the Trust

Current services

- Hyper acute stroke unit (HASU) with 20 beds at Charing Cross Hospital
- A stroke unit at Charing Cross Hospital with 20 beds, a gym, and day room
- A stroke unit at St Mary's Hospital with 14 beds and a small gym
- TIA (transient ischaemic attack) investigation services – at Charing Cross and St Mary's hospitals
- Outpatient follow-up clinics – at Charing Cross and St Mary's hospitals

Proposed stroke services

To support best practice, we propose moving the St Mary's Hospital stroke unit to Charing Cross Hospital to create a fully integrated service on one site. The service would be provided across one floor and would include:

- Hyper acute stroke unit (HASU) with 20 beds at Charing Cross Hospital
- A stroke unit at Charing Cross Hospital with 34 beds, an expanded gym, and day room
- TIA (transient ischaemic attack) investigation service at Charing Cross Hospital

In addition, there would be outpatient follow-up clinics at Charing Cross and St Mary's hospitals.

Under the proposal, the total number of stroke inpatient beds and staff would remain unchanged. The pathway for our stroke patients who require further rehabilitation in their local community will also remain the same.

St Mary's Hospital is a major acute hospital for the region, with the designated major trauma centre for North West London. Given the important connections between Accident and Emergency (A&E), major trauma and the HASU, our longer term plan is for all stroke services to be co-located on a re-developed St Mary's site.

The benefits of the proposed co-location would be realised through:

- Better usage of beds allowing consistency of management, reduction in the average length of stay by avoiding internal waits for transfers, availability of senior therapy and nursing staff expertise
- Better staff utilisation:
    - Consultants able to participate in combined clinics
    - Additional flexibility to provide internal cover
    - No requirement to maintain consultant cover on both sites
    - More efficient use of therapy staff and strengthened cover with senior staff all on one site
    - Ability to increase the critical mass of staff to cross cover sickness and annual leave
    - Ability to increase the critical mass of patients in order to run efficient models of working such as group exercise classes and stroke education groups for patients.
- Management issues will be improved significantly with standardised operating procedures and consistency of pathways
- Better informed staff who will be able to access teaching and departmental meetings on one site
- More efficient stroke departmental management eg: audits, infection control issues and other trust procedures
- Less duplication of meetings

- More rapid referral of patients from HASU to the stroke unit
- Improved TIA service running seven days a week with a simpler referral system for primary care physicians
- Overall improved access to training, teaching and research. There are currently no training grade junior staff within the existing stroke service on the Charing Cross Hospital site where there is a wealth of clinical material available for teaching and training purposes.

There are also opportunities for efficiencies:

- Improved bed usage through reduced average length of stay
- Reduction in the use of bank and agency staff due to greater staffing resilience
- Improved efficiency due to reduction in transferring between sites
- Larger potential for research opportunities because of the larger cohort of patients available in one place
- The ward foot print would allow for future re–design for the rehabilitation pathway.

Potential timescales
The proposal is for the co-location to take place during the second half of 2015 before the winter period, subject to the outcomes of the public engagement and staff consultation processes and further consideration of these by the Trust Board before reaching its decision.

Public engagement

Planning for engagement
In the run up to the May Trust Board meeting, chief executive Dr Tracey Batten discussed the stroke service proposal and the appropriate form of engagement with Westminster Council's Chair of the Adults, Health and Public Protection Committee and the Cabinet Member for Adults and Health.

St Mary's Hospital is located in the local authority area of Westminster City Council. The local authority as a whole holds health scrutiny powers, but in practice it chooses to operate through a health overview and scrutiny committee (OSC). In Westminster the Health OSC is called the Adults, Health and Public Protection Policy & Scrutiny Committee.

Where a proposed service change is considered a "substantial variation" and being made by an NHS provider of services, there is a requirement to consult with the Health OSC which also has a formal power to refer any variation in health services to the Secretary of State for Health.

In the case of the stroke service proposal to re-locate the St Mary's Hospital stroke unit to Charing Cross Hospital, we approached the Chair of Westminster's Health OSC to say it would be very useful to have his thoughts and views on involving patients, local public and stakeholders should the Trust board give its approval to proceeding with the process of engagement on the proposal.

We sought the Council's thoughts and guidance on the appropriate and reasonable public and patient engagement approach around this particular proposal. Specifically we said it would be very helpful to have their view on whether or not this proposed service change would be considered as a "substantial variation".

In our approach to Westminster Council we referenced advice received from NHS England which indicated that if a service change was deemed as substantial by the relevant local Health OSC then formal public consultation was required which must be led by the relevant CCG. However, if the service change was not deemed to be of a substantive nature by the local Health OSC then engagement of the public, patients and relevant stakeholders by the Trust would be considered the appropriate method of engagement.

The Chair of Westminster Health OSC subsequently confirmed that this proposal did not constitute

a substantial change on which formal public consultation was required and we should proceed on a less formal basis with a planned four-week engagement period.

During this period we also contacted Professor Tony Rudd, NHS England's National and London Clinical Director for Stroke to gain his initial feedback on the proposal which was supportive.

Engagement activities

We wrote to over 650 of our stakeholders to notify them in advance that the Trust Board was due to meet on 27 May and to let them know that the agenda and papers were available to see online via the Trust website. Several members of the public, patients and interested stakeholders including a scrutiny councillor from the London Borough of Brent attended the May Trust Board meeting.

Articles on the stroke service proposal have been published in the Trust's three main newsletters: 'Partner Update' sent to stakeholders on 5 June; 'GP Bulletin' sent to General Practices on 9 June; and, 'Member Update' sent to shadow foundation trust members on 11 June.

At the end of the week previous to the launch of the engagement process on Friday 12 June we wrote via email to provide advance copies of the draft proposal document and draft news release to local CCGs, local authorities, Westminster MPs, Healthwatch, the Stroke Association, NHS England, NHS Trust Development Authority and other neighbouring NHS providers of stroke services.

When we started the engagement process on Monday 15 June we wrote via email to some 400 individual stakeholders in more than 150 organisations. We issued a news release to local media and placed this on the Trust website together with a new dedicated section with information and the proposal document both which was highlighted from the homepage. We issued messages via Twitter from @Imperial NHS which has over 7,000 followers and updated our Facebook page.

Follow up messages were sent via email to CCGs for Brent, Central London, Hammersmith & Fulham and West London on 24 June.

Other suggestions for individuals and organisations have been added to the engagement database and contacted via mail. Further stroke clinician-to-clinician contact has been undertaken to solicit feedback from neighbouring NHS stroke service providers.

The following external face-to-face meetings have discussed the proposal:

30 June: Westminster Council's Health Urgency Policy & Scrutiny Committee, where the dedicated agenda item was the proposed co-location of stroke services. Westminster Council has established a Health Policy & Scrutiny Urgency Sub-Committee with the purpose of specifically considering any matter in respect of the statutory functions relating to engagement and consultation with health partners.

30 June: Travel Plan Advisor to 'Shaping a healthier future' (SaHF) Travel Advisory Group

3 July: Group of stroke survivors at a meeting organised by the Stroke Association in Hammersmith & Fulham. This meeting was facilitated through our discussions with Healthwatch Central West London.

7 July: Private seminar session of NHS Hammersmith & Fulham CCG's Governing Body.

13 July: City Transport Advisor at Westminster Council.

15 July: Karen Buck MP (Westminster North), Mark Field MP (Cities of London and Westminster) and Andy Slaughter MP (Hammersmith) during a regular contact meeting on Trust issues and

developments.

15 July: Head of the Travel Demand Management Team at Transport for London.

22 July: NHS Brent CCG's executive committee.

28 July: Head of Transportation at Brent Council.

The initial plan was for the engagement period to cover a four-week period, however to allow for further comments and views to be submitted, the deadline was extended to Wednesday 22 July (covering a period of five and a half weeks). We updated the Trust website and issued a message via Twitter about the extension on Friday 10 July.

Engagement feedback

The Trust made a commitment to engage with patients, service users, partner organisations and the public about the proposal. Our proposal document outlined and explained the proposed co-location plans in detail and was published on our website with printed copies or alternative formats available on request. We asked for views, comments and questions to be sent to: trust.communications@imperial.nhs.uk

The initial deadline for submitting comments was extended from the original date of Friday 10 July to Wednesday 22 July 2015. It was stated that the Trust would carefully review and consider all the feedback we received as we considered the Trust's decision on the proposal expected in late July 2015.

We received over 40 individual pieces of feedback via email on the proposal which have been generally favourable and supportive. We have also noted the feedback received through the various face-to-face meetings listed above.

The main issues raised are listed below:

- Transport, travel and access issues
- Engagement process
- Measuring stroke service performance and patient outcomes
- Plans and timescales for the re-development of St Mary's Hospital
- Plans for services at Charing Cross Hospital
- Staffing levels
- Education and training
- Number of beds
- Access to stroke consultants
- Interim period for the co-location at Charing Cross Hospital
- Cost of the co-location proposal
- Therapy services
- Stroke patient discharge arrangements
- Community rehabilitation services
- Plans for refurbishment of areas at Charing Cross Hospital

All the issues raised have been considered. Many were due to gaps or lack of clarity in the information supporting the proposal, which we have addressed directly with those feeding in and we have ensured the relevant further information is covered clearly in this report. The most significant issue – around travel and access – is covered in some detail in a stand-alone section below, and proposals made for immediate and longer term responses.

The positive and supportive feedback we have received includes the following NHS organisations and individuals:

- NHS England: Professor Tony Rudd, National and London Clinical Director for Stroke
- The Hillingdon Hospitals NHS Foundation Trust: Richard Sumray, Chairman
- University College London Hospital NHS Foundation Trust: Dr Robert Simister, HASU Lead Clinician
- West Middlesex University Hospital NHS Trust: Jacqueline Totterdell, Chief Executive
- Barts Health NHS Trust: Patrick Gompertz, Stroke Consultant
- NHS clinical commissioning groups for Brent, Hammersmith & Fulham, Central London and West London

On the specific issue of the possibility of repatriating stroke patients who are Westminster residents from the HASU at University College London Hospital NHS Foundation Trust (UCLH), UCLH confirmed that it would not have sufficient capacity to admit additional Westminster patients on their stroke unit. Under the proposal therefore, these Westminster patients in the UCLH HASU would continue to be stepped down into the Imperial College Healthcare stroke unit at Charing Cross Hospital.

Trust staff consultation

The staff consultation process commenced concurrently with the public engagement on Monday 15 June 2015. The consultation process consisted of a formal document which was issued to the individual staff working in the St Mary's Hospital Grafton Ward stroke unit which was supplemented by an information section on the Source intranet. Several group meetings have been held and all staff affected were given the opportunity to request one-to-one meetings for further in depth discussion.

St Mary's Hospital stroke unit staff

Current Post	Established WTE	Impact
Ward Manager Grafton (Band 7)	1.0	There is one person in this post. This post would re-locate to Charing Cross Hospital (CXH)
Staff Nurses (Band 5)	12.0	These posts would be relocated to CXH
Senior Staff Nurses (Band 6)	4.0	These posts would be relocated to CXH
HCA (Band 3)	2.0	These posts would be relocated to CXH
HCA (Band 2)	5.0	These posts would be relocated to CHX
Ward Clerk (Band 2)	1.0	This post would be relocated to CHX
Consultants stroke physicians	5.0	Consultants currently work at both CXH & SMH sites and would work on CXH

All the staff involved in the consultation agreed with the overall reasons for the proposal and welcomed the case for change. It was noted there was general sadness at leaving the St Mary's site as many of the staff have a strong personal attachment developed through their tenure with Grafton Ward and St Mary's Hospital.

A key theme of concern was the issue of travelling distance and times. For some staff the proposed integrated unit at Charing Cross Hospital was closer to home, however for some individuals it was further and access to external travel connections was raised, particularly at weekends.

All concerns raised have been addressed and all requests around travel and working hours will be considered in line with the Trust's Change Management and Excess Travel Policies.

Access and travel issues

We appreciate the proposed change may have an impact on travelling times particularly for some visitors, but we believe this would be more than offset by the improvements in patient outcomes and experience.

A single, integrated stroke unit at Charing Cross Hospital could mean a potentially longer journey for visitors of patients who would currently be cared for in the St Mary's Hospital stroke unit – particularly, those from the boroughs of Brent and Westminster. However, there would still be outpatient stroke services at both Charing Cross and St Mary's hospitals so there would be no travel impact for patients once they were discharged from hospital.

Alongside the engagement process, we commissioned a detailed transport analysis on the proposal.

Travel times analysis

As patient access will not be directly affected by our proposal, as patients admitted to the St Mary's Hospital stroke unit would have been transferred from a HASU at Charing Cross Hospital or another hospital, it is the impact on travel time for visitors that is at issue. The Trust does not collect data on visitors' home addresses and so for the purpose of this analysis we have assumed that visitors may be travelling from any one of the areas within the main 11 clinical commissioning group (CCG) boundaries whose patients use St Mary's Hospital stroke unit. We carried out a comprehensive analysis of travel times across each of the referring CCGs as detailed below.

The analysis used all lower super output areas (LSOAs) within the 11 main referring CCGs, 1,566 LSOAs in total. A LSOA is a geographic area which on average covers a population size of around 1,500 residents. Relevant LSOAs have been identified for each CCG area, using data from the Office of National Statistics (ONS).

The travel times were obtained from the 'Here Maps' tool, a well established software programme, and reflect a range of transport options across different times of the day including peak, off-peak, night drive and public transport.

Public transport includes all modes of transport, based on the fastest possible route, with a maximum connection distance of 800m between transport types.

There are several limitations to any travel analysis that should be considered in interpreting the results of our travel time analysis; peak and off peak travel times often lead to drivers taking different routes in an attempt to avoid peak traffic, public transport times are influenced by the traveller's personal preferences, in particular around interchanges between travel types.

Our proposals would increase all travel times for visitors of patients from five CCGs, this includes the two CCG areas with the highest number of residents using the St Mary's Hospital stroke unit – Westminster/Central London CCG (41 per cent) and Brent CCG (18 per cent). There would also be an increase for visitors of patients from Camden, Islington and West London CCGs (representing a further 11 per cent of patients on the St Mary's Hospital stroke unit). There are also some additional minutes added to public transport only travel times for Ealing, Hillingdon and Wandsworth. The maximum average increase in journey time is 20.5 minutes – for visitors in Islington, using private transport at peak times.

Full details are shown in the following table below:

Mode of Transport	Average Travel Time to SMH per CCG (Minutes)	Average Travel Time to CXH per CCG (Minutes)	Change in travel times per CCG from service move to CXH (Minutes)
Brent CCG			
Private Transport (off peak)	21.5	25.0	Increased by 3.5
Private transport (peak)	34.7	39.5	Increased by 4.8
Night drive times	14.2	16.5	Increased by 2.3
Public transport	28.5	47.3	Increased by 18.8
Camden CCG			
Private Transport (off peak)	12.8	24.8	Increased by 12.0
Private transport (peak)	21.5	40.3	Increased by 18.8
Night drive times	8.0	16.2	Increased by 8.2
Public transport	24.8	39.7	Increased by 14.9
Central London CCG			
Private Transport (off peak)	7.7	17.4	Increased by 9.7
Private transport (peak)	12.5	28.9	Increased by 16.4
Night drive times	4.8	11.3	Increased by 6.5
Public transport	13.6	29.7	Increased by 16.1
Ealing CCG			
Private Transport (off peak)	23.6	20.7	Decreased by 3.0
Private transport (peak)	37.3	32.4	Decreased by 4.9
Night drive times	16.5	14.1	Decreased by 2.4
Public transport	33.2	39.0	Increased by 5.8
Hammersmith & Fulham CCG			
Private Transport (off peak)	15.2	6.9	Decreased by 8.3
Private transport (peak)	23.1	10.5	Decreased by 12.7
Night drive times	9.7	4.2	Decreased by 5.6
Public transport	23.4	17.6	Decreased by 5.8
Hillingdon CCG			
Private Transport (off peak)	34.1	30.5	Decreased by 3.6
Private transport (peak)	54.1	46.5	Decreased by 7.6
Night drive times	24.9	22.2	Decrease by 2.7
Public transport	46.2	56.9	Increased by 10.7
Hounslow CCG			
Private Transport (off peak)	30.4	19.1	Decreased by 11.3
Private transport (peak)	48.7	30.0	Decreased by 18.7
Night drive times	21.2	13.6	Decreased by 7.6
Public transport	46.3	40.7	Decreased by 5.6
Islington CCG			
Private Transport (off peak)	17.5	29.6	Increased by 12.1
Private transport (peak)	31.8	52.4	Increased by 20.5
Night drive times	11.1	19.5	Increased by 8.4
Public transport	30.7	41.9	Increased by 11.2
Richmond CCG			
Private Transport (off peak)	32.2	20.8	Decreased by 11.4
Private transport (peak)	54.6	35.3	Decreased by 19.2
Night drive times	21.6	13.9	Decreased by 7.7
Public transport	53.5	42.0	Decreased by 11.5
Wandsworth CCG			
Private Transport (off peak)	27.1	18.6	Decreased by 8.5
Private transport (peak)	41.2	28.8	Decreased by 12.5
Night drive times	16.6	11.2	Decreased by 5.4
Public transport	38.2	39.7	Increased by 1.5
West London CCG			
Private Transport (off peak)	9.5	12.0	Increased by 2.5
Private transport (peak)	13.9	19.6	Increased by 5.7
Night drive times	5.9	7.6	Increased by 1.7
Public transport	15.4	24.6	Increased by 9.2

Current transport options

At the St Mary's Hospital site there is no 'Pay and Display' parking facility due to space constraints. There is only one 'Disabled Bay' on the St Mary's site, situated at the Paterson Centre. Disabled bays are provided by Westminster Council for Blue Badge holders and are available at three bays in South Wharf Road, six bays in London Street and seven bays at Winsland Street.

At the Charing Cross Hospital site 'Pay and Display' parking is provided for patients and visitors at the front of the hospital and adjacent to the Education Centre. There are 77 parking places at a charge of £2 per hour. There are 23 disabled bays provided at various locations on the Charing Cross site including at the front and rear of the hospital, adjacent to the Riverside Wing, and adjacent to the Claybrook Centre and A & E bays.

We carried out an audit of capacity at the Charing Cross site of parking and disabled bay spaces over a period of one week with monitoring during mornings, afternoons and evenings to capture usage across the day. The results demonstrate there is capacity to accommodate the expected number of additional visitors to the site within the existing facilities.

Our practice is that all disabled drivers are asked to display their valid Blue Badge and if the disabled bays are occupied, drivers may park in any other parking bay, including staff car parking areas, provided the Blue Badge is displayed on the vehicle.

Immediate improvements

We reviewed the travel information available on our Trust website and on the websites of the other HASUs in London. We have had discussions with the Head of the Travel Demand Management Team, Transport for London (TfL) who is reviewing online and hard copy travel information that we provide to identify areas for improvement. This review also includes the information we provide to users of our Non-Emergency Patient Transport Service. With input from users, we will use the outcomes of these reviews to improve the travel information that we provide and promote it more widely with key audiences.

We will also promote the NHS leaflet 'Help with Travel Costs' which details eligibility to claim travel costs and how to access support from the voluntary sector, the Stroke Association 'Life after a Stroke Grants' and local authorities' schemes.

Longer-term approaches to transport and travel

As part of our commitment to improving travel to all our main hospital sites, we are aiming to develop an overarching transport strategy by the end of 2015/16, with input from all of our key stakeholders. As part of this work, the Trust commissioned AECOM, an engineering company, to conduct detailed travel surveys comprising face to face interviews with patients and visitors at St Mary's, Charing Cross and the Western Eye hospital sites during the week commencing 13 July 2015. Questions covered access to the sites, modes of travel, information and suggestions for improvements. Over 1,000 survey responses were received and the results will inform our overarching Transport Strategy. This data will also help us in understanding visitor travel flows and the responses are being analysed.

We are also conducting an online staff travel survey, due to close at the end of July.

We are also working to:

- explore how we can deploy volunteers as a resource to help patients and visitors with travel needs
- review travel information that is included in correspondence from the Trust and ensure there is clear and accessible information on how to get to our hospital sites, assistance and referral for assessment of eligibility for Non-Emergency Patient Transport Services.

- review the available space at the Charing Cross site and explore options with London Taxis to establish taxi facilities
- explore establishing online parking permits for use across all our sites and promote parking concessions more widely in our information.

Finance issues

While finance is not the primary reason for the proposed co-location there are opportunities for savings which arise from the efficiencies which would follow:

- Reduction in transfers of patients between sites
- Reduced average length of stay for patients and improved bed usage
- Avoiding use of agency staff
- Larger cohort for research opportunities

The service would be provided across one floor - the ninth floor - of Charing Cross Hospital and would include:

- Hyper acute stroke unit (HASU), with 20 beds
- A stroke unit with 34 beds, an expanded gym, and day room
- TIA (transient ischaemic attack) investigation service

There would be a non-recurrent capital cost for refurbishing the area for the expanded stroke unit at Charing Cross Hospital.

Risks

Risk	Likelihood	Mitigation
Lack of wider staff support for the changes	Low	Clinical consensus on the need to co-locate services to improve quality and efficiency and full staff consultation on changes to roles and main place of work
Impact on junior grade doctors covering the medical acute rota at St Mary's Hospital	Low	This would be reviewed alongside a proposal for a new junior grade rota at Charing Cross Hospital. Furthermore, co-location of services would increase consultant presence on one site providing additional flexibility.
Access issues for some patients impacts negatively on patient experience	Medium	Ensure access/transport – and any other concerns – are fully covered and addressed as part of the public engagement.

References:

http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/London-Stroke-Strategy.pdf
https://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf

Recommendation to the Board

The Board is asked to approve that the proposed stroke service co-location proceeds as outlined, along with immediate improvements to information on transport options and support for visitors and further consideration of longer-term improvements as part of the developing Trust-wide transport strategy.

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	3.2
Title	Values, behaviour and promise project
Report for	Approval
Report authors	Dr Bob Klaber, consultant paediatrician Pippa Nightingale, head of midwifery Olivia Cramond, communications manager Sue Grange, associate director, people and organisational development
Responsible Executive Director	Michelle Dixon, director of communications Karen Charman, interim director of people and organisational development

Executive summary:

At its meeting in January 2015, the board gave the go ahead to an organisation-wide project to refresh our values, articulate the behaviours that should follow, and to define our ethos and core promise to patients, local communities, staff and other stakeholders.

This paper summarises how the project was approached and delivered, presents the four planned outputs for approval, recommends further exploration of suggestions that emerged for a potential fifth output around changes to our name, and sets out proposals for implementation.

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.

1 Introduction

At its meeting in January 2015, the board gave the go ahead to an organisation-wide project to refresh our values, articulate the behaviours that should follow, and to define our ethos and core promise to patients, local communities, staff and other stakeholders.

By involving as many staff as possible in that process, and ensuring good external engagement too, the project was intended to be the foundation for a programme of work to develop an organisational culture where all our people feel they are part of a shared endeavour to achieve a compelling vision. There is much evidence from leadership and organisational development research that this is essential to becoming an outstanding organisation, driving and sustaining quality improvement.

The project was initiated by a group of staff who had taken part in the Horizons leadership development programme. These emerging senior clinical and managerial leaders from across the organisation felt that our current values, developed in 2009, were no longer fit for purpose and that we needed to do more to translate our values into behaviours that must come through in all our interactions with each other and with our patients and partners.

A second driver came from a review of communications in 2014 which showed that we needed to do more to articulate a clear, overarching vision that resonates with all our audiences – one that places our hospitals, and increasingly our community-based services, within a single organisation where the whole is more than the sum of the parts. The CQC inspection in 2014 also identified that we needed to make improvements to ensure the Trust is well led at all levels of the organisation. The inspection report touched on the need to translate values into actions, the continuation of silo working and the need for a continued focus on increasing staff engagement.

2 Project approach

The project was led by a small group made up of alumni from the Horizons leadership programme, staff from the communications and people and organisation development directorates and Darzi Fellows. It was supported by an oversight group, made up of senior leads from all directorates and Imperial College Healthcare Charity.

We were working to deliver four key outputs:

- **Our ethos - what we stand for and who we are**
  Unlikely to be used in this form with our external audiences; more to act as a touchstone to guide us and keep us on track in all we do.
- **Our promise - the essence of what we stand for and who we are**
  May help inform a future ‘strapline’ but its primary purpose is to be a simple and powerful summary of our ethos
- **Our values - our collective, fundamental beliefs that shape what we stand for and who we are**
  To act as the foundations for everything we put in place to run and develop our organisation
- **Our behaviours: high level examples of how our values shape our actions**
  To be a simple and powerful summary of the types of behaviour we all expect to see in evidence in our organisation at all times, particularly to guide more detailed work for specific activities.

There were two main phases:

Phase 1, March – May: gathering inputs
- Over 60 workshops/interviews with more than 1,200 staff (and including Trust board)
- Analysis of existing audience research and strategy work

Phase 2, June – July: testing draft outputs
- Feedback sessions/online responses with over 700 staff and 200 external partners

The main themes from the phase 1 input are provided in appendix 1.

The final versions of the four planned outputs follow.

A potential fifth output also emerged from the phase 1 engagement. Many staff, without prompting, raised the issue of our name – that it was cumbersome and often got shortened which lost any meaning. This was tested out further through the engagement and, while not all staff felt the same and we did not test with external audiences, there was a large groundswell of staff who would like us to consider developing our name into something simpler and with more resonance. Imperial Health was the most popular suggestion.

The board are asked to approve the planned outputs and further exploration of possible changes to our name.

3 Final drafts of outputs – for approval

Our ethos

To help everyone to be as healthy as they can be, we want to look out for the people we serve as well as to look after them.

We look after people by providing care, whenever and however they need us, listening and responding to their individual needs. We look out for people by being their partner at every stage of their life, supporting them to take an active role in their own health and wellbeing.

We are one team, working as part of the wider health and care community. We are committed to continuous improvement, sharing our knowledge and learning from others. We draw strength from the breadth and depth of our diversity, and build on our rich heritage of discovery.

By doing all this, we ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. And we are able to play our full part in helping people live their lives to the fullest. Our promise is better health, for life.

Our promise

Better health, for life
We are committed to helping the people we serve to live their lives to the fullest. We do this by providing high quality care, whenever and however they need us, and by working in partnership, supporting them to take an active role in their own health and wellbeing.

Imperial College Healthcare NHS Trust

Our values

Kind We are considerate and thoughtful, so you feel respected and included	**Collaborative** We actively seek others' views and ideas, so we achieve more together
Expert We draw on our diverse skills, knowledge and experience, so we provide the best possible care	**Aspirational** We are receptive and responsive to new thinking, so we never stop learning, discovering and improving

Our behaviours

To be kind:	To be expert:	To be collaborative:	To be aspirational:
• we put people first	• we're informed and up to date	• we work as a team	• we strive for excellence
• we listen, notice and respond	• we're reliable	• we're open and approachable	• we embrace innovation
• we see things from others' point of view	• we're responsible	• we're adaptable	• we champion better care

Our behaviours in practice

Kind
- notice when someone needs help
- make eye contact and smile
- introduce ourselves by name and role
- actively listen and respond to others
- make time for meaningful interactions

Collaborative
- involve others in the development of ideas and plans from the start
- actively build partnerships
- share information and knowledge, openly and honestly
- respect others' time and contributions
- be willing to change our mind

Expert
- keep our practice up to date
- do what we say we will do
- be sure of our facts and the limitations of our knowledge
- use money, time and other resources efficiently
- seek solutions to problems and secure help if we can't resolve them ourselves

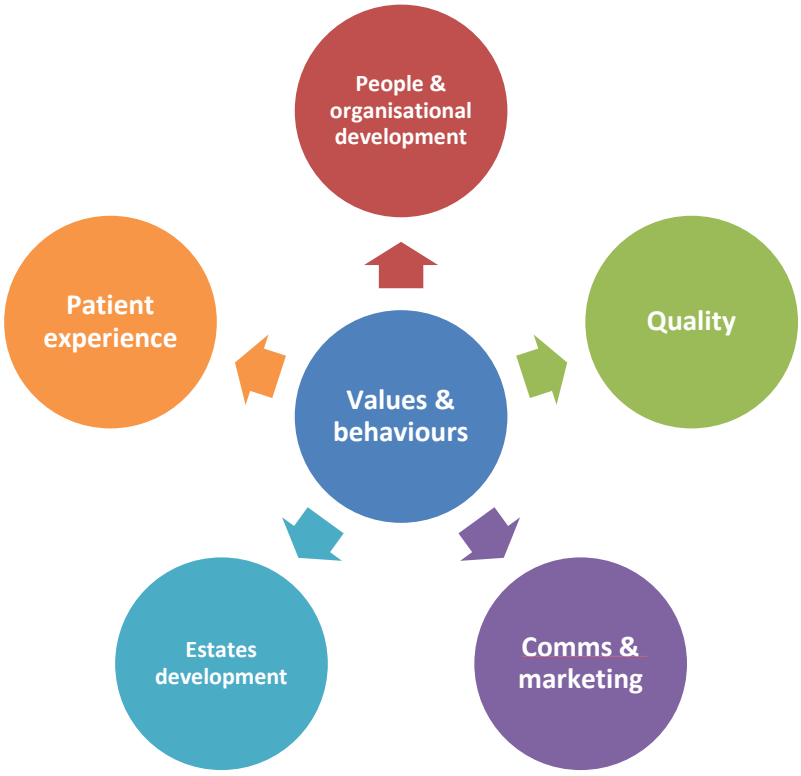
Aspirational
- always look for ways to improve what we do
- make time for reflection and learning
- recognise and celebrate achievements
- not be afraid to challenge or be challenged
- enable and support others to learn and develop

4 Next steps and implementation

Generally, there has been a very positive response to the project. But understandably some staff are cynical about the value of what they see to be currently a paper exercise. Even amongst staff who did embrace the project, many struggle to see how we will be able to deliver our promise fully given the challenges we and the wider health care system face and the pressures of their day-to-day working lives.

Ensuring the outputs from this project, once approved, become the foundation for genuine transformation is vital, and that means ensuring implementation supports our staff in everything they already do rather than being seen as another thing to add to the list. We have an excellent opportunity to do that as we are already looking to refresh our approach to a number of programmes that already exist and to begin other programmes that are intended to support staff. Collectively, they will have a huge impact on what we do and how we work.

We are developing an implementation plan based on the following framework:



There will be a number of workstreams within each implementation area, including:

People and organisational development
Develop and roll out refreshed approaches and processes for:

- recruitment
- personal development reviews
- recognition programme
- new joiners/induction

- leadership development.

Quality

The new quality improvement methodology to be rolled out from the autumn will:

- include values and behaviours within the core training modules and resource materials
- have a major focus on staff engagement, experience based co-design and building skills for continuous improvement.

In addition, our developing ward accreditation programme will be able to include an assessment of values and behaviours within its approach.

Patient experience

We are planning a new programme of work to support improvement in patient experience. In the shorter term, we will use the values and behaviours to:

- pilot 'customer care' training
- explore the establishment of customer care standards.

Communications and marketing

A communications and engagement strategy is in development for approval later this year and will include proposals for:

- how we can better present and package our services to make it easier for patients and others to understand
- a new focus and look and feel for all of our materials, letters and website content
- public and patient engagement fora and activities.

In addition, we are working on a number of immediate resources to help raise awareness of the new values and behaviours from September, including a video and an infographic. These resources will be used as stand-alones but will also feed into other implementation workstreams, especially quality improvement and induction/recruitment.

Estates development

Planning for the major redevelopment of our hospitals will incorporate how design and look and feel can support the delivery of our values and behaviours.

Monitoring and governance

We will evolve the oversight group for the project to establish an implementation oversight group, responsible for high level co-ordination of the implementation activities and for ensuring we monitor and assess the impact of this work on our primary aim to develop an organisational culture where all our people feel they are part of a shared endeavour to achieve a compelling vision. As such, we are working to establish a set of metrics, for example to include a tracker question in the quarterly staff engagement survey. The work of this group will be reported to the executive committee – and then to the board - at key intervals.

The board are asked to approve the proposed approach to implementation.

Appendix 1 – summary of phase 1 inputs

Think differently: learn; challenge; question; push boundaries; discover; simplify

"Have the courage to do the right thing (by patients), not the easy thing."
"Re-invent what a hospital is."

Good enough is not good enough: we need to constantly strive to improve

"Just reaching a target shouldn't be what counts."
"We have big aspirations for our patients."

Share: expertise; education; knowledge; information

"We need to work together – in our teams, across departments, with our patients and their families, and with our communities."
"We need to be more open and transparent."
"We love our academia, research and education, but we have to utilise it more."

Partnerships are key – with our patients, other providers, social care

"We're part of the solution, not the whole story."
"We need to play our role in the wider community"

Patients are individuals, with wider goals and needs

" We see the patient in the round – as an individual, as part of a family and as a member of the community."

We have a rare **depth and breadth of expertise and experience**

"We're a world-class specialist hospital with a front door in the local community."

We need to **celebrate our achievements** and **empower our staff**

"We need to harness our people's enthusiasm and talent."
"We need to criticise less and trust our staff more."
"The working environment needs to be fun and enjoyable."
"We expect our leaders to be honest, open and brave."

Our heritage is important across all our site

***"**We want to hold on to the unique characteristics and histories of our sites, but we also want to be part of one whole Trust."*

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	3.3
Title	Draft Quality Strategy
Report for	Approval
Report Author	Shona Maxwell, Chief of Staff
Responsible Executive Director	Chris Harrison, Medical Director

Executive Summary:

This paper introduces the Trust's final draft quality strategy (appendix A) for review and approval from the Board.

The new Quality Strategy will be the plan by which we improve our CQC rating to "Good" as a minimum and to "Outstanding" where we can. It will underpin delivery of the Trust's overall vision and objectives. The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. The strategy also includes the trustwide improvement projects which will address the issues raised by the CQC. Since the draft document was last presented to the Board, the following changes have been made:

- Trust's new governance structure incorporated;
- Confirmed goals and targets included – these reflect those published in the final quality account on 30th June;
- Narrative refined to simplify how the strategy will be delivered;
- Further information included regarding the values based Quality Improvement programme.

Next steps are:

- Communication programme under development to support launch of Quality Strategy;
- Launch and publication of strategy – August 2015;
- Launch of values based quality improvement programme in September 2015.

Recommendation(s) to the Board: The Board is asked to approve the content of the final draft of the Quality Strategy.

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
NHS Trust

Quality Strategy
2015-18

Creating a culture of continuous improvement to increase and sustain the quality of our services for our patients, people and stakeholders

Contents

Foreword from the Medical Director

In 2013 we launched our first Quality Strategy, which outlined our aim to put quality at the forefront of everything we do. In this, the second Quality Strategy for the Trust, we build on the progress made so far in our journey and bring our plans in line with the CQC framework as well as working to ensure sustainable and continuous improvement across our services. Through this strategy, we want to achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding' where we can be across our sites and services by the end of 2017/18.

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing population. However with these challenges, we have an exciting opportunity when it comes to improving healthcare quality. We hope our commitment to improvement and our determination to get things right for our patients, people and stakeholders is clear in this strategy.

Events at Mid-Staffordshire have helped to generate a sector-wide commitment to quality, with quality improvement now seen as everybody's business. As we gain more understanding of the different ways we can improve, we are in a better position than ever before to look critically at what we can do better, and test and apply improvements. We are working to harness these opportunities in order to provide safe, high quality, patient-centred care for all our patients. This is our commitment as an organisation – but we also want it to become a personal commitment for each of our people, from surgeon to receptionist.

To achieve this, we are rolling out a programme of quality improvement training and support to build an organisation-wide culture of continuous improvement. At the same time, patients have a stronger voice than ever before, and we have begun working more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

Our current position 2015

We have seen some inspiring work across our five hospital sites since we launched our first strategy, particularly in the last year. We have made significant improvements in patient experience and our mortality rates are amongst the lowest nationally, reflecting the excellent clinical outcomes achieved for many of our patients. We have focused on developing our culture with promising signs of improvement already showing through.

However, in some ways, 2014/15 has been a challenging year for us as a Trust. Like many hospitals, we saw unprecedented demand on our A&E departments over winter, which put increased pressure on all our services. We have challenges around our elective pathways which mean that patients are waiting longer than we would like to receive the care they are expecting. Our trust was also inspected by the Care Quality Commission (CQC) in September 2014 who gave us an overall rating of 'requires improvement' in their final report. Although a number of services were rated as "good" the standards observed were not consistent nor of the quality the trust aspires to deliver. We have a comprehensive action plan in place however we recognise we have much to do to achieve our ambitions.

A focus on quality

This strategy shows our commitment to a continued focus on quality. We will use it to strengthen confidence and pride in the services we provide. We want patients to be confident that Imperial is among the best in the world – safe, effective, caring, well led, and responsive to our patient's needs. We want people working within and alongside Imperial to know that they are providing the best service they can, and that what they do is important and valued.

This three year strategy is the plan by which we will continue our journey to achieve our ambitions and a positive outcome in subsequent CQC inspections as continuous quality improvement becomes our business as usual.

Professor Christopher Harrison
Medical Director
Imperial College Healthcare NHS Trust

Introduction to our Quality Strategy 2015/18

This is the second quality strategy for the Trust bringing our plans in line with the Care Quality Commission (CQC) framework 2014. The purpose of the strategy is to set out the goals and targets for ICHT in providing high quality services over the next three years and therefore delivering our vision and objectives.

The Trust's vision is:

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

This vision will be delivered through the achievement of the Trust's strategic objectives which are:

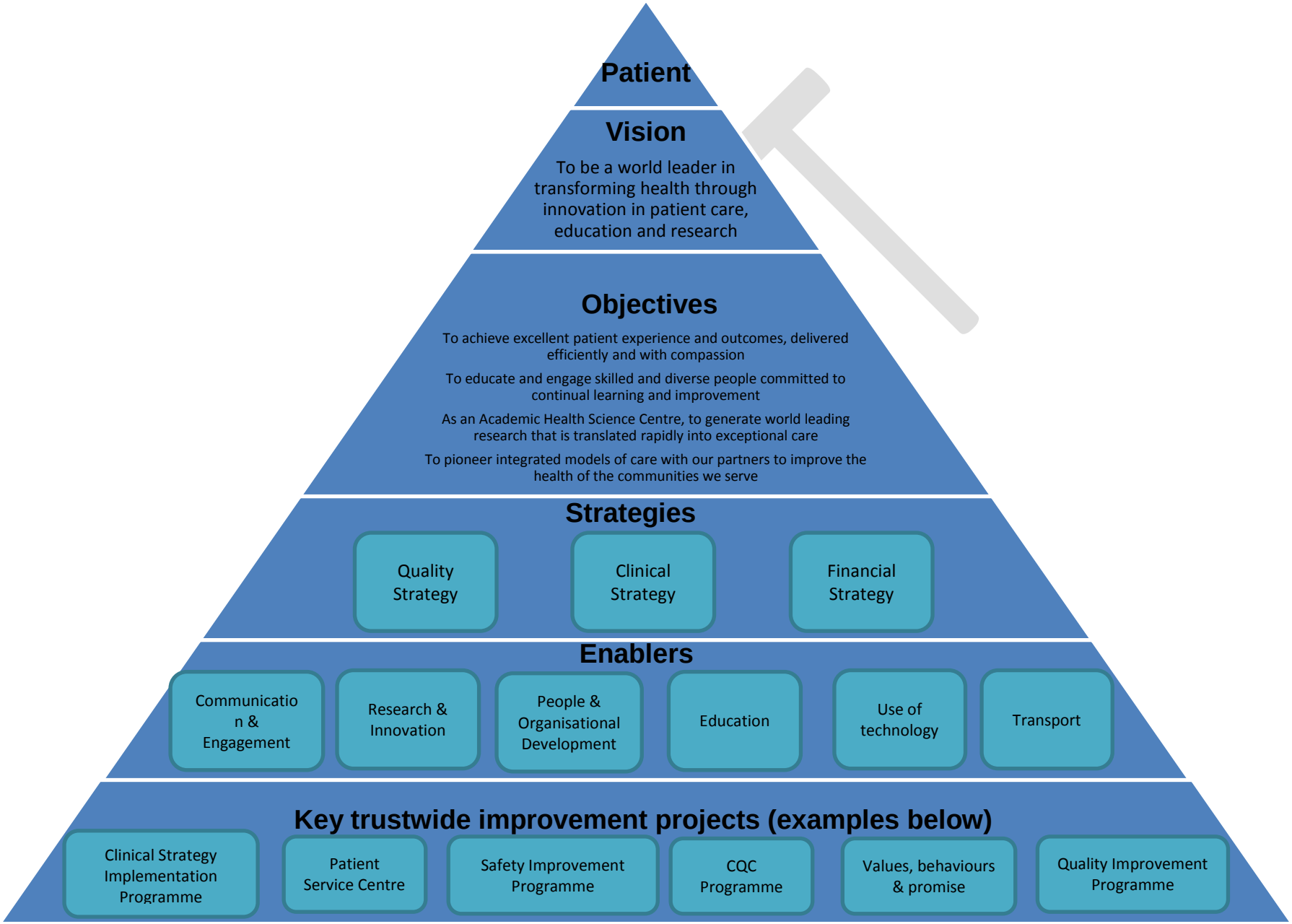
- to achieve excellent patient experience and outcomes, delivered efficiently and with compassion
- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an Academic Health Science Centre, to generate world-leading research that is translated rapidly into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

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.

Diagram 1 below shows how improvement, and therefore this strategy, supports delivery of our vision and objectives. It sets out a number of the key enablers and examples of the projects required to improve performance to illustrate the breadth of our work programme. We have the patient central to our improvement planning and our priorities are aligned to achievement of our vision through annual goals and targets

This strategy sets out the five quality domains with our goals and targets to be delivered over the first year. It also outlines a number of projects which we must deliver to ensure we can evidence that our services are safe, effective, caring, well-led and responsive. The links between the projects and the goals and metrics are highlighted making impact assessment transparent.

Diagram 1 – Imperial Quality Delivery



What is the Quality Strategy?

Our Quality Strategy is the plan through which we focus on the quality of clinical care and ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of all that we do.

This strategy sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number-one priority. It sets out our five quality goals and associated targets and a number of projects which we must focus on to ensure we can evidence that our services are safe, effective, caring, well led and responsive. It also describes the governance arrangements to ensure delivery and sustainability over three years from 2015/16. The strategy also outlines our current position, showing improvements we have made over the lifespan of our original Quality Strategy and what we are building on for the second.

It is ambitious, setting out our commitment to make quality central to all that we do. It also reinforces that wherever possible, our focus will be on embracing new ways of working to improve care for patients and their families and integrating healthcare across community services and social care.

It provides a modern approach to continuous improvement and acknowledges that our people are central to delivering our potential as the hospital in which we would want our loved ones cared for.

We will use the implementation of the Quality Strategy to strengthen confidence and pride in the services we provide. We want patients to be confident that Imperial is amongst the best in the world – safe, effective, caring, well led and responsive.

We want people working in and with Imperial to be confident that they are providing the best service they can, are valued and are important. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so.

We want a shared pride in Imperial and assurance that it is the very best it can be.

How we developed the strategy

The strategy has been informed by the reports and recommendations from Francis, Keogh, Berwick and the CQC framework. We also assessed our progress against priorities in our last strategy and quality account.

Comparison was also undertaken of trends and variation from a range of intelligence including:

- Patient surveys
- Staff surveys
- Governance data e.g. incidents, complaints, claims and audit

This was then merged with feedback from key stakeholders, including our patients, members of the public, our people and our commissioners, through development workshops held in 2014/2015 to form our goals and targets.

The engagement events highlighted that we should be more transparent with our performance data and make it as simple as possible and easily accessible. We have therefore been careful to develop goals and targets that are measurable whilst trying to encapsulate our commitment to the qualitative elements of our work. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and reportable goals to aim for. These targets will be redefined each year throughout the three years of the strategy. They will be described in our annual quality account, with progress monitored through the trust's governance system (appendix 1). We believe that if we can meet our targets under each quality domain, we will see significantly improved outcomes for our patients and a better working environment for our people. Our goals and targets have been selected to have the highest impact across the Trust and are purposely challenging.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. A series of trustwide improvement projects, informed by our CQC inspection action plan and a review of the key lines of enquiry that the CQC use, have been established to

deliver specific time bound programmes of work.

We therefore believe the strategy is relevant to our people and stakeholders and reflects the areas we should be prioritising.

What is our definition of quality?

We have based our definition of quality on the CQC's 2014 framework:[http://www.cqc.org.uk/sites/default/files/20150327_acute_hospital_provider_handbook_march_15_update_01.pdf], which draws on the Francis, Keogh and Berwick reviews and recommendations, and incorporates public consultation.

Our approach aligns Berwick's six improvement principles which were used in our first strategy to the five domains that patients have defined as important during the CQC consultation to construct their new framework. Quality at Imperial is therefore defined by whether services are Safe, Effective, Caring, Responsive and Well-led

The combination of performance in each of the five domains determines the overall quality of the healthcare we provide. We believe that we can improve services only by supporting continuous improvement in all areas hence our commitment to this driver.

The first year of our three-year strategy is focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding'.

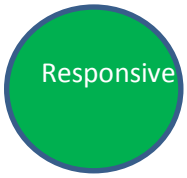
The quality domains

The quality domains are outlined below together with the descriptor of what these mean. The domains match those used by the CQC to ensure we are focused on making improvements which are aligned with our regulatory body's expectations.

People are protected from abuse and avoidable harm

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Staff involve and treat people with compassion, kindness, dignity and respect



Services are organised so that they meet people's needs

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Delivering the Strategy

How will the strategy be delivered and progress reported?

Quality Goals & Targets
The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. These are outlined below under each quality domain and have been chosen to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our goals and targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff. The goals and targets under each domain will be incorporated into the performance scorecards ensuring they can be tracked from ward to board. This will provide clarity on the trust's priorities and will show the impact of the improvements we have made.

Trustwide Improvement Projects
Alongside the quality goals and targets, we have developed measurable and structured improvement projects (appendix 2). These projects have been informed by analysis of a number of measures of our performance including:

- current performance against national and local targets
- our quality account
- areas of known risk
- our CQC inspection action plan
- review of the key lines of enquiry that the CQC publish.

The projects span all quality domains and have an executive lead responsible for their delivery. Each project has been assessed for their potential to positively impact on the goals and targets we have set. This analysis is included in appendix 3 and we are confident that we have the necessary work in progress to deliver the required improvements.

Progress with these improvement projects will be reported on a quarterly basis though the trust's governance structure (appendix 1). This will allow us to measure and monitor the milestones, outcomes and timeframes of the projects, with clear lines of accountability and responsibility to the project owners.

Executive oversight of quality of care in the Trust is through the Executive Quality Committee, which will report quarterly progress and exception to the Quality Committee.

Trust board reporting will occur on a bi-annual basis. Our annual Quality Accounts will report on progress against the three-year strategy and confirm the targets for the following year.

Quality improvement – building capability to deliver the strategy

We recognise that our people are key to delivering the strategy. We therefore must make sure that we are training and supporting our people to make improvements continuously as well as carrying out their roles. We want to implement new ways of working to improve our processes, systems and services with transparent measurement to track progress.

We have therefore decided to adopt a standardised approach to quality improvement to make this possible. This is designed to encourage and support our people by providing them with the tools they need to make sustained improvements. We believe this will be one of the long term drivers to delivery of the strategy. We want this to stimulate energy for learning and development in improvement methodology and ensure that change becomes the way of doing things at Imperial.

Recognising the importance of organisational culture on the successful implementation of QI programmes, the Trust's quality improvement (QI) programme will be grown out of the 'values & behaviours' project established at the beginning of 2015. This project has to date engaged with c.1500 staff from across the organisation. Throughout the process, all staff groups have been clear that for the values & behaviours project needs to be grounded in action which will be realised via the QI programme. Key to this is the development of a culture of sharing ideas and learning, celebrating success and the developing new perspectives.

The approach is made up of two elements: a values based quality improvement training programme which will provide blended training for our people and a new team called the 'Imperial Quality Improvement (iQI) Hub' to support improvement delivery and potential.

The new team will offer a wide range of skills, including leadership, stakeholder and staff engagement, clinical and nursing, training, research, education, clinical audit, project management, data analytical and administrative support. They will specifically be responsible for providing training & education in QI methodology and tools, supporting and guiding teams undertaking QI projects and monitoring & reporting QI activities. The hub will involve patients, carers and members of the public as well as our people.

The Values Based QI programme will provide staff with the necessary skills and tools to enable and empower them to lead QI projects in their own work areas via a comprehensive education and training programme. The focus is to build capacity in people who can act as QI enablers across our workforce. There will be 3 arms to the training and education delivered by the QI Programme:

- 'Reaching Out' – the QI programme will be launched jointly with the new Trust Values & Behaviours and all of our staff will receive an introduction to both. This will be achieved through a variety of methods and 60% of people trained by 31st December 2015 and 100% by 31st March 2016;
- Targeted Training will be delivered to teams responsible for priority workstreams and teams who nominate a QI project. This will be delivered over 2 days and will include training in QI tools using a 'live' project to support learning;
- An ongoing development programme offering a range of QI training will be accessible to all staff.

We have identified a series of priority workstreams from new Quality Strategy, the Clinical Strategy Implementation Programme (CSIP) and CQC action plan, which are outlined in the table below:

As well as these defined workstreams, we will identify individual QI projects through in-depth reviews

of clinical services, theme reviews, self-referral by staff and executive referrals.

All quality initiatives or projects will demonstrate how they will support delivery of the strategy before being initiated. This will increase our improvement potential by having a co-ordinated approach to delivery of our goals and targets.

Our goals and targets

Our goals are set out below under each of the five quality domains. The targets which support delivery of these goals have been developed for year one of the strategy. Each year we will review our progress and redefine our targets to ensure we are focused on the areas where improvement is most needed. These targets will be defined in our annual quality account.

Quality domain 1: Safe - People are protected from abuse and avoidable harm

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable.

Research conducted by NHS England suggests that around 10% of patients will experience an adverse event while in hospital, half of which are considered avoidable. We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal will be to be below the national average for the number of incidents causing severe and extreme harm in year one and continue to reduce the number throughout the 3 years of the strategy. Throughout year one of our Quality Strategy we will be focusing on achieving sustainable improvements in the target areas outlined below; these targets aim to reduce avoidable harm in specific priority areas and set the trajectory to ensure that we can achieve our goal of eliminating avoidable harm by the end of year three.

Target 1: We will have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage of shifts meeting planned safe staffing levels.

We believe our staff, patients and the public need to feel assured that our wards and outpatient areas are adequately staffed to provide the safest possible care. This includes clinical, administrative, management and nursing staff. Our aim is to have a vacancy rate of less than 5% for band 2-6 ward roles and less than 10% generally, and to maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff.

This was one of the key themes from our engagement events for both staff and patients. It is also one of the Berwick recommendations: (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf).

By ensuring we have enough staff in place, we will be able to better protect our patients from avoidable harm and abuse.

Target 2: We will demonstrate the development of a safety reporting culture by increasing our incident reporting numbers and therefore remaining within the top quartile of trusts

We chose this target to enable us to demonstrate that we are willing to report adverse events, learn from them and deliver improved care as a result. A high reporting rate with below average levels of harm will show that staff feel supported to report incidents and that we take action to prevent future harm for patients. Our overall goal to eliminate avoidable harm shows our commitment to improving patient outcomes.

Target 3: We will have zero 'never events'.

'Never events' are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Target 4: We will ensure we have no avoidable infections

We chose this target as we want to ensure that our patients are safe from infection in our hospitals. At present, we are not meeting all our infection control targets, so we have chosen this as a 'stretch' target, to make sure we are doing everything we can to reduce the risk of patients picking up an infection during their stay with us.

Target 5: We will ensure we maintain a compliance rate of 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams.

Anti-infectives (drugs that are capable of acting against infection) include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics. They are extremely important and are potentially life-saving therapies. However, if they are used inappropriately and excessively, drug-resistant organisms can emerge, putting patients at an increased risk of developing a more resistant strain of an infection. We will aim to maintain a compliance rate of 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams in 2015/16.

Target 6: We will reduce avoidable category trust-acquired pressure ulcers by at least 10% in year one.

We have made some achievements in reducing the number of pressure ulcers over the last year, however with 33 graded 3 or 4 during 2014/15 we have more we would like to do. For 2015/16, we have chosen to focus on reducing category 3 or 4 pressure ulcers by 10%.

Target 7: We will assess at least 95% of all patients for risk of venous thromboembolism (VTE) and prevent avoidable death as a consequence of VTE.

Venous thromboembolism incorporates both deep-vein thrombosis and its possible consequence: pulmonary embolism. A deep-vein thrombosis is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream, it can travel to the lungs and cause a blockage (pulmonary embolism) that could lead to death. This target is important because the risk of hospital-acquired venous thromboembolism can be greatly reduced by risk-assessing patients and prescribing them appropriate measures that prevent it from occurring.

Target 8: We will promote safer surgery by ensuring 100% compliance with the elements of the WHO checklist in of all relevant areas.

The World Health Organization Surgical Safety Checklist was introduced in 2008 to increase the safety of patients undergoing surgery. As part of our drive to promote safer surgery, we will be auditing the use of the checklist in all relevant areas in the Trust to ensure that our surgical teams are using the checklist correctly and that the 'five steps to safer surgery' are embedded in practice. The five steps are:

1. Team Brief: At start of theatre session
2. Sign in: Before anaesthesia
3. Time out: Before skin incision
4. Sign out: Before patient leaves theatre
5. Team Debrief : At the end of the theatre session

The use of the checklist was highlighted as an area of concern in the CQC report, and this was another reason that we chose this target.

Target 9: We will stop non-clinical transfers of patients out-of-hours.

Transferring patients at night when it is not clinically necessary can cause unnecessary distress and, in some cases, harm to patients – particularly among older people. Patients attending our engagement event raised this as one of their concerns. As part of our drive to eradicate avoidable harm we will set up a process to enable us to monitor and report out-of-hours transfers, which will give us the tools to analyse the cause, review cases for clinical harm and put a stop to all transfers at night which are not deemed clinically necessary.

Quality domain 2: Effective - People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Goal: To be in the top quartile for all national clinical audit outcomes

Clinical audit is a key improvement tool through which we continually monitor and improve the quality of care that we provide. By fully taking part in national clinical audit programmes, we are able to benchmark our performance against our peers, ensure the care we provide is evidence-based and measure improvements on a year-by-year basis.

We aim to be in the top quartile for outcomes for all those national clinical audits in which we are eligible to participate and where data is analysed this way. This enables us to have evidence that each of our services is effective and promotes a good quality of life for our patients. Further assurance of this will be provided by the chosen indicators below, which will demonstrate low morality rates, improved outcomes for patients in key areas (cardiac arrest, surgical procedures) and an improved and safer discharge process.

Target 1: We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk NHS organisation and improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third.

HSMR and SHMI are two indicators that enable us to compare our mortality rates with our peers. We currently have the second lowest SHMI and HSMR for non-specialist acute providers in the country according to the latest available data. However, we aspire to have the lowest rates during this strategy. We will also monitor the percentage of admitted deaths with palliative care coded, with the aim of being below the national average.

Dr Foster's Global Comparators Programme compares the HSMR of 39 hospitals from Australia, Belgium, Denmark, England, Finland, Holland, Norway and the USA. We have not previously measured our performance against our international peers; this year, we will start to compare ourselves to the members of the Global Comparators Programme with the target of being within the top third.

Target 2: We will reduce the number of out-of-ICU / ED cardiac arrests calls

Although our mortality rates are excellent, incidences of cardiac arrest calls to patients outside of our intensive care units or emergency departments are higher than we would want them to be, with 286 occurring last year. We want to work to reduce this number and introduce a root cause analysis process to support this improvement programme.

Target 3: We will increase the Patient Reported Outcome Measures (PROMs) participation rates to 80% and have reported health gains which are better than the national average.

PROMs measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of these four clinical procedures: groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery. We have not met the national targets for these measures and have much to do to improve our performance.

Target 4: We will ensure mortality reviews are carried out using a standardized format whenever a patient dies in our care. We will also ensure that the review outcome is presented at a multi-disciplinary team meeting.

Reviewing every death which occurs in our hospitals will enable us to learn from any errors and pick up quickly on potential issues which could result in harm to other patients. Currently this does not happen uniformly across the Trust, and the results are not reported in a standardised format. In year one, we will focus on implementing the processes to ensure that all cases are reviewed at multi-disciplinary team meetings, and results are reported through our governance process. In year three, we will aim to demonstrate 100% compliance across the organisation.

Target 5: We will discharge at least 35% of patients on relevant pathways before noon.

We have chosen this target to enable us to provide more effective care for our patients, by optimising capacity in our hospitals. By discharging patients earlier where clinically appropriate, we are in a better position to place elective and emergency patients appropriately in the right ward, in the right bed and at the right time. This target also improves clinical outcomes for elective surgery patients, as they do not have an extended stay in theatre recovery or on a ward while waiting for a bed to become available.

Timely discharge is important for good patient experience and discharge has been a key theme from our engagement events, and has been identified as a priority by members of the public and our staff.

Target 6: We will consistently meet the national target for recruiting the first patient into clinical trials

within 70 days and sustain year on year improvements.

As the UK's first Academic Health Science Centre (AHSC), we are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into novel diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere.

Since 2012, the National Institute of Health Research (NIHR) has published outcomes against public benchmarks, including a target of 70 days or less from the time a provider of NHS services receives a valid research application to the time when that provider recruits the first patient for that study.

As part of our focus to provide safe, effective and innovative care for our patients, we have chosen to focus on delivery of the NIHR's key 70 day metric. This will allow us to measure our performance against our peers and provide assurance that we are giving as many of our patients as possible the opportunity to participate in potentially ground-breaking and life-saving research. =

Throughout 2014-15 we have improved our performance from 57.1% in Q1 to 71.9% in Q3 (Q4 data not yet available), however we want to see this improvement sustained, with year-on-year improvements. To facilitate this, we will set up a centralised monitoring process for research and agree trustwide targets.

Quality domain 3: Caring - Staff involve and treat people with compassion, kindness, dignity and respect

Goal: To provide our patients with the best possible experience by increasing the percentage of inpatients who would recommend our trust to friends and family if the needed similar care or treatment to 95%, and the percentage of A&E patients to 85%.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we need to listen to our patients, their families and carers, and respond to their feedback. The Friends and Family Test (FFT) is one key indicator of patient satisfaction. This test asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

We will aim to improve our position, with our goal being that 95% of our inpatients and 85% of our A&E patients would recommend our trust. This will help to assure us that the services we provide are caring, putting the individual at the centre of their own care, and treating them as we would like our own friends and family to be treated. The indicators outlined below will support this goal and help us determine whether our services are caring and patient centred in all aspects.

Target 1: We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs (amalgamation of five questions from national survey).

Responsiveness to inpatients' personal needs is a composite score taken from five questions in the national inpatient survey. The score is a driver to ensure that people have a positive experience of care by focusing on hospitals' ability to meet the personal needs of their patients. We have chosen this target because we believe it is a helpful way to measure how we are improving the experience of our inpatients, while allowing us to compare our performance with that of our peers.

Target 2: We will achieve and maintain a FFT response rate of 40% for inpatients 20% for outpatients.

In order to attain a more complete picture of our inpatient and A&E experience, and make improvements in response where necessary, we will focus on increasing the response rate to the FFT question in our inpatient and A&E departments to 40% and 20% respectively.

Target 3: We will improve our national cancer survey scores year on year.

We will continue to make improvements to the care that our cancer patients receive, and will use the survey scores to show how our developments are affecting patient experience. We will aim to increase our scores year on year.

Target 4: We will increase our responsiveness to complaints and reduce their overall number.

Complaints were high on the national agenda in 2014/15, with the Ombudsman, Healthwatch and the Patients Association all highlighting the value of each complaint as an opportunity to learn and support continuous improvement. We have been reviewing the way we work to look at how we can create a more responsive and caring complaints service for our patients and identify learning for our staff.

During 2014/15, we investigated 1242 complaints, 63.8% of which were responded to within the timescale agreed by the patient (nominally 25 working days). With the improvements we are making as part of the quality strategy in all aspects of our services, we hope to reduce the overall number of complaints we receive, as this will be an important demonstration of quality improvement, while responding to 100% within the timeframe agreed by the patient.

Target 5: We will develop a dataset that enables monitoring of protected characteristics against patient experience measures.

We are in the process of changing our systems for collecting patient experience feedback. The new system will enable us to capture feedback from a more diverse patient population through the introduction of new surveys that can be completed by more of our patients.
We will have surveys available in:

- the top ten languages used by our patients
- makaton symbols
- yellow and black for patients with visual impairment
- age appropriate graphics for children and young people

We have reviewed the demographic data that we will collect to ensure it matches the information we collect for all our patients. This will enable the Trust to directly compare how different groups respond and to identify any specific concerns that may impact on one group more than another.

Quality domain 4: Responsive - Services are organised so that they meet people's needs

Goal: To consistently meet all relevant national access standards through responsive patient pathways in year one, and exceed them by year three.

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events have shown that our patients agree. They would like to see improvements in our performance against national access targets, as we do not consistently meet them. The feedback was particularly focused on our out patients offering.

Our ultimate aim is to exceed the national targets by 2017, when our Quality Strategy will be updated. To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

As well as the national targets above, we will focus on the following targets to improve our responsiveness as a trust:

Target 1: We will reduce the unplanned readmission rate for both under and over 15s and be below the national average.

We are carrying this target over to monitor the work we are doing to reduce readmissions, particularly for over 15s as we are currently above the average. This is a good measure of the effectiveness of care we provide; as if a patient is discharged appropriately he or she should not require unplanned readmission.

Target 2: We will have no inpatients waiting over 52 weeks for elective surgery and ensure a clinical validation process is in place for each patient who waits for over 18 weeks.

We have chosen this target to ensure that effective processes are in place when we do not meet our 18-week referral to treatment targets for all our patients. This is an issue highlighted in the CQC report, as we had a backlog of patients still awaiting surgery. We are working to improve surgical pathways and will consistently monitor the clinical impact of any future delays.

Target 3: We will reduce the number of hospital initiated cancellation of outpatient appointments.

Improving our processes and the experience of our outpatients was a key theme both of the CQC inspection and at our engagement events. We will develop a process to improve our performance and set targets to ensure that our patients are not inconvenienced or harmed by cancelled appointments.

Target 4: We will improve outpatient letter turnaround time.

As above, throughout 2015/16 we will be focusing on improving our processes in outpatients, and therefore the experience and outcomes of our patients. We will aim to improve the turnaround time for outpatient letters.

Target 5: We will reduce the proportion of clinics that are delayed due to late arrival of doctors.

We have chosen this target in response to the CQC inspection; on the day of the inspection, the team found that several clinics they observed did not have all doctors present before the planned clinic start time. We want to prevent this happening in future.

Target 6: We will improve the number of out-patient consultations that occur with the original set of medical records available.

Following Cerner implementation, we have had an on-going issue with original medical records being available at outpatient consultations. We have been auditing this during the year with temporary notes and clinic letters being used where required. It is important that full clinical records are available in outpatient areas and our focus will be on ensuring this.

Target 7: We will improve our National Patient Led Assessment of the Care Environment (PLACE) to be in the top 25% nationally where possible.

PLACE was introduced in 2013 as an annual patient led initiative that monitors and scores the patient environment under the following headings:

- Cleanliness
- Privacy, Dignity & Well Being
- Food & Hydration
- Condition Appearance & Maintenance

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The trust's environment was a key issue raised by patients during our engagement process, and was also picked up by the CQC as an area of concern during their inspection. We will focus on improving our PLACE scores annually, with the goal of being in the top 25% nationally for the first three PLACE headings. The condition, appearance and maintenance of our estates are dictated by the age of our buildings and the future plans which are in place to redevelop all our sites. Whilst we go through the planning stages of our redevelopment, we will continue to face challenges in this area. Our goal for heading four is therefore to maintain our current performance.

Quality domain 5: Well led - The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Goal: To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their patients. Our goal is to increase the percentage of staff who would recommend our trust as a place of work or a place to come for treatment to friends and family by 2% in year one. This will enable us to have evidence that by supporting our staff to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a place to be a patient. This goal will be supported by the targets outlined below.

Target 1: We will launch our ward accreditation programme with evidence documented of rapid improvements where issues arise.

Following the CQC inspection, we have decided to launch our own internal programme of ward inspection so that we can carry out regular checks and instigate immediate improvement where necessary. This target has been chosen to ensure this is implemented effectively throughout the Trust as we believe it will be a valuable tool in ensuring consistent levels of care across our wards.

Target 2: We will achieve a voluntary turnover rate of 10% or less.

We have chosen to focus on reducing voluntary turnover as retention of staff is a key aspect of building a strong, consistent workforce able to sustain the quality improvements we need to achieve over the next three years. Our turnover rate is currently 11.74%; we want to reduce this to at least 10% in year one.

Target 3: We will reduce our sickness absence rate to 3.40% in year one.

Low sickness absence is an indicator of effective leadership and good people management. As such, we have chosen this target as a measure of staff satisfaction and wellbeing. We believe that our new health and wellbeing programme will play a significant part in improving our staff's physical and mental health. We aim to reduce the rate of sickness absence from its current position of 3.46% to 3.40% or less in year one.

Target 4: We will achieve a performance development review rate of 95% and a non-training grade doctor appraisal rate of 95%.

In 2014-5 we rolled out a new appraisal scheme 'Performance Development and Review (PDR)' for all staff, excluding doctors, aimed at driving a new performance culture across the Trust. We required all our managers to undergo re-training in the skills of having effective performance conversations, training 1600 during 2014. The new PDR process involves ratings for staff and for the first time makes a link between performance and obtaining increments, and also a clear link to our Values and Behaviours.

As a result of this programme, our National staff survey results show that the number of staff believing they had a well-structured appraisal was in our top 5 scoring questions and in the top 20% of Acute Trusts. We also conducted our own evaluation which showed us that "80% direct reports felt that their PDR had been an improvement on previous experience" and also "90% managers felt that the PDR process will improve the engagement of their team and will improve the performance of the team." The current rate for PDR at the end of 2014/15 is 93.65%, a big improvement on the appraisal compliance results from previous years; however our target is to make sure the improvements made this year are sustained by ensuring at least 95% of our non-clinical staff have had their performance development review on an annual basis.

Non-training grade doctors have an appraisal on a yearly basis as part of the General Medical Council's Revalidation process, during which the doctor has a formal structured opportunity to reflect on his or her work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. Currently, we are behind our target of ensuring at least 95% of our non-training grade doctors have had their appraisal on an annual basis, with a rate of 88.9% at the end of March 2015. We have chosen this target to bring doctors' appraisals in line with non-clinical PDRs and to ensure that they receive the same opportunities to develop.

Target 5: We will achieve consistent compliance of 95% with statutory and mandatory training.

Our statutory and mandatory training programme ensures the safety and well-being of all our staff and patients. During 2014/5 we moved the majority of our training to on line e-learning and also implemented a new reporting tool (WIRED 2) to improve our ability to monitor and report on compliance. We have chosen a target of 95% compliance to demonstrate that our staff comply with statutory and mandatory requirements which have a direct impact on patient safety.

Target 6: We will reduce the number of programmes with red flags in the General Medical Council's national trainee survey by 5% and increase the overall number of green flags.

As one of London's largest teaching hospitals, we want to provide the best training for our junior doctors, as we believe this is a key element of us being a 'well-led' organisation. The General Medical Council's annual national survey is an important measure of trainee satisfaction, which can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining. Although we have seen improved survey results in recent years, in the 2014/15 survey 39% of our programmes currently have a 'red flag' (where we are shown to be a significant national outlier). We have chosen this target to drive improvements across education in

order to reduce the number of programmes with red flags by 5%, while increasing our number of 'green' flags.

Target 7: We will obtain a minimum score of 0.5 for placement satisfaction for all medical student placements as measured by Student Online Evaluation (SOLE) feedback.

As well as junior doctors, we also run placements for medical students at the Trust and are keen to focus on how we can improve their experience. The feedback we receive through the national SOLE system is usually mixed. We will focus on how we can improve their experience throughout the year in a consistent manner, with the aim of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements.

Target 8: We will have trained departmental safety co-ordinators in all specialties.

Departmental Safety Coordinators (DSCs) are appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities. In year one, we want to ensure that 90% of our specialties have a fully trained DSC, with all departments having one in year three. Currently, we have around 300 trained DSCs in post, with a view to increasing this number to 400 by the end of the year. Ensuring that our specialties are fully compliant with health and safety will ensure a safer environment for our staff and consequently for our patients.

Summary of our quality performance 2013-15

The targets and goals we have set for 2015/16 are designed to sustain and improve on achievements made through the implementation of our first Quality Strategy. We also recognise that we have some way to go before we can meet all our goals. Some examples of our achievements over the two years of our first Strategy, and continued work to improve the quality of healthcare in our trust are outlined below, under the headings of our new quality domains.

Safe

Incident reporting

In April 2014, we upgraded Datix, our incident reporting system to provide improved systems and processes for monitoring, reporting and learning from adverse events. Since then, we have seen an increase in our reporting rate to its current level within the top quartile when compared to our peers. We believe this is also due to a culture of increasing openness and transparency, which is reflected by the improved responses to the safety questions in our staff survey. We have exceeded our targets for reporting, while maintaining a low level of harm and continuing to have one of the lowest mortality rates in the country.

Harm Free Care

We consistently deliver over 95% harm free care for our patients as measured by the safety thermometer. This includes reporting a low level of harm when compared with the national average for pressure ulcers, falls, VTE and urinary catheter infections.

Reporting and Monitoring Safety & Effectiveness

In 2014, we appointed an Associate Medical Director to be the trust lead for safety and effectiveness, and have set out to improve the ways in which we monitor how safe and effective our services are. We

have undertaken the following actions:

- Weekly incident review meetings for all divisions held with the Associate Medical Director for Safety & Effectiveness. This ensures that issues are highlighted and action taken in real time.
- Monthly Safety & Effectiveness reports for each clinical division - these include information regarding mortality rates split by specialty, themes from serious incidents, including lessons learnt and actions to be taken, divisional incident reporting rates and participation in local and national audit. These allow divisions to monitor their performance at specialty level and make improvements were necessary.
- Monthly Quality Reports report the same information at Trust level to our Executive Committee and Quality Committee.

Effective

Mortality rates

We have maintained consistently low mortality rates. Our SHMI and HSMR scores are excellent when compared nationally, with the rate for each being the second lowest for non-specialist acute providers across the available data for this last year.

Clinical Audit

In 2014, a business case was approved to develop a clinical effectiveness team in the medical director's office. This team will mean we can run a more comprehensive programme of local audit, focusing quality improvement on those areas where it will be most helpful, to improve outcomes for patients. We anticipate that the team will be in place in summer 2015.

Specialist Services

We are proud of our high performing specialist services at Imperial including our hyper acute stroke service at Charing Cross, our heart attack and arrhythmia centre at Hammersmith and our Major Trauma Centre at St Mary's, which was recently ranked the best in the country by independent expert clinicians who assessed the service.

Caring

Improvements in patient experience

We have seen improvements in our results in the national inpatient, cancer and A&E patient surveys over the last year, and have fully implemented the 'Friends and Family Test' question in all outpatient areas. A number of key programmes of work have contributed to our improved scores, including:

- the introduction of carers' passports which enables carers of patients who have dementia or are vulnerable to visit outside hospital visiting hours,
- the introduction of SMILE to improve the experience of patients with cancer in response to the 2013 survey results
- a research study to improve dignity for older people in hospital.

Patient stories

This year we have changed the way patient stories are presented to the board. Patients now attend in person and share their experience directly with the board. The patient story 'opens' the meeting to remind everyone of why we are here and to ensure our patients are at the forefront of everyone's mind as they discuss board matters. The board have the opportunity to ask the patient questions and have used this to really understand what matters to our patients.

We will continue to have our patients share their experiences and hope to extend this further using video technology to reach more patient groups.

Responsive

We have not consistently met all national access targets this year. We have been focusing on improving and streamlining our operational processes and are seeing some gradual improvements in our performance. Some of the initiatives have included:

- Enhanced the cancer administrative team, recruiting more tracking staff to support the delivery of cancer targets.
- Network-wide pathway mapping work with other providers in North West London to reduce the number of cancer delays related to inter-trust referrals.
- 'Breaking the cycle' week to focus on and address the operational difficulties we were experiencing in A&E, developments include facilitating early discharge, early escalation of potential breaches and improving out-of-hours operations.

Well-led

We have seen significant improvements in our staff engagement throughout 2014/15, with the following key programmes of work contributing to our improved scores:

- We run local engagement surveys every quarter. Each manager receives local results at specialist and ward level and then develops quarterly action plans to address the issues raised.
- We have produced a new Health and Wellbeing strategy for staff. This includes activities such as yoga, weight management, health and wellbeing days on all sites, and walking challenges.
- We have developed a suite of leadership development programmes, for clinicians and non-medical managers.
- We have rolled out a new Performance Management Review process throughout the Trust. This has involved training for 1,600 managers in effective performance conversations.
- We introduced 'Make a Difference' awards as our way of recognising the hard work, dedication and achievements of our staff. The scheme has been very popular with high take up rates throughout the year with an estimated 1500 instant recognition award and 250 nominations for the other awards.

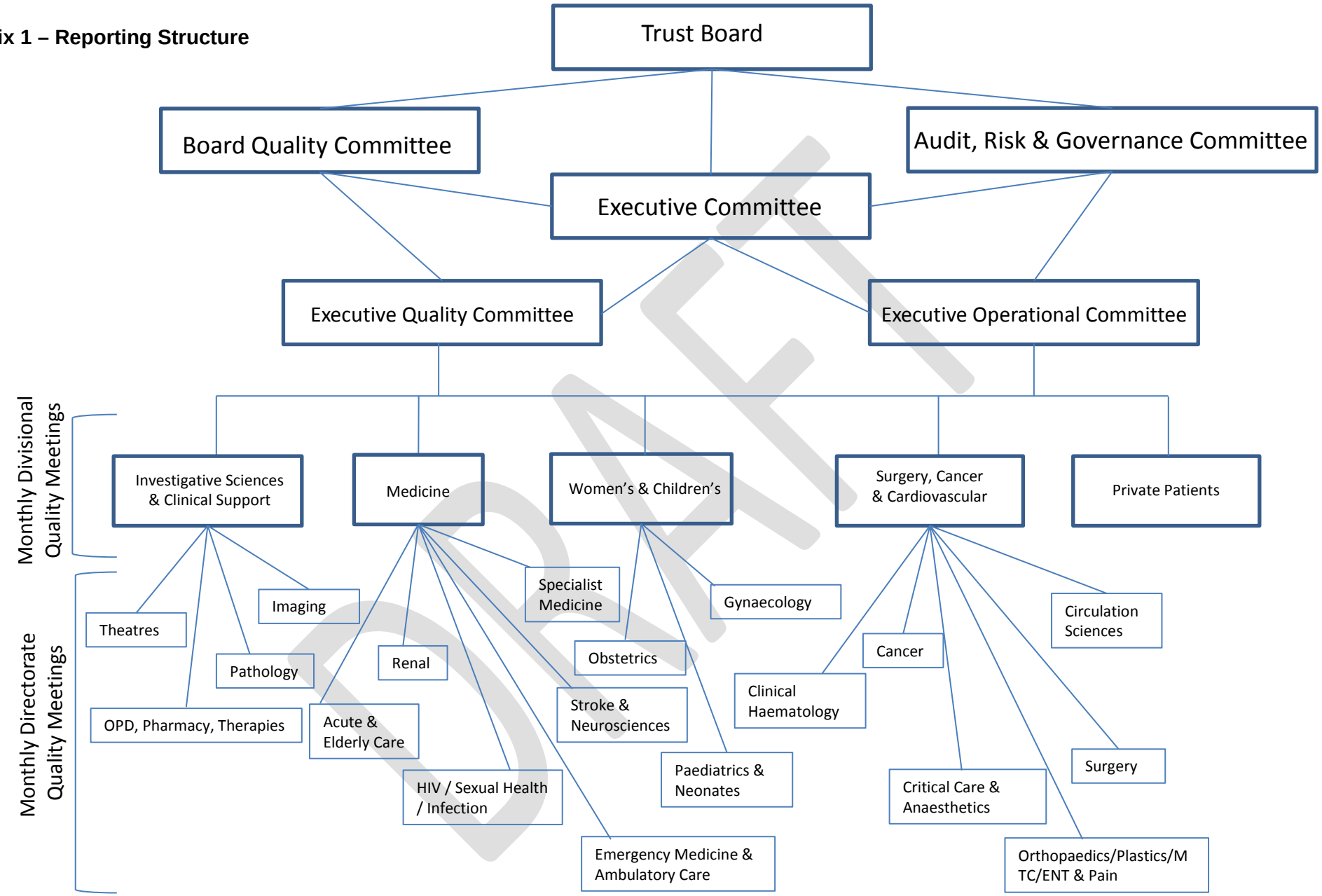
Conclusion

We believe implementation of this strategy will ensure our services are safe, effective, caring, responsive and well-led, leading to better outcomes and experience for our patients, improved engagement for our people and a strengthened confidence in our trust as an organisation committed to continuously improving.

We have an exciting opportunity to use our values based quality improvement programme to make Imperial the best it can be, with all our people sharing in leading and delivering improvements, whether big or small, ensuring that the needs of the individual patient are central to all that we do.

We look forward to working with our patients, our people, our commissioners and other external stakeholders over the next three years as we work to deliver the ambitious goals and targets set out in this strategy.

Appendix 1 – Reporting Structure



Appendix 2 – Trustwide Improvement Projects

Safe	Effective	Caring	Responsive	Well-led
Critical Care Development Programme *Chief Operating Officer*	Clinical guideline assurance programme *Medical Director*	Equality programme *Director of Nursing*	Surgery backlog reduction programme *Chief Operating Officer*	OD strategy implementation *Director of People & Organisational Development*
Sign up to Safety Improvement Programme *Medical Director*	Local clinical audit programme – safety improvement programme *Medical Director*	End of life improvement programme *Director of Nursing*	Cancer standard management (sustained delivery of targets) *Chief Operating Officer*	Quality Improvement methodology programme *Medical Director*
Paediatric Intensive Care Unit (PICU) Redevelopment Programme *Chief Operating Officer*	CAS alerts/medical devices/new interventions *Medical Director*	Volunteer development programme *Director of Nursing*	A&E performance improvement programme *Chief Operating Officer*	Education Improvement Programme *Medical Director*
Isolation facilities Improvement Programme (usage and increasing provision) *Chief Operating Officer*	Discharge process improvement programme *Chief Operating Officer*	Ward leader development *Director of Nursing*	Operational target strategy/improvement programme *Chief Operating Officer*	Values, behaviour & promise project *Director of Communications*
Quality Impact Assessment process for Cost Improvement Programmes *Director of Nursing*	Nursing and Midwifery Revalidation *Director of Nursing*	Time To Care Project *Director of Nursing*	Complaint improvement programme *Director of Nursing*	Board development programme *Director of People & Organisational Development*
Safety thermometer – reduction in harm *Medical Director*			Out-patient improvement programme *Chief Operating Officer*	Ward accreditation programme *Director of Nursing*
Safe-guarding programme *Director of Nursing*			Site capacity improvement plan *Chief Operating Officer*	Communication Improvement Programme *Director of Communications*
			Integrated care service *Chief Operating Officer*	Divisional structure – Mid-term review of effectiveness *Chief Operating Officer*
				Clinical Strategy Implementation Programme *Medical Director*

Appendix 3 – Project Analysis

KEY	
	*** major contributor to target
	** contribution to target but not essential
	* Small contribution but not critical to target
	x No relationship or contribution to target

Domain: SAFETY		GOALS & TARGETS										
		Reduction in incidents causing severe and extreme harm	Sufficient staffing - vacancy rate	To achieve agreed fill rates for nursing staff	Safety culture - high reporting, low harm	Zero 'never events'	No avoidable infections	Compliance with anti-infective policy	Eradicate avoidable category 3/4 Trust-acquired pressure ulcers	Venous thromboembolism assessment & harm reduction	WHO checklist auditing	Reduce out-of-hours transfers
PROJECTS	Critical Care Development Programme - COO	***	***	***	***	***	***	**	**	x	x	***
	Sign up to Safety Improvement Programme (PU, CTG, WHO, HCAI, SI - MD	***	x	x	***	***	***	**	***	***	***	x
	PICU Re-development Project - COO	***	**	**	***	x	***	x	x	x	x	***
	Isolation facility Improvement Programme (usage and increasing provision) - COO	***	x	x	x	x	***	**	x	x	x	***
	QIA process for CIP - DON	**	***	*	**	*	**	*	x	x	x	x
	Safety thermometer – reduction in harm - MD	***	x	x	***	***	***	***	***	***	x	x

Domain: EFFECTIVE		GOALS & TARGETS						
		National clinical audit outcomes - top quartile	SHMI and HSMR Ratios	Reduction in out-of-ICU / ED cardiac arrests	PROMS reporting performance & health gain	Mortality reviews in all specialties	35% increase in discharges before noon	70-day research target
	Clinical guideline assurance programme - MD	*	*	*	x	x	*	*
	Local clinical audit programme – safety improvement programme - MD	***	**	**	*	***	x	x
	CAS alerts/medical devices/new interventions - MD	*	*	*	x	x	x	**
	Discharge process improvement programme - COO	**	**	x	*	x	***	x
	Nursing and Midwifery Revalidation - DON	*	x	x	x	x	x	x

Appendix 3 – Project Analysis continued

Domain: CARING		GOALS & TARGETS					
		Increasing percentage of our patients would be happy to recommend the Trust to friends and family if they needed similar care or treatment	Improve our score in the national inpatient survey relating to responsiveness to patients' personal needs	Achieve and maintain a FFT response rate of 40% in inpatients and 20% in A&E	Improve our national cancer survey scores	Increase our reponsiveness to complaints and reduce overall number	Develop a dataset that enables monitoring of protected characteristics against patient experience measures
PROJECTS	Safe-guarding Programme - DON	**	*	x	x	x	**
	Equality programme - DON	***	**	**	**	*	**
	End of life improvement programme - DON	**	***	*	***	*	x
	Volunteer development programme - DON	**	**	*	**	x	x
	Ward leader development - DON	***	***	***	***	*	x
	Time To Care programme - DON	***	***	***	***	*	x

Domain: RESPONSIVE		GOALS & TARGETS							
		Meet all national access standards	Reduce the unplanned emergency readmission rate	Reduce the backlog of patients waiting 52 weeks for elective surgery and ensure clinical validation in place for 18 week waits	Hospital initiated cancellation of outpatient appointments	Outpatient letter turnaround time	Reduction in number of delayed clinics due to late arrival of doctors	Improve number of outpatient consultations where original medical records are available	PLACE target improvement to be in the top 25% nationally
PROJECTS	Surgery backlog reduction programme - COO	***	**	***	**	**	**	**	x
	Cancer standard management (sustained delivery of targets)- COO	***	**	**	**	**	**	**	x
	A&E performance improvement programme - COO	***	***	*	*	*	*	*	*
	Operational target strategy/improvement programme - COO	***	***	***	***	***	***	***	*
	Complaint improvement programme - DON	*	*	***	***	***	***	***	**
	Out-patient improvement programme - COO	*	**	**	***	***	***	***	*
	Site capacity plan - COO	***	***	***	**	**	**	**	**
	Integrated care service - COO	**	**	*	**	**	**	**	*

Appendix 3 – Project Analysis continued

Domain: WELL-LED		GOALS & TARGETS									
		Increase percentage of staff who would recommend the Trust as a place for treatment or a place to work	Ward accreditation programme launch	Voluntary turnover rate of 9.5% or less	Sickness absence rate to 3.40% or less	Performance development review rate of 95%	Doctors appraisal rate of 95%	95% statutory and mandatory training	Reduction in number of programmes with GMC NTS red flags by 5% and increase in green flags	Minimum score of 0.5 for Student Online Evaluation (SOLE) feedback	Safety co-ordinators in 90% of departments
PROJECTS	OD strategy - DOPOD	***	**	***	***	***	**	***	**	**	***
	Quality Improvement methodology programme - MD	***	**	**	***	***	***	**	***	***	x
	Education improvement programme - MD	***	***	***	***	***	***	**	***	***	x
	Values, behaviour & promise - DOC	***	**	**	**	**	**	*	***	***	x
	Board development programme - DOPOD	***	*	x	x	x	x	x	x	x	x
	Ward accreditation programme - DON	***	***	**	**	**	**	***	**	*	x
	Communication programme - DOC	***	***	**	**	**	**	**	x	x	x
	Divisional structure – Mid-term review of effectiveness COO	**	x	x	x	x	*	x	*	x	x
	Clinical Strategy Implementation programme - MD	***	*	**	**	*	**	*	**	**	x

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	3.4
Title	Quality Improvement Programme implementation plan
Report for	Monitoring
Report Author	Lauren Harding, Project Manager
Responsible Executive Director	Chris Harrison, Medical Director

Executive Summary: This report provides the Trust Board with a progress update on development of the Trust wide Quality Improvement (QI) programme.

- The values-based QI programme will be intrinsically linked with the new Trust Values & Behaviours and will be the way they are enacted. The focus is on removing the need to seek permission to make changes and to build a workforce who can conduct QI work and enable others to do so;
- Engagement workshops with over 280 staff have confirmed strong support for the QI programme and informed its design;
- Dr Bob Klaber has been appointed as Associate Medical Director (Quality Improvement) and will lead the programme. A programme committee will be established and report to Executive Quality Committee (ExQu);
- The Model for Improvement (PDSA) will form the core methodology underpinned by a core set of QI tools which will be used flexibly according to the needs of the project;
- A core team (iQI Hub) is currently being recruited and will deliver QI training, provide ongoing support & facilitation to teams conducting QI projects and monitor & report QI activities. The team will including QI project leads, project managers and information analysts;
- QI training will have 3 strands:
  - ‘Reaching Out’ – the QI programme will be launched jointly with the new Trust Values & Behaviours and all of our staff will receive awareness training through various mechanisms;
  - Targeted Training will be delivered to teams responsible for running QI projects. This will be delivered over 2 days and will include training in QI tools using a ‘live’ project to support learning;
  - An ongoing development programme offering a range of QI training will be accessible to all staff;
- A series of priority workstreams have been identified from the new Quality Strategy, CSIP and CQC action plan and will receive facilitation support from the QI team to enable the teams to deliver their QI projects.

Recommendation(s) to the Board: The Board is asked to the note the proposed approach and progress made with the implementation of the values based QI programme.

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.

Imperial College Healthcare NHS Trust

QI programme implementation plan

1) Purpose of the report

This report provides the Trust Board with a progress update on development of the Trust wide values-based QI programme.

2) Introduction

On 3rd March ExCo supported the recommendation for a coordinated approach to QI and the development of an in-house model with external support during the development and embedding phase. An initial proposal for the QI programme was included in the Quality Strategy update paper reviewed at Quality Committee in April.

A key enabler to the delivery of the new quality strategy, which will launch in summer 2015, is the adoption of a proactive and standardised approach to QI. Our aim is to build a culture of continuous improvement within the Trust where all of our staff feel that they have the support and permission to make improvements to the quality and efficiency of care.

3) Values-based QI & Organisational Culture

The evidence from other organisations, who have successfully built systems and cultures to enable QI, is that three key elements need addressing: the development of a strong and open leadership and culture; widespread use of QI methods across the organisation; and the development of an 'Operating System' for improvement.

Recognising the importance of organisational culture on the successful implementation of QI programmes, the Trust's QI programme will be grown out of the 'values & behaviours' project established at the beginning of 2015. This project has to date engaged with c.1500 staff from across the organisation. Throughout the process, all staff groups have been clear that for the values & behaviours project needs to be grounded in action which will be realised via the QI programme. Key to this is the development of a culture of sharing ideas and learning, celebrating success and the developing new perspectives.

It is envisaged that the values-based QI programme will be central to a number of interrelated work streams will emerge from the values & behaviours project (see figure 1).

Figure 1: Workstreams results from Values & Behaviours projects

One of the strongest areas of feedback from this engagement has been the expectation that leaders and line managers should be "honest, open and brave". In order to develop a genuine culture of continuous improvement, all of our leaders and line-managers will need to become 'enablers' who encourage, support and give permission for their teams to make improvements.

An important feature of the Trust's values & behaviours work has been the strong support and engagement from the Trust Board and executive team. This level of support is recognised to be one of the most important determinants of whether or not an organisational QI programme is likely to be successful.

We also need to take an innovative and ambitious approach to how we meaningfully involve patients and our local communities within the QI programme.

The Health Foundation has published a checklist (Building the foundations for improvement, 2015) to inform organisational readiness when embarking on a large scale QI programme (Appendix 1). Self-assessment of ICHT's position against the checklist suggests that the Trust is in a strong position to launch the QI programme and has already considered and made provision for the key requirements for success.

4) Staff Engagement

A number of staff engagement workshops took place from April - June, which included a brief introduction to QI, followed by an open feedback session. The feedback session was an opportunity for staff members to share their experience in QI, the barriers they faced and to help co-produce the design of the programme.

The workshops involved 280 staff members across the three main hospital sites (SMH, HH and CXH) from a range of specialties and professional groups ranging from consultants to porters and domestics.

Key themes identified about what support staff wanted from a QI programme were:

- **Sufficient time** – a lack of dedicated time to deliver QI projects, particularly with competing clinical demands, was cited as one of the main barriers to making improvements. There was a strong message that to create time for new initiatives staff need to be given 'permission' to stop doing some things they feel add very little value. There were many different opinions on how best to provide protected time particularly within clinical placements and rotations. There was some concern about the ability to backfill with locums/bank staff;
- **QI Support** – the value of having a central team with QI expertise, who could provide ongoing project and supported and guidance, was recognised as an important way to provide expertise & troubleshooting, maintain the momentum of projects and to ensure alignment to the Trust's priorities;
- **IT / data support** – staff identified a need for a function within the central team to provide data analysis and IT support;
- **Sharing projects** – there was strong support for the availability of mechanisms and communications expertise within the QI hub in order to efficiently share project methods, outcomes, evaluation approaches and support networks;
- **Team-based projects** – most staff felt that projects should be MDT team-based projects, led by a consultant or ward manager. At present there is a feeling amongst junior staff that they are not always involved in QI projects by the senior team;
- **Education & Training** – many staff expressed an interest in getting involved in QI projects but identified a need for training in QI methodology, QI tools and project planning.

5) Governance

The programme will be led by Dr Bob Klaber, who has been appointed to the role of Associate Medical Director (QI).

A committee, chaired by Dr Klaber, will be established to oversee the development and progress of

the programme. The committee will be developed from the existing Values & Behaviours steering group and will be extended to include Divisional representation. The QI programme committee will report to the Executive Quality Committee through Dr Klaber, who will have membership of both groups.

QI projects will report progress dually to the QI programme committee as well as through the appropriate governance structures depending on where the project is owned i.e. the relevant clinical service or corporate department.

Formal reporting links will be established between the QI programme and related programmes, including education, safety & effectiveness, risk & audit, to ensure that outputs of QI workstreams are linked into these programmes of work and also to ensure that opportunities for QI input can be identified.

6) Patient Public Engagement

Meaningful Patient Public Engagement (PPE) will be a major component of the QI programme and the QI programme will champion innovative approaches to involving patients and citizens in the co-design of service improvements.

Further work is required to define how this will be implemented but a number of potential partners have been identified who have expertise in this area and would be able to provide support. These include:

- North West London NIHR CLAHRC
- National Voices
- Citizens UK
- Imperial College Healthcare Charity

7) Conceptual Framework & Methodology

The paper to ExCo on 7th April stated that QI model would be based on the Virginia Mason Production System, which is based on Lean methodology, as well as incorporating the Model for Improvement (Plan-Do-Study-Act). Following feedback from external partners and the feedback from staff, a decision has been taken to simplify the approach.

The core improvement methodology will be The Model for Improvement (see figure 2), also commonly known as Plan-Do-Study-Act (PDSA). The model for improvement enables testing of incremental change on a small scale to see whether it achieve the aims laid out, if not, provides an opportunity for learning why it does not.

The key benefits of the Model for Improvement are:

- well recognised model utilised by highly reputable healthcare organisations nationally and internationally with proven success – *including IHI and the Health Foundation*;
- the concept is easy to understand, role-model and to learn by doing
- the availability of many different existing resources to support teaching & use of the model;
- staff are more likely to be open to trying out new ways of working if it requires incremental small scale changes;
- it focuses on engaging stakeholders and so reassures staff they will be listened to;
- staff are more likely to feel ownership and commitment if they are responsible for creating the ideas for improvement based on their experiences.

Figure 2 – Model for Improvement

a) Key Tools

Underpinning the core methodology, a small number of core QI tools which will be used flexibly according to the needs of individual projects; being too rigid and prescriptive would risk projects failings.

Action Effect diagrams (also known as driver diagrams) - structured logic charts to identify the levers required to enact change. These are also a way to indentify and refine appropriate required measures to demonstrate when a change has been made;

Value stream mapping (VSM) – a conventional form of process mapping with greater emphasis on what adds value for patients. VSM is a core tool used in Lean, which aims to maximise value for customers whilst minimising waste. VSM will be used to identify waste in the current system and map out where the value can be maximised in future re-designed processes. VSM provides an ideal opportunity to involve our patient and public partners in co-design of future processes.

Experience based co-design – bringing patients and staff together to share the role of improving care and re-designing services. Teams will be provided with training and resources to support them in involving services users in their projects.

8) Defining workstreams

Feedback from NHS Advancing Quality Alliance (AQuA) suggests that a small number (2-3 maximum) of bold transformational aims as the major focus of your improvement activity in Year 1, reviewed on an annual basis. The intent of such aims is to drive towards radical transformational change not simply incremental improvements.

A series of priority workstreams (figure 4) which will receive facilitation support from the QI programme have been identified from the new Quality Strategy, CSIP and CQC action plan. In addition to this a priority for the QI programme in the coming months will be to identify current ongoing QI activities and to further define the workstreams to be addressed by the QI programme in later phases.

As well as the defined priority workstreams individual QI projects can be identified through the following routes:

- In-depth reviews of clinical services will be conducted to identify opportunities for improvements, streamlining and efficiencies. Services will be prioritised for review according to the CSIP workstreams to ensure any service transformations are based on optimally efficient;
- Theme reviews - opportunities will be identified through a thematic analysis of action plans for aligned programmes including education, audit & risk, safety & effectiveness, CQC action plan, ward accreditation programme, staff survey, NHS change day pledges;
- Self-referral by staff – supporting bottom up improvement *i.e. where wards identify the need for support with their ward accreditation action plans;*
- executive referrals where further strategic priorities are identified.

Figure 4: Proposed phase 1 workstreams for QI support

Priority Area	***Reason for selection***
Reducing re-admissions	Quality account metric – above national average with worsening performance over recent years
Reducing out-of-hours transfers/discharge	Quality strategy priority with no current defined programme of work
Sepsis Care Bundle implementation	National patient safety programme
Reducing incidence of post-operative pneumonia	Outlier for NSQIP & CRAB datasets
Reducing catheter-acquired infections	Outlier for NSQIP & CRAB datasets
Improving interpretation of fetal monitoring	Sign up to safety workstream – source of highest values claims
Reduce out-of-ITU/ED cardiac arrests	Quality strategy priority with no current defined programme of work
Reduce avoidable deaths due to VTE	Quality strategy priority with no current defined programme of work
Out-patient department transformation	Key focus for CQC action plan
Vascular surgery	CSIP phase I priority workstream
Acute Medicine	CSIP phase I priority workstream
Cardiorespiratory care	CSIP phase I priority workstream
Stroke services	CSIP phase I priority workstream

The aim is to have engaged with 20 projects by 31st December 2015 and a further 30 projects by 31st March 2016.

9) Resourcing

a) iQI Hub

A central team, known as the 'iQI Hub' will be established to support the delivery of the programme. They will specifically be responsible for providing training & education in QI methodology and tools, supporting and guiding teams undertaking QI projects and monitoring & reporting QI activities.

Given the size of the organisation, the need to support staff across 5 sites and the scale of ambition for delivering improvement the iQI Hub will require a not insignificant amount of resource. It is important that there is sufficient capacity to support the delivery of priority workstreams as well as supporting staff groups who wish to engage in QI. A continued lack of capacity to provide this support is likely to result in staff disengagement and failure of the programme. The staff engagement work has confirmed the desire for a central team who can provide a wide range of skills, including leadership, stakeholder and staff engagement, training & education, project management, data analytical and administrative support. The hub will also involve patients, carers and members of the public.

The team will include:

- 1.0 WTE Programme Manager – Band 8C *within the MD's Office team*
- 4.0 WTE QI Project Leads – Band 8b
- 4.0 QI support officers – Band 6
- 1.0 Administrative support- Band 4
- 1.0 WTE Senior Information Analyst – Band 8b
- 1.0 WTE Data Analyst – Band 6
- 3.0 WTE QI Clinical Fellows *(nursing or AHPs)* Bands 8a - 8b

Initial phases of recruitment are underway. The QI leads & QI Fellows are currently out to advert and it is anticipated that they will be in post by September/October 2015. It is anticipated that the team will be fully established by 31st October 2015.

b) Capitalising on existing QI infrastructure

As well as the iQI Hub, it is important to recognise existing QI infrastructure within the Trust which can be harnessed to enable engagement and support spread. This will be achieved through:

- Darzi Fellows – *next cohort of 4 fellows will join in September 2015;*
- Health Foundation Q Initiative Fellows;
  - *two members of Trust staff have been selected to participate in the first cohort beginning July 2015;*
  - *the initiative aims to enhance the impact of people leading improvement in order to accelerate learning and improvement throughout the NHS;*
- QI Census – *work will be undertaken to identify existing QI skills within the current Trust workforce. We will then ascertain whether these people are willing to be involved in supporting the QI programme and how these skills can be best utilised.*

c) Generating QI capacity for staff

Funding will also be made available to provide backfill for internal secondees to provide them with protected time to deliver QI projects. Feedback to this proposal has indicated that there are practical challenges related to organising backfill, in particular the filling of bank shifts, which may hinder this in practise. Therefore further consideration is required as to the potential flexible use of different models.

d) Practical Resources

Support from the iQI Hub will be supplemented with a range of practical resources and support tools will be made available to provide guidance to staff whilst conducting QI. These will be made available and will include:

- Online reference guides & toolkits *via a highly searchable digital platform*
- Catalogue of projects to share progress & outcomes *via a highly searchable digital platform*
- Access to existing eLearning modules
- Coaching & mentoring

e) Project Funding

We are exploring possible avenues to finance a seed fund which will provide projects with small amounts of funding, where required, to enable the pilot work. One possible option is to generate links with the Imperial College Healthcare Charity's charitable grants process.

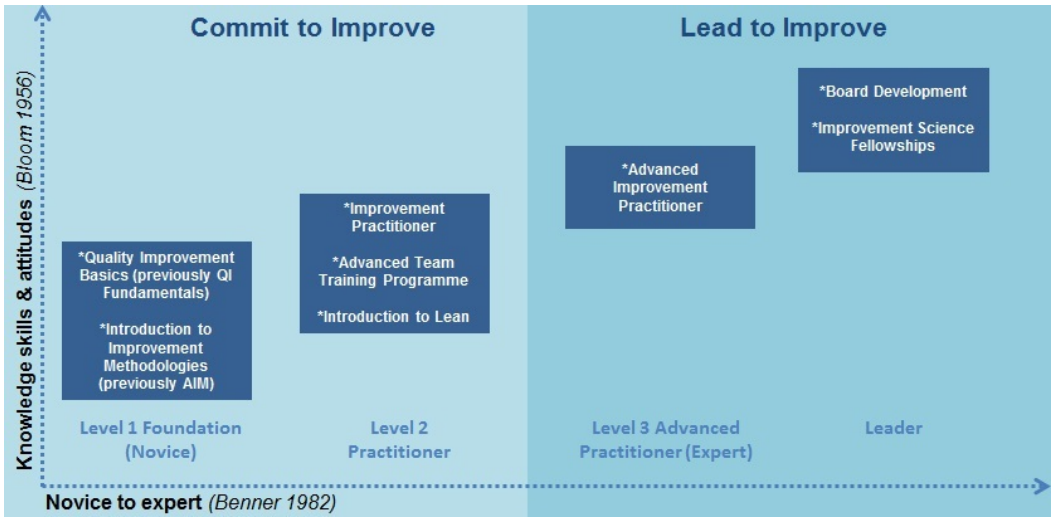
10) Training & Education

The QI programme will provide staff with the necessary skills and tools to enable and empower them to lead QI projects in their own work areas via a comprehensive education and training programme. The focus is to build capacity in people who can act as QI enablers across our workforce.

The training needs will differ according to the level of involvement with QI, as outlined in figure 5. The method and mode of training will need to be flexible to accommodate different learning styles and meet the needs of different QI project teams and their chosen project.

We will work closely with colleagues in People & OD to ensure alignment with existing training and development opportunities such as the leadership development programmes and coaching mentoring programmes.

Figure 5: Skills Escalator (NHS AQuA)



There will be 3 strands to the training and education delivered by the QI Programme, which are outlined below. It is intended that training is delivered by the iQI Hub staff however, supported by any willing staff identified through the QI census. However, it may be necessary to commission external support if timescales for recruitment are not aligned with the training schedule.

a) Strand 1 – "Reaching out"

To achieve a culture of continuous improvement all of our people must be aware of the programme and feel part of it. As previously highlighted, the QI programme is linked closely to the Values & Behaviours project. Therefore the two will be launched together and will require that all staff receive an introduction to both programmes. The introduction will include:

- Culture & engagement: why it is important for patients & staff
- Why & how this project has come about (values → QI)
- Our values → what is important to us
- Our behaviours → how we act, speak & look; how this place 'feels'
- Creating a culture of continuous improvement – *using QI to enact values & behaviours*
- Plan → Do → Study → Act - *the central approach to QI*
- Recognising that in order to do new things, there are other things we need to stop doing; 'permission' is important for that
- Being an enabler - *no matter how much direct involvement we have in QI projects we all have a role as an enabler.*

The 'Introduction' will be delivered through a numbers of different methods to ensure effective and timely engagement with all staff:

- Regular trust-wide 1 hour sessions open to all staff;
- 1 hour sessions targeted at team leads & managers designed to cascade the messages through their own locals session for their teams;
- Digital opportunities:
  - Online presentation videos i.e. TED talks
  - Webinars / web-chats

- Podcasts
- eLearning modules

It is expected that the new Trust Values and the values-based QI programme, will be launched at the end of September at the Leadership Forum. It is anticipated that 60% of Trust people will have received QI awareness training by 31st December 2015, with 100% completed by 31st March 2016.

b) Strand 2 – "Targeted team training"

This phase will run concurrently with Phase 1 and will be the way by which staff are trained in QI methodology and equipped with skills and tools to enable them to conduct QI work.

Participants will be identified via two streams:

- Teams involved in one of the defined priority workstreams will be expected to attend;
- People who are enthusiastic are QI and wish to participate – *whilst initial efforts must be focused on priority workstreams it is important not to risk disengaging enthusiastic staff by turning them away.*

The training will be delivered as a two day programme spread across 2-3 weeks. The training will be focused on the specific issue to be addressed using QI and therefore people must attend with a core multidisciplinary representation from their work-based teams. Each session will be able to accommodate multiple teams either from the same or different specialties. The structure of the two days will be as follows:

- Day 1: QI theory using PDSA and QI skills & tools to work through the live problem;
- Between sessions back in the workplace: use tools to continue defining the problem;
- Day 2: iQI sprint where teams work up potential solutions to kick start the project;
  - volunteers external to healthcare join teams to bring different perspectives – *e.g. designers, engineers, non-exec. directors, charities;*
  - Patients & carers are key participants to enable co-design

Project teams for 50% of the priority workstreams will have received the targeted team training by 31st December 2015 with 100% being trained by 31st March 2016.

c) Strand 3 - Ongoing development programmes:

To supplement the "reaching out" and "targeted training arms" a suite of ongoing training and development opportunities will be developed:

- Availability of coaching & mentoring support;
- Access to technology enhanced learning opportunities in QI;
- Lunch time 'bite-size' teaching workshops on specific topics (i.e. measurement, sustainability);
- Bespoke QI training programme for specific clinical groups:
  - Foundation Year Doctors - *build on the national Foundation Years curriculum;*
  - New consultants – *adapt current ½ day session into a full day focused on values and QI;*
- 'Paired Learning' – *expand current programme to include 20 pairs (clinicians & managers) from ICHT, with greater focus on QI projects aligned to Trust priorities;*
- 'QI showcase' sessions –*to present QI stories, share learning, celebrate success and collaborate;*
- Potential to link in QI learning with 'ward accreditation' programme;
- Share learning from existing national programmes – *e.g. Health Foundation Fellowships, Fellows, Darzi Fellows, IHI Fellowships;*
- Shadowing programme - *to give non-clinical staff exposure to clinical environments*

11) External Support

Although we want to build a culture of continuous improvement from within, there may be value in seeking external advice, guidance, expertise and resources for specific areas of the programmes. Potential partners include:

- Health Foundation
- NHS AQuA
- King's Fund
- Institute for Health Improvement (IHI)- *learning from IHI Open School movement*
- North West London NIHR CLAHRC – *expertise in measurement, PPI/E & evaluation*
- HENWL

Different agencies will be able to offer different types of support and we will evaluate them against i) support tools and resources, ii) delivery of face to face training sessions, iii) delivery of online training, iv) strategic programme development. Conversations have already begun with some of the external partners listed. It is anticipated that these scoping discussions will have been concluded by mid-August. Further to this a small external reference group will be formed to provide oversight and guidance to the programme from key external stakeholders.

12) Timescales & Next Steps

Key task	***Due***
Define how phase 1 "Reaching Out" QI training links with the Values & Behaviours	July / August 2015
Conduct QI Census	July 2015
Continue to engage with external agencies regarding training support	Ongoing
Plan content of education sessions	July 2015
Agree priority workstreams & schedule first wave of targeted training	July 2015
Agree model for providing protected QI time for staff (i.e. internal secondments)	July 2015
QI Leads & QI Fellows in post	Sept / Oct 2015
Launch QI programme *(coincide with Values & Behaviours launch)*	Sept 2015 ***TBC***
Begin staff training & education – Phase I & 2	October 2015
Begin staff training & education – 'Ongoing Development programme'	November 2015
Fully established iQI Hub	December 2015
60% Trust people received "QI awareness" training	December 2015
Complete phase I training "Reaching out" - 100% Trust people received "QI awareness" training	March 2016

13) Recommendation(s) to the Board

The Board is asked to the note the proposed approach and progress made with the implementation of the values based QI programme.

Imperial College Healthcare NHS
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APPENDIX A: Organisational Readiness Matrix

This matrix has been created using the checklist published by the Health Foundation in its report Building the foundations for improvement (2015). The report examines the improvement capability building approaches taken by five health and social care trusts across the UK and was compiled with the purposed of supporting other organisation to build their own improvement capability.

A self-assessment has been conducted of ICHT's organisational readiness for developing a QI programme against the checklist. Items which are rated as amber are assessed as being under-way but not yet fully met, much of which is owing to the lead-times required for implementation of the programmes.

Readiness Indicator	Descriptor from Health Foundation checklist	RAG	Comments
TESTING THE WATER			
Financial and organisational stability	*Stability is essential in order to get a programme up and running successfully and ensure that the workforce is ready to engage with it. Any imminent reorganisation, change of leadership or pressing performance or financial challenge will make it almost impossible to gain and retain the attention of your staff.*		The Quality Improvement programme has been given a clear direction to lead the development of a culture of continuous improvement across the Trust. Business case approved and funding identified.
Board and executive level support	*Getting the board, particularly the non-executive members, engaged and enthused about investing in improvement capability is critical. Visiting trusts with proven improvement track records and early support from the finance director can help to secure their buy-in.*		Through the values & behaviours work the Trust Board have been highly engaged and enthused about staff-led work to develop a culture of engagement and continuous improvement across the Trust. The programme aims to invite non-executive members to participate in iQI sprints.
Robust governance and performance structures	*Essential pre-requisites for any organisation are a sound quality assurance mechanism and an effective board committee structure. Moreover, adapting corporate processes to ensure that a focus on audit and assurance goes hand in hand with a focus on understanding variation and improving quality is important.*		As part of the QI governance processes we need to fully define how the QI programme will interact will inter-related programmes including audit & risk, safety & effectiveness & education.
Some existing QI capability and/or a willingness to recruit an external improvement partner	*In order to implement and sustain a capability building programme, an organisation must be able to call on people with established QI expertise and coaching skills. In the absence of such expertise internally, consideration must be given to working with an external partner.*		The Trust has a significant number of people with expertise in coaching, mentoring, facilitation and quality improvement methods. Our plans to utilise a QI Census and to develop a programme of internal secondments should help to build and sustain capability to deliver.
BUILDING THE RIGHT FOUNDATIONS			
Develop an integrated approach to quality improvement	*Ensure there is a purpose for building capability and all strategic aims, structures, work-streams and performance management structures are aligned with the programme.*		There is a clear purpose for building QI capacity which is to enable the delivery of the new quality strategy. Further work is required to ensure quality improvement is fully integrated into performance management structures throughout the organisation.
Make sure the approach reflects the culture and personality of the organisation	*The values and vision of an organisation aspiring to continuous improvement need to be clearly articulated and visible at every level.*		Trust Values & Behaviours currently being refreshed, once finalised these will be intrinsically linked with the QI programme with clear messaging throughout the organisation.

Imperial College Healthcare NHS
NHS Trust

Put together a business case	*How much will the programme cost? Where will the money come from? What approach will be taken? How will the impact be assessed? What return on investment is anticipated and how might one measure at least some of that return?*		Business case approved and funding identified.
Establish a central improvement team	*At the outset, form a central team to manage and promote the programme, teach QI skills and coach improvement teams. At least some of the team should know the organisation well and have the respect of clinicians and managers.*		Recruitment is underway.
Spend time introducing quality improvement to the workforce and service users	*Do not assume that the organisation knows about QI and its potential benefits.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be delivered.
Clearly set out the aims and objectives at the start	*Make every effort to promote and describe the value that such a programme will provide to patients and staff. Involving clinical and middle management staff is important.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be delivered.
Engage the main external stakeholders	*Try to get the key commissioners, education providers and regulators involved early on and engage other providers in the local health economy.*		Early discussions held with HENWL. Further discussions required with other external partners.
GETTING STARTED			
Give training participants the chance to learn by doing	*The evidence suggests that training programmes which include practical exercises and work-based activities are more likely to achieve positive changes in care processes and patient outcomes. However, organisations have to ensure that training participants are part of an improvement team in their service or ward and are supported by their managers.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be planned in detail and delivered.
Ensure that the training content is appropriate for all participants	*Giving staff dedicated time to participate in training helps to keep the drop-out rate low and signals the organisation's support for quality improvement.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be planned in detail and delivered.
Combine classroom-based learning with access to online resources	*Aligning what staff see and hear during face-to-face learning sessions with appropriate online content will help to reinforce key messages.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be planned in detail and delivered.
Work with the QI enthusiasts first to gain some early wins	*'Go where the energy is' and empower staff to focus on issues that really matter to them.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be planned in detail and delivered.
Focus at the start on QI methods and techniques that are really understood by the team	*But make sure they are appropriate for the improvement challenges being addressed.*		The need for this has been recognised with the QI programme implementation plan – this now needs to be planned in detail and delivered.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.5
Title	NHS Trust Development Authority Self-Certifications
Report for	Ratification & Approval
Report Author	Jan Aps, Trust company secretary
Responsible Executive Director	Tracey Batten, chief executive

Executive summary:

As part of the on-going oversight by the NHS Trust Development Authority (TDA) the Trust is required to submit self-certified declarations on a monthly basis.

A revised process has been introduced to strengthen the internal signoff and assurance process, and the executive committee.

The Trust board is asked to ratify the May 2015 submission and to approve the June 2015 submission; both submissions will be reviewed by the executive committee on 28 July 2015. There were only minor changes to the report from previous submissions.

Recommendation to the Board:

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

Trust strategic objectives supported by this paper:

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

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: May 2015, submitted 30/06/2015

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: The Board is satisfied that the Trust meets the CQC registration requirements and is registered with no conditions.** **Following the CQC inspection in September 2014, the Trust received a number of compliance actions. An action plan has been approved by the Trust Board and CQC to address these regulatory breaches. Furthermore, a new compliance and improvement framework outlining the Trust's approach to ensure on-going compliance has been approved by the Trusts' Executive Committee.**	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 2014/15 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Alan Goldsman, 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 detailed review of compliance with the NTDA Accountability Framework and the NHS Constitution is underway; ratings against the oversight model, and the well-led framework assessment templates will be reviewed when available.**	Jan Aps Trust company secretary
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.**	Janice Sigsworth Director of Nursing
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*	Janice Sigsworth Director of Nursing

these risks to ensure continued compliance. **ICHT Response: Yes** **Explanation: The Framework for 2015/16 has been reviewed by the Trust company secretary. The proposed oversight model and confirmed suite of indicators is awaited, but systems will be developed to ensure that all required indicators are monitored as part of business as usual. The Annual Governance Statement identifies significant issues for 2015/16. The Trust has a Risk Management Framework in place and risks / barriers to achievement of the strategic objectives have been identified and documented with appropriate actions in place to deliver. In addition, the risk management framework includes a rigorous review of scoring, 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.**	Alan Goldsman, Chief Financial Officer
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 been finalised and submitted. Compliance with AGS will be monitored using the Trust's risk management and assurance frameworks**	Jan Aps Trust company secretary
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.* **ICHT Response: No** **Explanation:** Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI): • Three cases of MRSA BSI occurred in April 2015 and are under investigation (One of these has been initially allocated to the Trust); • The first (initially non-trust) case was in a patient who regularly attends the dialysis unit and the source of infection was thought to be the dialysis catheter; • The second (initially trust) case was in a patient on a medical ward and the likely source of infection was skin contamination; & • The third (initially non-trust) case was in a patient who attended our A&E but who had recently had orthopedic surgery at the Trust. This case is still under investigation. Clostridium difficile infections: • Eight cases of C. difficile were allocated to the Trust for April 2015; • The annual objective for the Trust is 69 for 2015/16; & • The provisional definition of a lapse in care associated with toxin positive C. difficile disease within ICHT is described as a) non-compliance to the ICHNT antibiotic policy or b) If the patient shared a ward with another patient who was symptomatic and later found to be C. difficile positive (with the same ribotype). After a review of Trust attributable C. difficile cases from FY 2014/15, eight cases have been agreed with the IPC lead for the CCG, there are two additional cases from March 2015 that we are awaiting ribotyping on. Accident and Emergency: The Trust did not deliver the 95 per cent 4 hour waiting time standard for A&E in May. However, a focus on managing flow across the Trust and in particular, the number of discharges before noon, has seen the Trust return to a position at the beginning of June where performance is being met on a daily basis. The Trust met the access standard during the first week in June and has sustained this performance in the subsequent days. Referral to treatment (RTT): The Trust continues to focus on reducing the number of patients waiting over 18 weeks. The number of patients in the 'backlog' has reduced from 12,309 submitted in November 2014 to 4,375 in April 2015. It is expected that the Trust will submit a figure below 4,000 in May 2015. The Trust expects to return to achieving the three aggregate standards within quarter 2 of 2015/16. The Trust is waiting to hear more regarding the recent announcement that the number of RTT standards will be reducing. However, this does not change the approach that the Trust has to continue to treat longest waiter first, clinical and non-clinical validation of our waiting lists and increasing capacity in specialities where there is a backlog of patients waiting over 18 weeks.	Steve McManus, Chief Operating Officer.
Q11.	Kevin Jarrold,

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 submitted its most recent toolkit return on 31 March 2015, achieving a minimum level 2 assessment against all standards.**	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: Board members are reminded at each Trust board of the need to ensure that the register of interests is current; it is formally reviewed at every other Trust Board meeting. Arrangements for making declarations for all staff grade 8c and above are being reviewed (to strengthen assurance); a new process using the e-learning tool will ease management action and provide an audit tool for compliance. The Trust currently has one NED vacancy, and the Chief Financial Officer role is covered by an interim – a substantive replacement has been recruited and will commence in the summer.**	Jan Aps Trust company secretary
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 continues to run in 2015/16 on a bi-monthly basis.**	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.** **Development sessions continue in 2015/16.**	Jayne Mee, Director of People and Organisational Development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: May 2015 Submitted 30/06/2015

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 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:**	Alan Goldsman, 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:**	Alan Goldsman, Chief Financial Officer
Q6. Condition P2 Provision of information. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q7. Condition P3 Assurance report on submissions to Monitor. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes**	Alan Goldsman, 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:**	Alan Goldsman, 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 - Compliance Monitor.
Monthly Data: June 2015 Submitted 31/07/2015

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.
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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 Directors comply with the fit and proper persons requirements.	Karen Charman, Director of People and Organisational Development.
Q2. Condition G5 Having regard to Monitor guidance. **ICHT Response: Yes** **Explanation:** Where appropriate to NHS trusts	Alan Goldsman, 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 pricing information (particularly in relation to expenditure, and expenditure incurred by third parties delivering healthcare services) **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q6. Condition P2 Provision of information to enable Monitor (for which read TDA) to undertake their functions. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q7. Condition P3 Provision of assurance reports on submissions to Monitor (for which read TDA) which comply with requirements and provide a true and fair assessment **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer

Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes** **Explanation:**	Alan Goldsman, Chief Financial Officer
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:**	Alan Goldsman, 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 2015, to be submitted 31/07/2015

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: The Board is satisfied that the Trust meets the CQC registration requirements and is registered with no conditions.** **Following the CQC inspection in September 2014, the Trust received a number of compliance actions. An action plan has been approved by the Trust Board and CQC to address these regulatory breaches. Furthermore, a new compliance and improvement framework outlining the Trust's approach to ensure on-going compliance has been approved by the Trusts' Executive Committee.**	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 2014/15 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Alan Goldsman, 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 detailed review of compliance with the NTDA Accountability Framework and the NHS Constitution is underway; ratings against the oversight model, and the well-led framework assessment templates is underway.**	Jan Aps Trust company secretary
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.**	Janice Sigsworth Director of Nursing
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.*	Janice Sigsworth Director of Nursing

ICHT Response: Yes **Explanation: The Framework for 2015/16 has been reviewed by the Trust company secretary. The proposed oversight model and confirmed suite of indicators is awaited, but systems will be developed to ensure that all required indicators are monitored as part of business as usual. The Annual Governance Statement identifies significant issues for 2015/16. The Trust has a Risk Management Framework in place and risks / barriers to achievement of the strategic objectives have been identified and documented with appropriate actions in place to deliver. In addition, the risk management framework includes a rigorous review of scoring, 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.**	Alan Goldsman, Chief Financial Officer
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 been finalised and submitted. Compliance with AGS will be monitored using the Trust's risk management and assurance frameworks**	Jan Aps Trust company secretary
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.* **ICHT Response: No** **Explanation:** Clostridium difficile infections: • Seven cases of C. Difficile were allocated to the Trust for June 2015. One of these has been identified as a potential lapse of care because two cases had crossing pathways. In another one the ribotype was untypable so we are unable to determine whether transmission took place.; • The annual objective for the Trust is 69 for 2015/16; & • The provisional definition of a lapse in care associated with toxin positive C. difficile disease within ICHT is described as a) non-compliance to the ICHNT antibiotic policy or b) If the patient shared a ward with another patient who was symptomatic and later found to be C. difficile positive (with the same ribotype).	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 submitted its most recent toolkit return on 31 March 2015, achieving a minimum level 2 assessment against all standards.**	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: Board members are reminded at each Trust board of the need to ensure that the register of interests is current; it is formally reviewed at every other Trust Board meeting. Arrangements for making declarations for all staff grade 8c and above are being reviewed (to strengthen assurance); a new process using the e-learning tool will ease management action and provide an audit tool for compliance. The Trust currently has one NED vacancy, and the Chief Financial Officer role is covered by an interim – a substantive replacement has been recruited and will commence in the summer.**	Jan Aps Trust company secretary
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 continues to run in 2015/16 on a bi-monthly basis.**	Karen Charman, 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.*	Karen Charman, Director of People and Organisational Development.

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.** **Development sessions continue in 2015/16.**	

Imperial College Healthcare NHS Trust

Trust board – public

Agenda Item	3.6
Title	Reference Costs Submission – Costing Process
Report for	Noting
Report Author	Sandra Easton, Deputy Director of Finance
Responsible Executive Director	Alan Goldsman, Chief Financial Officer

Executive Summary:
The Reference Cost collection is mandatory for all NHS and Foundation Trusts. The collected reference costs are used to underpin the Payment by Results (PbR) tariffs.

The Trust Board is required to approve the costing process that supports the national Reference Costs submission for 2014/15. The finance and investment committee considered the submission on 22 July and have recommended that the Trust board approve the submission.

The attached report outlines the approach for the calculation of the Trusts Reference Costs, as well as the improvements made from 2013/14 reference costs. An initial Reference Costs submission must be made by 24 July 2015. The deadline for the final submission is 27 July 2015.

Recommendation to the Trust board:
The Trust board is asked to ratify, on the recommendation of the Finance and Investment Committee, the costing process, and the national Reference Costs submission for 2014/15.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Reference Costs Submission – Costing Process

1. Purpose

Similar to 2012/13 reference cost return, the Trust Board is required to approve the costing process that supports the national Reference Costs submission for 2014/15. The Trust Board delegated this approval process to the Finance and Investment Committee (FIC).

This report outlines the approach taken to prepare the Trusts 2014/15 Reference Costs, as well as the improvements made from 2013/14 reference costs.

An initial submission must be made by all Trusts by 24 July 2015. Imperial College Healthcare NHS Trust then has a final submission deadline on 27 July 2015. The Chief Financial Officer is required to sign-off the final submission.

2. Background

The Reference Cost collection is mandatory for all NHS and Foundation Trusts. The Department of Health has collected Reference costs since 1997. Monitor took charge of the collection in 2014/15. The collected reference costs are used to underpin the Payment by Results (PbR) tariffs.

As per the PbR tariffs, Reference Costs cover patient care in a number of settings –

- admitted patients
- non-admitted patients
- emergency medicine
- critical care

Within these settings are further sub-divisions into points of delivery: day cases, elective, non-elective, outpatients and other (direct access and community).

The Trust uses aggregated PLICS (Patient Level Information and Costing Systems) information to inform both Service Line Reporting as well as Reference Costs.

3. 2014/15 Reference Cost Process

The Trust adheres to the 2014/15 Reference Cost Guidance, which outlines the following principles:

(a) *costs will be prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance*
(b) *appropriate costing and information capture systems are in operation*
(c) *costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance*
(d) *procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return*

The Reference Cost process also involves two important external validations. These are:

1. Reconciling reference cost activity against the Hospital Episode Statistics (HES) activity. This task is carried out in conjunction with the Informatics team.
2. Establishing the cost quantum, as per Reference Cost guidance, reconciled to the 2014/15 Trust annual accounts.

Other enabling tasks being undertaken by the profitability and costing team are:

1. Using appropriate cost allocations to assign costs to patients;
2. Frequent validation, such as benchmarking and material variances from last year;
3. Ensuring overall compliance with Reference Cost guidance;

4. Ensuring overall compliance with the HFMA costing standards;
5. Collaborative working with key departments to ensure data is a reflection of the service, such as Income, Audiology, Genito-Urinary Medicine, Pharmacy and Informatics. For example we have worked closely with Pharmacists within Cancer, Clinical Haematology and Paediatrics to identify both the discrete chemotherapy drugs as well as those drugs classed as supportive. A feed from the e-prescribing has also been incorporated within the costing process to ensure that that activity that has not been coded within Cerner is captured.

Appendix A shows the Self-Assessment Quality Checklist which all Trusts have to complete. This acts as an overarching quality assurance mechanism for the submission. The profitability and costing team will keep working papers to evidence against the checklist and these will form a key part in the senior sign off process prior to submission.

4. Other changes in 2014/15 reference cost return

There are two key changes affecting the 2014/15 submission:

1. PAS system: 2014/15 return will be the first return using data from our recently implemented Cerner PAS system.
2. Transitional funding: In 2013/14, the reference costs were reduced by £8.5 million (1.3%) to take into the R&D costs funded from project diamond funding. This funding has ceased in 2014/15, so the cost quantum will no longer be adjusted.

Recommendation to the Trust board

The Trust board is asked to ratify, on the recommendation of the Finance and Investment Committee, the costing process, and the national Reference Costs submission for 2014/15.

GLOSSARY

Reference costs: *Reference costs are the average unit cost to the NHS of providing secondary healthcare to NHS patients.*

Payments by Results (PbR): *PbR is the payment system in England in which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.*

Patient-level Information and Costing System (PLICS): *Patient Level costing as its name implies involves costing hospital activity at the level of the patient.*

Hospital Episode Statistics (HES): *HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. It is a records-based system that covers all NHS trusts in England, including acute hospitals, primary care trusts and mental health trusts. HES information is stored as a large collection of separate records - one for each period of care - in a secure data warehouse.*

PAS: *Patient Administration System*

APPENDIX A: SELF-ASSESSMENT CHECKLIST

Check	Response
Total costs: The reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	o Fully reconciled to within +/- 1% of the signed annual accounts o Fully reconciled to within +/- 1% of the draft annual accounts [state reason]
Total activity: The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	o Fully reconciled and documented o Partly reconciled o n/a – reconciliation completed but to another source [state reason] o Not reconciled
Sense check: All relevant unit costs31 under £5 have been reviewed and are justifiable	o All relevant unit costs under £5 reviewed and justified [state reason] o n/a – no relevant unit costs under £5 within the submission
Sense check: All relevant unit costs over £50,000 have been reviewed and are justified	o All relevant unit costs over £50,000 reviewed and justified [state reason] o n/a – no relevant unit costs over £50,000 within the submission
Sense check: All unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	o All unit cost outliers reviewed and justified [state reason] o n/a – no unit cost outliers within the submission

Check	Response
Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes (the previous year's information is available in the National Benchmarker3)	o All cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission o All cost and activity data within the submission has been benchmarked using another benchmarking process [state] o Some but not all cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission o Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state] o No benchmarking performed on the cost data prior to submission

Data quality: Assurance is obtained over the quality of data for 2014-15	o An external audit has been performed on data quality o An internal audit has been performed on data quality o Internal management checks have provided assurance over data quality o Assurance has been obtained over data quality but not for 2014-15 o No assurance has been obtained over data quality
Data quality: Assurance is obtained over the reliability of costing and information systems for 2014-15	o An external audit has been performed on costing and information system reliability o An internal audit has been performed on costing and information system reliability o Internal management checks have provided assurance over costing and information system reliability o Assurance has been obtained over costing and information system reliability but not for 2014-15 o No assurance has been obtained over costing and information system reliability
Data quality: Where issues have been identified in the work performed on the 2014-15 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2014-15 reference costs submission	o All exceptions have been resolved and the risk of inaccuracy in the 2014-15 reference costs submission fully mitigated o Some exceptions have been resolved but not all o Exceptions have yet to be resolved o n/a – no exceptions noted
Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	o All non-mandatory validations have been considered and necessary revisions made o All non-mandatory validations have been considered and some but not all necessary revisions have been made [specify and state reason] o Some non-mandatory validations have been considered and necessary revisions made [specify and state reason] o No non-mandatory validations have been investigated [state reason] o n/a – no non-mandatory validations have occurred

Imperial College Healthcare NHS Trust

Trust board – public

Agenda Item	4.1
Title	2014 National Adult Inpatient Survey Results
Report for	Noting
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:

The 2014 National Adult Inpatient Survey Results were published by the CQC on 21 May 2015. Overall the survey results show a small improvement on the 2013 survey, with ICHT being rated as "about the same as" other trusts in all sections of the survey.

This paper provides more detailed information and analysis of the results.

Recommendation to the Board:
The Board is asked to note the results

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

1. Introduction

This is the twelfth annual adult inpatient survey. The results were published on the CQC website on 21 May 2015. The survey consists of 70 questions split into 11 sections and was sent to people who were inpatients in one of our hospitals during August 2014.

Overall the survey results show a small improvement on the 2013 survey, with ICHT being rated as "about the same as" other trusts in all sections of the survey. This year, the differential between our most obvious benchmark trusts, Guy' & St Thomas' and UCLH is very small and suggests that the quality of patient experience across all three trusts is similar.

2. Methodology

The survey is administered as a postal questionnaire. A total of 850 Imperial patients were sent a questionnaire. 813 were eligible for the survey of which 301 returned a completed questionnaire, giving a response rate of 37% (national rate = 47%). The full report is available under http://www.cqc.org.uk/provider/RYJ/survey/3

The survey is split into 11 sections; 9 covering various aspects of the patients experience and 2 that focus on overall impressions. These sections are shown in table 1.

3. Results and analysis

Before looking at individual questions and more detailed analysis of the results it is worth considering how the trust performs in relation to its peers. Table 1 shows the section scores and an overall mean of scores for Imperial alongside comparable trusts.

The colours in the table correspond to the 'about the same as', 'better' and 'worse' categories in the report. In past years, Guy's & St Thomas's has clearly performed better than other trusts in this table. However as can be seen, the differential is not that great this year with ICHT, Guy's and St Thomas and UCLH performing 'about the same as' across all sections of the survey.

The final question in the survey asks patients to provide an overall rating of care on a scale of zero to 10. ICHT scored 8.0 in this question.

Table 1: comparative section scores

Survey section	GSTT	UCLH	Imperial	C&W	Barts	NWL Hosp
The emergency/A&E department	8.9	8.7	8.7	9.0	8.6	8.6
Waiting list and admissions	9.0	8.5	8.7	8.7	9.0	8.2
Waiting to get a bed on the ward	7.6	7.6	7.5	7.6	7.3	6.9
The hospital and ward	8.3	8.0	8.0	8.1	7.8	7.8
Doctors	8.7	8.7	8.5	8.6	8.1	8.0
Nurses	8.5	8.2	8.1	8.2	7.9	7.9
Care and treatment	7.9	7.6	7.6	7.7	7.2	7.3
Operations and procedures	8.6	8.4	8.3	8.4	7.8	8.0
Leaving hospital	7.5	7.2	7.1	7.0	6.7	7.0
Overall views of care and services	5.9	5.8	5.8	5.0	5.4	5.0
Overall experience	8.3	8.1	8.0	8.0	7.8	7.7
Summary score (rounded)	8.1	7.9	7.9	7.9	7.6	7.5

In 2013, there were 3 questions where ICHT performed in the 'worse' category.

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

All 3 of these questions have improved in year. Nurses talking in front of patients "as if they weren't there" improved by 2% but remains in the 'worse' category in 2014. At a score of 8.4, this does however suggest that this is not the reported experience of the majority of patients.

In 2014 two other questions were rated as 'worse' than other trusts:

- Did you get enough help from staff to eat your meals? (6.1/10)
- Did hospital staff take your family or home situation into account when planning your discharge? (6.3/10)

Both of these scores are lower than in the previous year and will be subject to further examination and improvement work. The help with meals issue is obviously of concern but may not be as easily explained as it may appear. A recently completed secondary study of the 2012 Inpatient Survey suggests that there is a correlation between ratings of the food choices offered and trust in hospital staff and how people respond to the help with meals question. So, whilst actions to ensure that patients that need help with meals are getting it, tackling this alone may not lead to sustained improvement.

The need to address the issue of trust and confidence in nurses and doctors is further supported by more detailed analysis of the 2014 results by Picker. In this analysis, the correlation of each question to the overall rating of care is undertaken and mapped so that trusts can see the relative importance of questions that it scored well and not so well in.

The 5 questions with the greatest correlation, in descending order, are:

- Overall did you feel you were treated with dignity and respect?
- During your time in hospital did you feel well looked after by staff?
- Did you have trust and confidence in the nurses treating you?
- Did you have trust and confidence in the doctors treating you?
- How clean was the room or ward you were treated in?

Picker's view is that a focus on these key areas will drive an overall improvement in scores across the whole of the survey. It is therefore planned that improvement work will attempt to address these. More often than not, trusts tend to focus on poor scoring questions and, whilst year on year improvements can be achieved, the overall performance does not shift. For example, the question related to explaining how patients would feel after the operation has a low correlation. At ICHT, this question improved 13 percentage points in 2014, but the overall rating of care stayed exactly the same at 8.0.

Although this year's score for the dignity and respect question was reasonable (8.9/10), the top score achieved by a trust was 9.8, suggesting that there remains room for improvement. The ongoing work in relation to values and behaviours and an in-development customer care training programme are expected to drive this score up. Similarly the work related to safe staffing, ward accreditation, intentional rounding and

strengths based recruitment should be expected to lead to improve scores in response to feeling well looked after and the trust and confidence in staff. The new facilities contract provides opportunities to improve the cleanliness scores. The new quality strategy, quality improvement programme and the CQC action plan should all have a positive impact on the survey results.

In essence to achieve improvements in this survey, and ultimately to move into the 'better' category, the approach to needs to be systemic. The Trust saw significant improvements in the national cancer patient experience survey in 2013 and it is believed that this occurred because of cultural shift in the way cancer patients are treated and managed; not because individual questions were addressed. This is the model that should be adopted to improve the inpatient survey.

Of course, in common with the cancer survey, these improvements are not reflected in the survey results overnight and the Trust should be looking to the 2016 survey to see the effect of the work currently underway. The patient sample for the 2015 survey will be drawn from people who are inpatients in the trust in July this year, too early to see the impact of the improvement work already underway.

4. Summary

Overall the results of the 2014 inpatient survey are good. The Trust is performing, in all but three questions, as it is expected to and patients rate their overall experience at 8 out if 10. It is also encouraging to see that the differential between ICHT and the two most obvious comparative trusts, Guy's and St Thomas' and UCLH, is narrowing.

The significant programme of work now being undertaken at ICHT is expected to deliver an improvement in the Trust's performance in this and other surveys, although this may not be apparent in the results until at least the 2016 survey.

Recommendation to the Board:

The Board is asked to note the results

Imperial College Healthcare NHS
NHS Trust

Trust board - public

Agenda Item	4.2
Title	CQC Update Report
Report for	Noting
Report Author	Priya Rathod, Deputy Director of Quality Governance (Nursing Directorate)
Responsible Executive Director	Janice Sigsworth Director of Nursing

Executive Summary

The following report provides an update to the Trust board in relation to the implementation of the compliance and improvement framework and progress against the CQC inspection action plan.

The action plan is being regularly monitored, and progress can be demonstrated across a wide number of the individual actions. There are three areas which have outstanding 'must-do' actions that have not been completed: WHO checklist (x1 action); Medicines management (x2 actions), and Statutory and mandatory training (x3). These are being addressed.

The core service reviews concluded that in a number of areas the actions undertaken to lead to improvement had thus far not had the planned impact, and considered that the rate of implementation of actions needed to increase.

Recommendation

The Trust board is asked to note the paper; particularly, that further action will be undertaken to ensure improved performance against the CQC standards.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

CQC Update Report

1 Background

The Board will be aware from its meeting in May 2015 that a trust-wide Compliance and Improvement Framework Procedure has been developed to ensure that the Trust meets the requirements of its CQC registration and supports the delivery of 'good' and 'outstanding' care. The framework consists of the following components:

- **The CQC intelligent monitoring report (IMR):** These are published twice a year and an update provided in the quarterly CQC reports to the Executive Committee. The last update against the IMR was presented to the Executive Committee on 5th May 2015.

- **Director-led compliance reviews:** In order to ensure on-going compliance with regulatory requirements, a Director lead has been identified for each regulation against which they will undertake a review to determine compliance levels.

- **Core service reviews**: These reviews will be in-depth unannounced improvement reviews and will be undertaken for services which were rated as 'Inadequate' or 'Requires Improvement' by the CQC.

- **Deep dive reviews:** These will be undertaken for:
  - Services where a particular issue or cause for concern has been raised by the CQC that needs further investigation and assurance.
  - Services which were rated as 'Good' by the CQC to test out if that service has maintained this level of rating.

- **Ward accreditation programme:** The programme is designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed.

In addition we have the 'must do compliance' actions, 'must do' and 'should do' actions identified by the CQC during its inspection in September 2014. These are all addressed within the CQC action plan.

2 Purpose

The following report provides an update to the Trust Board in relation to the implementation of the compliance and improvement framework and progress against the CQC inspection action plan.

3 Compliance and Improvement Framework

3.1 Director led compliance reviews

- Learning from other trusts recommends a two phase assurance process.
    - **Phase 1** will consist of each director undertaking a self-assessment against the regulation.
        - A review will take place with each responsible director to consider the outputs and understand how any gaps identified are to be addressed.
        - Any actions will form part of the responsible director's action plan and 2015/16 objectives. Phase 1 will be completed during the summer of 2015.
    - **Phase 2** will consist of a more comprehensive review looking at evidence to underpin compliance and will focus on how the Trust maintains compliance on a quarterly basis going forward. It is anticipated that phase 2 will be implemented later in the year.

3.2 Core service reviews

- These involve a review of services using the five CQC domains.
- Two core service reviews (CSRs) have now been undertaken for: outpatients (across all sites) and for accident and emergency at the St. Mary's site.
- The findings of both reviews demonstrated some examples of good practice as well as areas for further improvement which are already being addressed.
- The next core service reviews will take place in September.
- The reviews concluded that in a number of areas the actions undertaken to lead to improvement had thus far not had the planned impact. The rate of implementation of actions needed to increase.

3.3 Deep dive reviews

- Two deep dive reviews have taken place for: critical care at the Charing Cross site and for maternity and gynaecology services at the St. Mary's site.
- The Trust board will remember from its last meeting that the review of critical care services was undertaken in order to obtain further information and assurance about the process for accessing medical staff out of hours. Whilst a number of actions have been completed, further work is required to evidence improvement, eg auditing of practice.
- The maternity and gynaecology service at St. Mary's was rated as 'Good' by the CQC. The deep dive found that the service has maintained a 'good' rating and many examples of good patient care were observed.
- The next deep dive reviews will commence at the end of July.

3.4 Ward accreditation programme

- The implementation of a ward accreditation programme started in July and it is anticipated that over 60 wards will be accredited by the end of October.
- A Darzi Fellow is currently being appointed to assist in the delivery of the programme, which has been supported and part funded by Health Education North West London.

4 CQC action plan

- All actions within the plan are largely on track. A summary of progress is outlined below.

CQC 'Must-do Compliance' Actions Overview	
Summary of actions	**No.**
Actions completed on time	32
Actions on track	8
Actions completed late	6
Actions off track	0
Actions not completed	9
Total	**55**

CQC 'Must-do' Actions Overview	
Summary of actions	**No.**
Actions completed on time	25
Actions on track	3
Actions completed late	2
Action off track	1
Actions not completed	6
Total	**37**

The exceptions relate to the following areas:

- **Cleaning and decontamination of equipment**
  The actions largely relate to the review, ratification and dissemination of the cleaning and decontamination policies which have been subject to extensive review. The policies will be ratified by September.

- **Outpatients**
  A number of work streams are in place to deliver a programme of improvement for outpatients that include progressing the actions from the CQC inspection.

- **WHO checklist**
  The outstanding action relates to the launch of an enhanced training and education programme which is anticipated to commence in July.

- **Medicines management**
  - The actions relate to the review and subsequent launch of the self-medication policy and the standard operating procedure for the monitoring of room temperatures and the storage of medication.
  - The policy and SOP have been approved by the Drugs and Therapeutics Committee and will be ratified by the end of July.

- **Statutory and mandatory training**
  - The Trust is working to achieving a target of 90% compliance for all areas and the actions within the action plan relate to this.
  - Divisions regularly monitor compliance and have plans in place to improve performance.

5 Recommendation:

- The Trust board is asked to note the paper; particularly, that further action will be undertaken to ensure improved performance against the CQC standards.

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	4.3
Title	Clinical strategy implementation and estates redevelopment
Report for	Discussion
Report authors	Dr William Oldfield, deputy medical director Michele Wheeler, director of planning and redevelopment
Responsible Executive Director	Dr Tracey Batten, chief executive

Executive summary:

The Trust's clinical strategy was approved by the Board in July 2014, together with an outline business case for the estates redevelopment required to support implementation of the clinical strategy.

This paper provides a brief recap on the key elements of the clinical strategy and estates redevelopment plans, an update on work since July 2014 to implement the clinical strategy, and a summary of the process underway to secure investment for redevelopment of our estates.

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.

Background

The Trust's clinical strategy was approved by the Board in July 2014, together with an outline business case for the estates redevelopment required to support implementation of the clinical strategy. The strategy is designed to improve clinical outcomes and patient experience, to help people stay as healthy as possible and to increase access to the most effective specialist care.

The Trust's clinical strategy reflects the wider North West London service reconfiguration programme led by local clinical commissioning groups, *Shaping a healthier future*. It shares the same overarching principles for service change. The key principles of the clinical strategy are to:

- localise where possible
- centralise where necessary
- integrate care across traditional service boundaries
- personalise care and medicine for the individual.

The two key elements of the Trust's clinical strategy framework are:

- developing new care models:
- achieving optimal clinical adjacencies.

The clinical strategy sets out three new models of care, and a fourth has been added as implementation has progressed. The four models of care are:

- systematised planned care
- integrated care
- personalised medicine
- improved urgent and emergency care pathways.

The clinical strategy, together with our new quality strategy (being presented to the July board meeting for approval) and our financial strategy, are the key drivers of our overarching organisational strategy and, as such, for organisational transformation.

These key strategies are supported by a number of enabling strategies covering:

- estates redevelopment
- information and communications technology
- people and organisational development
- education and research
- communications and engagement
- transport.

To achieve optimal clinical adjacencies – how we connect our many different services and specialties across our sites in order to achieve the best clinical outcomes - and to support full implementation of our new models of care, the estates strategy is based on a re-development of our three main sites to have their own distinct, yet interdependent, offer. In addition, there will be integrated services and specialist outpatients operating out of local health and community centres.

Our three-site estates strategy is as follows:

Charing Cross Hospital, Hammersmith

- Evolving to become a new type of local hospital, offering a wide range of specialist, same-day, planned care, as well as integrated care and rehabilitation services for older people and those with long-term conditions. Charing Cross Hospital will retain a 24/7 A&E appropriate to a local hospital.

Hammersmith Hospital/Queen Charlotte's & Chelsea Hospital, Acton

- Building on their reputations as specialist hospitals, with strong research and education links. For Hammersmith Hospital, particularly with regard to renal, haematology, cancer and cardiology care, and maintaining the regional specialist heart attack centre; and for Queen Charlotte's & Chelsea Hospital, with regard to a wide range of maternity, women's and neonatal care. .

St Mary's Hospital/Western Eye Hospital, Paddington

- Developing as the major acute hospital for the region, covering a wide range of specialties. Co-location of hyperacute stroke unit with 24/7 A&E and major trauma centre. Relocation of Western Eye Hospital to the Paddington site. Continuing to provide maternity, neonatology and paediatric services.

Implementation of our clinical strategy

Deputy medical director William Oldfield has been appointed to lead the clinical strategy implementation programme, focusing on quality improvement and financial sustainability to help guide service priorities.

The implementation team are working on one to five year programme – in advance of estates redevelopment – as well as five year-plus plans – for how new care models and clinical adjacencies will work in detail on redeveloped estates.

To inform and support the development of the clinical strategy implementation programme and plans, the Trust is establishing a clinical reference group, a multi-professional and cross-organisational staff forum, and is also exploring the establishment of a similar forum made up of patients and local citizens.

This work builds on progress over the last 12 months in developing new models of care. Highlights include:

Systematised planned care

- Outpatients improvement programme underway.
- Proposals progressing for redevelopment of operating theatres at Charing Cross.

Integrated care

- Selected as lead health provider for tri-borough community independence service effective from 1 April 2015.
- Won a number of tenders to expand our specialist community services, including gynaecology, respiratory, cardiology.

- Preferred provider to take over tri-borough neuro-rehabilitation service.

Personalised medicine

- Designated one of the first 11 NHS genomics medical centres at the end of 2014.
- Leading proposals for the development of a north west London pathology service.

Improved urgent and emergency care pathways

- Closure of Hammersmith Hospital emergency department and investment in St Mary's and Charing Cross A&Es, with urgent care centres on all three main sites.
- Application for North West London to be designated an NHS England urgent and emergency care vanguard.
- Acute medical model planned for autumn 2015 to improve and expand capacity of emergency and urgent care pathways.

Process for securing investment for estates redevelopment

Our outline business case for the estates redevelopment required to support implementation of our clinical strategy was part of a wider bid for investment in the north west London sector led by the local clinical commissioning groups to support implementation of the *Shaping a healthier London* programme. Michele Wheeler has been appointed as Director of Planning & Redevelopment to lead on the estates redevelopment programme.

The following table sets out how that process has worked to date.

Process for securing investment in North West London NHS estates

When	What	How
October 2013	*Shaping a Healthier Future* (SaHF) – service reorganisation strategy for NW London, led by clinical commissioning groups (CCGs), finalised	Following formal public consultation, a 'decision-making business case' (DMBC), was agreed by the Independent Reconfiguration Panel and Secretary of State for Health.
July 2014	Trust's clinical strategy, reflecting SaHF context, published	Informed through intensive engagement with staff, agreed by Trust board.
July 2014	Trust's estates redevelopment proposals agreed	Outline business case (OBC) agreed by Trust board and submitted to CCGs. Included a more significant redevelopment at St Mary's than that envisaged in the DMBC, in order to provide more clinical space and to address the poor state of the estate.

March 2015	NW London estates redevelopment proposals, led by CCGs, submitted to NHS England and NHS Trust Development Authority	OBCs from across NHS in NW London amalgamated to create an 'implementation business case' (ImBC) for SaHF. The IMBC included the Trust's more significant redevelopment at St Mary's.

More recently, NHS England has asked that the local CCGs work with providers, including the Trust, to update the IMBC with the latest financial and activity data and to reflect NHS priorities as set out in their *NHS five year forward view*. The Trust is also taking this opportunity to propose a full redevelopment of the St Mary's estate to reflect more recent analyses establishing a large scale of backlog maintenance and increased potential for financial return from surplus land to offset the development costs.

The Trust has one of the largest backlog maintenance liabilities of all NHS Trusts. This is in large part due to the age of the estate - at St Mary's, dating from 1851, and at Hammersmith, from 1904. In particular it has been known for several years that the outdated estate at St Mary's Hospital is in need of significant investment and redevelopment to meet modern standards.

Progress on the updating of the IMBC – and the case for a full redevelopment of the St Mary's site - will be shared with the Board in its private session. This work will then be picked up the local CCGs and the updated IMBC is due to come back to the Board for formal support in September, when we would also expect to share updates on key aspects of plans and proposals for our estate, including capacity and costs.

The updated IMBC is expected to be submitted to NHS England, NHS Trust Development Authority and Monitor in the autumn, and from there to the Department of Health and Treasury. A decision would be expected by the following autumn, 2016. The next step would be development of a full business case over the next 12 months.

Once the IMBC has been put forward for approval, our focus will be on:

- developing detailed plans and planning application for St Mary's with input from clinicians, wider staff, patients and stakeholders
- working with CCGs on internal and external engagement programme to clarify in detail how Charing Cross can best be developed as a local hospital, and then onto detailed planning and planning application.

Additional work is also being undertaken to explore options for future estates redevelopment at Hammersmith Hospital to improve facilities, enable expansion and tackle backlog maintenance. We are working in close partnership with Imperial College Healthcare Charity and with Imperial College on all our estates proposals and planning.

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	4.4
Title	2015/16 Clean Sheet Review to set Nursing and Midwifery Establishments
Report for	Noting
Report Author	Priya Rathod, Deputy Director of Quality Governance
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:
The Trust has been through a detailed and comprehensive process of clean sheet establishment reviews to set nursing and midwifery establishments. This has been undertaken in partnership with divisions, people and organisation development and finance.

The establishment levels have been set based on patient acuity and dependency, bed numbers and opening hours using approved methodologies, professional judgement and benchmarking data where available. Each ward establishment has been reviewed by the Ward Sister/Divisional Director of Nursing, signed off by the Divisional Management Team and then reviewed and signed off by the Director of Nursing. During July 2015 the Director of Nursing will meet with a sample of Ward Sisters to validate the process and outcomes.

Of residual concern is the ability of the Trust to fill the vacancies and it is an on-going task to achieve the ambitious target of 5% for bands 2-6. This was identified as an issue by the CQC, and remains a challenge in some inpatient areas. It is subject to its own divisional improvement plans.

Our vacancy levels are reflective of the London position as a whole.

Recommendation(s) to the Board:

- To note completion of the 2015/16 clean sheet establishment review process that has been incorporated into the 2016/16 budget setting
- To note the operational risks to safe nurse staffing and mitigation

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

2015/16 Clean Sheet Establishment Reviews

1. Background

The 2015/16 Nursing and Midwifery clean sheet establishment review for inpatient ward areas follows that which was undertaken in 2014. This is an annual activity with a mid-term review. The Trust Board considered a paper presented in May 2014 and approved the recommendation, which included a range of establishment changes.

The 2015/16 clean sheet establishment review has been undertaken at the start of the budget setting for 2015/16. A mid-year review will take place in October/November 2015. The purpose of the clean sheet establishment reviews is to:

- Provide an assurance both internally and externally that ward establishments are safe and that staff are able to provide appropriate levels of care to patients. This is particularly important in light of key recommendations made in the Francis Report (2013), the Berwick Report (2013) and following the National Quality Board publication; "How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability (2013).*
- Ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the fundamental standard of 'staffing'.

Whilst the clean sheet establishment reviews largely focus on inpatient areas, a review has also been undertaken of other areas such as theatres and outpatients. These areas will be incorporated into the process fully for 2016/17.

It is important to note that the NHS Chief Executive has handed over the leadership for safe nurse staffing to the Chief Nursing Officer.

2. Purpose

This report sets out:

- The process for setting establishments and the evidence based tools used for all inpatient ward areas.
- The high level establishment changes by division.
- Highlights of the nursing and midwifery safe staffing initiatives undertaken over the past year.

3. The 2015/16 Clean Sheet Establishment Review Process

- The Trust has a policy in place for the provision of safe nurse and midwife staffing through the clean sheet establishment review process.
- The policy has been reviewed and is out for consultation. It will be presented to the Executive Committee for approval in August 2015. The policy incorporates new national guidance and lessons learnt over the last 18 months.
- The clean sheet establishment review process draws on approved methodology, professional judgement, benchmarking data and Royal College guidelines. The details are set out in **Appendix 1**.

4. Outcome of the 2015/16 Clean Sheet Establishment Review

- Clean sheet establishment reviews were undertaken by Divisional Nurse Directors between November 2014 and January 2015 and finalised from March to May 2015 as part of a budget setting exercise.
- A summary of the review findings can be found in **Appendix 2**.
- A more detailed ward level summary can be found in **Appendix 3.**
- There have been a number of ward acuity, bed base and service changes during 2014/15 which have had an impact on the 2015/16 clean sheet establishment review process. Divisional Nurse Directors have confirmed changes in establishment as a result of these and they are reflected in the 2015/16 baseline budgets.

4.1 Division of Medicine

Establishment required after review March 2014	Establishment required after review March 2015	Difference in WTE
1067.19	1117.77	+50.58

NB: These figures include South Green ward and exclude Renal PIU

4.2 Division of Surgery, Cancer and Cardiovascular Sciences

Establishment required after review March 2014	Establishment required after review March 2015	Difference in WTE
960.21	985.23	+25.02

4.3 Division of Women's and Children

Establishment required after review March 2014	Establishment required after review March 2015	Difference in WTE
581.75	599.25	+17.5

NB: These figures exclude Stanley Clayton, Ambulatory paeds, Westway, outpatients/community and caseload midwives

4.4 Division of Investigative Sciences and Clinical Support

Establishment required after review March 2014	Establishment required after review March 2015	Difference in WTE
544.50	564.16	+19.66

NB: These figures include outpatient areas

4.5 Division of Private Patients

This is the first year private patients have formally been incorporated into the clean sheet establishment review process.

Establishment required after review March 2015
184.90

5. Key safe staffing initiatives undertaken over the past year

5.1 Reporting of actual nursing/midwifery staff worked versus the planned nursing/midwifery staffing levels

- The agreed clean sheet establishment review translates into an establishment, which in turn becomes a roster. Since May 2014 the Trust has been reporting each month on the actual nursing/midwifery staff (registered and care staff) worked versus the planned nursing/midwifery (registered and care staff) staffing levels, for all inpatient ward areas using a retrospective analysis of e-roster. This information is included in the Trust's operational report and the integrated performance scorecard.
- The divisions report on exceptions where the average fill rate is less than 90% for registered staff and less than 85% of care staff. This is in line with the reporting of other Shelford Trusts.
- For each month over the last twelve months the Trust has achieved a fill rate of over 90% for registered staff and over 85% for care staff, for both the day and night.
- Across the Trust, ward sisters/charge nurses act in a supervisory capacity, however on occasions where there are shortfalls in the number of staff working or if the demand for care increases, they will also carry a caseload and care for patients in addition to their supervisory duties. This ensures operational safety.

The Trust continues to have challenges in achieving a 5% vacancy rate and improvements are being made within some areas and a clear vacancy reduction trajectory plan for each division for bands 2-6 is in place and monitored.

In addition, an assurance review of safe staffing levels was carried out by internal audit in November 2014. The review was rated as 'reasonable assurance' and no 'urgent' actions were given.

5.2 The Display and Publication of Staffing Information

- The Trust displays staffing information in all its inpatient ward areas for each shift which includes the actual number of staff versus the planned staff, and the roles and responsibilities for each staff member.
- The Trust publishes the monthly actual vs. planned information together with the establishment reviews on the Trust website.

5.3 Implementation of Safe Care and the mobile matron

- Since May 2014 the Trust has been implementing the HealthRoster v10 module 'SafeCare' to all 55 Inpatient wards. The module enables wards to enter Patient Acuity data at 8am and 8pm every day, allowing wards to have real time visibility of staffing levels required based on patient numbers and patient care needs.
- SafeCare is also available as an application on smart phones/tablets and is known as the 'mobile matron' which is currently being used on an ad-hoc basis by the site team and ward managers. Work is underway through the SafeCare steering group to improve usage of the app.

6. Recommendations

- To note completion of the 2015/16 clean sheet establishment review process that has been incorporated into the 2016/16 budget setting
- To note the operational risks to safe nurse staffing and mitigation

Appendix 1 - Using Evidence Based Tools/Recognised Standards to Undertake the Clean Sheet Establishment Review

- **Evidence Based tools/standards used**

Inpatient Ward Areas

- In order to determine patient acuity and dependency, the safer nursing care tool (SNCT) has been used together with the multipliers from the Association of UK University Hospitals.
- The Royal College of Nursing (RCN) recommendations suggest the skill mix ratio of registered nurse (RN) to unregistered nurse (healthcare assistant/HCA) should be no less than 65:35.
- The Safe Staffing Alliance suggests a nurse to patient ratio no greater than 1:8.
- Recognised standards are used for specialist areas such as critical care and stroke.

Midwifery

- Staffing levels for midwifery are set using the 'Birth rate plus' tool, and the national recommendation of 1:30.

Paediatrics (neonates and intensive care)

- The Paediatric Intensive Care Society 2010 standards are used
- The British Association of Perinatal Medicine (BAPM) staffing standards are used for neonates.

Theatres

- The Association for Peri-Operative Practice

- **The 2015/16 Clean Sheet Establishment Review Process**

- Divisions assess each ward area for patient acuity and dependency using the SNCT.
- The AUKUH multipliers are then used to inform the setting of establishments allied to the acuity and dependency measurement.
- Professional judgement is also applied in addition to this to check and balance the process
- The registered staff to unregistered staff ratios are reviewed
- The registered staff to patient ratios are reviewed
- A further 'uplift' is factored in for when staff are unavailable due to annual leave, sickness, maternity leave and study leave. Previously this has been set at 23% however it has been agreed that 1.5% of the total uplift will be held centrally for maternity leave. The uplift therefore applied is 21.5%.
- The nursing establishment is turned into an operational rota, which determines how many nurses and bands are working on each shift. This can vary from the agreed establishment, for example due to sickness, short notice leave, patients who require one to one care ('Specialling') and additional beds.
- All establishments post-clean sheet establishment review are signed off with a signature by the divisional director of nursing and ward sister/charge nurse.
- The establishments are also approved by the divisional leadership team to include colleagues from finance and people and organisation development.

- The Divisional Directors of Nursing then individually meet with the Director of Nursing to discuss their establishments and confirm in writing that the establishments are correct to provide safe patient care.
- The Director of Nursing also meets with a sample of ward sisters/charge nurses across the hospital sites to sign off their establishments. These meetings will take place in July 2015.
- An assessment against the clean sheet establishment review is undertaken six months after and these are presented to the Director of Nursing, the Executive Committee and to the Trust Board.

Imperial College Healthcare NHS
NHS Trust

Appendix 2 - Summary of clean sheet establishment review March 2015

SUMMARY OF CLEAN SHEET ESTABLISHMENT REVIEW - MARCH 2015

Division	Date of clean sheet review	Tools/standards used	Clean sheet establishment in March 2014 (WTE)*	Clean sheet Establishment in March 2015(WTE)	Gap (+/-) between est review in March 2014 and after review in March 2015	Skill mix (WTE) in March 2014		Skill mix ratio in March 2014		Skill mix (WTE) in March 2015		Skill mix ratio in March 2015	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
Surgery & Cancer	May-15	•AUKUH/SNCT •British Association of Critical Care Nurses standards for nurse staffing in critical care	960.21	985.23	25.02	817.19	143.02	85.3%	14.7%	826.69	158.54	83.9%	16.1%
Investigative Sciences	May-15	Association for Peri-Operative Pratice	544.5	564.16	19.66	413.64	130.86	76.0%	24.0%	427	137.16	75.7%	24.3%
Medicine	May-15	AUKUH/SNCT	1067.19	1117.77	50.58	825.09	242.10	77.3%	22.7%	828.76	265.82	74.1%	23.8%
Private patients	May-15	AUKUH/SNCT	N/a	184.90	N/a	N/a	N/a	N/a	N/a	147.92	36.98	80.0%	20.0%
Women's and Children's		• AUKUH/SNCT											
Gynaecology		•Paediatric Intensive Care Society 2010 standards	43.80	**52.67**	8.87	30.8	13	70.3%	29.7%	38.74	13.93	73.6%	26.4%
Neonates			124.2	**106.51**	-17.69	113.66	10.54	91.5%	8.5%	95.97	10.54	90.1%	9.9%
Maternity		•British Association of Perinatal Medicine staffing standards	285.30	**323.28**	37.98	219.5	65.8	76.9%	23.1%	250.47	72.81	77.5%	22.5%
Paediatrics	May-15	•Birth-Rate Plus	128.45	**116.79**	-11.66	122.95	5.5	95.7%	4.3%	111.29	5.50	95.3%	4.7%
TOTAL			**3153.65**	**3451.31**	**112.76**	**2542.83**	**610.82**			**2726.84**	**701.28**		

Figures reported:
- Exclusions: Women's and Children's: Stanley Clayton, ambulatory paediatrics, westway, outpatient/community and caseload midwives
Medicine: Renal PIU

SUMMARY OF CLEAN SHEET ESTABLISHMENT REVIEW - MARCH 2015

Division	Date of clean sheet review	Tools/standards used	Clean sheet establishment in March 2014 (WTE)*	Clean sheet Establishment in March 2015(WTE)	Gap (+/-) between est review in March 2014 and after review in March 2015	Skill mix (WTE) in March 2014		Skill mix ratio in March 2014		Skill mix (WTE) in March 2015		Skill mix ratio in March 2015	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
Surgery & Cancer	May-15	•AUKUH/SNCT •British Association of Critical Care Nurses standards for nurse staffing in critical care	960.21	985.23	25.02	817.19	143.02	85.3%	14.7%	826.69	158.54	83.9%	16.1%
Investigative Sciences	May-15	Association for Peri-Operative Pratice	544.5	564.16	19.66	413.64	130.86	76.0%	24.0%	427	137.16	75.7%	24.3%
Medicine	May-15	AUKUH/SNCT	1067.19	1117.77	50.58	825.09	242.10	77.3%	22.7%	828.76	265.82	74.1%	23.8%
Private patients	May-15	AUKUH/SNCT	N/a	184.90	N/a	N/a	N/a	N/a	N/a	147.92	36.98	80.0%	20.0%
Women's and Children's		• AUKUH/SNCT											
Gynaecology		•Paediatric Intensive Care Society 2010 standards •British Association of Perinatal Medicine staffing standards •Birth-Rate Plus	43.80	**52.67**	8.87	30.8	13	70.3%	29.7%	38.74	13.93	73.6%	26.4%
Neonates			124.2	**106.51**	-17.69	113.66	10.54	91.5%	8.5%	95.97	10.54	90.1%	9.9%
Maternity			285.30	**323.28**	37.98	219.5	65.8	76.9%	23.1%	250.47	72.81	77.5%	22.5%
Paediatrics	May-15		128.45	**116.79**	-11.66	122.95	5.5	95.7%	4.3%	111.29	5.50	95.3%	4.7%
TOTAL			**3153.65**	**3451.31**	**112.76**	**2542.83**	**610.82**			**2726.84**	**701.28**		
			***excludes ppts**	***includes ppts**	***excludes ppts**	***excludes ppts**				***includes ppts**			

DIVISION OF PRIVATE PATIENTS: Clean sheet establishment review findings - MARCH 2015

Division	Inpatient Ward / Department	Site	Nurse Grade	Clean sheet establishment required after review in March 2015	Skill mix WTE		Skill mix ratio		COMMENTS
					RN	HCA	RN	HCA	
	Lindo General Level 2	SMH	Band 8a	1.00					Level 2, 3, DU and OPD are on one establishment.
			Band 7	1.00					13 Single rooms fully funded
			Band 6	5.50					
			Band 5	9.30					
			Band 3	5.00					
	Lindo General Level 3	SMH	Band 6	0.00					5 Single rooms funded for 5 days and 4 nights
			Band 5	5.90					
	Lindo Day Unit Level 1	SMH	Band 5	4.00					5 Spaces funded from 8-8 Monday to Friday
	Lindo OPD	SMH	Band 7	1.00					7 Rooms funded 8-8 Monday to Friday
			Band 6	1.50					
			Band 5	3.00					
			Band 3	2.00					
				39.20	30.97	8.23	79.00%	21.00%	
	Lindo Theatres	SMH	Band 7	1.00					2 Theatres funded at Mon - Fri and 3rd emergency theatre during week hours. Part funded theatre establishment from NHS to cover out of hours emergencies.
			Band 6	18.00					
			Band 5	4.00					
			Band 3	2.00					
				25.00	23.00	2.00			
	Lindo Maternity Level 3 and 4 and ANC	SMH	Band 8a	1.00					Lindo 3 Labour Ward = 5 rooms Lindo 4 Post Natal = 11 rooms ANC 3xper week 9-5
			Band 7	12.53					
			Band 6	14.22					
			Band 4	8.91					
			Band 3	10.63					
IPH				**47.29**	27.75	19.54			
	15 North	CXH	Band 8a	1.00					15N, 15S, CDU and OPD are all on one establishment.
			Band 7	2.00					1 of these is a theatre coordinator
			Band 6	5.50					19 Single rooms fully funded
			Band 5	18.20					
			Band 3	6.00					
	15 South	CXH	Band 6	2.00					10 beds funded 5 days and 4 nights (5 day ward)
			Band 5	6.00					
			Band 3	2.00					
	Chemo Day Unit	CXH	Band 6	1.00					7 spaces Mon - Fri 9-5
	OPD	CXH	Band 5	1.50					5 rooms Mon- Fri 8-8
				45.20	36.61	8.59	81.00%	19.00%	
	Robert & Lisa Sainsbury Wing Level 4	HH	Band 8a	1.00					Level 3, 4 and OPD are all on one establishment.
			Band 7	1.00					13 Single rooms fully funded
			Band 6	4.61					
			Band 5	12.10					
			Band 3	4.00					
	Robert & Lisa Sainsbury Wing Level 3	HH	Band 6	1.00					This ward currently opens for over flow with a small number of funded posts, 2 beds funded for ad hoc flex.
			Band 5	2.00					Capacity is 13 single rooms but this is currently unfunded.
			Band 3	1.00					
	Robert & Lisa Sainsbury Wing OPD	HH	Band 5	1.50					5 rooms Mon - Fri 8-8
				28.21	22.85	5.36	81.00%	19.00%	
Total Establishment				**184.90**	**141.18**	**43.72**	**80%**	**20%**	
				-2.70					

DIVISION OF SURGERY: Clean sheet establishment review findings - MARCH 2015

Division	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Clean sheet establishment required after review (WTE) in March 2014	Clean sheet establishment required after review in March 2015	Skill Mix WTE		Skill Mix Ratio		COMMENTS
							RN	HCA	RN	HCA	
	6 South Ward	CXH	25		**36.25**	**34.25**					The reduction relates to a change in the acute oncology service
	6 South Ward	CXH	25	7	**3**		3.00				
				6	**9**		9.00				
				5	**15**		13.00				
				3	**3**			3.00	73%	27%	
				2	**6.25**			6.25			
	6 North Ward	CXH	26		**30.5**	**30.50**					
	6 North Ward	CXH	26	7	**1**		1.00				
				6	**4**		4.00				
				5	**18**		18.00				
				3	**2**			2.00	75%	25%	
				2	**5.5**			5.50			
	Ward 7 North - Gi	CXH	26		**36.75**	**36.75**					
	Ward 7 North - Gi	CXH	26	8A	**1**		1.00				
				6	**4**		4.00				
				5	**24**		24.00				
				3	**2**			1.00	79%	21%	
				2	**5.75**			6.75			
	Ward Riverside	CXH	26 + 18 trollies		**30**	**47.50**					Establishment in March 2014 was funded for 18 beds. Establishment for May 2015 is funded for 26 beds. Increase in bed base due to post-marjory warren ward closure and an increase in the acuity and case mix of patients.
	Ward Riverside	CXH	26	7	**1**		1.00				
				6	**3**		5.00				
				5	**22**		25.50				
				3	**2**			3.00	66%	34%	
				2	**2**			13.00			
	Alex Cross Eye Ward	WEH	4		**15.83**	**15.86**					
	Alex Cross Eye Ward	WEH	4	5	**11.33**		11.36				
				2	**4.5**			4.50			

HH CITU (A6)	HH	16		**64.56**	**61.56**			98%	2%	2 posts transferred to GICU and skill mix reviewed to increase by 1 band 7, 1 band 6 reduce band 5.
HH CITU (A6)	HH	16	8A	**1**		1.00				
			7	**5**		6.00				
			6	**21.74**		22.74				
			5	**35.82**		30.82				
			2	**1**			1.00			
Zachary Cope Ward	SMH	22 inc. 5 HDU beds		**49.75**	**47.60**					Establishment reduced post-review
Zachary Cope Ward	SMH	22	8A	**1**		1.00				
			6	**12.75**		12.75				
			5	**25**		24.22				
			3	**5**			3.63			
			2	**6**			6.00	78%	13%	
HH CCL & Day-Ward Nurse Staff	HH	12		**39.63**	**41.93**					Increased post HH EU closure due to pathyway changes
HH CCL & Day-Ward Nurse Staff	HH	12	8A	**1**						
			7	**1**		1.00				
			6	**13.6**		16.60				
			5	**16.23**		16.53				
			3	**5**			4.00			
			2	**2.8**			3.80			
Weston Ward	HH	14		**23**	**22.80**					
Weston Ward	HH	14	7	**1**		0.80				
			6	**7**		8.00				
			5	**13**		12.00				
			3	**1**				91%	9%	
			2	**1**			2.00			
D7 - Clinical Haem Ward	HH	16		**21**	**27.00**					Establishment in March 2014 was funded for 12 beds. Establishment for May 2015 is funded for 16 beds.
D7 - Clinical Haem Ward	HH	16	7	**1**		1.00				
			6	**6**		6.00				
			5	**10**		17.00				
			3	**2**			1.00	89%	11%	
			2	**2**			2.00			
Dacie Ward	HH	14		**24**	**24.00**					
Dacie Ward	HH	14	7	**1**		1.00				
			6	**9**		8.00				
			5	**12**		13.00				
			3	**2**			2.00	92%	8%	
11 West/ North	CXH	14		**85.48**	**85.90**					
11 West/ North	CXH	14	8A	**1**		1.00				
			7	**10.45**		9.87				
			6	**27.49**		27.49				
			5	**42.54**		42.54				
			3	**4**			4.00			
							1.00			

Division of Surgery, Cancer & CV	10 South	CXH	23		**30**	**31.00**					New tracheostomy nurse included in the establishment.
	10 South	CXH	23	8A	**1**		1.00				
				6	**6**		6.00				
				5	**18**		18.00				
				3	**4**			4.00	81%	19%	
				2	**1**			2.00			
	Western Eye A&E/OPD/DSU	WEH	0		**10.8**	**20.40**					Establlishment in March 2014 was for A&E at WEH. Establishment for May 2014 includes OPD and DSU
	Western Eye A&E/OPD/DSU	WEH	0	6	**1**		2.00				
				5	**9.8**		11.40				
				3				6.00			
				2				1.00			
	A7	HH	27		**35.77**	**35.77**					
	A7	HH	27	8A	**1**		1.00				
				6	**7.67**		6.67				
				5	**22.1**		22.10				
				3	**4**			4.00	83%	17%	
				2	**1**			2.00			
	A8	HH	24		**27.43**	**31.93**					Establlishment in March 2014 was funded for 20 beds. Establishment for May 2014 is funded for 24 beds.
	A8	HH	20	8A	**1**		1.00				
				6	**3**		3.00				
				5	**16.93**		22.93				
				3	**2**			2.00	84%	16%	
				2	**4.5**			3.00			
	A9	HH	20		**24.22**	**25.00**					
	A9	HH	20	7	**1**		1.00				
				6	**4.61**		5.00				
				5	**13**		13.00				
				3	**2.61**			2.00	76%	24%	
				2	**3**			4.00			
	Major Trauma	SMH	16		**30**	**30.00**					
				8A	**1**		1.00				
				6	**7.48**		7.48				
				5	**15.52**		15.52				
				3	**3**			3.00	80%	20%	
				2	**3**			3.00			
	Valentine Ellis	SMH	24		**28.12**	**28.22**					Trauma Co-ordinator post funded
	Valentine Ellis	SMH	24	8A	**1**		1.00				
				6	**5**		5.00				
				5	**15.51**		15.61				
				3	**1**			1.00	77%	23%	
				2	**5.61**			5.61			

Charles Pannett	SMH	25		**38.61**	**42.11**				HCA establishment increased to help maintain cleanliness and minimise IPC risks. This is in reponse to an outbreak of C.Diff and cross transfer of MRSA.
Charles Pannett	SMH	25	8A	**1**		1.00			
			6	**9.61**		9.61			
			5	**22**		22.00			
			3	**3**			3.00	77%	23%
			2	**3**			6.50		
Paterson	SMH	14		**21.5**	**24.00**				Increase in establishment to reflect increase in acuity.
Paterson	SMH	14	8A	**1**		1.00			
			7	**1**		1.00			
			6	**2**		3.00			
			5	**12.5**		13.00		75%	25%
			3	**2**			1.00		
			2	**3**			5.00		
Albert	SMH	20		**33**	**31.00**				Establishment reduced post-review
Albert	SMH	20	7	**1**		1.00			
			6	**4**		4.00			
			5	**16**		15.00			
			3	**1**			1.00	65%	35%
			2	**11**			10.00		
AICU	SMH	16		**101.94**	**98.05**				Establishment reduced post-review
AICU	SMH	16	8A	**1**		1.00			
			7	**10**		10.21			
			6	**33.94**		34.84			
			5	**53**		49.00			
			2	**4**			3.00	97%	3%
GICU	HH	11		**70.15**	**80.29**				Establlishment in March 2014 was funded for 11 beds. Establishment for May 2014 is funded for 14beds.
GICU	HH	11	8A	**1**		1.00			
			7	**5.86**		6.98			
			6	**25.29**		24.83			
			5	**35**		44.48		96%	4%
			3	**3**			3.00		
7 South	CXH	25		**31.81**	**31.81**				
7 South	CXH	25	8A	**1**		1.00			
			6	**5**		5.00			
			5	**17.81**		17.81			
			2	**6**			6.00	75%	25%
			3	**2**			2.00		
TOTALS				**960.21**	**985.23**	**826.69**	**158.54**	**84%**	**16%**	

DIVISION OF INVESTIGATIVE SCIENCES AND CLINICAL SUPPORT : Clean sheet establishment review findings - MARCH 2015

Division	Code	Inpatient Ward / Department	Site	Number of theatres	Nurse grade	Clean sheet establishment required after review (WTE) in March 2014	Clean sheet establishment required after review in March 2015	Skill mix WTE		Skill mix ratio		COMMENTS
								RN	HCA	RN	HCA	
	TH110	Theatres Main Cx	CXH									
					Band 8a	1	1	1				
					Band 7	11	10	10				
					Band 6	41	43	43				
					Band 5	55	65	65				
					Band 3	8	8		8			
					Band 2	15	17.43		17.43			
	TH110	Theatres Main CX	CXH			**131**	**144.43**			82%	18%	Increase due to additional theatre sessions.
	71800	Theatres Main Hh	HH									
					Band 8a	1	1	1				
					Band 7	8	8	8				
					Band 6	32	25.13	25.13				
					Band 5	38	37.7	37.7				
					Band 3	2	2		2			
					Band 2	14	17.3		17.3			
	71800	Theatres Main HH	HH			95	**91.13**			79%	21%	Reflects activity required for 2015
	THE01	Main Theatre	SMH									
					Band 8a	1	1	1				
					Band 7	9	11	11				Band 7 educator post transferred from CXH
					Band 6	71	68.62	68.62				
					Band 5	66	66.36	66.36				
					Band 3	16	11.45		11.45			
					Band 2	18	15		15			
	THE01	Main Theatre	SMH			181	**173.43**			85%	15%	Reflects activity required for 2015
	63000	Radiology Nursing	ALL									

Division of Investigative Sciences				7	Band 8a	1	1	1				
					Band 7	3	3	3				
					Band 6	7	8.75	8.75				
					Band 5	11	14.75	14.75				
					Band 3	1	0		0			This post has been moved to imaging
					Band 2	5.43	4.43		4.43			
	63000	Radiology Nursing	ALL			28.43	**31.93**			86%	14%	Increase in establishment due to increase in activity.
		Pre-assessment	ALL									
					Band 8a	1	1	1				
					Band 7	1	1	1				
					Band 6	5.64	4	4				
					Band 5	2	6	6				
					Band 3	2	3		3			
		Pre-assessment	ALL			11.64	**15**			80%	20%	Increase in establishment due to POA business case
	84800	Sir John Mcmichael Centre	HH									
					Band 8a	1	1	1				
					Band 7	6	6	6				
					Band 6	11	11	11				
	84800	Sir John McMichael Centre	HH			18	**18**			100%	0	
		OPD	SMH/SCH									
					Band 7	1	1	1				
					Band 6	0	0	0				
					Band 5	9	9	9				
					Band 3	8.86	17.75		17.75			
					Band 2	8.57	8.57		8.57			
		OPD	SMH/SCH			27.43	**36.32**			28%	72%	Additional posts added are conversion of temporary staff (floor walkers) to substantive
		OPD	HH/CXH									
					Band 8a	1	1	1				
					Band 6	6	7	7				
					Band 5	13	13.69	13.69				
					Band 3	28	28.23		28.23			
					Band 2	4	4		4			
		OPD	HH/CXH			52	**53.92**			40%	60%	2.6 Band 4 posts in dental
TOTAL						**544.5**	**564.16**	**427**	**137.16**	**76%**	**24%**	**INCLUDING OPD**

DIVISION OF MEDICINE: Clean sheet establishment review findings - MARCH 2015

Division	Inpatient Ward / Department	Site	Number of beds	Nurse Grade	Clean sheet establishment required after review (WTE) in March 2014	Clean sheet establishment required after review in March 2015	Skill mix WTE		Skill mix ratio		COMMENTS
							RN	HCA	RN	HCA	
	CX A&E	CXH	N/A		**54.00**	**65.64**	57.64	8.00	88%	12%	RMN posts in the day, introduction of nurse coordinator role and introduction of a
				8a	1.00	1.00					
				7	8.00	9.00					
				6	15.00	18.00					
				5	24.00	29.64					
				3	2.00	6.00					
				2	4.00	2.00					
	A&E HH	HH	N/A		**29.60**	Closed					
				7	3.00						
				6	6.00						
				5	18.60						
				2	2.00						
	A&E SMH (including paeds)	SMH	N/A		**59.63**	**97.68**	87.68	10.00	90%	11%	Establishment includes paediatrics and additional hours, a 4 hours guardian role and new RMN posts.
				8a	1.00	1.00					
				7	10.06	11.10					
				6	18.65	31.38					
				5	25.92	44.20					
				3	4.00	10.00					
				2 (HK)							
			N/A			15.60					
			N/A	7.00		1.00					
				6	15.12	9.60					
				5	2.00	4.00					
				3	7.12	1.00					
					5.00						
					1.00						

A&E Ward CX	CXH	10 beds + 8 trollies		**27.00**	**27.00**	19.00	8.00	70%	30%	
			7	1.00	1.00					
			6	3.00	3.00					
			5	15.00	15.00					
			3	4.00	4.00					
			2	4.00	4.00					
DAAU moving to 4 separate cost centres	SMH			**27.40**	**27.40**	27.40	0.00	100%	0%	
HDU	SMH	5 level 2 + 5 isolation	7	1.00	1.00					
HDU	SMH	5 -10 level 1 & 2	6	10.56	10.56					
			5	15.84	15.84					
CDU + A.Care	SMH	12.00		**17.84**	**22.25**	14.02	8.23	63%	37%	Establishment increased due ot addiitonal activity. This also includes the Pickering Unit.
CDU + A.Care	SMH	12.00	7	1.00	1.00					
			6	3.00	3.00					
			5	11.84	10.02					
			3	1.00						
			2	1.00	8.23					
Joseph Toynbee	SMH	16.00		**22.28**	**22.12**	16.84	5.28	76%	24%	
Joseph Toynbee	SMH	16.00	7	1.00	1.00					
			6	5.44	5.28					
			5	10.56	10.56					
			2	5.28	5.28					
AMU	SMH	10 beds + 8 trollies		**22.12**	**26.84**	19.84	7.00	74%	0.26	Increased uoe to extended hours for ambulatory care.
AMU	SMH	10 beds + 8 trollies	7	1.00	1.00					
			6	5.28	5.28					
			5	10.56	13.56					
			2	5.28	7.00					
5 South Ward Cardiology	CXH	9 level 2		**25.76**	**27.40**	27.40	0.00	100%	0.00	Increase in establishment due to acuity.
			7	1.00	1.00					
			6	8.15	10.56					
			5	16.61	15.84					
8 West Ward	CXH	22		**32.50**	**32.50**	20.50	12.00	63%	37%	
8 West Ward	CXH	22	7	1.00	1.00					
			6	3.00	3.00					
			5	16.50	16.50					
			2	12.00	12.00					
South Green Ward	CXH	15		**15.00**	**15.00**	11.00	4.00	73%	27%	
			7	1.00	1.00					
			6	2.00	2.00					
			5	8.00	8.00					
			3	4.00	4.00					
Ward 5 West - Acute Admissions	CXH	26		**38.00**	**39.85**	30.85	9.00	77%	23%	Increase in establishment due to acuity.
			8a	1.00	1.00					
			6	9.00	9.00					
			5	17.00	20.04					
			3	7.00	4.81					
			2	4.00	5.00					

	4 South	CXH	21		**27.50**	**27.50**	19.53	7.98	71%	29%	
				7	1.00	1.00					
				6	4.00	4.00					
				5	14.50	14.50					
				2	8.00	8.00					
	9 North Hasu	CXH	20		**49.00**	**49.00**	40.18	8.82	82%	18%	
				8a	1.00	1.00					
				6	11.00	11.00					
				5	28.00	28.00					
				2	9.00	9.00					
	Ward 8 South	CXH	25		**35.85**	**35.85**	22.59	13.26	63%	37%	
			25	8a	1.00	1.00					
				6	4.00	4.00					
				5	17.85	17.85					
				3	5.00	5.00					
				2	8.00	8.00					
	9 South Ward Medicine	CXH	26		**32.80**	**32.80**	22.30	10.50	68%	32%	
				7	1.00	1.00					
				6	4.00	4.00					
				5	17.20	17.20					
				3	7.00	7.00					
				2	3.60	3.60					
Division of Medicine	Stroke Unit/ New 9 West	CXH	20		**29.00**	**29.00**	19.00	10.00	66%	34%	
			20	7	1.00	1.00					
				6	5.00	5.00					
				5	13.00	13.00					
				2	10.00	10.00					
	Lady Skinner Ward	HH	15		**22.00**	**22.00**	15.00	7.00	68%	32%	
			15	7	1.00	1.00					
				6	2.00	2.00					
				5	12.00	12.00					
				2	7.00	7.00					
	Ward B1 Spam/Smac	HH			**25.00**	**18.82**	16.22	2.60	86%	14%	
				8a		1.00					
				7	1.00	3.00					
				6	5.00	5.22					
				5	14.00	7.00					
				2	5.00	2.60					
	Fraser Gamble Ward	HH	29 (21 in 2015/16)		**35.00**	**30.00**	19.50	10.50	65%	35%	Fraser Gamble has now reduced to 21 beds and is not being flexed so the posts have been removed
			29	8a	1.00	1.00					
				6	4.00	4.00					
				5	18.00	14.50					
				2	12.00	3.00					
						7.50					
	John Humphrey Ward	HH	21		**27.26**	**27.26**	17.26	10.00	63%	37%	
			21	7	1.00	1.00					
				6	3.00	3.00					
				5	13.26	13.26					
				2	10.00	10.00					

Christopher Booth Ward	HH	28		**33.00**	**33.00**	24.00	9.00	73%	27%	
			7	1.00	1.00					
			6	5.00	5.00					
			5	18.00	18.00					
			2	9.00	9.00					
Manvers	SMH	26		**33.00**	**33.00**	24.00	9.00	73%	27%	
		26	8a	1.00	1.00					
			6	7.00	7.00					
			5	16.00	16.00					
			3	3.00	3.00					
			2	6.00	6.00					
Samuel Lane Ward	SMH	24		**33.00**	**33.00**	22.50	10.50	68%	32%	no change establishment for 24 beds
		24	8a	1.00	1.00					
			6	4.00	4.00					
			5	17.50	17.50					
			3	2.00	2.00					
			2	8.50	8.50					
Thistle	SMH	20		**24.00**	**27.40**	19.40	8.00	71%	29%	
		20	7	1.00	1.00					
			6	2.00	2.00					
			5	14.00	16.40					
			3	2.00	2.00					
			2	5.00	6.00					
Grafton	SMH	16		**22.00**	**24.80**	16.80	8.00	68%	32%	
		16	7	1.00	1.00					
			6	4.00	4.00					
			5	11.00	11.80					
			3	6.00	8.00					
Witherow Ward	SMH	12		**22.00**	**24.80**	14.24	10.56	57%	43%	
			8a	1.00	1.00					
			6	3.00	3.00					
			5	12.00	10.24					
			3	2.00	2.00					
			2	4.00	8.56					
Lewis Lloyd Ward	SMH	14			**24.80**	14.24	10.56	57%	43%	
			7		1.00					
			6		3.00					
			5		10.24					
			3							
			2		10.56					
Almroth Wright	SMH	15		**20.00**		Combined with Rodney porter				
			8a	1.00						
			6	3.00						
			5	11.00						
			3	3.00						
			2	2.00						
Rodney Porter / Almroth Wright	SMH	8		**15.90**	**35.90**	25.50	10.40	71%	29%	Rodney Porter and Almroth Wright are now under one cost code and establishments have been combined. No change to establishment
		8.00		2.00	1.00					
			5	8.50	5.00					
			2	5.40	19.50					
					8.40					
					2.00					

C8	HH	15 - 20		**24.80**	**35.33**	27.53	7.80	78%	22%	Establishment is now fully funded for 20 beds therefore establishment increased.
			7	1.00	1.00					
			6	4.00	6.00					
			5	14.50	20.53					
			2	5.30	7.80					
10 North Ward Neurology & PIU	CXH	15 + 7 PIU		**28.00**	**28.00**	23.00	5.00	82%	18%	
		15 + 7 PIU	8a	1.00	1.00					
			6	6.00	6.00					
			5	16.00	16.00					
			3	4.00	4.00					
			2	1.00	1.00					
11 South Neurosurgery	CXH	25		**38.83**	**38.83**	33.00	5.83	85%	15%	
			7	1.00	1.00					
			6	6.00	6.00					
			5	26.00	26.00					
			3	5.00	5.00					
			2	0.83	0.83					
Piu (Planned Inv. Unit) Renal	HH	18 day case		**8.20**	**8.20**	6.20	2.00	76%	24%	
	HH		7	1.00	1.00					
			6	3.00	3.00					
			5	2.20	2.20					
			3	1.00	1.00					
			2.00	1.00	1.00					
Handfield Jones Ward	HH	21		**27.00**	**27.00**	19.00	8.00	70%	30%	
		21	8a	1.00	1.00					
			6	4.00	4.00					
			5	14.00	14.00					
			2	8.00	8.00					
Peters Ward	HH	24		**27.00**	**27.00**	19.00	8.00	70%	30%	
		24	8a	1.00	1.00					
			6	4.00	4.00					
			5	14.00	14.00					
			2	8.00	8.00					
De Wardener Ward	HH	12		**22.00**	**22.00**	21.00	1.00	95%	5%	
		12	7	1.00	1.00					
		level 1 & 2	6	10.00	10.00					
			5	10.00	10.00					
			2	1.00	1.00					
Kerr Ward	HH	22		**27.00**	**27.00**	19.00	8.00	70%	30%	
			7	1.00	1.00					
			6	4.00	4.00					
			5	14.00	14.00					
			2	8.00	8.00					
TOTALs				**1067.19**	**1117.77**	**845.96**	**271.82**	**76%**	**24%**	**INCLUDING SOUTH GREEN EXCLUDING RENAL**

DIVISION OF WOMEN'S AND CHILDREN'S: Clean sheet establishment review findings - MARCH 2015

Division	Code	Speciality	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Clean sheet establishment required after review (WTE) March 2014	Clean sheet establishment required after review in March 2015	Skill mix		Skill mix ratio		COMMENTS
									RN	HCA	RN	HCA	
	58900		Victor Bonney Ward	HH	20	Band7	1	1					clean sheet funded from July
						Band 6	3	3					
						Band 5	16	19.4					
						Band 3	1	0					
						Band 2	5	7.52					
	58900	Gynaecology	Victor Bonney Ward	HH	24		**26**	**30.92**	23.4	7.52	68%	32%	
	GYN02		Lillian Holland Ward	SMH	13	Band 7	1	1.00					appeas higher unqualified skill mix as Patin unit TOP service staffed from here too and has HCA
						Band 6	2	3.00					
						Band 5	7.8	11.34					
						Band 3	1	0.00					
						Band 2	6	6.41					
	GYN02	Gynaecology	Lillian Holland ward	SMH	13		**17.8**	**21.75**	15.34	6.41	71%	29%	clean sheet funded from July
	46500		QCCH Neonates	QCCH		Band 7	5	5.00					
					24	Band 6	49.7	49.70					
						Band 5	11.25	2.97					
						Band 4	4.6	4.60					
	46500	Neonates	QCCH Neonates	QCCH			**70.55**	**62.27**	57.67	4.60	93%	7%	QCCH - 8a needs to be added to current and proposed establishment NB band 7 educator not included
	NEO09		Winnicott Baby Unit	SMH	22	Band 7	8	8.00					
					19	Band 6	23.46	22.30					
						Band 5	16.25	8.00					
						Band 4	5.94	5.94					
	NEO09	Neonates	Winnicott Baby Unit	SMH			**53.65**	**44.24**	38.30	5.94	87%	13%	SMH - 8a and band 3needs to be added to current and proposed establishment. Current will then = 46.24 = trifold
	54700	Maternity	QCCH Maternity Inpatient	QCCH	19	Band 7	25	26.07					
					72	Band 6	84	115.5					
						Band 5	9	6					
						Band 3	28.5	26.74					
						Band 2	11.8	14.58					
	54700	Maternity	QCCH Maternity Inpatient	QCCH			**158.3**	**188.89**	147.57	41.32	78%	22%	this now meets 1:30 and ealing activity
	MAT10		SMH Maternity / Inpatient	SMH	72	Band 7	22	22.44					
					57	Band 6	77.5	77.46					
						Band 5	2	3					
						Band 3	18.5	21.49					
						Band 2	7	10					
	MAT10	Maternity	SMH Maternity / Inpatient	SMH			**127**	**134.39**	102.9	31.49	77%	23%	now meets 1:30 and Ealing activity
Division of Womens & Childrens	56300		Stanley Clayton Ward Priv Pats	QCCH	57	Band 7	1.8	1.7					
					7	Band 6	4	4					
						Band 3	4	5.2					
						Band 2	2						
	56300		Stanley Clayton Ward Priv Pats	QCCH			**11.8**	**10.9**	5.7	5.2	52%	48%	this now meets 1:30 and ealing activity
	62200		Ambulatory Paeds	HH	7	Band 7	1	0.5					
					9	Band 6	4	4					
						Band 5	1	1					
						Band 3	1	1					
						Band 2	0						
	62200		Ambulatory Paeds	HH			**7**	**6.5**	5.5	1	85%	15%	
	PAE01		Westway +Haem day unit	SMH	9	Band 7	1	1.5					
					9	Band 6	2	2					
						Band 5	5	5					
						Band 3	2	2					
	PAE01		Westway	SMH			**10**	**10.5**	8.5	2	81%	19%	

PAE02		Grand Union	SMH	9	Band 7	1	1					
				14	Band 6	11	6.7					
					Band 5	24.75	21.31					
PAE02	Paediatrics	Grand Union	SMH			**36.75**	**29.01**	29.01	0	100%	0%	Review of haematology service being completed - temporary reduction in BMT activity and consequent reduction in acuity in patients on GU ward
PAE03		Great Western/PSSU Staff	SMH	14	Band 8a	1	1					
				24	Band 7	1	0.5					
					Band 6	8.63	8.63					
					Band 5	24.37	20.85					
					Band 3	5.5	5.5					
PAE03	Paediatrics	Great Western/PSSU Staff	SMH			**40.5**	**36.48**	30.98	5.5	85%	15%	Current establishment previously 35.98. + 0.5 wte band 7 for PSSU and day care = 36 48
PAE07		Paediatrics ICU	SMH	24	Band 8a	1	1					
				8	Band 7	10.49	10.49					
					Band 6	21.49	21.49					
					Band 5	18.22	18.32					
PAE07	Paediatrics	Paediatrics ICU	SMH			**51.2**	**51.3**	51.3	0	100%	0%	
MAT04		SMH Community / Outpatient	SMH	8	Band 7	7.06	7.92					this now meets 1:30 and ealing activity
				0	Band 6	2.8	30					
					Band 2	1.6	3					
					Band 3	8.03	7					
MAT04	maternity	SMH Community / Outpatient	SMH			**19.49**	**47.92**	37.92	10	79%	21%	this now meets 1:30 and ealing activity
47100		Caseload Midwives	HH	0	Band 7	17.8	12.6					
				0	Band 6	7.5						
					Band 8a	1						
47100		Caseload Midwives	HH			**26.3**	**12.6**	12.6	0	100%	0%	this now meets 1:30 and ealing activity
55500		QCCH Community / Outpatient	QCCH	0	Band 7	4.65	12.3					
				0	Band 6	26.64	32.88					
					Band 3	6	8					
					Band 2	2	2					
55500	maternity	QCCH Community / Outpatient	QCCH			**39.29**	**55.18**	45.18	10	82%	18%	this now meets 1:30 and ealing activity
TOTAL						**581.75**	**599.25**	**496.47**	**102.78**			**EXCLUDING PPts, amb paeds, westway, o/pt and caseload midwives**

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	4.5
Title	ICHT Research update
Report for	Noting
Report Author	Prof Jonathan Weber (AHSC Director) & Dr Paul Craven (Head of Clinical Research Operations)
Responsible Executive Director	Dr Chris Harrison (Medical Director)

Executive Summary:

This report presents an update review of research highlights across Imperial College Healthcare NHS Trust (ICHT) and the Imperial Academic Health Science Centre (AHSC) in 2014/15. As well as specific examples of research progress with the potential to benefit patients, the report also includes the successes achieved in growing ICHT research capacity and capability, performance metrics, and in developing collaborations across the NW London sector. It also outlines the plans and key priorities for the next 12-24 months.

Recommendation(s) to the Board:

The Board is asked to note the research update for ICHT.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

ICHT Research Update

Purpose of the Report

To present highlights of research progress from the 2014/15 financial year; the third year of the current 5-year NIHR Imperial BRC programme and a key period for investment to deliver outputs before the re-application process. Slides accompany this summary paper.

Summary

In this 12-month period, following a mid-term review of the BRC, we have established the Institute of Translational Medicine & Therapeutics (ITMAT). ITMAT is built upon a number of core technology platforms across Imperial College and ICHT, in which the BRC has invested significantly in recent years. These range from gene sequencing and genome informatics facilities to the range of analytical techniques provided through the Imperial Clinical Phenotyping Centre, which aims to help doctors diagnose illness more efficiently and choose the best treatments based on a patient's individual metabolic and physiological characteristics. Other facilities include MRI and PET imaging and biobanks which store human tissue samples for research, and the NIHR / Wellcome Trust Clinical Research Facility.

We present several examples of early translational clinical research (facilitated by the Imperial Joint Translation Fund) – demonstrating how a strong pipeline of discovery science is established – and building on the strengths of Imperial College London and its multi-disciplinary Faculties of Medicine, Engineering and Natural Sciences. The Joint Translation Fund is a scheme designed to accelerate clinical and biomedical translation, which is worth £1.3m (contributions from MRC, BRC, Wellcome Trust, EPSRC , Imperial Innovations, Royal Marsden and Chelsea & Westminster). There is also a growing body of evidence demonstrating that BRC-funded / supported projects are progressing to attract significant additional grant awards ('pull through').

2014/15 saw further growth in ICHT commercial clinical trial activity and income. We present these data and explain how we are now incentivising clinical investigators in this area, with the intention of growing activity still further.

We review our performance in terms of the NIHR targets for initiating and delivering clinical trials to time and target. ICHT's performance has improved significantly over the year, and we now compare very favourably with our comparator organisations across both metrics.

We describe plans to recruit a new cohort of clinical academics in key strategic areas within the AHSC.

ICHT was successful in a competitive process to host the NW London Clinical Research Network (NWL CRN) from 1 April 2014 (with a budget of ~£13m per annum), following a national re-organisation of the NIHR Clinical Research Network. We include a brief review of the first year of the NWL CRN and the contribution of ICHT to its success.

2014/15 also saw the launch of NHS Genomics Medicine Centres (to deliver the Prime Minister's 100K Genomes initiative). In December 2014, it was announced that ICHT had been successful in bidding to host one of the first wave of NHS Genomic Medicine Centres – the mechanism by which the NHS will deliver the 100,000 Genomes Project.

December 2014 also saw the release of the results of the most recent Research Excellence Framework (REF) – the periodic exercise to assess the quality of research in

UK universities – in which Imperial College produced its best ever performance..

We recap on some major new NIHR infrastructure awards). Beginning April 2014, and following a national competition, Imperial was awarded four new NIHR Health Protection Research Units (HPRUs) worth £12m over 5 years, in partnership with Public Health England (PHE); these will provide centres of excellence in multi-disciplinary health protection research. Following a separate competition, Imperial was also awarded an NIHR Diagnostic Evidence Collaborative (DEC), worth £1m over 5 years, to develop in vitro diagnostic / device technologies.

Finally, we describe how we involve and engage patients and the public in our research (PPI/E). PPI/E activities run through all workstreams of the NIHR Imperial BRC, and we have established a cross-sector PPI Forum (through Imperial College Health Partners) for best practice and joint projects. The Imperial Patient Experience Research Centre (PERC) is leading on exemplar projects in PPI – Consent to Contact and Genomics & Informatics.

Recommendation to the Board: The board is asked to note the ICHT research update.

Imperial College Healthcare Trust
Research Update Q1 2015/16

Professor Jonathan Weber

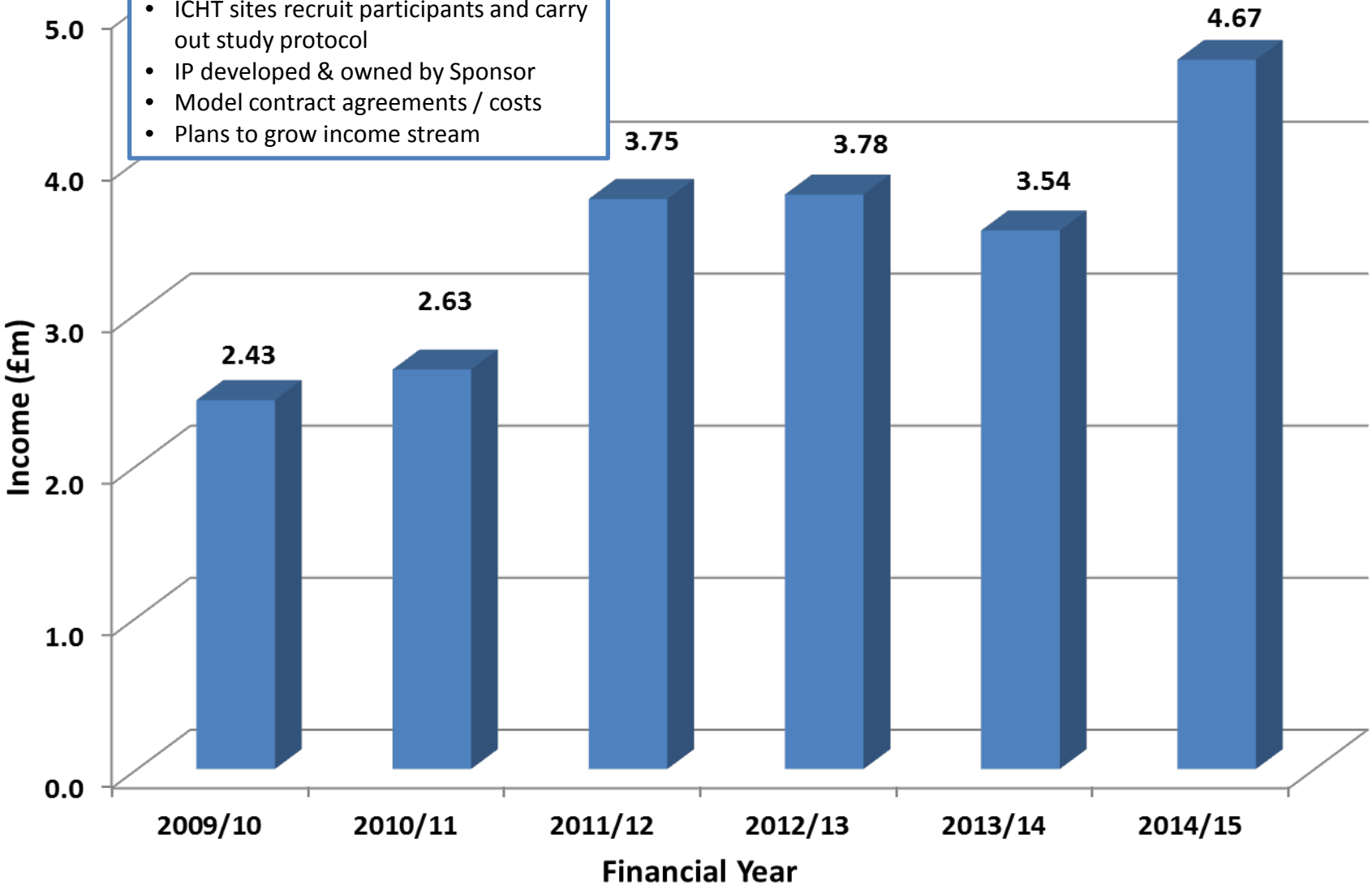
Director of Research

Recent Highlights

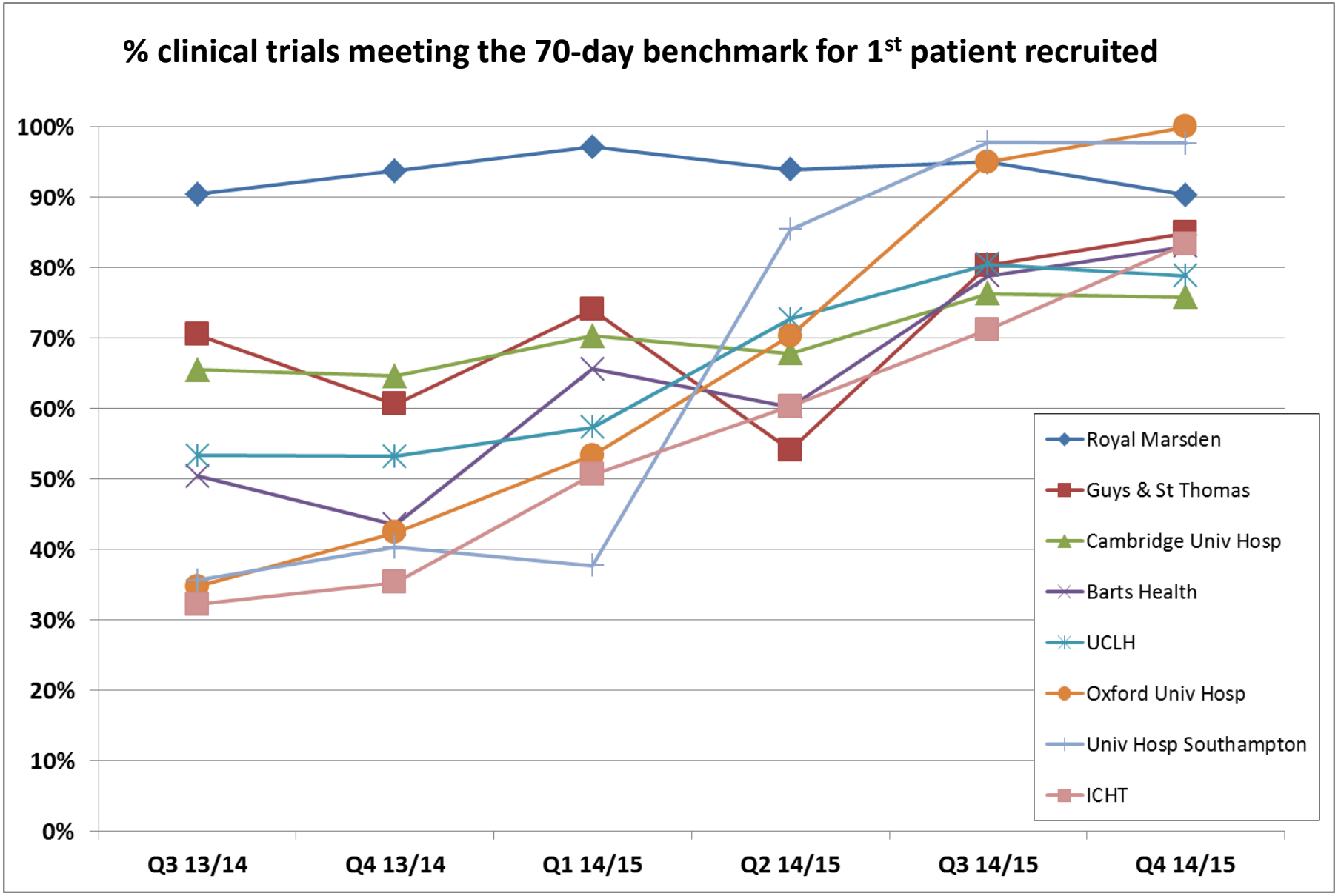
- **NIHR Imperial Biomedical Research Centre**
  - Creation of ITMAT – management structure & call for projects
  - New schemes for non-medical clinical staff
  - Imperial College Healthcare Charity fellowships / AMR nursing awards
- **Imperial Joint Translation Fund**
  - 65 active projects, many examples of leveraged funding
- **Commercial clinical trials**
  - Growth in activity and income
- **NIHR Clinical Trials Performance Targets**
  - Improvement in study initiation and delivery metrics
- **NW London Clinical Research Network (CRN)**
  - 3rd highest local network in terms of activity per head of population
- **NHS Genomic Medicine Centre (GMC) for NW London**
  - Cancer and inherited rare disease whole genome sequencing
- **Patient and Public Involvement & Engagement**
  - Imperial Festival

Commercial Clinical Trial Income (£m)

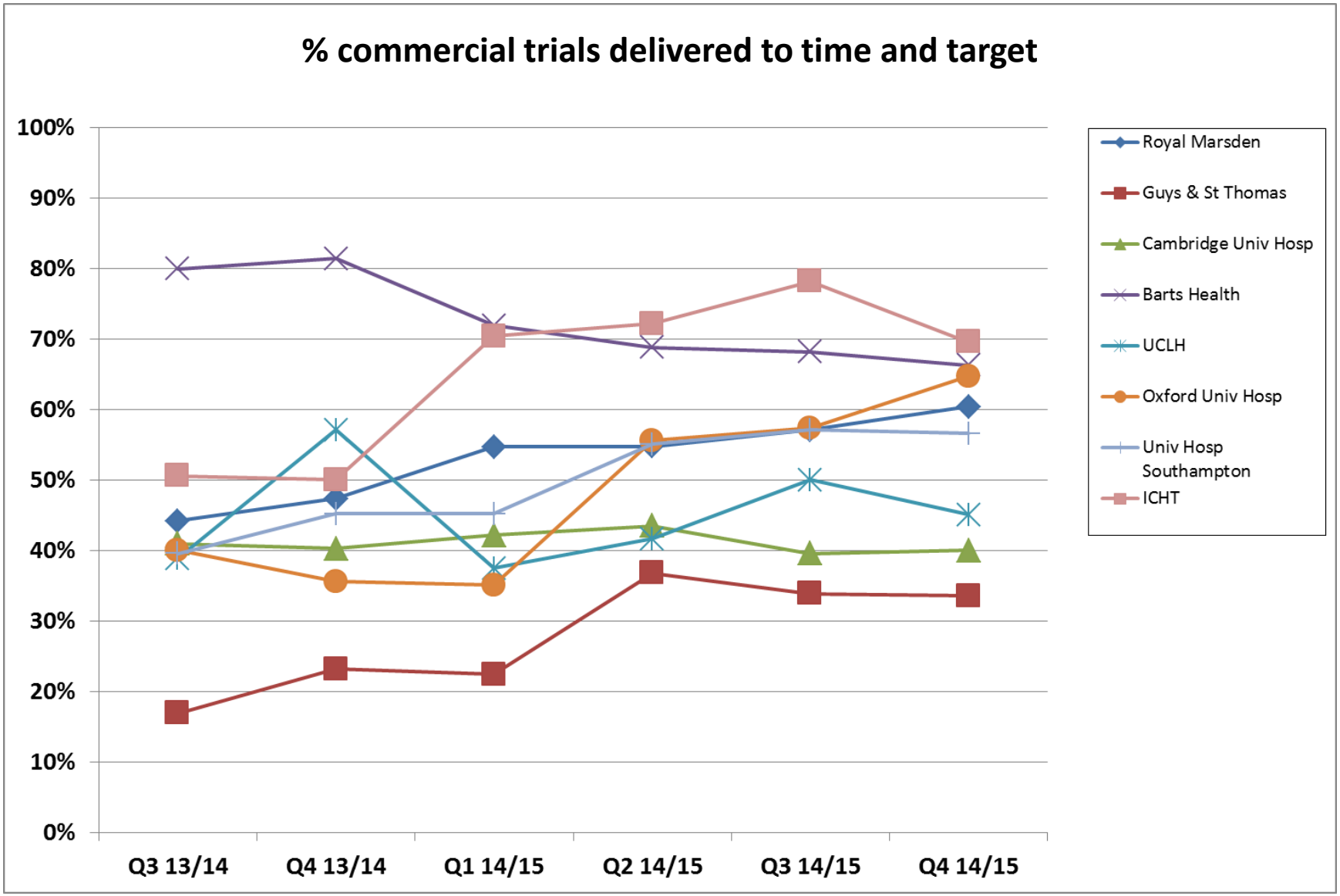
- Pharma contracts with ICHT as Sponsor
- ICHT sites recruit participants and carry out study protocol
- IP developed & owned by Sponsor
- Model contract agreements / costs
- Plans to grow income stream



Clinical Trials Performance: Initiation Times for Comparator Trusts

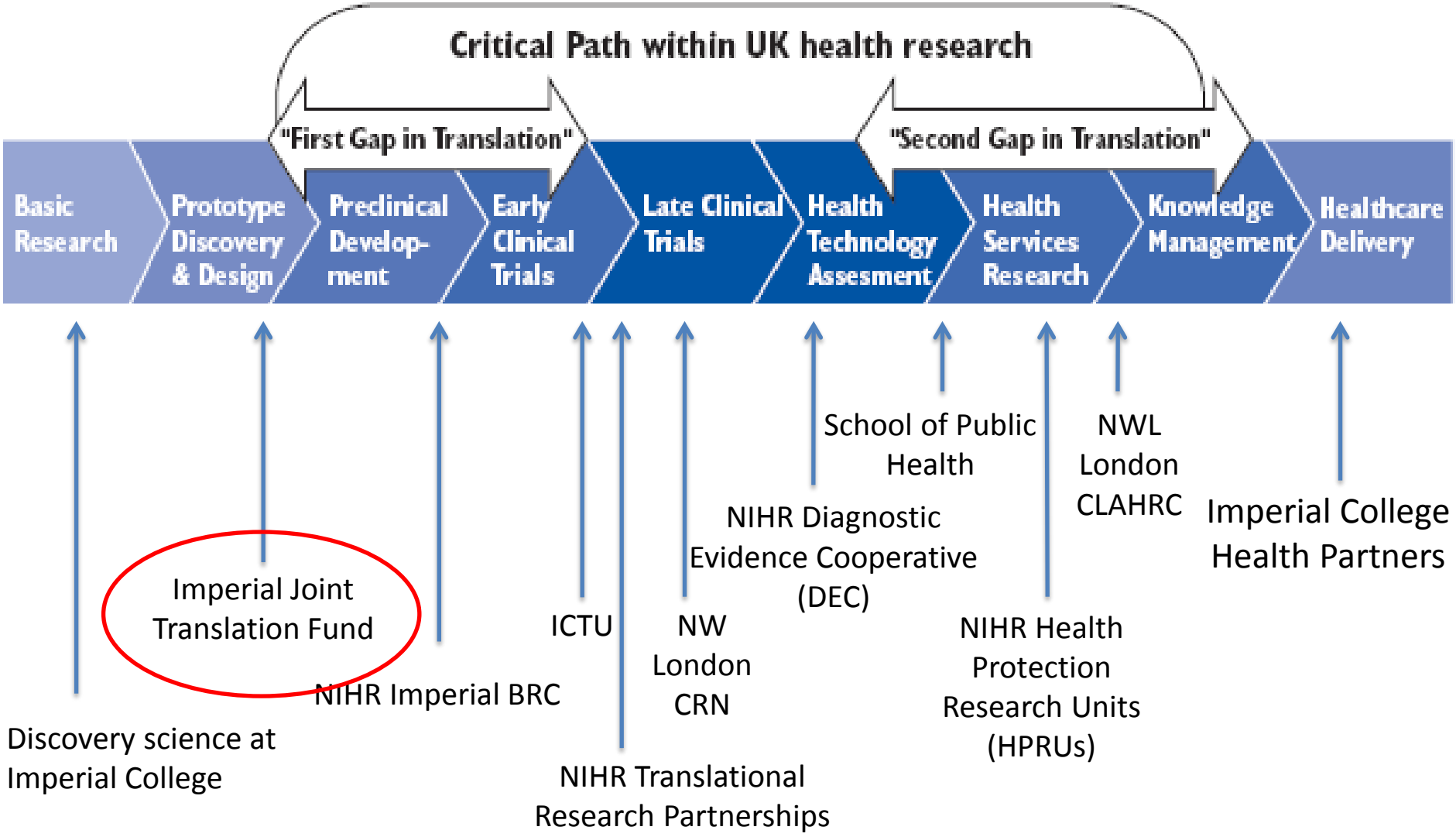


Clinical Trials Performance: Delivery of Commercial Studies for Comparators



Translational Research Infrastructure @ Imperial AHSC

a complex space…

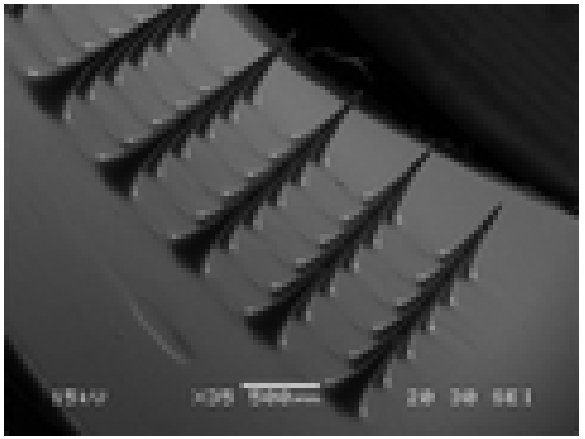


NIHR i4i: Clinical assessment of a novel microprobe array continuous glucose monitor in Type 1 diabetes

Prof Nick Oliver & Prof Des Johnston - £750k

- Novel trans-cutaneous microprobe continuously monitors [glucose] in interstitial fluid
- Collaboration between BRC Obesity Theme and Dept of Chemistry, **Prof Tony Cass**

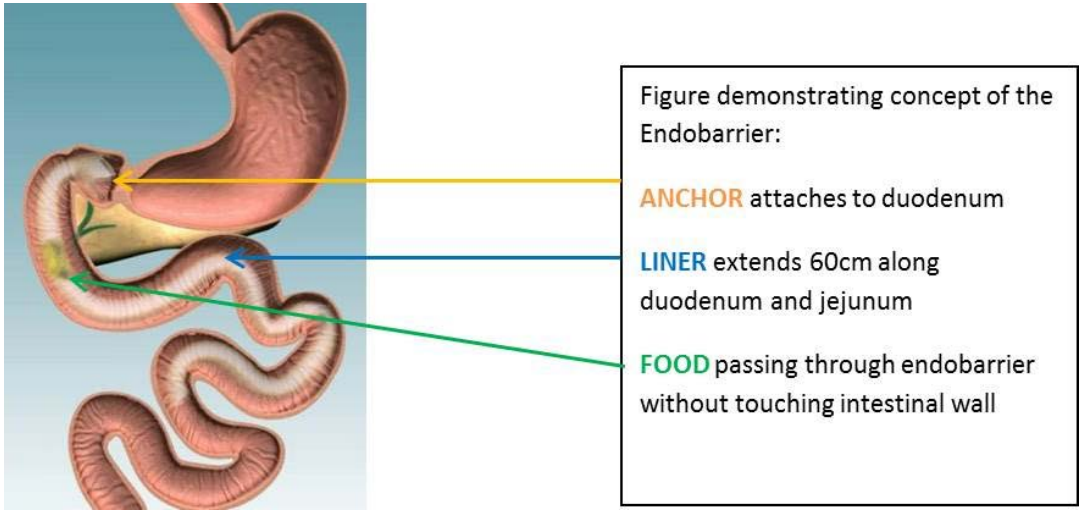
- Received £70k through Imperial Joint Translation Fund in 2013 to support phase 1 volunteer study
- i4i award for clinical study and further development of the device
- Team working with Imperial Innovations to protect the technology



NIHR/MRC EME: Randomized controlled trial of a duodenal sleeve bypass device (Endobarrier) compared with standard medical therapy for management of obese subjects with type 2 diabetes

Prof Julian Teare, £1.6M

- Co-I's: A Ahmed, S Bloom, A Darzi, A Goldstone, E Holmes, D Johnston, C Le Roux, N Poulter, J Nicholson
- Collaboration between Surgery, Cancer, Stratified Medicine & Obesity Themes of NIHR Imperial BRC
- Study running through Imperial Clinical Trials Unit (ICTU)
- Commercial partners: GI Dynamics / Elemental Healthcare



MRC DPFS: Evaluation of [18F]fluoroethyl triazole labelled [Tyr3] Octreotate analogues for the imaging of neuroendocrine tumours

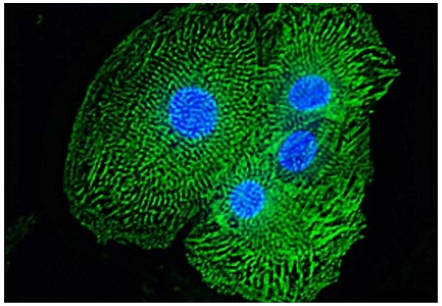
Prof Eric Aboagye, £1.3M

- Co-I's: A Frilling, R Sharma, A Al-Nahhas
- Aims to provide a more readily available, accurate diagnostic and staging technique for this tumour type
- Collaboration between Imaging and Surgery Themes of NIHR Imperial BRC
- Delivery through the new Imperial **Clinical Imaging Facility**

Wellcome Trust Seeding Drug Discovery: Novel inhibitors of MAP4K4 (HGK), an acute therapy to prevent cardiac muscle cell death following myocardial infarction

Prof Michael Schneider, £2.7M

- Cardiovascular Theme of NIHR Imperial BRC
- Received £78k through Imperial Joint Translation Fund for proof-of-concept tissue culture study
- WT Seeding Drug Discovery Award will enable innovative use of human cardiac muscle grown from stem cells to pinpoint the molecules responsible for cardiac injury and will take the research further towards the development of MAP4K4 inhibitors as clinically workable compounds
- Collaboration with Domainex for subsequent work
- Protection of technology via Imperial Innovations



Heart muscle cells grown from human stem cells

Non-Medical Clinical Research Training

- 1-year fellowships co-funded with Imperial College Healthcare Charity
  - 6 awards to date to dietetics, physiotherapists
  - further 8 awards planned for 15/16

- Establishment of Clinical Academic Training Office (CATO)
  - Focus on non-medical clinical research careers

- Funding stream established to support nursing-led research projects in the field of Anti-Microbial Resistance (AMR)

- Non-medical clinical research event scheduled for Q4, 2015
  - Identify research sponsors and supervisors across Imperial College

NHS Genomic Medicine Centre for NWL

- Prime Minister's 100,000 Genomes initiative
- Common cancers & inherited rare diseases
- ICHT leading consortium with
  - Royal Marsden Hospital,
  - Royal Brompton Hospital
  - Chelsea & Westminster Hospital
- One of 11 first-wave GMCs
- NHS transformation – embedding genomics into clinical practice
- New MSc in Genomic Medicine
- First three patients consented

Genomics england

NIHR Health Informatics Collaborative

- Sharing routinely collected NHS clinical data for research
- Five partners: ICHT, Oxford, Cambridge, GSTT, UCLH
- ICHT providing data in 5 clinical themes;
  - Acute coronary syndrome (ICHT lead)
  - Viral hepatitis
  - Critical care
  - Ovarian cancer
  - Renal transplantation
- Data sharing agreement & information governance
- Basis for data sharing for research with RBH, RMH

Health Informatics Collaborative

Research Priorities for 2015/16

NIHR Imperial BRC:

- Re-application in Q2, 2016

Training:

- Non-medical clinical fellowships and nurse-led AMR

NHS Genomic Medicine Centre:

- Realise NHS transformation of genomic medicine

Closer research collaborations:

- RBH & RMH informatics; Oxford AHSC mtg

Building industry links:

- Waters, A-Z, GSK, J&J, Pfizer

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (8 July 2015)**

KEY ITEMS TO NOTE

Internal audit report

The trust's internal auditors had issued final reports against the 2015/16 annual plan for:

- Corporate records
- CQC - Deep Dive review – Maternity & Gynaecology
- CQC - Deep Dive review - Critical Care at Charing Cross Hospital

A review of the Tertiary Fertility Treatment recharges had resulted in recommendations around the processes and procedures. The Safeguarding adults and do not attempt resuscitation (DNAR) audits were outstanding and would be followed up by Prof Julian Redhead on behalf of the Medical directorate.

Corporate Risk Register

The committee reviewed the corporate risk register noting that the trust risk manager had completed risk management workshops with the Estates and Operations directorates and further sessions with other directorates were planned. An internal audit of the risk management process had been undertaken in April and the trust was awarded a rating of 'reasonable assurance' and given some recommendations to consider for action.

Recording of data Mortality audit

The audit, by the corporate safety team, had been undertaken following an assurance review by Internal audit. The audit had assessed the comparative accuracy of the trust systems for recording patient mortality. Internal audit had confirmed they were satisfied the situation had improved.

Operating Theatre efficiency

The committee received an assurance report on the trust's operating theatre efficiency from the chief operating officer, Mr Steve McManus. The committee noted that on average over 75% of available operating time was utilised and the number of patients having to stay overnight in recovery had dropped significantly, which had improved patient experience. The committee would be provided with a progress report at the meeting in December 2015.

FOMI regulations (False or misleading information)

The committee received a progress report on compliance with the regulations that made the publication or supply of false or misleading information a criminal offence. The Trust board would be provided assurance with compliance of the regulations on an annual basis through the Audit, Risk & Governance Committee annual report.

Data accuracy of the scorecard indicators

The committee was asked by the Trust board to review the accuracy of the scorecard

Imperial College Healthcare NHS Trust

indicators. An audit of the data accuracy of the scorecard indicators is now being undertaken by internal audit and is incorporated into their routine reports to the Audit, Risk and Governance Committee. There is a rolling programme so that over a period of time all indicators are covered.

Committee annual report
This is attached as a separate paper.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Sir Gerald Acher, Chairman, Audit, Risk & Governance Committee
Report author: Tracy Walsh, Board committee secretary
Next meeting: 7 October 2015

Imperial College Healthcare NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Wednesday 27 May 2015
1.30pm – 2.30pm
W12 Conference Centre
Hammersmith Hospital

Present:	
Sir Gerald Acher (Chair)	Non-Executive Director
Prof Sir Anthony Newman Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Dr Andreas Raffel	Non-Executive Director
In Attendance:	
Jan Aps	Trust Company Secretary
Dr Tracey Batten	Chief Executive
Grant Bezuidenhout	Counter Fraud Manager, TIAA
Heather Bygrave	Partner, Deloitte
Sandra Easton	Deputy Director of Finance
Ian Garlington	Director of Strategy
Alan Goldsman	Interim Chief Financial Officer
Jonathan Gooding	Director, Deloitte
Prof Chris Harrison	Medical Director
Philip Lazenby	Director of Audit, TIAA
Leigh Lloyd-Thomas	Partner, BDO LLP
Steve McManus	Chief Operating Officer
Ian Sharp	Executive Director, TIAA
Prof Janice Sigsworth	Director of Nursing
Tracy Walsh	Committee Clerk (minutes)

1	**GENERAL BUSINESS**	
1.1	**Chair's opening remarks and apologies for absence** The Chair welcomed everyone to the meeting.	
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
1.3	**Minutes of the Committee's meeting on 22 April 2015** The minutes were approved as an accurate record.	
2	**GOVERNANCE & RISK BUSINESS**	
2.1	**Annual report and accounts** **<u>Going concern report</u>** Alan Goldsman introduced the report and highlighted: • The Financial Plan for 2015/16 had been submitted to the TDA showing the impact of the planned deficit on cash flow. The Trust was anticipating a reduction in cash in-year of £7.2m to £36.1m, with performance triggering a score of 2 on the Continuity of Services Risk Rating (CoSRR) liquidity ratio metric.	

	The committee reviewed the outcome of the going concern review and recommended that the Trust board confirm that the Trust was a going concern and that this was the correct basis on which the Annual Accounts had been prepared. **Accounts** Mr Goldsman introduced the report and noted the Trust board would be asked to approve the accounts in principle, with any further minor amendments being made prior to signing by all parties. The Committee would be notified of any material changes prior to submission. The Committee noted that remuneration report (included as part of the annual report) was prepared to a standard template. Dr Tracey Batten left the meeting while the figure relating to her expenses was discussed; the Committee agreed a footnote would be added to advise the amount related to relocation expenses agreed at appointment. **External audit** Heather Bygrave reported that the Audit Commission guidance refers specifically to having a break even budget as a requirement; the absence of such has led Deloitte LLP to report an exception in their conclusion. Ms Bygrave highlighted the following key risks: • Recognition of NHS revenue and recoverability of receivables • Property revaluations – the land valuation, while within requirements, was at the extreme end of the acceptable range, having reduced the value of the land by 75% since the valuation at 31 March 2014 • Property provisions – the cessation of rental payments by the subtenant of one of the Trust's leased properties. Deloitte would ensure BDO LLP, as incoming external auditors, were fully briefed. • Value for Money - £8.8m of the cost improvement plan was listed as "high risk", although work continued to reduce the risk associated with this. **Internal audit** Ian Sharp noted that all 48 reviews had been completed, of which 42 had been finalised. TIAA (the internal audit provider) was comfortable in providing reasonable assurance on the control framework. **Counter fraud** Grant Bezuidenhout reported that the previous year the Trust has self-assessed as green and he expected the same rating this year. There had been no major fraud incidents in year. The Chair thanked Alan Goldsman and his team for all their hard work on the accounts. The Committee recommended to the Trust board the approval of the accounts in principle, based on the opinions of the External and Internal auditors, noting that the signing of the management presentation letter would be delegated to the chairman and chief executive. **Annual report** The Committee reviewed the report and recommended to the Trust board approval of the Annual Report 2014-15.	
2.2	**Quality accounts** The Committee reviewed the final draft of the Trust's Quality Account 2014/15. Ms Bygrave reported that stakeholders had until the middle of June to provide comments to the Trust which must be included in the Quality Accounts, and noted	

	they could not complete their review until these were provided. The Committee recommended to the Trust Board for approval in principle the Quality Accounts and delegated the signing of the quality account document to the chief executive and chairman.	
3	**ANY OTHER BUSINESS** There was no other business to consider.	
4	**DATE OF NEXT MEETING** Wednesday 8 July 2015, 10.00am – 12.30pm, Clarence Wing Boardroom, St Mary's Hospital	

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Wednesday 22 April 2015
10.00am – 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
Dr Andreas Raffel	Non-Executive Director
In Attendance:	
Jan Aps	Trust Company Secretary
Dr Tracey Batten	Chief Executive
Michelle Dixon	Director of communications (item 5.1 only)
Alan Goldsman	Interim Chief Financial Officer
Jonathan Gooding	Director, Deloitte
Kevin Jarrold	Chief Information Officer
Prof Naresh Kikkeri	Divisional Director ISCS (item 1 to 2.1 only)
Philip Lazenby	Director of Audit, TIAA (item 1 to 5.2 only)
Arti Patel	Senior Counter Fraud Specialist (item 1 to 4.1 only)
Ellis Pullinger	Divisional Director of Operations, ISCS (item 1 to 2.1 only)
Prof Julian Redhead	Acting Medical Director
Ian Sharp	Executive Director, TIAA
Prof Janice Sigsworth	Director of Nursing
Nicola Strickland	Consultant – Radiology (item 1 to 2.1 only)
Tracy Walsh	Committee Clerk (minutes)

1	**GENERAL BUSINESS**	
1.1	**Chair's opening remarks and apologies for absence** The Chair welcomed everyone to the meeting. Apologies for absence were received from Steve McManus.	
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
1.3	**Minutes of the Committee's meeting on 11 March 2015** The minutes were approved as an accurate record.	
1.4	**Action log, forward plan, & matters arising report** The committee noted the updates to the action log, particularly that: • Progress in implementing actions relating to bank and agency audit would be reviewed at the July meeting • the implementation of 24 hour MRI services at St Mary's would be monitored by the quality committee.	SMcM
2	**GOVERNANCE & RISK BUSINESS**	
2.1	*Item redacted as commercially sensitive*	
3	**EXTERNAL AUDIT BUSINESS**	

4	**INTERNAL AUDIT BUSINESS**	
4.1	**Internal Audit and Counter Fraud Annual plans 2015/16** Alan Goldsman reported that both plans had been reviewed by the Executive Committee the previous day, and that subject to minor amendments, the Executive Committee had recommended that the plan be approved by the Audit, Risk and Governance Committee. Ian Sharp advised that the plan had been discussed with all Executive leads and that the key emphases in 2015/16 were on CQC related issues and data quality. Sir Gerry Acher commented that the Committee had previously raised concerns in relation to patient transport and junior doctors (hospital at night) and asked that Internal Audit provide a report to the July Committee confirming whether internal audit considered whether there were still issues (and details of what action was being taken to address them) or whether these had been addressed. TIAA would ensure that the following were included in the Internal Audit plan: • Medical staffing in critical care at Charing Cross Hospital; • CQUIN: funding against objectives; • The efficacy of, and adherence to, the recruitment process; and • Data validation, using patient notes: audit to include the process and sector benchmarks where available. Arti Patel reported that the Counter fraud plan was based on NHS Protect requirements. Alan Goldsman had agreed that 20 extra days be transferred to Counter Fraud from the Internal Audit allocation, noting that the overall budget had been quite generous. The Committee approved the Internal Audit and Counter Fraud plans subject to the amendments highlighted.	PL PL
5	**FINANCIAL & OTHER BUSINESS**	
5.1	**2014/15 annual report – content outline and approval process** Michelle Dixon confirmed that the foreword from Dr Batten and Sir Richard Sykes would include the Trust vision and strategy and that the clinical strategy would address 'services fit for the future'. The Committee asked, in addition to this, that the section on patient care be enhanced. A full draft would be circulated to Committee members on Friday 24 April; comments to be provided to Michelle Dixon by 17.00 on Wednesday 29 April. The final document would be presented to the Audit, risk and governance committee on 27 May for recommendation to the Board to sign off the annual accounts and report. The Committee noted the content outline.	
5.2	**Annual governance statement – draft statement** Jan Aps reported that the statement had been structured around Monitor's well-led framework (which had now been adopted by all health regulators); she noted that further additions now included business planning, the BGAF and QGAF, raising concerns, leadership development and emergency preparedness. Dr Andreas asked that success of stroke services be considered for inclusion in the clinical strategy. The Committee were satisfied with the progress of the statement and did not wish to review a further draft, noting that the Executive Committee would review a draft on 28 April. Any committee members would like to review a further draft would contact Jan Aps. The Committee noted the draft annual governance statement.	
5.3	**Draft annual accounts** Mr Goldsman highlighted that: • A small surplus had been achieved for the 2014/15 year; • There had been a strong cash position of £43m at year end; and • The Trust had met the capital resource limit and external financing limit. Mr Goldsman noted that while additional income had been received from private	

	patients and winter pressure funding, expenditure had risen due to investments made to address the requirements of 'safe staffing' and improve the midwife ratios. The efficiency programme for 2015/16 would need to address continuing issues from 2014/15 such as the shortfall in project diamond income. Jonathan Gooding reported that Deloitte had received the land valuation from the valuer which, while at the higher end of the scale, was acceptable. Work continued in building valuation; the reduced value would be benchmarked against other London trusts. The Committee noted the draft annual accounts information.	
5.4	**Quality Accounts – draft report** Prof Julian Redhead reported that the draft report had been reviewed by Executive Committee the previous day; revisions would include cleanliness targets, how the Trust involves patients in their care, staff and patient safety, research and education and the WHO checklist. Jonathan Gooding would draft a statement for inclusion regarding providing false and misleading information. Any further comments should be forwarded to Prof Redhead. The Committee noted the draft quality accounts.	JR/JG
6	**ANY OTHER BUSINESS** There was no other business to consider.	
7	**DATE OF NEXT MEETING** Wednesday 27 May 2015, 13.45pm – 15.15pm, Oak Suite, W12 Conference Centre, Hammersmith Hospital (to recommend approval of the Annual report and accounts).	

AUDIT, RISK AND GOVERNANCE COMMITTEE – ANNUAL REPORT 2014/15

Introduction:

The audit, risk and governance committee is a standing committee of the board. The terms of reference for the audit committee have been approved by the board. The committee, which consisted of three independent non-executive directors, met five times during the year 2014/15. At all meetings there was appropriate representation and support from the internal and external auditors and local counter fraud provider.

Private meetings between committee members and the internal and external auditor can take place at the end of each meeting. At no time have the auditors indicated urgent or serious concerns.

Minutes of each meeting have been reported to subsequent meetings of the Trust board. A high level of commitment from board members, in their capacity as members of the audit committee, is demonstrated by their regular attendance at committee meetings – see table below.

Member	Attendance
Sir Gerald Acher (chair)	6/6
Professor Sir Anthony Newman Taylor	5/6
Sarika Patel	6/6
Dr Andreas Raffel	5/6

The committee has recently introduced a formal annual plan of scheduled agenda topics, which guides discussion, along with a range of specific issues that are subject to review. A catalogue of agenda items and meeting papers is maintained.

Principal review areas:

The report is divided into six sections reflecting the key duties of the committee:
1. Governance, risk management and internal control
2. Financial reporting
3. Internal audit
4. External audit
5. Counter fraud and whistleblowing
6. Annual self-assessment of effectiveness.

1. Governance, risk management and internal control

The committee has reviewed relevant disclosure statements, in particular the annual governance statement together with the head of internal audit opinion, external audit opinion and other appropriate independent assurances, and considers that the governance statement is consistent with the committee's view on the trust's system of internal control. Accordingly, the committee supported board approval of the governance statement as part of the annual report and annual accounts in May 2015.

The committee has undertaken a number of in-depth reviews, including data quality issues following Cerner implementation (where a comprehensive action plan saw most areas back to normal [or even more improved] by February 2015), radiology information system and picture archiving computer systems (where close management attention and clinical attention has minimised risk of patient harm; this is reviewed via the corporate risk register) and pharmacy medication issues (where there have been significant improvements). The committee is also cognisant of the work of other committees within the Trust whose work can provide relevant assurance to the committee's own scope of work.

The committee has taken a keen interest in the development and improvement of the corporate risk register and considers that it accurately reflects the risks facing the Trust, and the controls and mitigations in place to minimise them.

2. Financial reporting

The committee has reviewed the process and controls the trust has put in place to ensure that its financial obligations were achieved.

It has also received the Head of Internal Audit Opinion; it was pleased to note that the opinion stated that there was substantial assurance (the highest rating that can be awarded) that the trust had a generally sound system on internal control on key financial and management processes.

The committee reviewed the annual financial statements before submission to the board and believed them to be accurate.

The committee received regular reports on losses and compensation payments, and waver of tendering process and competitive quotations.

The committee approved the revised standing financial instructions.

3. Counter fraud

The committee has received regular reports in the counter-fraud activity at the Trust ensuring that appropriate action in matters of potential fraudulent activity and financial irregularity. The trust's local counter fraud service (LCFS), has been supplied by TIAA, and the annual LCFS workplan was agreed by the committee. As required under the Secretary of State's directions on fraud and corruption, the LCFS has reported at least annually to the committee, and the committee has received summary reports on all alleged fraud. LCFS had undertaken a number of pro-active reviews and made recommendations to strengthen the trust's processes against attempted fraud.

4. Internal audit

TIAA continued to supply the trust's internal audit services. Throughout the year, the committee has worked effectively with internal audit to strengthen the trust's internal control processes.

The committee approved and reviewed the internal audit plan regularly. Over the year, a total of some 33 internal audits were undertaken.

Internal audit score	Number
Substantial assurance	13
Reasonable assurance	17
Limited assurance	3

The committee considered the major findings of internal audit and were assured that management have responded in an appropriate and timely manner. The committee asked for further information to allow it to monitor the implementation of all audit recommendations.

5. External audit

The Trust's external audit service during 2014/15 was provided by Deloitte LLP. The committee approved the external audit plan for 2014/15, and continued to receive progress reports from Deloitte in delivering their responsibilities as external auditor, together with other matters of interest. In addition, the committee has received year-end reports from Deloitte in respect of the 2014/15 annual accounts and limited assurance report on the quality report and mandated indicators.

Deloitte's term of office being due to expire at 31 March 2015, the Trust was informed by the Audit Commission (responsible for the appointment of the Trust's auditor) that Deloitte had withdrawn from the market. The committee noted that the external auditor from 2015/16 would be BDO LLP.

6. Annual self–assessment of effectiveness

A questionnaire, developed by the Audit Commission for use in NHS trusts, was sent to all committee members, the external and internal auditors, and standing attendees for completion.

Overall, all groups had a reasonably positive view of the committee. Full results are attached, but the summary results are:

	NED mean	Board ED mean	Auditor mean	Standing attendee mean
Behaviours	4.0	4.2	4.4	4.2
Processes	4.1	4.6	4.7	4.2

Areas of particular strength are seen to be:

- quality of interaction with external auditors;
- handling of bad news;
- quality of chairmanship and members;
- skills and commitment of members; and
- feeding back to the board of key issues.

Areas where improvements could be made are seen to be:

- the Committee's understanding of the interaction of sources of assurance and how these map to risk;
- the length, relevance and timeliness of papers; and
- the interaction with internal auditors.

The widest range of answers related to 'all committee members actively and effectively contribute at meetings'.

Further thought will be given to delivering improvement in those areas which have most widely been identified as only delivering on each of the statements 'sometimes'.

Conclusion:

The committee is of the opinion that it has the authority and capacity to comply with its role as described in the terms of reference, and that it has delivered on such role. This is confirmed by the findings of internal and external audit.

	Non-executive					Executive directors						Auditors			Other		
n/a = Not applicable or unknown 1 = Hardly ever/Poor 2 = Occasionally/Below average 3 = Some of the time/Average 4 = Most of the time/Above average 5 = All of the time/Fully satisfactory					Mean NED						Mean ED			Mean Auditor			Mean other
Behaviours					**4.0**						**4.2**			**4.4**			**4.2**
1. Understanding of core business, business model and risks All Committee members have a good understanding of the different risks inherent in the Trust's activities.	5	4	4	4	4.3	4	4	4	4	5	4.2	5	4	4.5	4	4	4
2. Understanding the risk management framework All Committee members have a good understanding of the risk management and internal controls framework.	4	4	4	4	4.0	5	4	4	3	4	4	4	4	4	4	4	4
3. Understanding of how assurance is gained a) The Committee understands the interaction between the various sources of assurance available to it; and b) How these sources map to the significant risks of the organisation.	5	3	4	3	3.8	5	4	3	3	5	4	4	4	4	3	3	3
4. Focus on appropriate areas a) The Committee focuses on the right questions. b) The Committee is effective in avoiding the minutiae.	5	4	4	4	4.3	3	4	4	4	4	3.8	4	4	4	3	4	3.5
5. Quality of interaction with external auditors a) The Committee actively engages with the external auditors regarding scope of work, audit findings and other relevant matters. b) The Committee ensures that issues raised are appropriately resolved in a timely manner.	4	5	4	5	4.5	5	5	4	4	5	4.6	4	5	4.5	4.5	4	4.25
6. Quality of interaction with internal auditors The Committee demonstrates an appropriate degree of: a) Involvement in setting the remit of the internal audit; and	3	3	3	4	3.3	4	5	4	4	4	4.2	0	4	4	5	4	4.5
b) Involvement in the findings of internal audit and in their resolution.	3	4	4	3	3.5	4	5	4	4	4	4.2	0	4	4	5	3	4
7. Quality of interaction with counter fraud The Committee demonstrates an appropriate degree of: a) Involvement in setting the remit of counter fraud services; and	3	3	4	4	3.5	4	4	4	4	5	4.2	0	4	4	5	4	4.5
b) Involvement in the findings of counter fraud and in their resolution.	3	4	4	4	3.8	4	5	4	4	5	4.4	0	4	2	5	3	4
8. Understanding of key financial issues The Committee has a good understanding of the key financial issues, for example critical accounting policies and complex transactions.	4	4	4	5	4.3	4	4	5	4	4	4.2	4	5	4.5	4	4	4
9. Rigour of debate Committee meetings encourage a high quality of debate with robust and probing discussions.	5	5	4	4	4.5	4	4	4	4	5	4.2	5	4	4.5	4	4	4
10. Reaction to bad news The Committee responds positively and constructively to bad news in order to encourage future transparency.	5	5	4	4	4.5	5	5	4	3	5	4.4	4	4	4	4	5	4.5
11. Quality of chairmanship The chairman operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings.	0	5	4	5	4.7	5	4	5	4	5	4.6	5	4	4.5	4	4	4
12. Ongoing personal development to remain up to date All Committee members, in conjunction with the Board chairman, undertake ongoing personal development activities to update their skills and knowledge.	4	4	3	0	3.7	4	3	4	0	5	3.2	0	5	**5**	0	4	4
13. Frank, open working relationship with executive directors The Committee members have a frank and open relationship with the executive directors, without themselves becoming 'executive'.	4	3	4	4	3.8	4	4	4	4	5	4.2	4	4	4	5	3	4
14. Open channels of communication The Committee has open channels of communication with trust contacts which facilitates the surfacing of issues.	4	3	4	3	3.5	4	4	4	4	5	4.2	4	5	4.5	4	4	4
15. Perceived to have a positive impact There is an appropriate balance between the monitoring role of the Committee and it being an ''influencer for good''.	4	4	4	4	4.0	4	4	3	4	5	4	4	5	4.5	3	4	3.5
16. Impact at board level The Committee exercised judgement and assiduously pursues issues to influence management and board decisions.	4	4	4	4	4.0	4	4	4	3	5	4	4	4	4	3	4	3.5
17. Appropriate links with other board committees The Committee has appropriate links with the other board committees.	4	5	4	5	4.5	4	4	4	4	5	4.2	4	5	4.5	3	4	3.5
Processes					**4.1**						**4.6**			**4.7**			**4.2**
18. Clear terms of reference a) There are clear terms of reference, with clarity as to role vis a vis the board as a whole and other committees, including in relation to risk management. b) The terms of reference are reviewed annually.	4	4	4	5	4.3	4	5	4	4	5	4.4	4	5	4.5	5	4	4.5
19. Structured and appropriate annual agenda a) There is a structured annual agenda of matters to be covered. b) The structured agenda focuses on the right areas.	5	4	4	5	4.5	4	4	4	4	5	4.2	4	4	4	5	5	5
20. Sufficient number and timing of meetings a) The number and length of meetings is sufficient. b) Meetings are sufficiently in advance for board meetings for issues to be resolved.	4	4	4	5	4.3	4	5	4	4	5	4.4	4	5	4.5	4	4	4
21. Right people invited to attend and present at meetings Executive management and others are asked to present on topics, as appropriate.	4	4	4	4	4.0	4	5	4	4	5	4.4	4	4	4	4	4	4
22. Concise, relevant and timely information a) Committee papers are concise, relevant and timely.	4	3	3	3	3.3	4	4	4	3	5	4	4	4	4	4	3	3.5
b) Committee papers are received sufficiently in advance of meetings.	4	3	3	5	3.8	4	4	4	3	5	4	4	4	4	3	4	3.5
23. Sufficient time and commitment to undertake responsibilities a) All Committee members have sufficient time to fulfil their responsibilities. b) All Committee members demonstrate sufficient commitment to fulfilling their responsibilities.	5	4	4	5	4.5	4	5	3	4	5	4.2	5	5	**5**	3.5	4	3.75
24. Contribution at meetings All Committee members actively and effectively contribute at meetings.	5	4	4	5	4.5	4	4	4	2	4	3.6	4	5	4.5	4	4	4
25. Feeding back to board meetings a) All key issues are identified; and b) Reported back to board.	5	4	4	5	4.5	4	5	5	3	4	4.2	0	5	**5**	4.5	5	4.75
26. Appointment and independence of external audit The Committee fulfils its responsibilities to assess the independence and objectivity of the auditor annually, taking into consideration relevant UK law, regulation and professional requirements.	4	5	4	0	4.3	4	5	5	4	4	4.4	3	5	4	4	5	4.5
27. Adequate resources The Committee has sufficient resources available to support it in its role.	4	5	4	3	4.0	4	5	3	0	4	3.2	5	5	**5**	4	4	4
28. Members with appropriate skills and experience The Committee comprises members with an appropriate mix of skills and experience, including recent and relevant financial experience.	4	5	4	3	4.0	4	5	5	3	5	4.4	5	5	**5**	4	5	4.5
29. Private meetings with internal and external auditors Private meetings with the Committee, without management, are held at least annually with both the external auditors and internal audit.	4	5	4	5	4.5	4	5	5	0	4	3.6	5	5	**5**	0	5	5
30. Role in relation to whistleblowing The Committee has been informed of the whistleblowing procedures in place within the organisation and undertakes its defined role in relation to them.	4	4	4	3	3.8	4	5	4	3	4	4	0	5	**5**	5	3	4

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust Board**

Report from: **Quality Committee (15 July 2015)**

KEY ITEMS TO NOTE

Divisional Director's risk register update
The committee reviewed in depth divisional risks and noted that two never events had occurred in the surgery, cancer and cardiovascular division. The WHO brief and debrief had been made mandatory, and a training module was being added to Moodle to retrain staff.

Quality report
The committee received an update on infection control on the Zachary Cope vascular ward (which was also on the surgery, cancer and cardiovascular division risk register) which had reopened following the outbreak of CRE on the ward. In response to the outbreak, weekly admission screening of all patients in renal and vascular patients had been put, and remains, in place. In line with the guidance issued by Public Health England and NHS England, the screening toolkit had been put in place, with targeted screening implemented for identified high risk patients. Increased surveillance of cleaning and an even greater focus on hand hygiene had also been introduced. Professor Chris Harrison highlighted that PHE had given positive feedback as to the way in which the checklist had been introduced. Following screening the previous week, three more cases had been identified, all of which had been previous hospitalisations; two in the UK and one abroad. On-going review of the situation continues and the committee will receive real time updates.

Quality improvement report: Outpatient services
The committee reviewed the action plan for improvement, noting the plan had been designed to ensure an improved score in any subsequent CQC inspection, not expected until at least January 2016. The committee asked that progress against targets be reported to each meeting until March 2016.

Quality improvement report: Vacancy management in medicine division
The committee received a report on vacancy management in the medicine division noting that recruitment activity for band 5 nurses was due to commence, and that staff retention rates had improved since amendments to local induction and support.

Annual Workforce Equality report 2014-15
The committee discussed the report which provided a statistical overview of key workforce equality metrics for the year 2014-15 as well as the information required by the Workforce Race Equality Standard. The report identified a number of current and future initiatives aimed at promoting workforce equality. The committee heard how the Trust would be investigating particular areas to enhance our understanding of ethnicity and successful appointment and the relationship between ethnicity and PDP gradings. There were some positive movements in the balance of promotions in relation to ethnicity and the decline in

the number of BME staff as a percentage of disciplinary and grievance procedures. With this further information and data the Trust would apply the learning of the London wide *Unconscious bias* work to training and procedures.

Committee annual report
This is attached as a separate paper.

RECOMMENDATION:

The Trust Board is requested to:

- Note the report

Report from: Prof Sir Anthony Newman Taylor, Chairman, Quality Committee
Report author: Tracy Walsh, Board committee secretary
Next meeting: 16 September 2015

Imperial College Healthcare NHS Trust

MINUTES OF THE QUALITY COMMITTEE

Wednesday 13 May 2015
10:00am – 12.45pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Prof Anthony Newman Taylor	Chairman
Sir Gerald Acher	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director
Dr Tracey Batten	Chief Executive
Kerensa Heffron	Divisional Director: Private Patients
Prof Alison Holmes	Director of Infection Prevention and Control
Prof Naresh Kikkeri	Divisional Director: Investigative Sciences & Clinical support
Prof Jamil Mayet	Divisional Director: Surgery & Cancer (until item 3.1.4 only)
Prof Janice Sigsworth	Director of Nursing
Prof TG Teoh	Divisional Director: Women's & Children's
In attendance:	
Jan Aps	Trust Company Secretary
Sanjay Dhir	Interim Head of Health and Safety (item 3.2.1 to 3.3.4 only)
Prof Bryony Franklin	Executive Lead Pharmacist Research & Director, Centre for Medication Safety and Service Quality
Sally Heywood	Divisional Director of Nursing - medicine on behalf of Prof Tim Orchard
Keith Loveridge	Associate Director Employee Relations & Planning (item 3.1.7 to 3.2.1 only)
Ann Mounsey	Chief Pharmacist (until item 3.1.5 only)
Julian Redhead	Acting Medical Director
Justin Vale	Associate Medical Director for Safety and Clinical Lead PSTRC
Tracy Walsh	Committee Clerk (Minutes)

1	**GENERAL BUSINESS**	
1.1	**Chairman's opening remarks and apologies for absence** Prof Anthony Newman Taylor welcomed all present to the meeting. Apologies had been received from Prof Chris Harrison, Steve McManus, Jayne Mee and Prof Tim Orchard.	
1.2	**Declarations of Interest or conflicts of interest** There were no conflicts of interest declared.	
1.3	**Minutes of the Committee's meeting on 4 March 2015** The minutes were approved.	
1.4	**Action Log** The committee noted there were no outstanding actions on the action log.	
1.5	**Matters Arising report** The matters arising report was addressed under the Divisional director's risk	

	register update.	
1.6	**Chief Executive's introduction** Dr Tracey Batten reported that the executive team had completed a significant amount of work on revising the Quality Strategy which had been aligned to the five CQC domains (safe, effective, caring, responsive and well-led) and would be monitored through measurable KPIs. The quality improvement methodology would be provided to the Committee meeting in July.	CH
2	**CLINICAL RISK**	
2.1	**Divisional director's risk register update** **Investigative sciences & clinical support** Prof Kikkeri highlighted: • Radiology information system (RIS) and Picture archive and communication system (PACS) – Dr Batten had the previous week spoken to John Flannery, President and CEO of GE Healthcare who had committed to a smooth transition over the next 12 months as the Trust sourced a new provider. • Increased demand in imaging – radiology staffing rotas were being reviewed to mitigate. It was reported that further breaches were likely over the coming months. • Traceability of blood to recipients – areas had been identified that were not 100% compliant with MHRA regulations; action would be taken by Division. The transfusion team had asked to present to the Quality Committee. Prof Kikkeri reported he did not believe there were any patient safety risks arising from the Division's cost improvement plans. **Medicine** Sally Heywood highlighted: • A&E performance – overall numbers attending had not increased but there had been an increase in the number of Category A patients. • Grafton ward location – the consultation process to move the service to Charing Cross was due to commence. Sally Heywood reported she did not believe there was any patient safety risks arising from the Division's cost improvement plans but that there could be a reputational risk in relation to the transfer of patients requiring haemodialysis at St Mary's Hospital to Hammersmith Hospital. **Surgery, cancer & cardiovascular** Prof Jamil Mayet highlighted: • Charing Cross emergency surgery medical cover – the recruitment of three substantive Consultants was in progress. It was agreed to remove the risk from the corporate risk register. • Compliance with NICE guidance for the management of patients with glaucoma – the outpatient list was being managed. Discussions were taking place with CCGs to match funding to capacity. • Outbreak of CRE on Zachary Cope vascular ward - an existing dialysis patient had returned from India carrying the infection which had spread to other patients and led to the ward being closed. A root cause investigation was being undertaken to ensure lessons were learned. • Lack of 24 hour MRI at St Mary's Hospital – training of substantive staff was due to commence and it was planned that full 24 hour cover would be available by the end of the calendar year. Prof Jamil Mayet reported he did not believe there were any patient safety risks arising from the Division's cost improvement plans. **Women's & Children's**	KN JS/ CB

	Prof Teoh highlighted: • Midwifery WTE staffing levels were not meeting the recommended requirements for one to one care for women in established labour – recruitment was on-going and staff had been redeployed from areas of lowest need to provide one to one care when possible to do so safely. • Inadequate nurse staffing levels for gynaecology in-patients – funding had been agreed to address this risk. • Risk of not meeting RCOG and London Health programme standards of 168 hours of consultant obstetrician presence on labour ward at QCCH – funding had been agreed to appoint five consultants which would increase staffing levels, but not to 168 hours. • Grand Union Ward (environmental) – Prof Alison Holmes reported that the mitigation of infection was reasonable. Prof Teoh reported he did not believe there were any patient safety risks arising from the Division's cost improvement plans. **Private Patients** Kerensa Heffron highlighted: • Risk of loss of business and income due to a change in competition law – being reviewed as to whether the 7 WTE Medical Secretaries that had not previously been paid for by Consultants could be moved elsewhere. Kerensa Heffron reported she did not believe there were any patient safety risks arising from the Division's cost improvement plans. The Committee noted the key Divisional risks.	
3	**QUALITY OVERSIGHT**	
3.1.1	**Quality report** Justin Vale highlighted: • It was the Trust's fourth successive month of low relative mortality in HSMR (following the raised indicator in August) • There was one mortality alert for the December 2014 data which was being reviewed as it may have been a coding issue • Serious Incidents (SIs) reporting had increased for the year. Mr Vale would meet with Divisions on a monthly basis to ensure SIs were being reported within 48 hours as per the NRLS measure • A retrospective clinical review (for potential patient harm) of RTT patient pathways waiting over 18 weeks would be implemented and include an independent external reviewer. • The Friends and Family Test in February, 96% of our inpatients would recommend the Trust to their family or friends, as compared with 95% nationally. A breakdown by division would be provided to the Committee meeting in July. **Infection Prevention and Control** Prof Alison Holmes highlighted: • Year to date there had been 8 cases of MRSA BSI allocated to the Trust; two were still being considered and three were contaminants • Eight cases of C.Diff were reported for March, and the 2014/15 total was 78 against a threshold of 65 cases. A C. Diff outbreak in Samuel Lane had resulted in two SIs. The Quality report submitted to Executive committee would be circulated to members of the Quality committee monthly, rather than bi-monthly as was currently the case. The Committee noted the Quality report.	JS CH

3.1.2	**Quality Strategy 2015-18** Dr Julian Redhead reported that Commissioners were satisfied with the structure of the report. The Committee welcomed the document and considered that it would be a key part of supporting quality improvement. An additional indicator would be added which outlined the percentage of complainants whose complaints were responded to satisfactorily by the first full response. The Committee noted the draft Quality Strategy.	
3.1.3	**Quality Account 2014-15** Dr Julian Redhead reported that the Quality Account was a review of the previous year and looking ahead to the next year. The account had been produced in consultation with members of the public, Healthwatch, Health and Wellbeing Boards, local authorities and commissioners. Statements from these stakeholders would be inserted as the document was finalised and approved. The Committee noted the draft Quality Account 2014-15.	
3.1.4	**CQC update report** Prof Janice Sigsworth reported that the Trust continued to be registered at each site without any conditions. It had been agreed at the executive committee that quarterly reviews of activities with divisional directors would take place to ensure the Trust's CQC registration remained accurate and up to date. The first review had identified 25 community clinics that had not previously been included within the Trust's registration; the Statement of Purpose for the main sites would be amended and submitted to the CQC. Internal audit had been requested to conduct a series of in-depth reviews, in line with the CQC format, for areas that were rated as 'good', the first of these had taken place on 6/7 May in critical care services. Prof Sigsworth noted that, in response to all outpatient services having been rated as inadequate by the CQC, a detailed action plan would be agreed at the Executive committee by the end of May, and presented to the Quality committee meeting in July. The Committee noted the update report.	SMcM
3.1.5	**Medicine – optimisation and incident reports** Ann Mounsey reported that a Medicines optimisation committee had been formed in 2014, whose responsibility it was to undertake a performance management role for medicines optimisation through the medicines related committees. A framework assessment of medicine optimisation had been carried out November 2014 and the TDA had reported the Trust was the second highest scoring of acute trusts. The report would be submitted to Executive committee and the July meeting of Quality committee. Ann Mounsey highlighted that: • Incident reporting has increased year on year • The number of incidents causing harm had reduced. The Committee noted the reports.	KN
3.1.6	**Quarterly update on the quality impact assessments (QIA) for Trust cost improvement programmes (CIP)** Prof Janice Sigsworth reported that approximately 98 per cent of QIAs for 2015/16 CIP schemes had been signed off and would be circulated to the divisions again for review before the end of the week. Prof Sigsworth, in response to a query from Prof Anthony Newman Taylor, confirmed that any new CIPs introduced through the year would be subject to the same scrutiny as those agreed initially. The Committee noted the update.	

3.1.7	**Annual complaints report** Prof Janice Sigsworth highlighted that: • During 2014/15 the Trust received a total of 1242 complaints - a 28% increase compared to 2013/14 • There had been a noticeable increase in the complexity of complaints received • The Division were focusing on a 'cause and effect' approach to reducing complaints Kerensa Heffron noted that Imperial Private Healthcare managed its own complaints but figures were included in the report (approximately two complaints per month). A further update would be provided in six months with a medicines snap shot by ward to the July meeting and lessons learnt from complaints on an annual basis. The Committee noted the update.	JS
3.2	**PEOPLE**	
3.2.1	**Raising concerns update** Keith Loveridge highlighted: • The Raising Concerns (Whistleblowing) Policy had been updated to include a Freedom to speak up guardian (Director of people & OD) and a named Non-executive director for raising concerns (Professor Sir Anthony Newman Taylor). • The Trust was in the top 20% scores in the most recent NHS staff survey for staff confidence in the procedures for reporting errors and incidents. The Committee noted the update.	
3.3	**SAFETY**	
3.3.1	**J. Savile / Kate Lampard lessons learned report** Jan Aps reported that the Trust was required to respond with an action plan to the TDA by 31 May. There was one recommendation which required further action; a joint Trust /charity VIP policy was under development. The Committee noted the report.	
3.3.2	**Responsible Officer's annual report** Julian Redhead highlighted: • FQA appraisal compliance for 2014/15 had increased significantly in comparison with 2013/14 (+21%). • Revalidation recommendations for doctors in training were dealt with by the Local Education Training Board. The Committee noted the report.	
3.3.3	**Annual Safeguarding reports inc Annual Safeguarding Children declaration** Prof Janice Sigsworth highlighted: • Training rates in adults safeguarding had improved • The internal audit report had provided 'reasonable' assurance about the trust safeguarding systems and processes • A key priority for 2014/15 was to screen for and report incidences of female genital mutilation (FGM) and to provide an associated counselling service for these women. The Committee noted the report.	
3.3.4	**Health & Safety update** Sanjay Dhir highlighted: • The development of a new Health and Safety policy statement • That the majority of RIDDOR accidents related to slips, trips and falls followed	

	by manual handling injuries • That a complaint had been received from the HSE regarding vehicle safety at Hammersmith Hospital. The HSE had since confirmed they were happy with the project plan and risk assessments completed and no further action would be taken • The creation of relevant and simple guidance/SOPs/checklists for staff and users. It was reported that the substantive Head of Health and Safety would join the Trust 15 June. The Committee thanked Dr Batten for raising the Health and Safety profile and Mr Dhir for all his hard work. The Committee noted the update.	
3.3.5	**Patient Safety Translational Research Centre** This item was deferred to the Committee meeting in July.	TW
3.3.6	**Closure of Hammersmith emergency unit – 6 month review** Sally Heywood highlighted: • There had been no SIs as a result of the closure of the unit • Pathways for acute medicine into ICHT sites are now coordinated by the Single point of Access Medicine (SPAM) telephone line. The Committee noted the update.	
4	**COMMITTEE WORK PLAN**	
4.1	**Committee work plan** An updated work plan would be circulated to paper authors the week following the meeting. The Committee noted the update.	
5	**ANY OTHER BUSINESS** There were no items of any other business.	
6	**DATE OF NEXT MEETING** Wednesday 15 July, 10am to 1pm, Clarence Wing Boardroom, St Mary's Hospital.	

QUALITY COMMITTEE – ANNUAL REPORT 2014/15

Introduction:

The quality committee is a standing committee of the board. The terms of reference for the quality committee have been approved by the board. The committee consists of three independent non-executive directors (four until December 2014), the chief executive, medical director, director of nursing, and chief operating officer. The divisional directors and director of infection prevention and control are standing attendees. Attendance of the members is recorded in the Trust's Annual report, and no issues were identified.

The committee has a heavy agenda but maintains a regular review of its cycle of work to ensure appropriate timing of reports and streamlining of the agenda where possible. There have been changes to the formats of key risk updates from divisional directors and the quality report to improve the level and type of information provided and to enable the committee to identify any common themes, where they exist, and therefore discharge its responsibilities more effectively.

A catalogue of agenda items and meeting papers is maintained and a report is made to the Trust board following each meeting.

Principle review areas:

The report is divided into six sections reflecting the key duties of the committee:

1. Quality governance
2. Patient centeredness
3. Effectiveness (monitoring and improving clinical performance)
4. Safety (managing service user safety and clinical and other risks)
5. Equity (equality and diversity)
6. Efficiency and timeliness.

1. Quality governance

The committee reviewed, at each meeting, the key divisional risks, frequently seeking clarity and suggesting amendments to the risk description, scoring, and actions in place to mitigate risks. It also regularly sought assurance and evidence that controls, action plans and, if necessary, contingency arrangements, were adequate.

2. Patient centeredness

The committee received reports on the Friends and Family Test, National Inpatient Survey results and Staff Engagement surveys and has received regular updates regarding "you said, we did" staff engagement arrangements.

The committee received an annual report on complaints which focused on themes and trends together with the actions in place to reduce recurrence. The report provided assurance that the Trust was taking action where required in response to issues raised.

The Committee was notified of new health and social care regulations coming into force; the regulations set out a duty of candour for NHS bodies, which came into force in October 2014. The Committee was assured that appropriate actions were in place to comply with the new regulations and received further updates which focused particularly on the implementation of the Duty of Candour policy, staffing implications and a procedure specific consent form.

3. Effectiveness (monitoring and improving clinical performance)

Following the Care Quality Commission (CQC) inspection in September 2014, the committee monitored closely the Trust's compliance with standards and received, at each meeting, an assurance report. Implementation of the requirement to publish CQC ratings on the Trust website as well as across premises, and public entrances from 1 April 2015, was also noted.

The committee reviewed actions that had arisen from the Francis Review in 2013. It was noted that many of the recommendations already formed part of the Trust's existing practices and had been evidenced as part of the CQC inspection. The committee will continue to monitor the Trust's compliance with the Francis report's recommendations through agenda items reported at each of its meetings (e.g. reports on quality, patient experience, workforce and CQC).

The committee ensured that it monitored compliance with a range of regulations and standards on a periodic basis, including infection control, health and safety, controlled drugs, and the winter operational plan. The committee also ratified the duty of candour policy.

4. Safety (managing service user safety and clinical and other risks)

Over the year the committee has received through the Quality report updates on all serious events and never events.

The committee has continued to closely monitor the Trust's mortality rates through regular reports from the medical director; the detailed information which has been received by the committee has included analysis of trends and performance variations underlying the figures.

The committee has continued to maintain a focus on key risk areas from a patient safety perspective, including drug control and administration, safeguarding and staff training compliance.

The committee has received a report on litigation from the Legal team and receives regular medico-legal updates as part of the Quality reports to provide assurance that risk is being managed appropriately.

5. Equity (equality and diversity)

The committee continues to keep oversight of equality and diversity within its scope of activity, particularly in relation to patient and staff responses to experience surveys.

6. Efficiency and timeliness

The Quality Impact of proposed Cost Improvement Plans was considered at regular intervals during the year, with examples provided of where mitigating action had been taken to minimise the risk to Quality.

7. Annual self–assessment of effectiveness

At the time of circulation of the papers not all the responses had been received from members and standing attendees – this will be completed prior to submission to the Trust board.

Conclusion:

The committee believes that this report demonstrates that it has discharged its duties under its terms of reference.

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Finance & Investment Committee (22 July 2015)**

KEY ITEMS TO NOTE

Community Ophthalmology bid

The committee was pleased to note that the Trust had been awarded the tender to provide an innovative model of ophthalmology services embracing community providers.

Finance report - for the 3 months ended 30 June 2015

Mr Goldman reported that at quarter one, the Trust was reporting a deficit of £11.0m; an adverse variance to plan of £1.9m. Over the first quarter, £4.6m (69%) of planned CIPs have been delivered and in-month delivery is forecast to improve from July (to 88%). An early view of the position for the quarter shows that the Trust was operating within its approved and funded staffing establishment with bank and agency overspends balanced by underspend in substantive pay. Whilst there was limited information on activity and performance, there was underperformance in activity resulting in reduced income particularly in the surgical division and private patients. The Medicine Division had been asked to bring forward a plan to return to budget and claw back their quarter one overspend.

The committee reviewed the CIP programme, and particularly those of highest value, and those most at risk – the divisional directors were being held to account for their delivery of these plans. The committee requested a separate paper on this for every meeting led by operations.

Shaping a Healthier Future – revised business case

The revision had allowed for amendment to activity modelling and bed numbers, and a reshaping of the St Mary's site, and the committee discussed the changes in the capital requirements of the changes, and the recent changes to expected land values. Some concern was expressed as to the efficiency of the required process, but the committee noted that once approved by Treasury the business case would give the Trust greater flexibility of approach.

The committee recommended the case to the Trust board for approval, noting that revenue costs had yet to be made available.

RIS /PACS re-procurement – outline business case

The committee noted that re-procurement was progressing well, and that a preferred bidder was expected to have been agreed by mid-August. The committee recommended the outline business case for approval by the Trust board.

Microbiology automation – full business case

The committee noted that the outline business case had been approved in March 2014. It

was confirmed that the cost of the equipment would be taken into account as part of the joint venture. On this basis, the committee recommended the outline business case for approval by the Trust board.

2015/16 Capital programme report
The committee noted the robustness of the prioritisation process in place (aligned to the risk register) to decide how capital expenditure was allocated. It was agreed that the audit, risk and governance committee would be asked to have oversight of estates risks in a similar way to that which the quality committee had over the clinical risks. It was also noted that the capital spend may have to be relooked at if there was adverse financial performance.

Hotel and catering services - post implementation review
The effective use of multi-department involvement in the procurement process was commended, and the committee noted the effective handover that had been achieved. Lessons had been learned in relation to increasing the pace of driving improvement.

Reference costs submission
The committee recommended the process undertaken and the reference cost submission to the Trust board for approval.

Treasury Policy
The committee approved the proposed policy.

Terms of reference
The committee formalised the inclusion of private patients oversight within the terms of reference.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Sarika Patel, Chairman, Finance & Investment Committee
Report author: Tracy Walsh, Board committee secretary
Next meeting: 23 September 2015

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE FINANCE & INVESTMENT COMMITTEE

Wednesday 20 May 2015
4.00pm – 6.00pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sarika Patel	Non-Executive Director (Chair)
Dr Rodney Eastwood	Non-Executive Director
Dr Andreas Raffel	Non-Executive Director
Dr Tracey Batten	Chief Executive
Alan Goldsman	Interim Chief Financial Officer
In Attendance:	
Jan Aps	Trust Company Secretary
Sandra Easton	Deputy Director of Finance - Business Partnering & Profitability
Jonathan Evans	Deputy Director of Finance - Financial Planning
Ian Garlington	Director of Strategy
Doyin Ogunbiyi	Women's and Children's Business Partner – Finance (items 1 – 2.4)
Jon Schick	QuEST Manager (items 2.1 – 2.5)
Marina Stanton	Women's and Children's Divisional Director of Operations (items 1 – 2.4)
Prof TG Teoh	Divisional Director Women's and Children's (items 1 – 2.4)
Tracy Walsh	Committee Clerk (minutes)

1.	**GENERAL BUSINESS**	**Action**
1.1	**Chair's opening remarks & apologies for absence** The Chair welcomed everyone to the meeting. Apologies had been received from Jeremy Isaacs and Steve McManus. The Chair specified that only items that were agreed at the agenda setting meeting would be discussed by the committee. Papers need to be received at least 5 working days before the meeting.	
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
1.3	**Minutes of the Committee meeting on 19 March 2015** The minutes were approved as an accurate record.	
1.4	**Action log and forward plan** The action log was noted and would be updated: • Item 2.2, Private Patients – a date would be added to the action log for a further review of progress. • Item 2.1, CQUIN payments – the Committee would be updated via email of the outcome of negotiations.	SMcM AG

	• The treasury policy that was due to come to the committee meeting in May should be presented in July The forward plan was noted and would be updated: • Cerner post-project implementation review – a date for this to be presented to the Committee would be confirmed. • Treasury policy – July • Post implementation review of hotel services – July Capital report 2015/16, including backlog maintenance – a report would be submitted to the Committee in July, and a 10-year plan in September.	AG/KJ AG/IG
2.	**MAIN ITEMS**	
2.1	**Finance report** Alan Goldsman introduced the report for the 12 months ended 31 March 2015 and highlighted that: • The year-end position showed a surplus of £15.4m, a favourable variance to plan of £4.2m. This included Project Diamond income of £24.4m, without which a deficit position was likely • The operating deficit was circ £8mn • There was a reasonable cash position at the end of year • During February and March approximately 500 substantive posts had been recruited to and the consequent reduction in Bank and Agency staff had taken place in April. Alan Goldsman highlighted in the summary for April 2015 (month 1): • A deficit of £5.6m (with the removal of Project Diamond there was an underlying deficit of £22.8m) • A substantive increase in the insurance premium (CNST) which was expected to continue to increase year on year • Private patient revenue was below plan for April • Additional funding of £0.6m had been received through a 'right to light' payment. The Committee noted the Finance report for month 12 (2014/15) and month 1 (2015/16).	
2.2	**Annual plan submission** Alan Goldsman introduced the annual plan submission for 2015/16, which had been approved by the Trust board on 13 May and highlighted: • The Default Tariff Rollover (DTR) would apply from 1 April 2015 until such point as new contract terms were agreed • The current value of the Cost Improvement programme was £36.8m. The Committee noted the annual plan submission noting that final confirmation of contracts was outstanding. Any variance from submission would be highlighted to committee members.	AG
2.3	**PICU full business case (FBC)** Prof TG Teoh highlighted the significant changes since the business case was last presented: • Costs had increased since the outline business case (£900k), mainly due to additional extensive ventilation work required in the Clarence wing and strengthening of the 7th floor in the Queen Elizabeth Queen Mother building	

	• A revised fee structure had reduced the overall cost of fees • £4.3m of the gross capital requirement would be funded by Imperial College Healthcare Charity and COSMIC. In response to a question from Sarika Patel with regard the £1.8m increase in staffing costs, Prof Teoh confirmed they would be substantive posts (not temporary cover), and there would be an element of staff recruitment from overseas. Prof Teoh confirmed the FBC met the TDA's requirements. TG was urged to look at additional revenue opportunities from commissioners, the College and private research. The planning application would include any other changes to adjacent space. The Committee would be kept updated should any matters of import arise. The Committee recommended to the Trust board the approval of the full business case, requiring the recommendations made in discussion to be considered.	TT
2.4	**Ealing maternity** Prof TG Teoh introduced the update and highlighted: • That no agreement on finalising the 2014/15 transformation funding had been agreed • An extra £0.4m for maternity theatre refurbishment was being considered by the commissioners • The Steering Group awaited confirmation of ICHT bridging costs, circa £308k, assuming go-live date of 28 May. The decision to proceed with the transition would be made by Ealing CCG governing body later that day. The Committee noted the update.	
2.5	**Cost improvement plans** Jon Schick reported that a total of 209 CIPs had been identified for 2015/16 with a total value of £36.8m; he highlighted some of the key efficiency programmes: • A new e-rostering programme • Reduction of readmissions being enabled by a new reporting tool developed by IT • Medicines management. The committee asked that the report, to be presented at each meeting, be more specific – with analysis of schemes by type of CIP, and by division, with a demonstration of progress for each scheme. The top ten schemes by value (to include the description of the scheme, the value and the risks) should be presented to the next Committee meeting in July.	SMcM/JS SMcM/JS
2.6	**Ealing integrated intermediate care services tender** This item had been withdrawn as the Trust had made the decision not to proceed with the tender process, due to the financial model proposed by Ealing CCGs and perceived lack of engagement in primary care.	
2.7	**Community ophthalmology tender** This item was not discussed during the meeting given that Prof Mayet had not been able to attend. A telephone conference was arranged for Friday	

Imperial College Healthcare NHS Trust

	22 May.	
	ITEMS FOR READING	
3	**GOVERNANCE ITEMS**	
4	**FINANCE ITEMS**	
5	**ANY OTHER BUSINESS**	
6	**DATE OF NEXT MEETING** Wednesday 22 July 2015 4.00pm – 6.00pm, Clarence Wing Boardroom, St Mary's Hospital.	

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE FINANCE & INVESTMENT COMMITTEE

22 May 2015
11.00 – 11.30
By teleconference

Present:	
Sarika Patel	Non-Executive Director (Chair)
Dr Rodney Eastwood	Non-Executive Director
Steve McManus	Chief operating officer
In Attendance:	
Prof Jamil Mayet	Divisional director, Surgery and Cancer
Nicola Grinstead	Director of operational performance
Jan Aps	Trust Company Secretary

1.	**GENERAL BUSINESS**	**Action**
1.1	**Chair's opening remarks & apologies for absence** Sarika Patel welcomed members to the additional teleconference meeting arranged to discuss the Community Ophthalmology tender bid which it had not been possible to discuss at the meeting on 20 May. Apologies had been received from Jeremy Isaacs, Dr Andreas Raffel, Alan Goldman and Tracey Batten.	
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
2.	**MAIN ITEMS**	
2.1	**Community Ophthalmology tender bid** Prof Mayet apologised for not having been available for the original meeting. In relation to tenders more generally, and the Trust's approach to bidding for community services, Ms Patel, asked that: • The executive clarify the agreed strategy for community services, noting Steve McManus's point that the Trust was actively seeking to increase delivery and leadership of community services. • The Trust develop a clear rationale against which individual bids can be evaluated. • That a paper be presented to the Trust board outlining how oversight and assurance systems will be achieved for community services. • All bids presented to the committee to contain financial and resource implications. • Outline information be shared with committee members as soon as invitations to tender (ITT) that are likely to be submitted are received by the Trust. The following were the key points of discussion: • Additional overhead and administration costs: most of this cost was considered to be absorbed in local teams, but it was acknowledged	IG/SMc IG SMc

	that as the volume of bids resource would need to increase. Steve McManus noted that the business planning team were the focus for this activity and further thought would be given to resourcing and the need to prepare 'template' information to ease the burden on operational teams. • Clinical liability: Prof Mayet confirmed that some clinical liability would lie with the Trust and that this would be worked through in the working group should the Trust be successful in the bid. • Heads of agreement documentation: Ms Patel asked that the HoA documentation be legally reviewed prior to signing. • Value of the contract: Direct value of the contract was £2m (a contribution of 17%, with income from additional procedures as a result of diagnostics increasing this to a contribution of 21%. If volumes increased beyond those outlined in the specification, the Trust would be able to either renegotiate the value, or see patients at the Western Eye which would be paid for as cost and volume activity. • General activity /funding: Prof Mayet explained that demand for follow up activity was currently outstripping capacity at the Western Eye Hospital, and that commissioners had funding some specific additional activity. This would hold income at similar levels should the Trust not be successful in this bid, but income would be enhanced if the bid were successful. • Additional resources: These were identified as two consultants, additional nurses, optometrists, technicians, administration staff and consumables. Sarika Patel asked that these be detailed for the Trust board discussion. Given the level of engagement and collaboration, it was considered that the costing and resources requirements were appropriate. • Likelihood of success: the committee noted it was considered to be a strong bid, with good support from the community, but noted that there was a clear private sector alternative. **The committee agreed to recommend the bid for approval at the Trust board, but asked for additional information to be made available in the presentation in relation to risks; profitability; governance arrangements; and the Trust's approach to future tender bids.**	JM JM/ SMc

Imperial College Healthcare NHS Trust

MINUTES OF THE FINANCE & INVESTMENT COMMITTEE

15 June 2015
15.30 – 16.00

Present:	
Sarika Patel	Non-executive director (Chair)
Dr Tracey Batten	Chief executive
Alan Goldsman	Interim chief financial officer
Steve McManus	Chief operating officer
In Attendance:	
Jan Aps	Trust company secretary
Ruth Dixon del Tufo	Head of major trauma and emergency pathways (by teleconference)

1.	**GENERAL BUSINESS**	**Action**
1.1	**Chair's opening remarks & apologies for absence** Sarika Patel welcomed members to the additional teleconference meeting arranged to discuss the Tri-borough interim neuro-rehab services proposal. Apologies had been received from Jeremy Isaacs and Dr Rodney Eastwood; unfortunately Dr Andreas Raffel was also unable to attend, which meant that the meeting was not quorate. Deferral was not considered appropriate due to commissioner timescales, and Jan Aps agreed to arrange for a request to the Trust board chairman for approval of action to be taken under paragraph 24.2 of the Trust Standing Orders – emergency powers.	**JA**
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
2.	**MAIN ITEMS**	
2.1	**Tri-borough interim neuro-rehab services proposal** Sarika Patel was concerned that a further bid had required committee review outside the normal meeting timetable. It was confirmed that commissioners had expected to extend the existing contract with UCLH foundation trust, but protracted negotiations had failed to reach agreement on providing a service for the remainder of the year, and contact offer had been made in the last week of May outside the usual market engagement process, with bids to be returned by 9 June 2015 (the longer term contract had been announced via the market engagement process). The committee noted the Trust's submission (on 9 June) of the proposal to provide, in partnership with The Hillingdon Hospital Foundation Trust, interim neuro-rehabilitation services commencing in September 2015 for an 8 month period; Ms Patel challenged whether the stated 25% contribution figure was accurate, and asked for confirmation of minimal usage of diagnostics. Alan Goldsman outlined that he had enquired into these areas and have been assured by the information provided (both from the existing provider and from the Trust's knowledge). It was noted that should patients require further	

	diagnostics, this would normally be associated with a further stay. The costings were considered to be appropriately conservative, having used a high level of agency cost for staffing, and included capital requirements; the pricing would not prejudice pricing for any future contract. Although acting as a partner, Hillingdon had not been approached to provide the service as the tri-borough wanted the service provided within the locality. The committee, noting the risks and controls and mitigation to these, felt that the proposal fitted with the clinical strategy, and would make an appropriate contribution. It recommended approval (for action under paragraph 24.2 of the Trust's Standing Orders) of the proposed service, should the Trust's bid be successful. The committee noted that, if appropriate, a further discussion will take place at the July meeting in relation to the longer-term contract, which would, if presented, provide further details on the costings and margins.	
	Post meeting note Approval of action to be taken under paragraph 24.2 of the Trust Standing Orders – emergency powers was sought and received from the Trust board chairman on 15 June 2015 – this will be reported at the Trust board.	

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Remuneration Committee (24 June 2015)**

Key points to note:

Appointment of chief financial officer: The committee ratified the appointment of Richard Alexander as chief financial officer, noting that he would start at the beginning of August 2015
.

Update on appointment of director of people and OD: Noting that there were two candidates in the final round of recruitment, the committee agreed that options would continue to be explored to ensure that the best appointment was made.

Executive team – salary market positioning and recommendations: The committee noted the benchmarking review undertaken by Jackie Reeves Associates. The committee agreed that no executive salary increases would be considered at that time.

Executive director performance & development reviews: The committee ratified the rating given to the each of executive directors by the chief executive.

Chief executive performance & development review: The committee ratified the rating given to the chief executive by the chairman, and also the objectives set for 2015/16.

Chief Executive succession planning: The committee agreed that a succession plan for the role would need to be considered for the future.

Redundancy approval: The committee, whilst noting that the individual concerned continued to seek alternative employment, agreed to recommend the redundancy for consideration by the Trust Development Agency.

Recommendation:

The Trust Board is requested to:

- Note the report

Report from: Jeremy Isaacs, chairman, Remuneration committee
Report author: Jan Aps, Trust board secretary
Next meeting: To be confirmed

Imperial College Healthcare NHS
NHS Trust

Trust board - public

Agenda Item	6.1
Title	Update on Emergency Preparedness, Resilience and Response (EPRR) at Imperial
Report for	Monitoring and Noting
Report Author	Nicola Grinstead, Director of Operational Performance
Responsible Executive Director	Director of Operational Performance

Executive Summary: At the Trust Board Meeting on 28th January 2015 an update on the annual external EPPR assurance process was reported and discussed (in paper 3.2)

The Trust Board was reminded that all acute Trust's must demonstrate compliance with 66 indicators based on 12 core EPPR standards. It was noted that against these 66 indicators ICHT achieved 55 green ratings (83%), 11 amber ratings (17%) and zero red ratings.

An action plan setting out how to improve the Trust's resilience, particularly in relation to those amber ratings, was presented to the Trust Board.

This paper sets out the progress made in relation to that action plan since January, demonstrating that all actions are on track for completion with agreed timelines.

Main themes:
- Risk register and risk assessments need to be updated
- Business continuity plans
- EPRR trust wide forum to be set up quarterly
- Incident training for on-call teams
- Training records to be updated.

Recommendation to the Board:

1. Note and acknowledge updated position on EPRR action plan

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.

1. Introduction and Context

1.1. The Civil Contingencies Act (2004) places a legal obligation upon emergency services and local authorities (defined as Category 1 responders under the Act), including ICHT, to assess the risk of, plan, and exercise for emergencies, as well as undertaking Business continuity Management. It also places legal obligations for increased co-operation and information sharing between different emergency services and also to non-emergency services that might have a role in an emergency.

1.2. Additionally, the Care Quality Commission regulate by inspection the health service to independently asses health care including providers emergency planning as part of its patient safety and quality agenda.

1.3. NHS England's assurance framework pulls together various strands of legislation. Yearly the Trust self-assesses itself against these standards, helping us to understand our position in relation to readiness, resilience and compliance with legislation. NHS England validates this self-assessment.

1.4. Progress is always on-going and dynamic as planning requires regular review to ensure fit for purpose planning and to incorporate latest guidance an issues. Staff turnover also requires a rolling programme of training and testing. Although the next formal validation will not be until later in the year, updated records and ongoing training are important in light of the significance of the subject.

1.5. As part of the assurance process the Board (or equivalent) must be sighted on the organisation's level of compliance, and following the EPRR assurance process, later this year, the results of the assessment and the action/ work plan for the forthcoming period.

2. 2014 EPRR Assurance Assessment

2.1. In November 2014, the NHS England London EPRR team undertook a review of the emergency preparedness activities at Imperial College Healthcare NHS Trust against the 12 nationally defined EPRR core standards.

2.2. Trusts were required to submit evidence in relation to the 12 core standards by demonstrating how they meet 66 indicators. ICHT achieved 55 green ratings (83%), 11 amber ratings (17%) and zero red ratings.

2.3. Single overall Level of Compliance, approved by the AEO (Accountable Executive Officer – Steve McManus), was self-assessed as 'Substantial' and agreed by NHS England

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address several core standard themes that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address multiple core standard themes that the organisation is expected to achieve.

2.4. Attached is the updated action plan which is on track and in hand to deliver all the amber ratings within the EPRR annual plan.

2.5. The following actions have been prioritised by the team to ensure our EPRR plans remain GREEN rated through the next round of assurance aiming for "full compliance;

- Continued development of business continuity plans
  i. Collation and compilation of outstanding business impact analysis
  ii. Revision of risk assessment in relation to business continuity
  iii. Alignment to ISO 22301 standard.
  iv. Revision of critical services, utilities, IT and telecoms business continuity plans and centralisation within the Strategic Business Continuity Plan.
  v. Further development of Cerner-related business continuity plans
  vi. Revision of Cerner downtime plan
- Improved planned arrangements for Surge and Escalation Management (including links to appropriate clinical networks e.g. Burns, Trauma and Critical Care),
- Revised Major Incident plans and evacuation plans
- Arrangements in place for resilient communications, particularly in relation to NHS England command and control
- Compilation of evidence of incident commanders (on-call directors and managers) and training records
- On-going internal training based upon current good practice and using material that has been supplied as appropriate specifically in relation to staff personal protective equipment for outbreak management.

3. Recommendation to the Board:

1. Note and acknowledge updated position on EPRR action plan

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Appendix 1

Table matrix of amber assessed EPRR standards and actions associated with 2014 Emergency Preparedness,

	Core standard	Clarifying information	Evidence of assurance	Action to be taken	Completed/ Timeframe
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	EPRR risks to be aligned with the ICHT Risk Management process.	Recently aligned (action completed pending review).
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	Business continuity plan to be updated and signed off.	SEE 11 BELOW
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)		Critical care network to be referenced within EPRR Strategy	Completed
		Evacuation		Evacuation plan to be completed and signed off	Plan completed – for sign off only. Agreed formation of EPRR forum wherein this will be reviewed (end October 2015)
		Utilities, IT and Telecommunications Failure		All local BC plans to be reviewed. Completion of Cerner risk assessment and BC plan (Further development of Cerner-related business continuity – on-going and for entry to plan end September 2105)	Cerner BC plan in place, revision due by end September 2015) Review of Utilities, IT and Telecommunications Failure plans by end November 2015

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	Core standard	Clarifying information	Evidence of assurance	Action to be taken	Completed/ Timeframe
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	- Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	• Continued development of business continuity vii. Pulling together of corporate and service level business continuity arrangements including plans (and revision Strategic Business Continuity Plan) viii. Collation and compilation of outstanding business impact analysis returns ix. Revision of risk assessment in relation to business continuity x. Continued endeavour to align to ISO 22301 standard. xi. Revision of critical services, utilities, IT and telecoms business continuity plans and centralisation within the Strategic Business Continuity Plan.	April 2016
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		• Specify who has been consulted on the relevant documents/ plans etc.	Internal key stakeholder engagement to be implemented as per EPRR Strategy.	Agreed formation of EPRR forum (end October 2015)
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	NHS England recommends satellite telephony purchase. Resilience to be reviewed.	Trust and NHS London differ on views of comms. response. Trust assured of own process though NHS London not currently concurring with self-assessment (on-going dialogue)

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	Core standard	Clarifying information	Evidence of assurance	Action to be taken	Completed/ Timeframe
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Management staff rolling training package to be developed and implemented.	End September 2015
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Risk assessment specific to CBRN to be completed	Completed

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	Core standard	Clarifying information	Evidence of assurance	Action to be taken	Completed/ Timeframe
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include on-going fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme Clarifying Information also includes: • Including, where appropriate, Initial Operating Response (IOR) and other material.	On-going fit tester training programme to be revised since moving to disposable masks.	Completed (though On-going fit tester training)

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Trust board - public

Agenda Item	6.2
Title	Local Supervising Authority (LSA) Report of Standards of Supervision of Midwives
Report for	Noting
Report Author	Jackie Baxter, Supervisor of Midwives
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:

There is the need for the findings of the annual audit of activity undertaken by the local team of supervisors of midwives by the Local Supervising Authority (LSA) to be conveyed to the Trust Board. This report will summarise the findings of this audit undertaken in October 2014. In the LSA report the authors comment that the Supervisors of Midwives (SoM) team worked extremely hard to achieve a high level of audit activity whilst meeting the Standards for Statutory Supervision and raising the profile within the organisation. The authors also state that all of the Standards for Statutory Supervision have been met and the recommendations relate to fine tuning of the statutory function.

Recommendation to the Board:

The Board is asked to note this report for information only.

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

Local Supervising Authority (LSA) report of standards of Supervision of Midwives

This report is to inform the Board of the findings of the annual audit undertaken by the Local Supervising Authority, which was conducted on 2nd October 2014. This process is in accordance with the Local Supervising Authority Standards for the local Supervision of Midwives' team to communicate its activity with the Trust. Four key domains were assessed:

- the interface of Statutory Supervision of Midwives with clinical governance;
- the profile and effectiveness of Statutory Supervision of Midwives;
- team working;
- leadership and development and Supervision of Midwives the interface with service users.

1. The audit was successful with all four domains being met. The assessors acknowledged that the supervisory team have worked extremely hard during the year to achieve a high level of audit activity, whilst meeting the Standards for Statutory Supervision and raising the profile within the organisation. It is also mentioned in the report that the recommendations relate to fine tuning of the statutory function only. The report notes that the team has further developed since the previous audit in 2013 and were commended at the London LSA Awards event in October 2014.

2. Twelve minor recommendations are listed below. These as mentioned above relate to fine tuning of the statutory function only and will be monitored by the quarterly meeting of the local Quality and Safety Committee :

   - Strengthen the contribution of Statutory Supervision at unit meetings;
   - Monitor the implementation of audit recommendations in an effective way to ensure that midwifery practice improves;
   - Implement quarterly briefings with the Director of Midwifery and Director of Nursing;
   - Evaluate a new reflective tool and add a date to the reflective tool;
   - Create a pathway of referral to the Supervisors of Midwives (SoM) led Birth Reflections Service for obstetricians and midwives to directly refer;
   - Consider how the leaflet for parents following pregnancy loss to also be available for women at the Queen Charlotte's and Chelsea Hospital (QCCH) site;
   - Feedback from SoM walkabouts - there is the need to consider how this is reviewed and acted upon (to reassure midwives of the responsive nature of supervision);
   - Continue the resource of full time SoM to further enhance the function of statutory supervision;
   - Work with the management team to further support and engage with the work of the MSLC;
   - Consider how to further raise the profile of supervision within the unit and with information for women in the maternity notes;
   - Consider how to test the process or improve for contacting the SoM on-call by telephone;
   - Encourage greater user involvement and feedback overall to proactively seek the views of seldom heard groups.

3. One recommendation from the previous audit was on-going at the time of the report however this will be resolved in July 2015 with the introduction of a senior midwife on-call out of hours and at weekends. This related to the appropriate use of the on-call system for Supervisors of Midwives out of hours. They should only be called for supervisory concerns, whereas previous audit findings showed that Supervisors of Midwives were being used to solve management issues. This is out with national standards for midwifery supervision.

There are no risks related to this report. Item 3 above which was brought over from the previous report has been corrected with the introduction of a new practitioner role out of hours from July 2015.

Recommendation to the Board:
The Board is asked to note this report for information only.