Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
25 November 2015
11.30 – 13.00
Maple & Ash suites, W12 Conference Centre, Hammersmith Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	11.30	Oral
1.2	Board member's declarations of interests	Chairman		1
1.3	Minutes of the meeting held on 30 Sept 2015	Chairman		2
1.4	Record of items discussed at Part II board meeting 30 Sept 2015	Chairman		3
1.5	Action Log	Chairman		4
2	**Operational items**			
2.1	Patient story	Director of nursing	11.35	5
2.2	Chief Executive's report	Chief executive		6
2.3	Operational report & scorecard	Chief ops officer		7
2.4	Finance report	Chief financial officer		8
3	**Items for decision or approval**			
3.1	NHS TDA self-certifications – Sept/Oct 2015	Trust co secretary	12.00	9
3.2	Redevelopment Committee	Chief executive		10
4	**Items for discussion**			
4.1	Improving the quality of care – CQC update report	Director of nursing	12.10	11
4.2	Corporate risk register	Director of nursing		12
4.3	Patient and public involvement framework	Director of communications		13
4.4	ICHT website update	Director of communications		Verbal
5	**Board committee reports**			
5.1	Audit committee minutes (8 July) and report (7 October)	Committee chair	12.45	14
5.2	Quality committee report (11 Nov)	Committee chair		15
5.3	Finance and investment committee report (18 Nov)	Committee chair		16
6	**Items for information**			
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			12.55	
9	**Date of next meeting**			
	27 January 2016, New Boardroom, Charing Cross Hospital			

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Board Members' Register of Interests

Sir Richard Sykes Chairman
- Director, EDBI Pte Ltd since 2011
- 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, Royal 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
- President'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
- Member of the International Advisory Board of Cranfield School of Management
- Non-Executive Director, Olswang LLP
- Trustee and board member Crime Reduction Initiative (CRI)

Dr Tracey Batten Chief Executive

- Trustee of The Point of Care Foundation

Richard Alexander Chief Financial Officer

- Non-Executive Director of HDI – Health Data Insights
- Ex Oracle employee and current shareholder

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

Wednesday 30 September 2015
12.00 – 1.00
Clarence Wing Boardroom, St Mary's Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy Chairman (until item 4.1)
Dr Rodney Eastwood	Non-executive director
Jeremy Isaacs	Non-executive director (until item 2.4)
Prof Sir Tony Newman Taylor	Non-executive director
Sarika Patel	Non-executive director (until item 4.1)
Andreas Raffel	Non-executive
Dr Tracey Batten	Chief executive officer
Richard Alexander	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)
Ruth Brown	Associate Medical Director Education (item
Karen Charman	Interim director of people and organisational development
Michelle Dixon	Director of communications
Ian Garlington	Director of strategy & redevelopment
Prof Alison Holmes	Associate medical director infection prevention and control (item 4.3)
Dr Ruth Brown	Associate medical director for education (item 4.4)
Prof Jonathan Weber	Vice Dean of the Faculty of Medicine (Research), Imperial College
Guy Young	Deputy Director of Patient Experience (item 2.1)

1	**General business**	**Action**
1.1	**Chairman's opening remarks and apologies** The chairman welcomed members to the meeting. Apologies for absence had been received from 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 29 July 2015** The minutes were agreed as an accurate record.	
1.4	**Record of items discussed at Part II board meeting 29 July** 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 Trust board noted the updates to the action log.	
1.6	**Minutes of annual general meeting 9 September 2015** The minutes were agreed as an accurate record.	
1.7	**Draft Trust board & committee schedule 2016-17**	

	Jan Aps introduced the schedule for 2016/17; overall, the schedule follows a similar pattern as for 2015/16. The annual general meeting would be held on 7 or 14 September 2016; members were asked to confirm their preference to Jan Aps. The Trust board agreed: • to the proposed schedule, noting that the Audit, Risk and Governance meetings may move once annual accounts submission dates are confirmed; • to moving the meeting due on 30 March 2016 to 6 April 2016.	**All**
2	**Operational items**	
2.1	**Patient story** Guy Young introduced the patient story as unfortunately the patient concerned had not been able to attend due to family sickness, but had been keen that the experience was shared. CB, a profoundly deaf 50 year old gentleman communicates using British Sign Language (BSL). CB had attended St Mary's A&E department at St. Mary's site on three occasions with neurological symptoms. On each occasion, the Trust was unable to provide a BSL interpreter and staff made assumptions about his ability to understand. He subsequently attended the Stroke ward for a series of tests and examinations, when again, no interpreter was provided. CB and his partner were upset as they had not been able to ask questions or fully understand what was being proposed – a surgical procedure. A friend was called, who was a BSL interpreter and she attended the hospital with them the following day and was able to translate for him. Further examples of thoughtlessness followed, including being told he would receive a phone call (he was told a text could not be provided), no BSL interpreter available for support; and poor communication regarding personal needs. The episode had been very distressing; he could not ask questions and had been confused by what was being said. His friend acted as interpreter to take him through consent, as no other facility had been arranged. On discharge, a similar situation occurred, with drugs being prescribed but inadequate information provided. The patient had complained; his main concern being the lack of reasonable adjustments for dealing appropriately with deaf people, including the non-availability of interpreters. The Trust acknowledged that it had not provided the care deserved, and had now taken action to: ensure interpreters were always available when required; reviewed the translation policy and processes; created resources for teams; introduced video links for translation; made available sign language classes for staff. Both the patient and her his friend were involved in the design of resources and processes. Jeremy Isaacs suggested a review of potential technological solutions. Dr Tracey Batten noted that the Trust had been very responsive after the event, and that the Trust needed to use this as an opportunity to review services for patients with other disabilities The Trust board noted the experience outlined in the patient story.	
2.2	**Chief Executive's Report** Dr Tracey Batten particularly highlighted the following items: • Cerner – There had been good progress in starting the implementation of the clinical documentation and e-prescribing elements of the Cerner system; the care of patients in approximately 150 beds was now covered by the new system. Clinicians were reporting good functionality and ease of use, and inevitable teething problems were being addressed. Sir Richard Sykes queried the level of in-built clinical review that ensure that patients received the correct drugs in the new system, and it was confirmed that prescribing errors would in fact reduce as a result of the system, and that there would be improved feedback, and the opportunity for learning where errors did occur. • Stroke co-location – Dr Batten had visited the unit and feedback from both staff and patients had been very positive; the operational arrangements had gone smoothly, and the larger cohorts of staff were providing opportunities for improving the patient service.	

	Sir Gerry Acher commented that staff from the unit had provided positive feedback when he had met them at the leadership forum. • Leadership forum - Over 100 of the Trust's leaders had joined together to discuss new values and behaviours and the quality improvement methodology. Staff had welcomed the attendance of non-executive directors. • Shaping a healthier future implementation business case- the plan had been to submit this in September, but further work was now required by all parties and the business case was now expected to be submitted early in 2016. • Cancer vanguard application – the application, made in association with The Royal Marsden NHSFT (The Marsden), had been successful. It would be progressed, as a collective, with those submitted by UCLH NHSFT and Central Manchester University Hospitals NHSFT, to design a series of patient pathways using an accountable care model. The Trust board noted the chief executive's report.	
2.3	**Operational Report & Integrated Performance Scorecard** Steve McManus noted the continuing development of the scorecard – each indicator now had a forecast attached, and benchmark performance and stretch targets would shortly be introduced. Particular items discussed were: • 30 day readmission rates were improving, with the ambulatory care services having a positive impact • The spike in day attenders was a result of a change in coding (from day-case to day-attenders) and, in agreement with the commissioners would be re-set • The overall backlog of elective patients waiting over 18 weeks for their operation was showing a continued reduction; achievement against target for August was 91.83%. Waiting times for diagnostics were also showing improvement • Whilst performance in the A&E four hour wait target had shown improvement over the summer months, achieving the target continued to be a challenge, particularly at St Mary's, with overall Trust performance in August of 94.68%. Further actions were being implemented, including: increasing the opening times of the urgent care centre; developing capacity for a surgical assessment unit which would help emergency surgical patient pathways; a new rota for additional medical cover; and extended hours of access to the complex discharge teams. Sir Gerry Acher asked that Type 1 patients were identified within the graphs. • Seven of the eight cancer targets had been achieved, and the Trust was focusing attention on improving the pathways for patients from other trusts to improve performance against the 62 day wait target. • Dr Andreas Raffel requested that bank and agency usage be added to the scorecard. Karen Charman noted that the executive committee increased the level of resources focussing on recruitment which appeared to be successful (improved offer rate, and offering posts to students), and further attention would now be focused on retention to ensure that newly recruited staff were encouraged to remain with the Trust. • Sir Richard Sykes highlighted the high proportion of patients who did not attend their outpatient appointments, and the small variation in the rate; Mr McManus confirmed this was one of the areas being addressed in the outpatient improvement programme, with an aim of reducing this to 7% of appointments. The Trust board welcomed the improvement to the scorecard, and noted the operational report and integrated scorecard.	
2.4	Richard Alexander noted that both executive and non-executive directors were well-briefed on the financial position (Executive Committee, Finance and Investment Committee and informal non-executive briefing), and the response being taken to return the Trust to plan and be in a strong position to start 2016/17. He reiterated the overall position: at end of month 5, the Trust had a deficit of £12.8million, and, if no action were taken, would miss the year-end budget. The Executive team had been completely clear that this was not an acceptable position, and	

	had taken a programme of activities to return the Trust to the year-end plan of an £18.5million deficit. Month on month savings would now require to be of a greater magnitude, not only to return to plan, but to ensure the Trust would be in a position to achieve the reduced run rate required in 2016/17. The Executive team acknowledged this was not a trivial exercise, but there was complete commitment to achievement. The board noted the report, expressing concern at the adverse position, and requested close board and Finance and Investment Committee oversight of the recovery plan.	
3	**Items for decision or approval**	
3.1	**Equality Delivery System (EDS) grading outcome** The EDS was launched to assist organsiation's in meeting their obligations under the 2010 Equality Act, and reviews how trusts are improving services in relation to the protected characteristics. The scoring was undertaken as part of a series of workshops, where stakeholders, including patients, are asked to consider evidence provided against a number of experience outcomes. As a result of the findings, the Trust will focus on improving services for those with learning difficulties, an area where it is often difficult but important to deliver both good care and experience. The Trust board noted the report.	
3.2	**NHS TDA self-certifications – July/August 2015** Jan Aps reported that the self-certifications had been reviewed by individual directors and at executive committee. The Trust board ratified the submission of the July return and approved the submission of the August return.	
4	**Items for Discussion**	
4.1	**Improving the quality of care – CQC update report** Prof Janice Sigsworth noted that the Trust continued to work closely with the CQC in relation to re-inspection; they were still working through trusts they had yet to inspect and the Trust had been informed that it would not be visited in quarter three. The Trust continues to be registered at each site without any conditions. The Trust was focusing on the action plans agreed following the CQC inspection; as progress was made on the 'must do' items, attention was turning to reporting on the 'should do' actions. The key areas of risk, and therefore focus of attention, are outpatients, compliance with mandatory and statutory training, and nursing vacancies. Both the Quality and Audit, risk and governance committees were ensuring oversight of progress against the improvement trajectory. Sir Richard Sykes commented that the Trust was driven by improving the quality of care and experience for the patients, rather than the CQC requirements, noting that the two were closely aligned. Prof Sigsworth also noted that staff would need support in preparing for inspection. The Trust board noted the report.	
4.2	**Trust engagement surveys** Karen Charman introduced the survey results, highlighting the sustained improvement since the survey had been introduced, and the areas which needed further attention. She commented that the Trust needed to work with the information to ensure there was 'engagement with a purpose', and suggested that retention of staff would be a good focus for this. The Trust board noted the report.	
4.3	**Infection prevention and control report** Prof Alison Holmes highlighted: • One case of MRSA BSI had been allocated to the Trust in July 2015. Year to date, two cases had been allocated to the Trust (compared to three at the same point in the previous year). There had been seven cases of MRSA BSI identified at the Trust YTD. • Three cases of C. difficile had been allocated to in Trust in July 2015. None of	

	these had been identified as a potential lapse in care. 26 cases had been allocated to the Trust year to date, compared to 31 at the same point in the previous year; the annual threshold being 69. Two cases of potential lapse in care had been identified. • Surgical site infection was well managed in orthopaedics and cardio-thoracics; similar reporting was needed in other areas. • The Trust had experienced an outbreak of CRE affecting 35 patients since July 2014, of which 33 had been in 2015. There had been a very successful response to this. External stakeholders were engaged in addressing future plans; no new cases had been reported since 3 August, and all areas had been reopened. • Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in the returning traveller – the policy in place had been tested several times; the Trust has had no positive samples to date. The Trust board thanked Prof Holmes, and noted the report.	
4.4	**Medical Education report** Dr Ruth Brown, introduced the first annual report on the medical education transformation programme, which had commenced in 2014, noting that the response from and relationship with the divisions had been strengthened. In highlighting the broadening of training, she noted that the new intranet based-training system would be particularly welcome, as would the education strategy which would be complete by the end of 2015. An Imperial College GEMV visit to the Trust had raised concerns about variable student experience and a robust action plan had been put in place to address this. Dr Brown also reported that the 2014/15 SOLE results shown good improvement on 2013/14; feedback from Charing Cross showed a significant improvement, and a small improvement at Hammersmith. She also reported that an annual quality visit to the Trust from Health Education North West London (HENWL) was scheduled for 2/3 November. In response to a question from Sir Richard Sykes, Dr Brown explained that the Trust was usually given reasonable warning when a training post was to be removed, but the latest incidence had not been expected. She also noted that overall training numbers were reducing as the training was moved away from being London-centric. Dr Rodney Eastwood noted that Dr Brown had also made a welcome presentation to the Quality Committee. He commented that good quality clinical education was key ; the three areas of research, education and service were closely linked and the Trust needed to be delivering well in all areas. The Trust board thanked Dr Brown, and noted the progress with the medical education transformation programme and planned future actions to improve the quality of medical education at the Trust.	
5	**Board Committee Items**	
5.2	**Report from Quality Committee** Dr Rodney Eastwood, noted that a number of the items discussed at Quality Committee had been subject to further discussion at Trust board. He highlighted that while the Charing Cross elective surgery medical rota was provided safe care for patients, it continued to be a challenge to provide comprehensive cover; the risk was been effectively mitigated. The Trust board noted the report.	
5.3	**Report from Finance & Investment Committee** Referring to the committee report, Sarika Patel noted that the key items discussed had also been the subject of discussion at Trust board. The Trust board noted the report.	
6	**Items for information**	
	There were no items for information.	
7	**Any other business**	
	Sir Richard Sykes extended the Trust board's thanks to Karen Charman for her	

	contribution as interim director of people and organisation development.	
8	**Questions from the public relating to Agenda items** In response to a question from the public the following point was made: • In informal discussion at the AGM, Sir Richard Sykes had suggested that, due to the constant flux and development in health needs and delivery mechanisms, the Shaping a Healthier Future plan outlined originally could not be viewed as 'a blueprint set in stone', as services would continue to be shaped to meet constantly evolving patient need.	
9	**Date and time of next meeting** The next meeting would be held on 25 November 2015, Hammersmith Hospital	

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	1.4
Title	Record of items discussed at the confidential Trust board on 30 September 2015
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.

Issues of note and decisions taken at the Trust board's confidential meetings held on 30 September:

- **Cancer Vanguard**: the cancer vanguard application, made in association with the Royal Marsden NHSFT had been successful, and would be progressed, as a collective, with those submitted by UCLH NHSFT and The Christie NHSFT, to design a series of pathways using an accountable care model.
- **Radiology information system (RIS) / Picture archiving communication system (PACS) business case:** the full business case, was approved by the Trust board, with particular note to the support and engagement of the clinical staff.
- **Patient services centre business case:** the Trust board approved the business case, which sought to develop a single point of access for patients throughout their elective pathway, through the establishment of a patient services centre. This would improve service quality to patients and deliver efficient and effective equitable service to patients whilst addressing a number of service issues highlighted by the CQC inspection. Much of the capital funding required would be provided by the Charity.
- **Linen and laundry services supply tender:** the Trust board approved the appointment of Synergy to provide linen and laundry services to all sites from 1 January 2016.
- **Waste services supply tender:** the Trust board approved the appointment of Grundon Waste Management to provide waste services to all Trust sites, with a start date of 1 January 2016.
- **Hammersmith and Fulham CCG community cardio-respiratory service development tender:** The Trust board ratified the submission of the bid to provide community cardiology and respiratory services, in partnership with Chelsea and Westminster NHSFT.
- **Specialist neuro-rehabilitation service development tender:** The Trust board approved the submission of the bid to provide specialist neurological rehabilitation services at Charing Cross Hospital, in partnership with Hillingdon Hospitals NHSFT.

Imperial College Healthcare NHS Trust

Recommendation to the Trust 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)
No outstanding actions				

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible
TBC	**Dementia briefing paper** – reflecting on the work that Trust had already done on Dementia – what further work the Trust could do – and how it could learn from others.	29 July 2015 2.1	Prof Janice Sigsworth

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
Freedom of Information Status	Report can be made public

Executive Summary:

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

This month's patient story focuses around a patient's experience of day care facilities and how poor processes and communication has led to a poor patient experience.

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.

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

GS's story

GS is a professional musician and is currently working as a piano and singing teacher. She was diagnosed with multiple myeloma in August 2014 for which she had a course of treatment in haematology day care. In February 2015 she was admitted for a stem cell transplant and was an inpatient for 3 months. Since then she has been using the day care facilities on a regular basis.

GS therefore has significant experience of our Trust; in particular she would like to share her experiences of the day care unit.

She has observed that patients were often left waiting without any consistent or timely communication or information and that the system relied upon nursing staff to update patients. GS noted that nurses were often busy with a number of tasks. GS feels that the processes are not well organised and could be much more efficient and helpful. For example:

- At one appointment she had had to use a wheelchair for a short period following an operation. She was advised at her appointment that she required an interventional test and was asked to wait. She waited for 2 hours and no one communicated with her. She telephoned the desk (as she was in a wheelchair) and asked when she would be seen and was then told they had just finished treating a patient and had to clean the room but this had not been communicated to her. During this time she felt anxious as she thought she had been forgotten.
- GS said she felt vulnerable when using the outpatient services as people did not communicate with her. She reflected that once they 'get to know you' they are nicer.
- She felt that the staff were generally kind but that the organisation of the service left patients feeling anxious. She could not understand why the service was organised in this way.

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
Freedom of Information Status	Report can be made public

Executive Summary:

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

Recommendation to the Trust 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.

Imperial College Healthcare NHS
NHS Trust

Key Strategic Priorities

1. Financial performance

This year is continuing to be extremely challenging financially. At the end of October (month seven) the Trust was £9.3m behind its financial plan, reporting a year to date deficit of £20.1m. Whilst our NHS income levels are 4% above levels at this point last year, they remain lower than our plans. We have also not met our own ambitious growth targets for treating private patients. And we are encountering more challenge to the level of our NHS activity from our commissioners. We are committed to recovering our financial position back to plan by the end of the year but based on more recent trends recognise this will be a challenge. Our most recent forecast shows we will be adverse to plan and the Executive has agreed a programme of 'urgent measures', including a non-clinical vacancy freeze, to turn this around whilst maintaining safe and high quality care. These actions will support our long term sustainability.

2. Operational performance

Cancer: In November, performance is reported for the cancer waiting times standards in September and Quarter 2. In Quarter 2, the Trust achieved all eight national cancer standards. This included recovery of the 62-day screening standard which the Trust failed to meet in Quarter 1. In September, the Trust achieved seven of the eight national cancer standards. The Trust failed to meet the two week wait standard for first attendance after a GP referral. There were a high number of breaches relating to patient choice in September after the end of the summer period, which significantly contributed to the poor performance position. A demand and capacity exercise has been undertaken for all services receiving two week wait referrals from GPs to support capacity planning going into 2016/17.

Diagnostic waiting times: The Trust continued to meet the monthly 6 week diagnostic waiting time standard in October with 0.4% waiting over 6 weeks against the 1% tolerance. Additional capacity, in particular within imaging modalities, has contributed to the Trust improving performance within this standard.

Accident and Emergency: Performance against the four hour access standard for patients attending Accident and Emergency remained below threshold at 92.07 per cent in October. A number of initiatives to improve flow within the organisation are on-going. 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. The Trust is also working with local Commissioners to ensure that patients who are awaiting social care, and don't need an acute bed, can be transferred in a timely way as appropriate.

Referral to treatment (RTT): The Trust performance for October was 90.87 per cent and therefore did not meet the 92 per cent incomplete standard. This was a slight worsening of the position from the previous month with an increase in the number of patients waiting over 18 weeks. This was as a result of a combination of individual capacity constraints at speciality level, and bed pressures, resulting in the need to cancel a small volume of elective surgery. Additional capacity is now in place in many specialities, and it is expected that performance submitted for November will show a reduction in the pathways over 18 weeks and achievement of the 92% standard.

3 Winter resilience

Our winter resilience plans focus on:

- embedding and extending efforts to optimise our urgent and emergency care pathways
- providing capacity where it is most needed (including opening 8 North at Charing Cross and additional beds at St Mary's).

We are particularly seeking to avoid unnecessary hospital admissions and long hospital stays, drawing on three key initiatives:

- new frailty units
- community independence service
- expanding ambulatory care.

And we are continuing to make improvements to ensuring efficient and effective discharge, including through:

- discharge lounges at St Mary's and Charing Cross hospitals with dedicated staff
- 7-day working for hospital discharge teams beginning 30 November
- dedicated transport co-ordinator
- weekend tri-borough social services support onsite at Charing Cross and St Mary's hospitals
- developing guidance and patient information for wards
- community independence service.

4. Cerner Implementation:

The roll out of the Cerner functionality to support clinical documentation for doctors, nurses and therapists along with the implementation of electronic prescribing is progressing according to plan. The surgical specialties at St Mary's went live in September and the second tranche covering the medical specialties went live in October. Feedback from wards and departments has been positive. Take up by nurses, junior doctors and therapists has been excellent. The approach being taken which is to provide floorwalker support rather than class room training has been highly effective. The first tranche of wards at Hammersmith Hospital went live in mid-November with planning for the second tranche go live well advanced.

The pilot for the integration of bedside medical devices will go live this month. This will enable vital signs information to flow directly from the medical device into Cerner.

Having successfully migrated out of the BT data centre in September we are now able to move forwards with plans for an upgrade of the Cerner system - from the 2010 version of the code to the 2015 version of the code. This is scheduled to take place in February 2016.

5. Stakeholder engagement

Early October saw a successful stakeholder event as Macmillan Cancer Support and the Trust came together to discuss 'Supporting you through your cancer care – the story so far and our next steps'. Our organisations are working together to improve the care experience of people affected by cancer in North West London. We are combining our expertise to ensure people are well informed, know where to go for help and support, and guided with care through their experience from the point of diagnosis through to the end of treatment.

The event provided an opportunity to celebrate the highlights of the partnership so far and share future plans, with presentations from key stakeholders involved.

Our regular contact programme has continued including discussions with the Cabinet Member for Health and Chair of the Health Scrutiny Committee for Westminster City Council. We are also due to attend a formal meeting of Ealing Council's Health Scrutiny Panel in late November.

We continue to publish our suite of e-newsletters which are tailored to stakeholders, GPs and our shadow foundation trust members to keep them up to date with what is happening at our Trust. It is pleasing to see that increasing numbers of stakeholders are reading the *Partner Update* publication according to the figures for the October edition.

6. Re-launch of the Trust website

The Trust Board will mark the first phase of the Trust's website redevelopment launch.

This is the first significant redevelopment of the Trust website since 2007. The aims of this project were to provide an accessible, easy to navigate, mobile-optimised website, populated with up-to-date, accurate and compelling content based on information our users want to access. The project also aspired to rationalise the 2,000 plus pages on the existing website, alongside multiple Trust-affiliated microsites, into one digital platform with priority content to service what has emerged as the Trust website's three key audiences: patients, GPs and staff.

Alongside audience research and the technical build of the site, practically all the content on the current site has been rewritten or generated from scratch. The website will feature a comprehensive services directory with a new taxonomy of services. Users will have access to engagement functionality such as the ability to comment on blog posts, take part in online polls and share content via social networks. The site will feature more multi-media content such as infographics and videos. Nearly all photographs on the new website are authentic and were shot as part of the website redevelopment. New floor plans have been developed for each of our hospital sites to improve way-finding and provide useful travel advice.

The website project began in September 2014 with an intensive period of audience research, which culminated in a new information architecture for the site and digital look and feel. The site build commenced in June 2015. The first iteration of the website, populated with priority content, is available to view at the Trust board meeting.

7. Revalidation

From April 2016, all nurses and midwives will be required to revalidate every three years in order to remain on the nursing and midwifery council (NMC) register and practice as a registered professional. Those not meeting the requirements set out in the application at a three yearly interval or not submitting their application by the renewal date will fall off the register and will have to re-apply to be admitted to the register in order to practice as a nurse or a midwife.

Revalidation for nurses and midwives is a registrant driven activity and the responsibility for meeting the requirements lies with the individual registrant as outlined in the *Professional standards of practice and behaviour for nurses and midwives (The Code).* However, the Trust has a duty to ensure that all nurses and midwives are supported to meet the requirements for their registration renewal through revalidation. Plans are in place to

provide such support and to oversee the implementation, governance, and on-going delivery of the revalidation requirements for nurses and midwives.

8. Executive team update

David Wells joined the Trust at the beginning of October as the Director of People and Organisational Development. David started his career in the Navy and was previously the group HR director at Glory Global Solutions. He has held leadership roles in a number of pharmaceuticals companies, including seven years at Novartis vaccines and diagnostics. David has an impressive track record, with significant achievements in increasing staff engagement, embedding new ways of working and improving staff retention in large, complex organisations. These are currently critical issues for the Trust and the wider NHS and David will be bringing his strengths in these areas to the executive team.

Chris O'Boyle (Director of Estates and Facilities) has now been appointed as the interim Director of Strategy and Redevelopment.

Key Strategic Issues

1. Shaping a Healthier Future (SaHF) Outline Business Case (OBC)/Implementation Business Case (ImBC)

Work has continued over the past month with the NW London Clinical Commissioning Groups to do a stocktake of the Shaping a Healthier Future Implementation Planning Business Case (ImBC). This has included sectorwide work on strengthening the business case and looking at opportunities to improve efficiency, particularly around elective orthopaedics, end of life care and bank and agency usage. The outputs from the stocktake are currently being finalised for discussion with NHS England and the TDA. A further update will be provided at the next Board meeting, including the timetable for completion of the ImBC.

2. Cancer Vanguard

On 25 September 2015, Simon Stevens, chief executive of NHS England, announced that the Royal Marsden NHS Foundation Trust's (RMH) application to develop an Accountable Clinical Network for Cancer, of which Imperial College Healthcare NHS Trust (ICHT) is a key partner, has been successful. This is a really exciting opportunity for us all to transform the quality, efficiency and models of care for patients with cancer. RMH will develop a plan for alignment of the emerging new service delivery model with the quality and accreditation function of the London Cancer Alliance (LCA). 'Town Hall' style meetings will also be set up for wider clinical discussion on the concept and next steps as soon as possible.

NHS England and the New Models of Care Team have asked to ensure that the partnership also works with the Christie NHS Foundation Trust in Manchester and University Hospitals London NHS Foundation Trust (UCLH) so that there is an appropriate national focus on cancer improvement.

3. Industrial action

Junior doctors are set to take industrial action next month as part of a national dispute over changes to their contracts. The BMA has announced three days of action:

- 1/2 December: 24 hour emergency only cover from 08.00-08.00
- 8 and 16 December: 08.00 – 17.00 complete walk out by junior doctors

Imperial College Healthcare NHS
NHS Trust

We are working in partnership with the BMA locally to ensure patient safety and to minimise disruption to patients, while also ensuring junior doctors are able to exercise their right to take industrial action. Through detailed planning now underway, we are considering scaling back services where necessary and co-ordinating cover for junior doctors' duties from consultants and trust grade doctors. There will no new annual leave requests for doctors on 1, 8 and 16 December.

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 October 2015.

Where monthly data for October 2015 are not yet available, this is highlighted in the chart title in red.

Recommendation(s) to the Committee:

The 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

Operational Performance Report

Report Period Month 7 (to end October 2015)

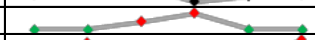
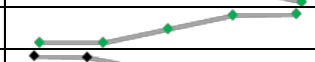
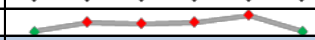
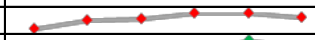
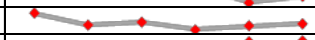
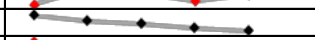
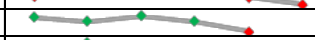
Trust Board, 25 November 2015

Imperial College Healthcare NHS Trust

Contents

Imperial College Healthcare NHS Trust

1. Scorecard Summary

Pg	Metric	Period	Standard	Performance	Direction of Travel
	Safe				
5	Serious Incidents (S.I.s)	Oct-15	0	7	
6	Staffing fill rates		tbc	96.1%	
8	MRSA		0	0	
8	Clostridium difficile		38	44	
9	Harm Free Care (Safety Thermometer)		90.0%	96.9%	
	Effective				
10	Hospital Standardised Mortality Ratio (HSMR)	Qtr 1 15/16	100	67.2	
11	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	Qtr 2 15/16	70.0%	97.5%	
11	30 day readmissions	Oct-15	tbc	4.2%	
12	Average length of Stay (elective)		3.4	3.7%	
12	Average length of stay (non-elective)		4.5	4.2%	
13-14	Activity: First Outpatient	Sep-15	29,333	32,867	
13-14	Activity: Follow-up Outpatient		47,082	52,183	
13-14	Activity: Daycase		6,059	7,385	
13-14	Activity: Elective Inpatient		1,308	1,297	
13-14	Activity: Non-elective Inpatient		8,742	9,203	
13-14	Activity: Adult Critical Care		3,390	3,853	
13-14	Activity: Regular Day Attender		1,114	281	
	Caring				
15	Mixed-Sex Accommodation	Oct-15	0	1	
16	Friends and Family Test - Inpatients		95.0%	96.0%	
16	Friends and Family Test - A&E		85.0%	96.0%	
17	Friends and Family Test - Maternity		tbc	95.0%	
17	Complaints (total number received)		100	80	
	Well Led				
20	Vacancy rate (%)	Oct-15	10.0%	12.3%	
20	Voluntary Turnover Rate (%) 12-month rolling position		9.5%	11.0%	
20	Sickness absence rate (%)		3.4%	3.1%	
21	StatMand excl. doctors in training / Trust grades (%)		95.0%	81.8%	
21	StatMand - doctors in training /Trust grades (%)		95.0%	56.2%	
22	Consultant appraisal rate (%)		95.0%	86.5%	
22	Band 2-9 & VSM PDR rate		95.0%	91.4%	
24	Health and Safety RIDDOR		0	3	
24	GMC NTS open actions		tbc	113	
25	Bank and Agency Spend (%)		9.0%	14.0%	
25	Staff engagement score	Qtr 2 15/16	tbc	44	
	Responsive				
26	18 Weeks Incomplete (%)	Sep-15	92.0%	92.0%	
26	18 weeks Incomplete Breaches (number)		tbc	4,030	
27	52 Weeks Waits (Number)		0	6	
28	Diagnostic tests waiting longer than 6 weeks (%)		1.0%	0.8%	
29	A&E Type 1 Performance (%)	Oct-15	95.0%	81.6%	
29	A&E All Types Performance (%)		95.0%	92.1%	
30-31	Two week GP referral to 1st outpatient, cancer (%)	Sep-15	93.0%	90.5%	
30-31	Two week GP referral to 1st outpatient – breast symptoms (%)		93.0%	94.6%	
30-31	31 day wait from diagnosis to first treatment (%)		96.0%	96.4%	
30-31	31 day second or subsequent treatment (surgery) (%)		94.0%	96.2%	
30-31	31 day second or subsequent treatment (drug) (%)		98.0%	100.0%	
30-31	31 day second or subsequent treatment (radiotherapy) (%)		94.0%	99.0%	
30-31	62 day urgent GP referral to treatment for all cancers (%)		85.0%	86.5%	
30-31	62 day urgent GP referral excl. late ITRs (%)		85.0%	89.0%	
30-31	62 day urgent GP referral to treatment from screening (%)		90.0%	93.9%	
31	New Outpatient DNA rate (%)	Oct-15	12.3%	13.2%	
32	Follow-up Outpatient DNA rate (%)		11.3%	12.0%	
32	Hospital initiated outpatient cancellation rate (%)		tbc	6.7%	

Imperial College Healthcare NHS Trust

2. Indicator Overviews

2.1 Safety

2.1.1 Safety: Serious Incidents (SIs)

Seven serious incidents were reported in October 2015. The year to date total is 60, in comparison to 75 this time last year. We continue to review each case.

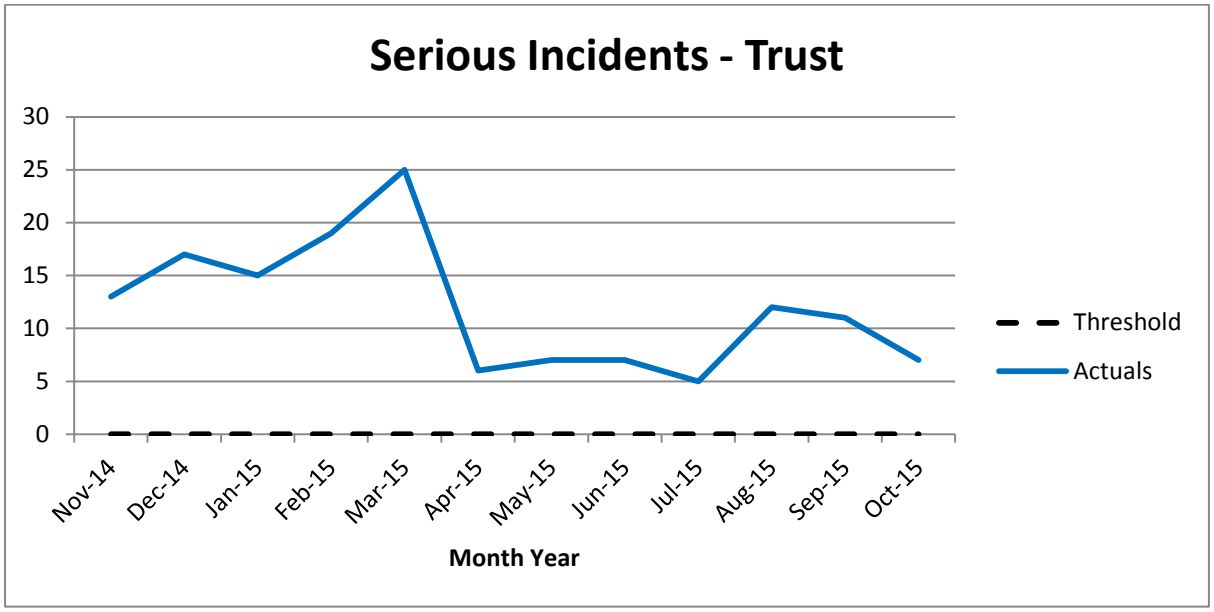


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period November 2014 – October 2015

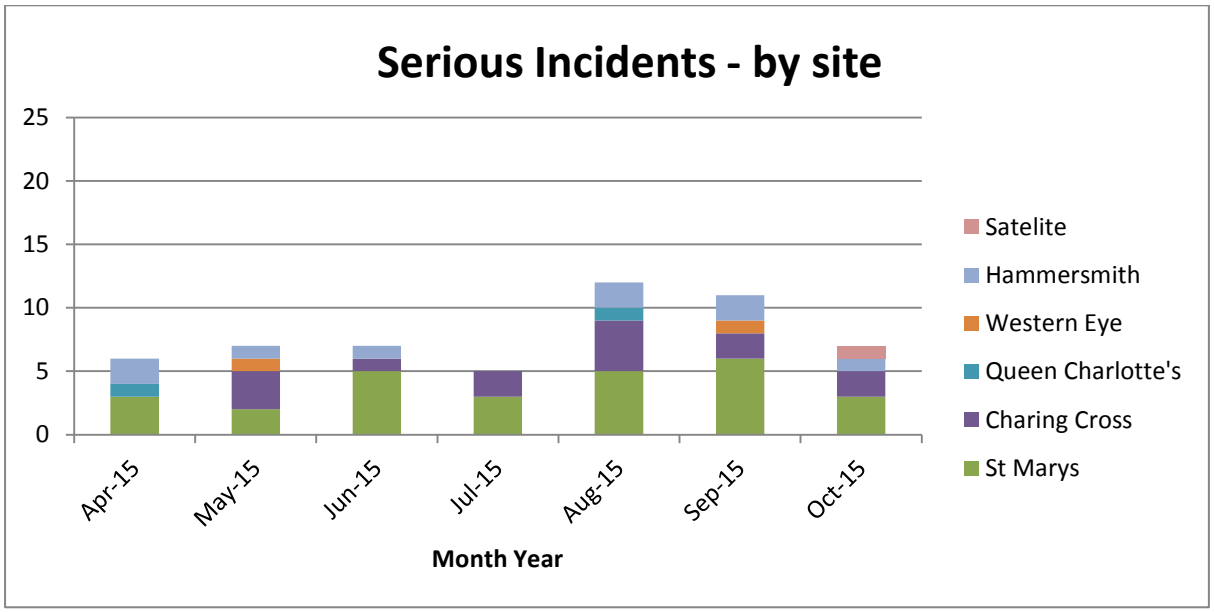


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period April 2015 – October 2015

2.1.2 Safety: Nurse / Midwife staffing levels

In October the Trust reported the following for the average staffing fill rate overall:

- 90 per cent or above for registered nursing/midwifery staff during the day and night;
- Above 90 per cent for care staff during the day; and
- Above 95 per cent for care staff during the night.

The average staffing fill rate for October by hospital site was as follows:

	Day		Night	
Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Charing Cross	95.03%	92.53%	97.62%	97.32%
Hammersmith	94.99%	91.84%	98.03%	97.32%
Queen Charlotte's	96.34%	92.66%	97.05%	98.28%
St. Mary's	96.74%	92.92%	97.44%	97.56%

Please refer to Appendix 1 for ward level detail.

October saw the Trust achieve safe staffing levels for registered nurses and midwives and care staff at night and during the day.

There were a small number of clinical areas where the fill rate was below 85 per cent for care staff and below 90 per cent for registered staff. Reasons for this include:

- A continued high requirement to meet the enhanced support needs of patients with 'specialling' (especially within the Medical Division); &
- Application of consistently stringent controls on the use of agency staff; &
- The tool being used to judge patient need for staffing in a small number of our clinical areas not being sufficiently sensitive to reflect this accurately.

On the occasions where small numbers of shifts were unfilled, the Trust's senior nursing and midwifery leadership took actions to optimise the staffing arrangements and mitigate any risk to the quality of care delivered to patients. These actions included:

- Using the workforce flexibly across floors and clinical areas: &
- The nurse or midwife in charge of the area working clinically and taking a case load; &
- Specialist staff becoming hands on for all or part of the shift to support their ward

based colleagues; &

- Adjusting the case mix in clinical areas by cohorting patients ensure efficiencies of scale.

The Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in October were safe and appropriate for the mix of patients in each Division.

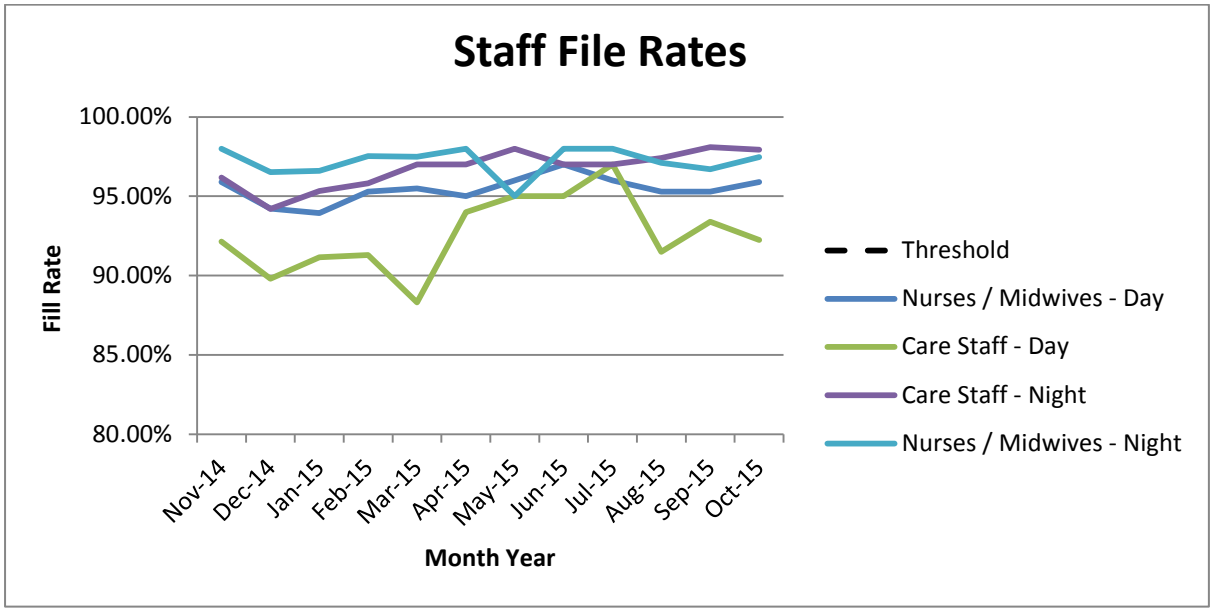


Figure 3 – Staff fill rates by month for the period November 2014 – October 2015

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

No cases of MRSA BSI were allocated to the Trust in October. So far this year, 5 cases have been allocated to the Trust compared to 3 cases this time last year. A 6th case has been preliminlary attributed to the Trust but is currently in arbitration.

Each case is reviewed by a multi-disciplinary team. Actions arising from these meetings are reviewed regularly to identify themes. Contributory factors are addressed with the Divisions via the Taskforce weekly group meetings.

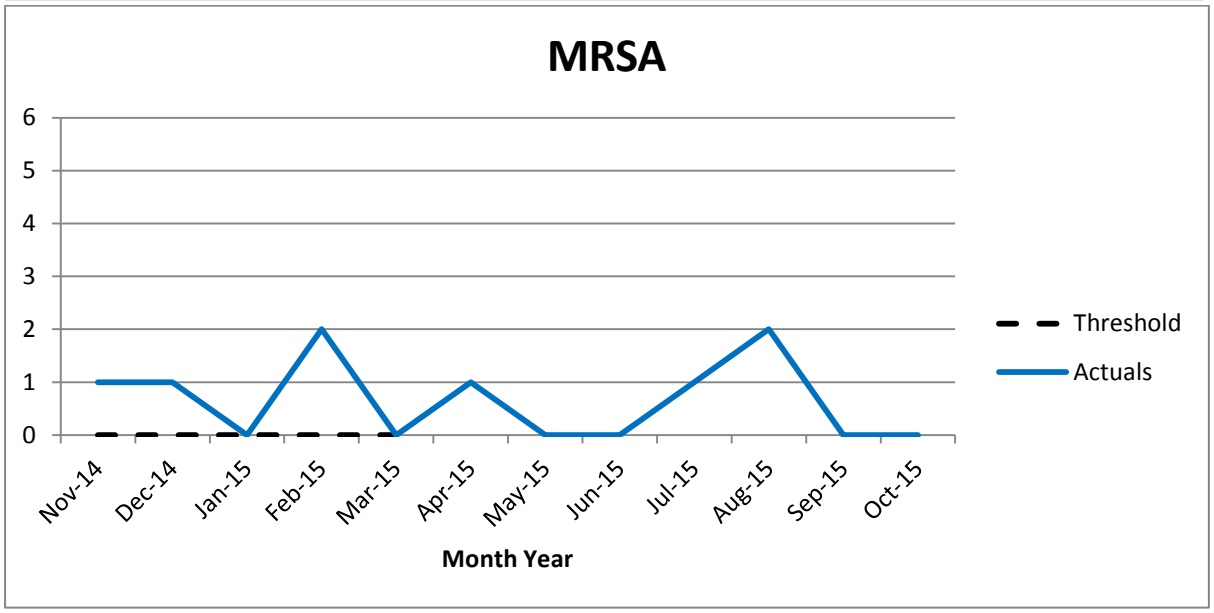


Figure 4 - Number of MRSA (b) infections by month for the period November 2014 – October 2015

2.1.4 Safety: Clostridium difficile

Nine cases of Clostridium difficile were allocated to the Trust for October 2015. One of these cases has been confirmed to be attributable to a lapse in care, with another case identified as a potential lapse in care, pending investigation.

Compared to 51 cases this time last year, a total of 41 cases have been allocated to the trust so far this year. Four of these have been confirmed to be attributable to lapses in care.

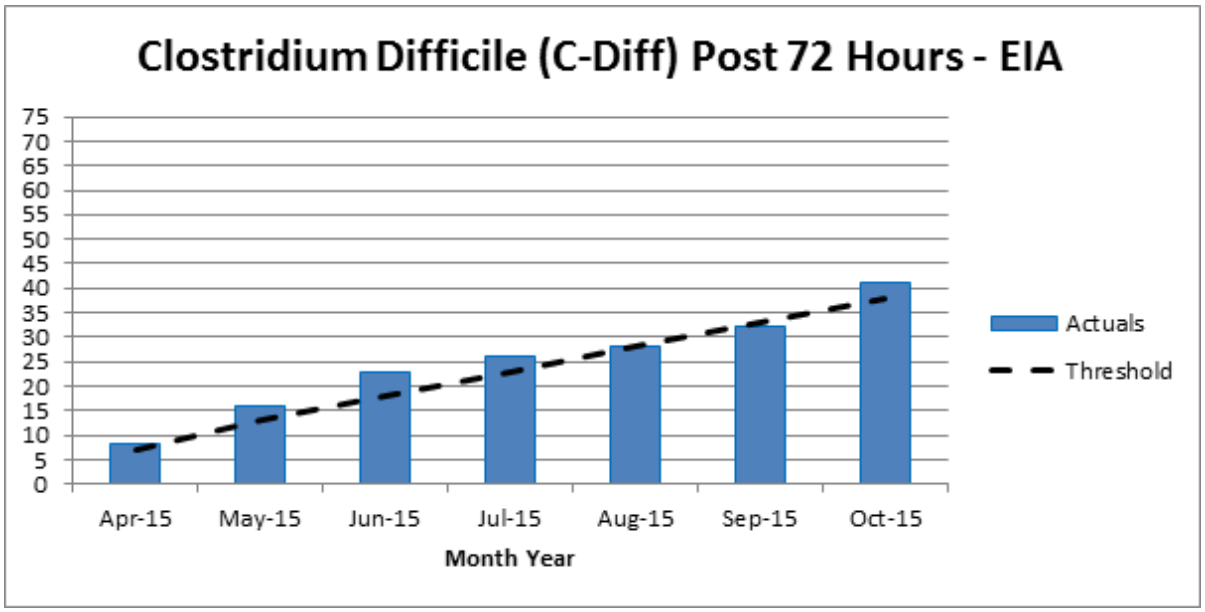


Figure 5 - Number of Clostridium Difficile infections above cumulative plan by month for the period April 2015 – October 2015

2.1.5 Safety: National Safety Thermometer – Harm Free Care Score

The Trust's scores for harm free care as measured by the NHS Safety Thermometer continue to be comparable with both the London and Shelford average.

There are specific work programmes in place for each of the four indicators which make up the overall 'harm free care' score (pressure ulcers, falls, VTE, CAUTI) to ensure performance is continually monitored and improved.

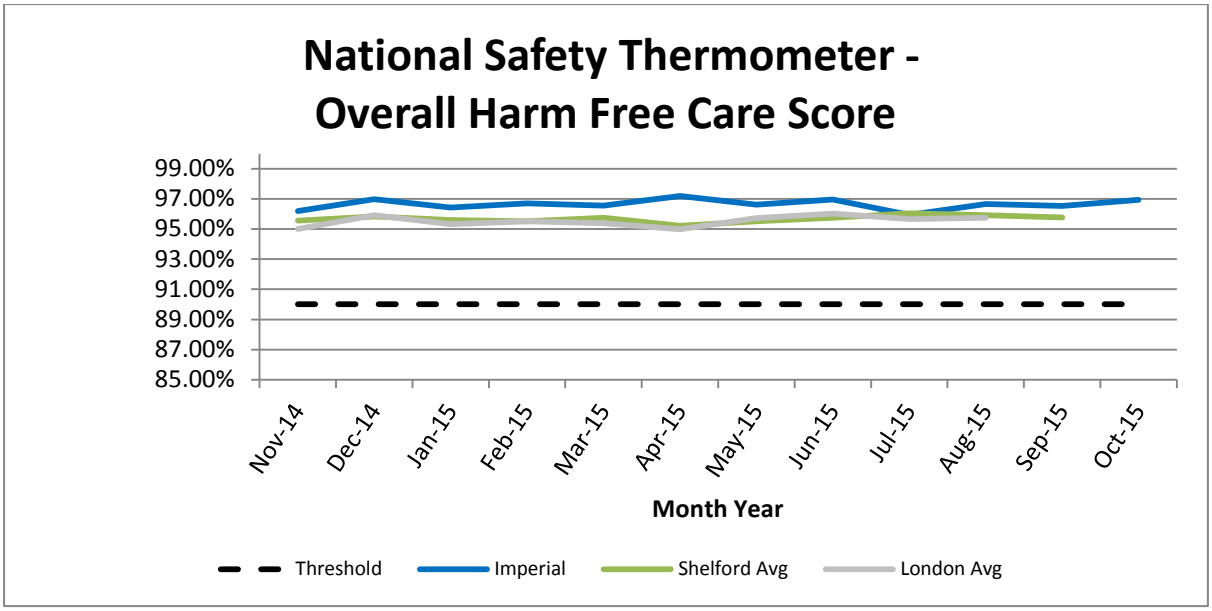


Figure 6 – Harm Free Care (Safety Thermometer) November 2014 – October 2015

2.2 Effectiveness

2.2.1 Effectiveness: Mortality Data

The Trust's Hospital Standardised Mortality Ratio (HSMR) is 71 for June 2015. Across the last year of available data (July 2014 – June 2015), the Trust has the lowest HSMR rate for acute non-specialist trusts nationally and the lowest in the Shelford Group. The Trust also has the second lowest Summary Hospital-Level Mortality Indicator (SHMI) of all non-specialist providers in England for Q4 2013/14 to Q3 2014/15.

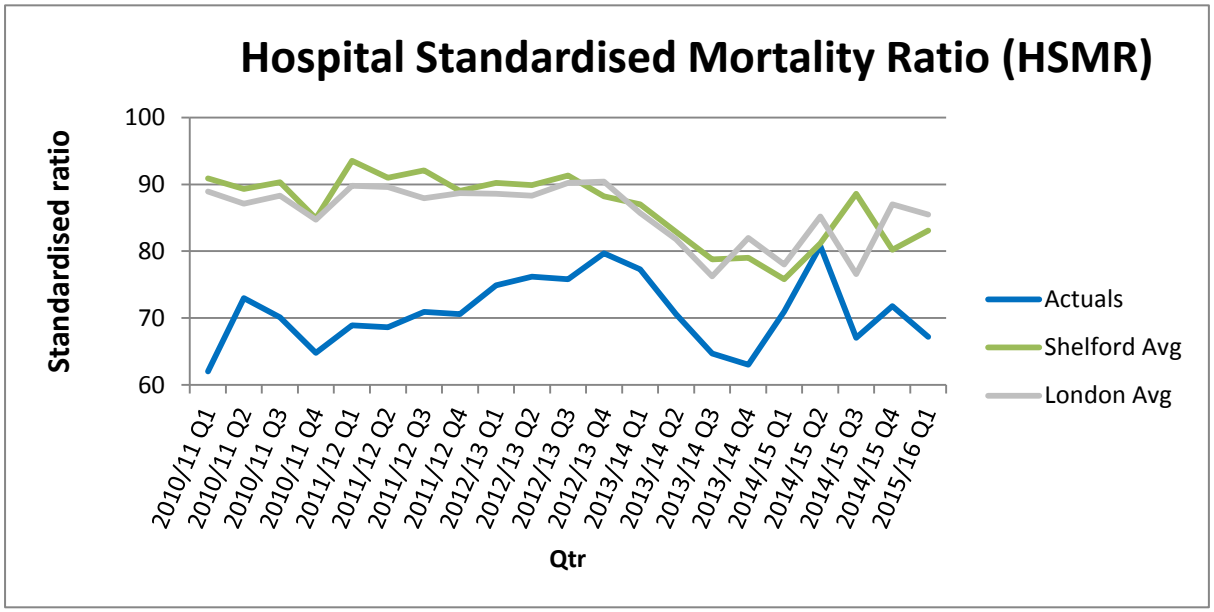


Figure 7 - Hospital Standardised Mortality Ratios for the period Q1 2010/11 to Q1 2015/16

2.2.2 Effectiveness: Recruitment of patients into interventional studies

The national target for recruiting the first patient into clinical trials within 70 days is 70 per cent. Trust performance for Q1 2015/16 was 95.6 per cent; and for Q2 2015/16 we are forecasting 97.5% per cent.

Note: Q2 data are provisional and subject to NIHR verification.

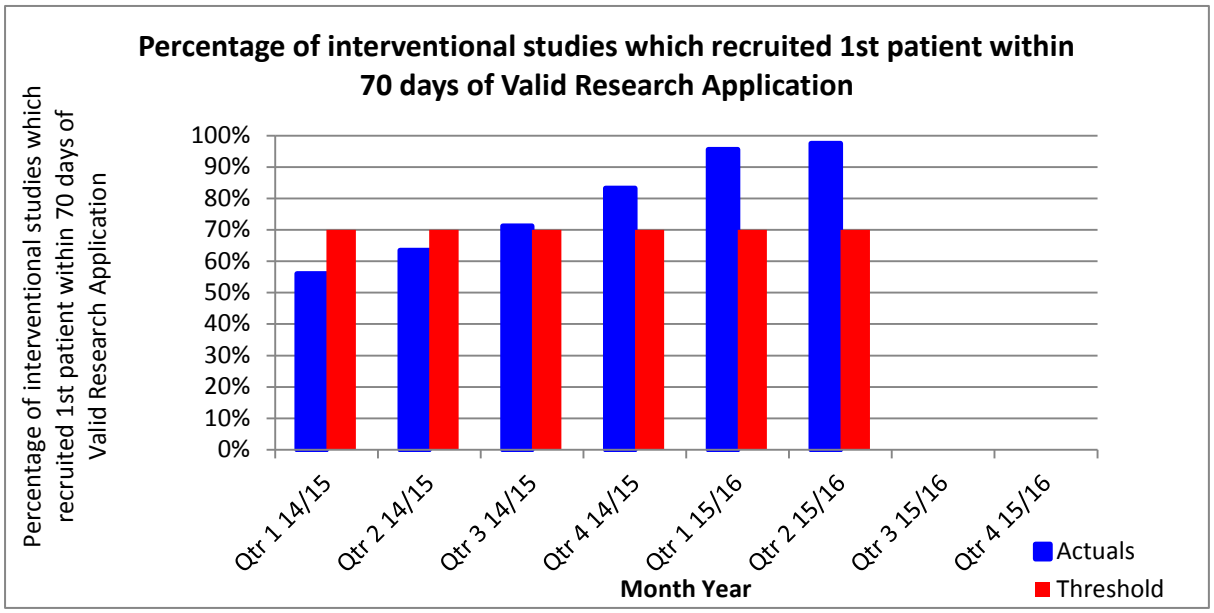


Figure 8 - Interventional studies which recruited First patient within 70 days of Valid Application Q1 2014/15 – Q2 2015/16

2.2.3 Effectiveness: 30 Day Readmissions

The improvement in reported performance for 30 day readmissions may reflect, in part, the increased focus on accurate discharge recording through the admissions and discharge team.

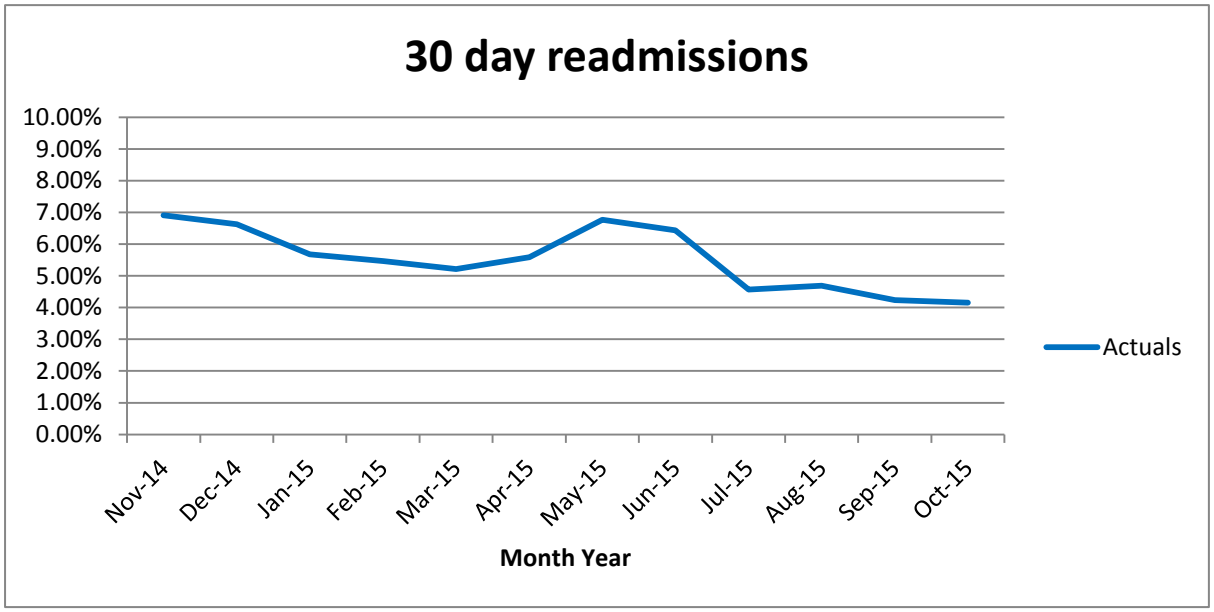


Figure 9 - 30 day readmissions for the period November 2014 - October 2015

2.2.4 Effectiveness: Average Length of Stay

The length of stay working collective (constituted by the site, information, and performance teams) identified an issue in the data warehouse extract used to determine average length of stay, as presented in the previous report. This resulted in the Trust average length of stay for elective admission reporting higher actual. This has now been remedied.

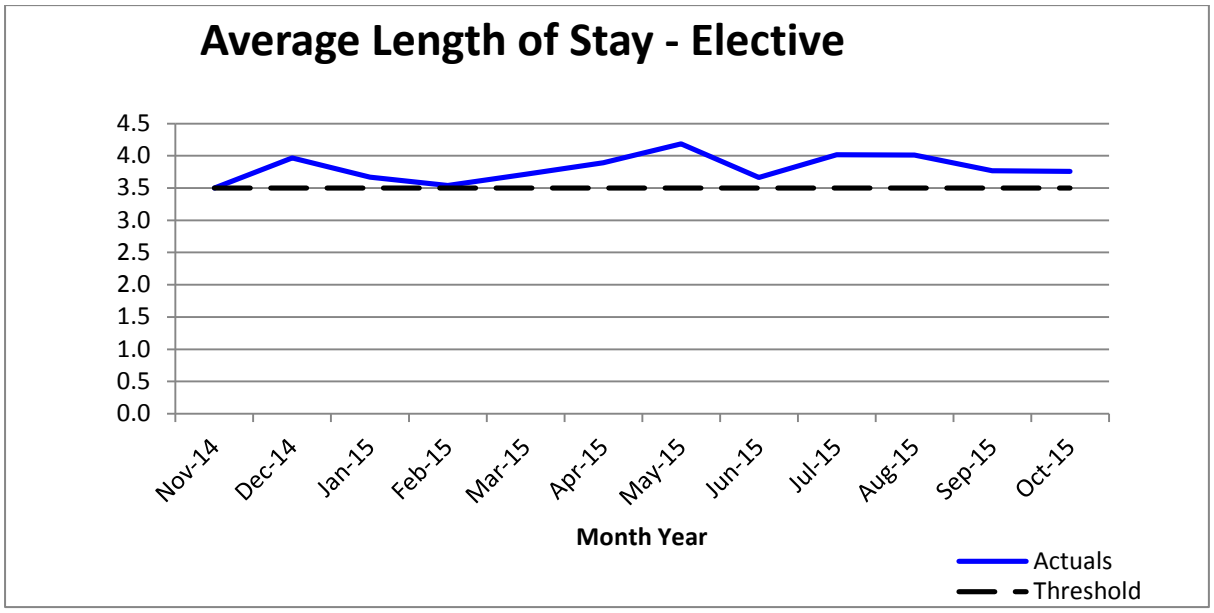


Figure 10 – Average Length of Stay – Elective for the period November 2014 – October 2015

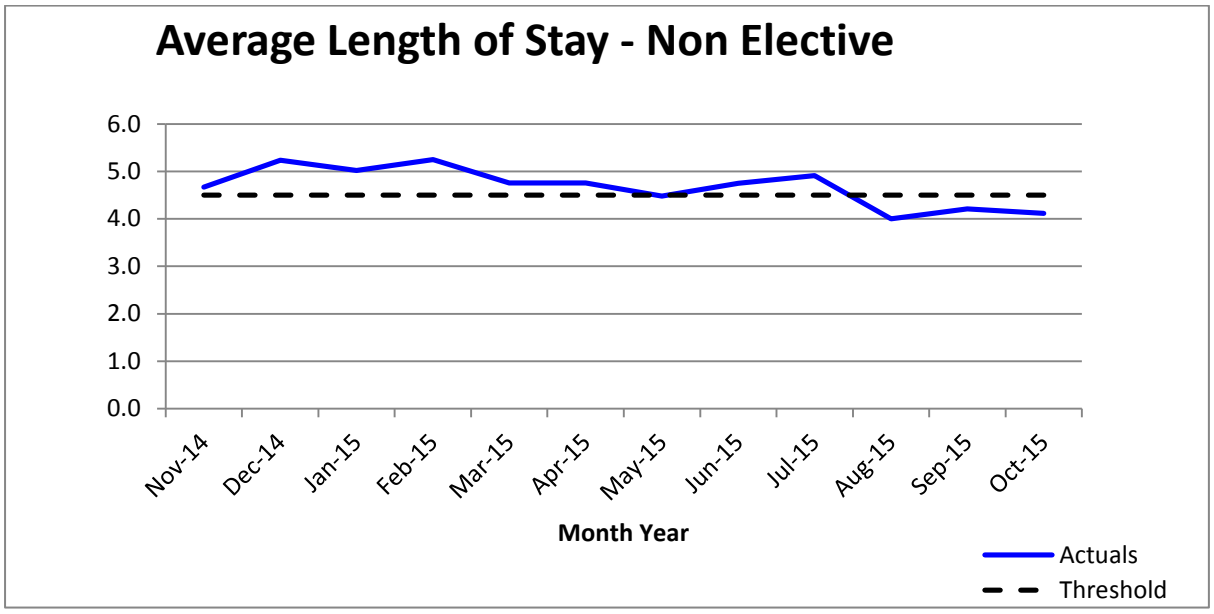


Figure 11 – Average Length of Stay – Non-Elective for the period November 2014 – October 2015

2.2.5 Effectiveness: Activity data

Plans are in place to operationalise a regular review with the Finance, Operational, and Corporate teams to ensure correct depth of coding. These reviews commenced in October and outcomes of analysis will be reported within the operational report.

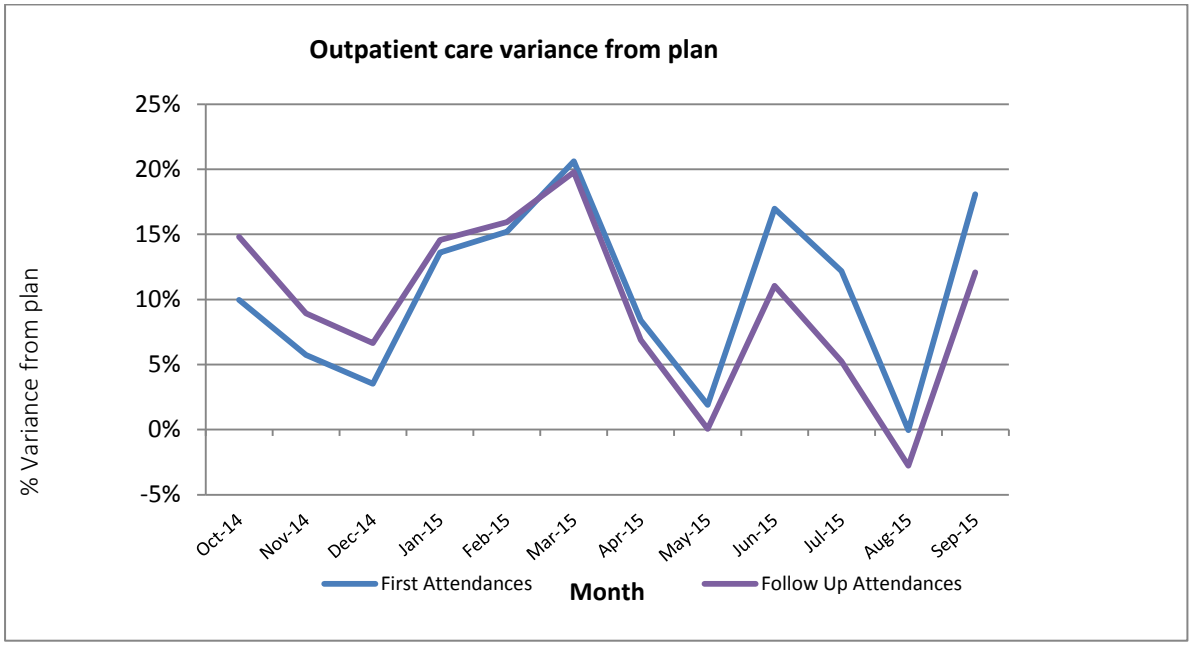


Figure 12 – Outpatient Care Variance from Plan for the period October 2014 – September 2015

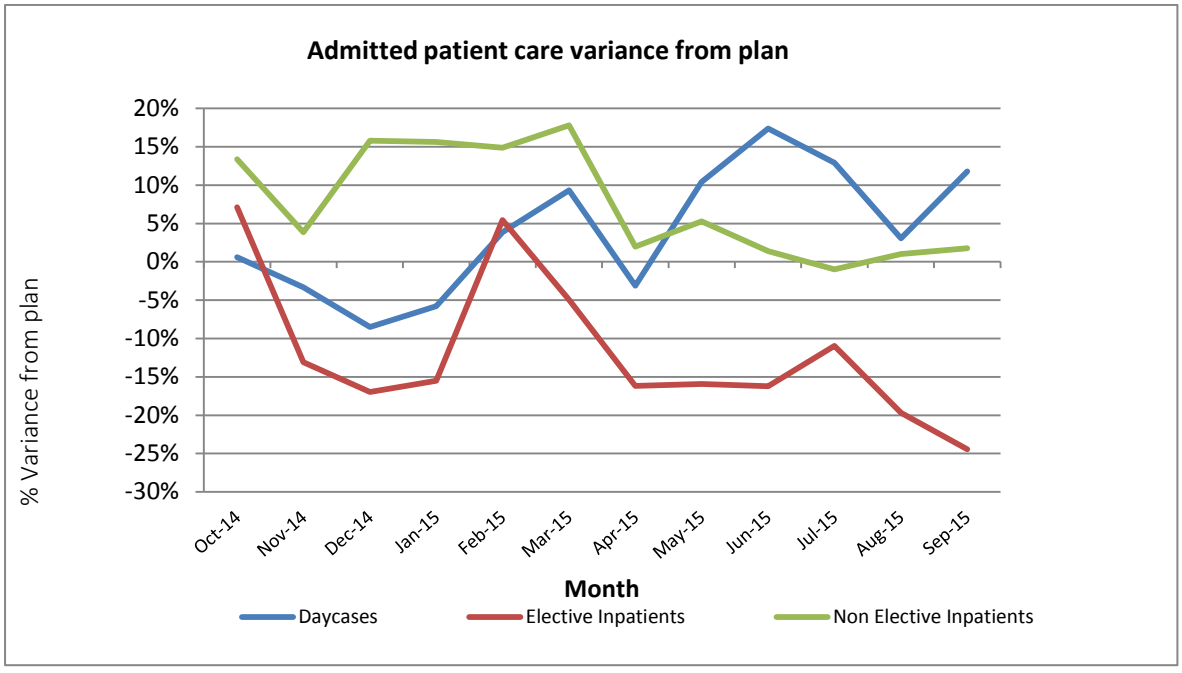


Figure 13 – Admitted Patient Care Variance from Plan for the period October 2014 – September 2015

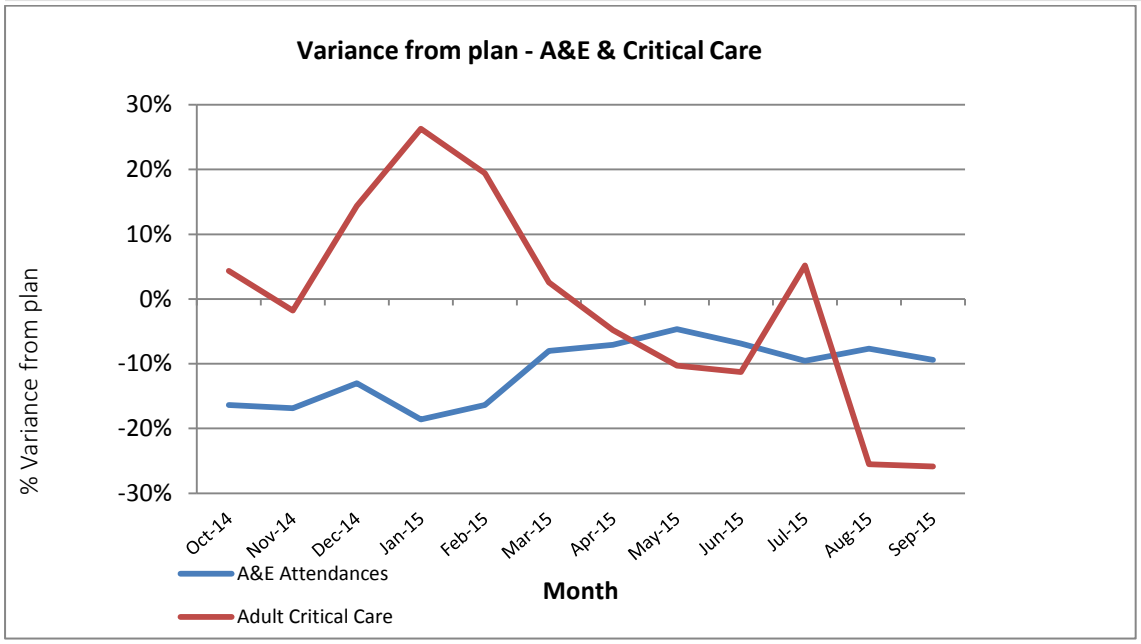


Figure 14 – A&E and Critical Care Variance from Plan for period October 2014 – September 2015

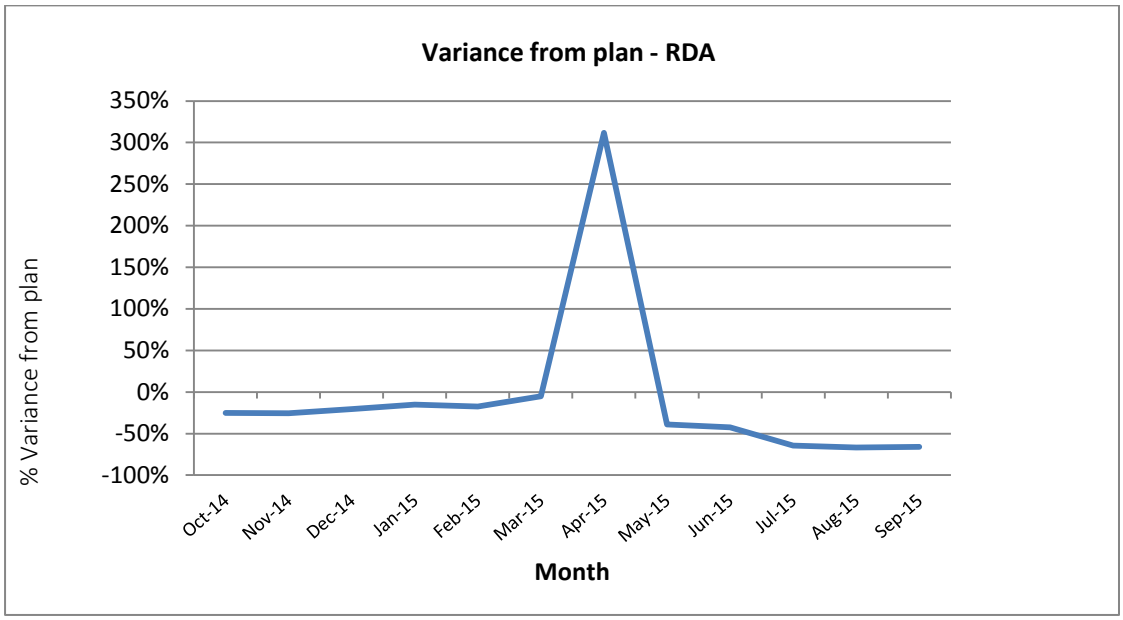


Figure 15 – Regular Day Attender (RDA) Variance from Plan for the period October 2014 – Sepember 2015

There was a notable spike in the variance against plan for the Regular Day Attenders (RDA) data in April 2015. This was due to a counting and coding change for our Oncology service. The Trust agreed with commissioners to record activity as day cases rather than regular day attenders from April 2015 onwards. However, there was a delay and this did not happen until May 2015, hence the significant variance against plan. From May the recording of Oncology as Day Cases was correct.

2.3 Caring

2.3.1 Caring: Eliminating mixed sex accommodation

The Trust reported 1 instance of mixed-sex accommodation breaches during October 2015. This was related to step down from critical care.

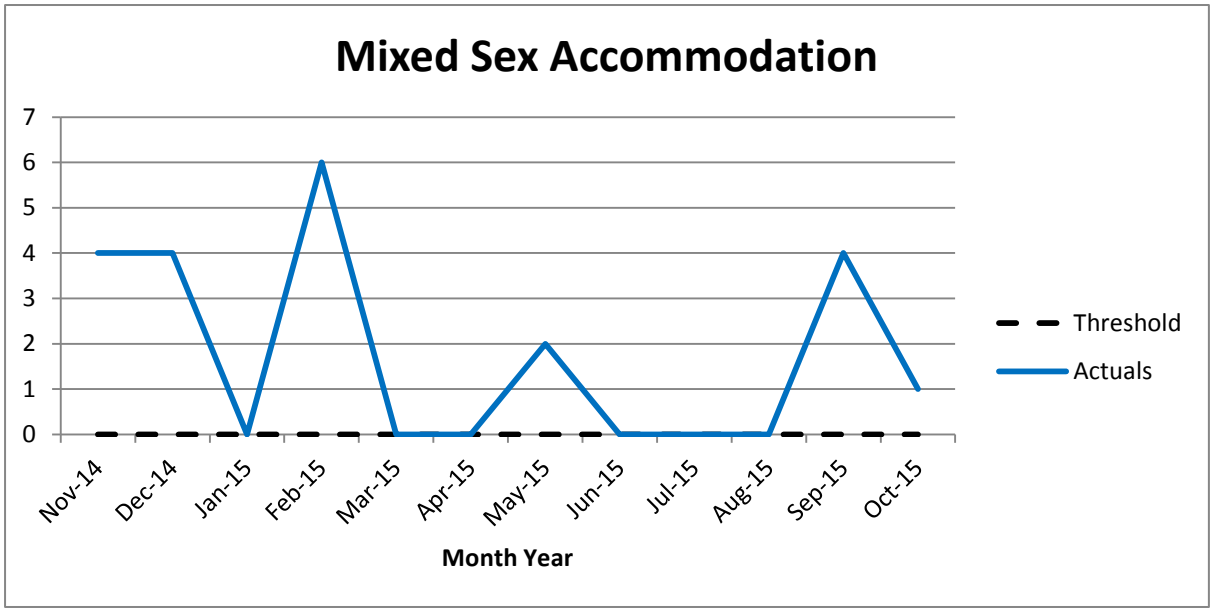


Figure 16 - Mixed Sex Accommodation breaches by month for the period November 2014 – October 2015

2.3.2 Caring: Friends and Family Test

The inpatient FFT willingness to recommend remains high at 96 per cent and the response rate continues to increase. At 35 per cent this was the highest response rate since March and equates to 2,500 responses.

Having been on a slow upward trend the A&E FFT response rate dropped to 10 per cent in month. Although A&E response rates have dropped nationally this financial year, this is likely to put us below the average when the national comparative results are published. The overall rate is derived from all A&E and Urgent Care Centre departments across the Trust. In October, Charing Cross and Western Eye A&E departments returned particularly low numbers. The reasons for this are being reviewed but the withdrawal of temporary staff that supported the collection of response will have had an impact. This response rate represents 2,100 responses. The willingness to recommend remains high at 96 per cent.

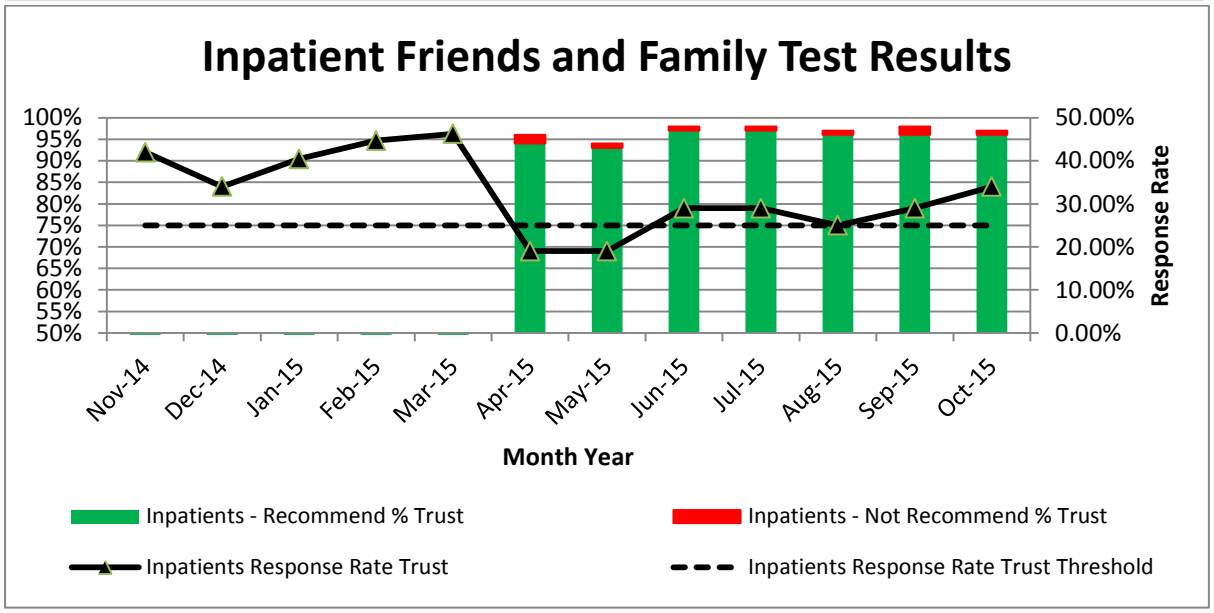


Figure 17 - Friends and Family: Percentage who would recommend ICHT Inpatients for the period April 2015 – October 2015

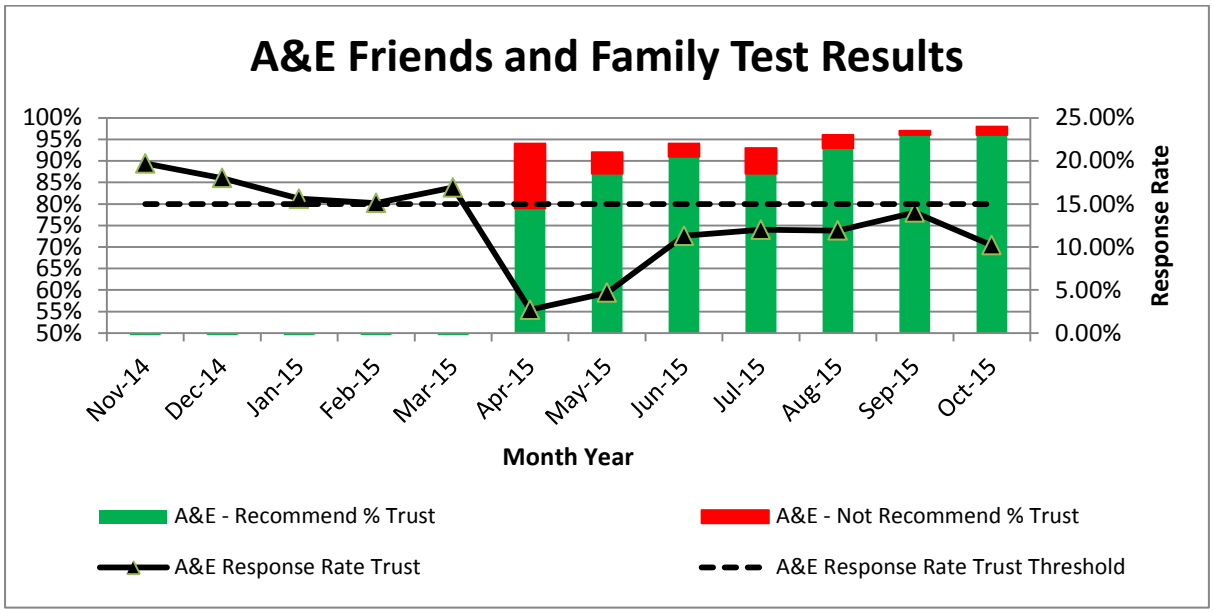


Figure 18 - Friends and Family: Percentage who would recommend ICHT Accident and Emergency for the period April 2015 – October 2015

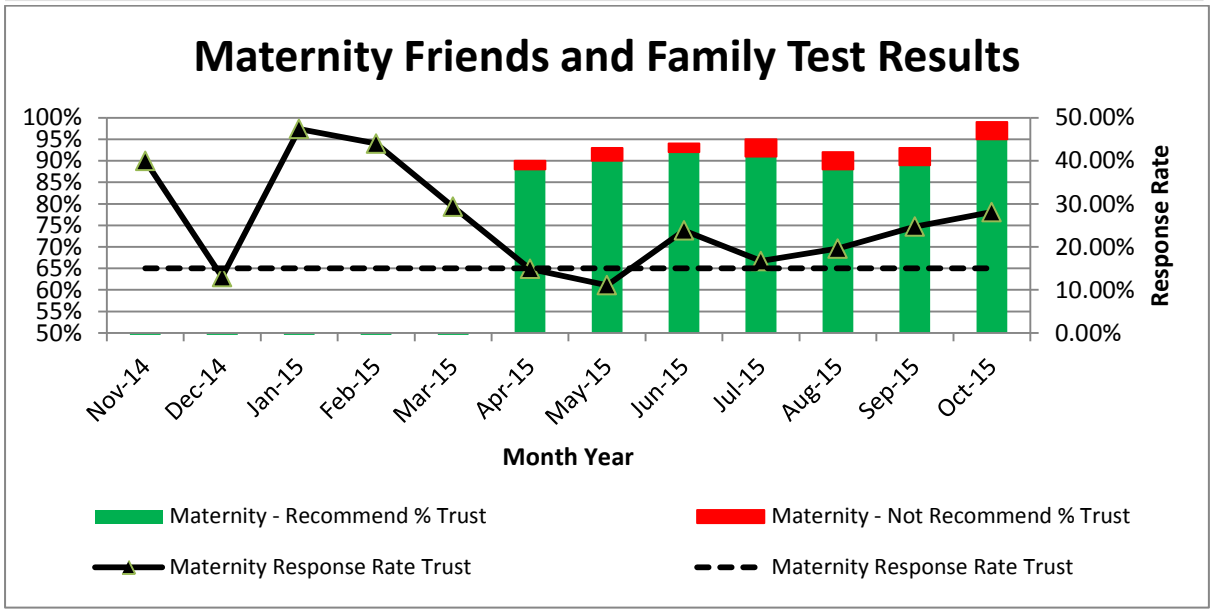


Figure 19 - Friends and Family: Percentage who would recommend Maternity for the period April 2015 – October 2015

2.3.3 Caring: Complaints

The new system for managing complaints went live at the beginning of October 2015. In month there has been a notable reduction in the volume of formal complaints, which is primarily due to a greater number being dealt with by PALS as was anticipated. This means that more people have had their concerns resolved promptly rather than being processed through the formal process. The response rate average increased to 76 per cent.

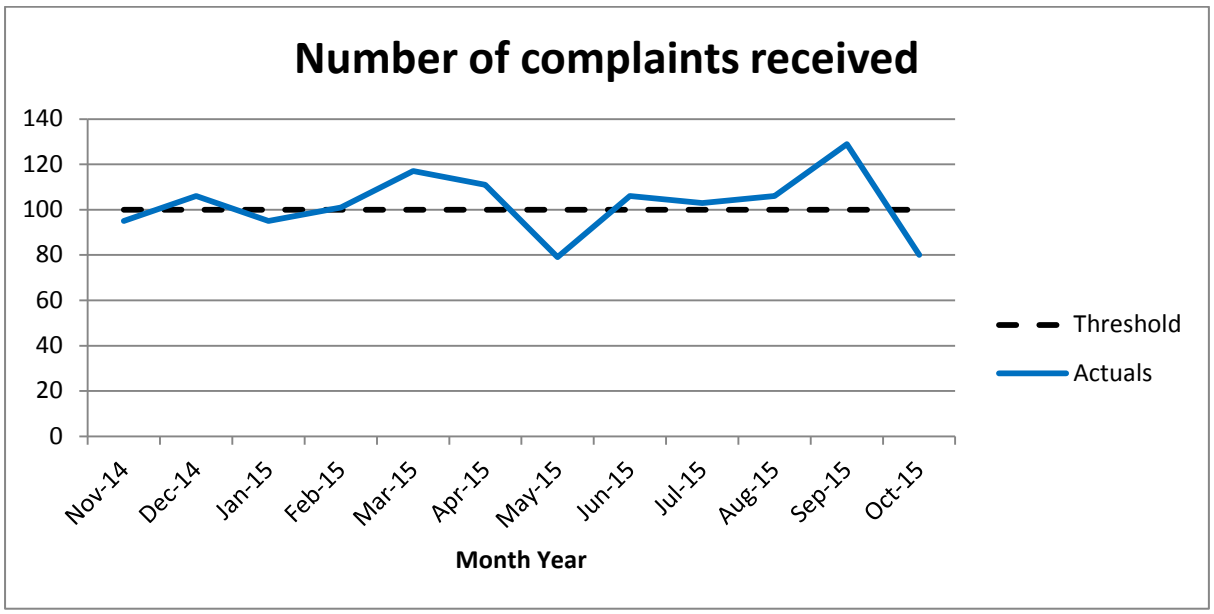


Figure 19 – Number of complaints received for the period November 2014 – October 2015

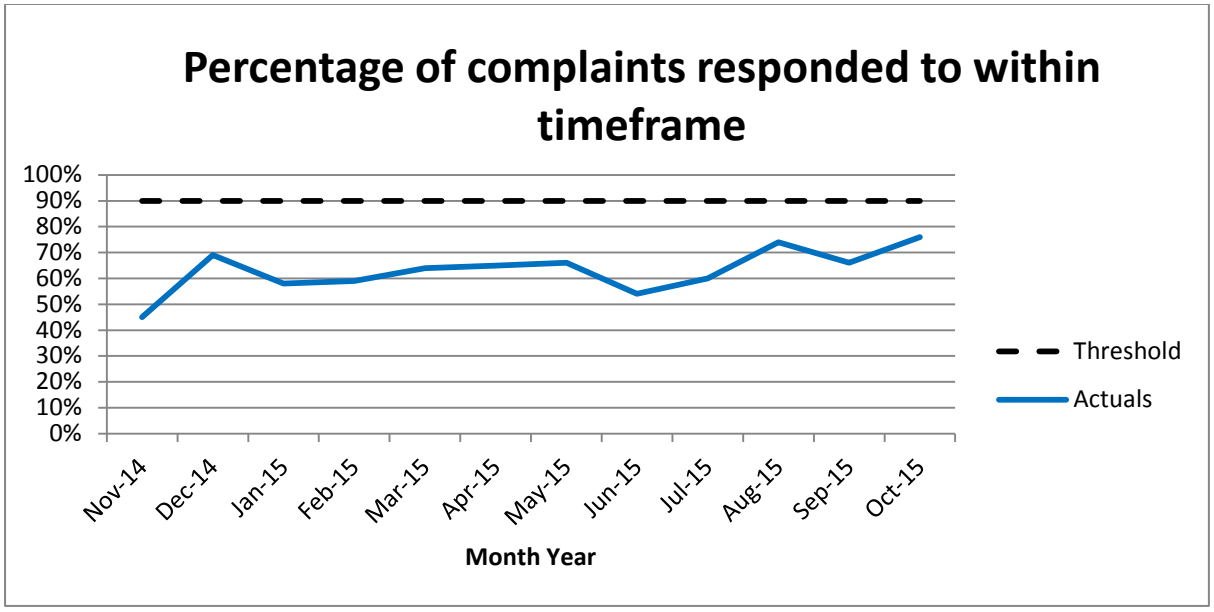


Figure 20 – Number of complaints responded to within the period November2014 – October 2015

2.4 Well-Led

2.4.1 Well-Led: Vacancy Rate

All roles

At the end of October, we directly employed 9,405 Whole Time Equivalents (WTE) (51 WTE greater than end of September) which, when factored in with approved establishment increases for service transfers (Neuro Rehabilitation, TB and Community Cardiology), has seen a small increase in vacancies of 18 WTE to 12.31 per cent. A further 1,434 WTE was worked through bank and agency staffing giving a total staffing compliment of 10,838 WTE; 67 WTE above the ESR post establishment. During the coming months, additional staffing resource will be required to support delivery of the newly won community tenders; Ealing Cardiology and Ophthalmology Triborough as well as continued support for the roll-out of Cerner documentation (ClinDocs) and e-Prescribing.

Bespoke and generic recruitment strategies and campaigns continue to support the reduction of vacancies with 551 WTE pipeline candidates waiting to join us over the coming months. The Trust voluntary turnover rate is 10.98 per cent, one of the lowest when compared to other London Acute Teaching Trusts, which equates to approximately 92 WTE leavers per month.

Bands 2~6 Nursing & Midwifery on Wards

Within the wards, the band 2-6 Operational Vacancy rate was 17.54 per cent (433 WTE vacant); marginally higher than the figure reported at the end of September, relating to the opening of the Neuro Rehabilitation service. Since July, we have been including in our vacancy calculation, those vacancies created by contracted staff on maternity leave; enabling an Operational Vacancy rate to be reported for our wards. When we exclude vacancies which relate to maternity leave, we have a Contractual Vacancy rate of 14.63 per cent. There are currently 161 WTE candidates, waiting to fill these ward vacancies and we expect them to join over the coming months; during which time we will lose to turnover approximately 18 WTE per month. The current turnover rate for ward based band 2 – 6 staff is 10.60 per cent.

In addition to the campaign to recruit and additional 200 Band 2 - 6 ward based nurses, all rolling advertisements have been switched back on and there is a range of focused activity taking place. The selection process for the Student Nurses has been redesigned for those who finish at the end of February 2016 to convert more students nurses into substantive posts, there is activity underway to convert agency to substantive posts and there are targeted campaigns underway in Women's and Children's and Surgery Cancer and Cardio-vascular. From November there will be fortnightly planning meeting with all Divisions to track their vacancy rates to review what additional is needed to achieve the 5 per cent target.

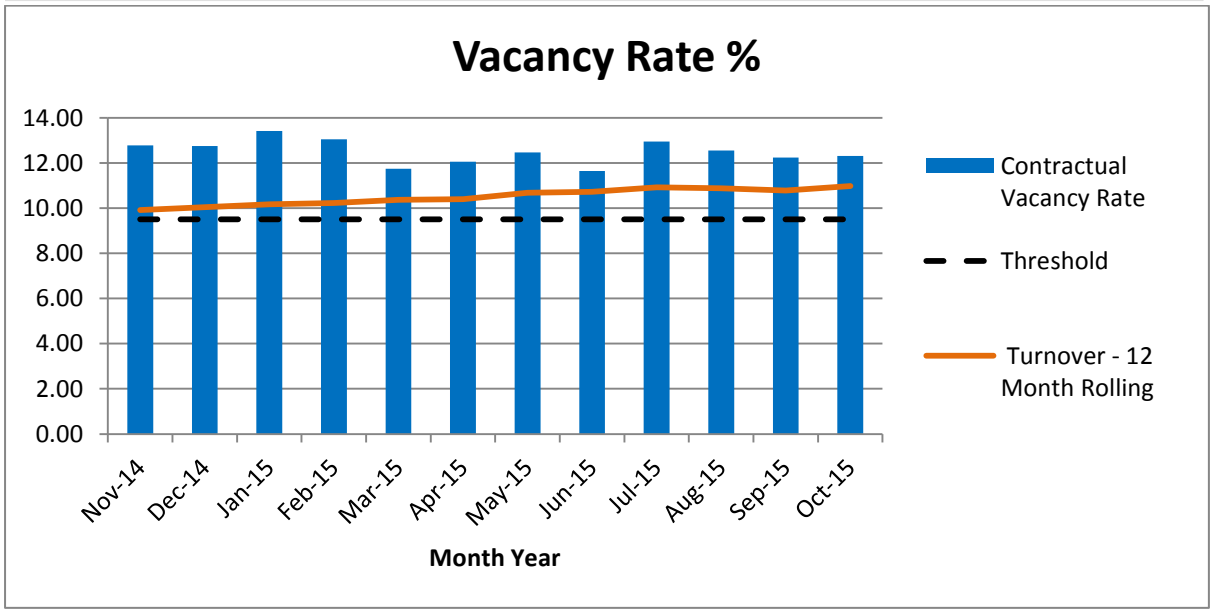


Figure 21 - Vacancy rates for the period November 2014 – October 2015

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence decreased in month from 3.28 per cent to 3.12 per cent, significantly lower than the 3.66 per cent recorded in October 2014. Overall, this brings the rolling 12-month position to 3.30 per cent which remains within the 2015/16 target of 3.40 per cent.

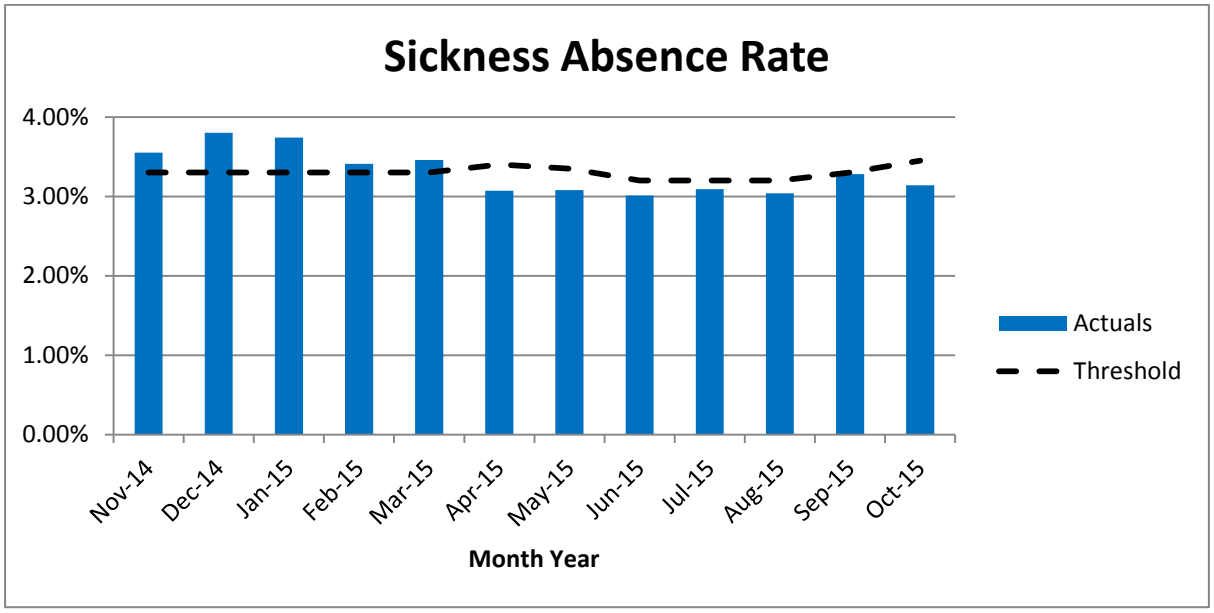


Figure 22 - Sickness absence rates for the period November 2014 – October 2015

2.4.3 Well-Led: Statutory and mandatory training

Excluding doctors in training / trust grade

Compliance has improved significantly from 69 per cent in March 2015 to 82 per cent currently, but is not yet at the target of 95 per cent. A campaign has been running specifically in Fire Training Level 2 and Manual Handling Level 2 where compliance was significantly lower, and these have now improved from 45 to 79 per cent (Fire Level 2) and 31 to 67 per cent (Manual Handling Level 2). Overall compliance still remains a challenge particular in the context of the increase numbers of new starters requiring training at the current time. Campaign will launch in November to improve Consultant compliance specifically.

Doctors in training / trust grade

Reports for doctors in training mirror those of other staff groups and shows an overall compliance rate of 56 per cent. Some issues have been identifies with under recording and a project group has been established to improve systems and processes ready for the next large intake in February.

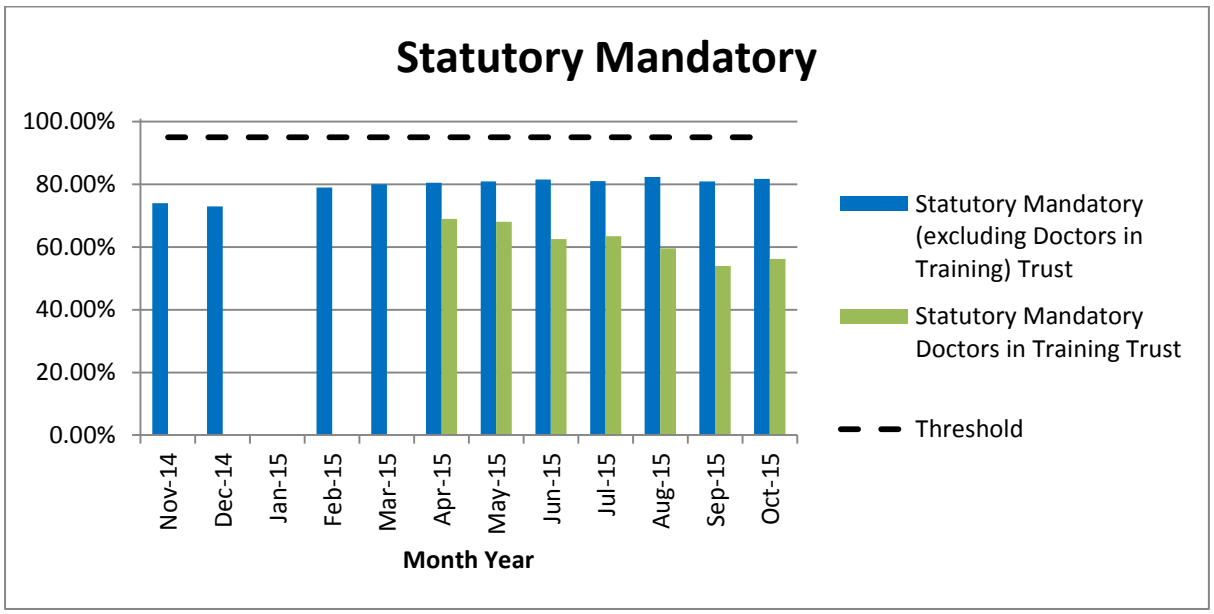


Figure 23 - Statutory and mandatory training for the period November 2014 – October 2015

2.4.4 Well-Led: Non-training grade Doctor Appraisal Rate

The Trust has made significant improvements in aligning appraisal reporting with the national standards, improving the accuracy of the data. We are now starting to see an increase in the appraisal rates after the expected decline following the changes in June 2015.

Compliance will continue to be monitored through the divisional performance meetings chaired by the Chief Operating Officer, with non-compliance managed through the policy.

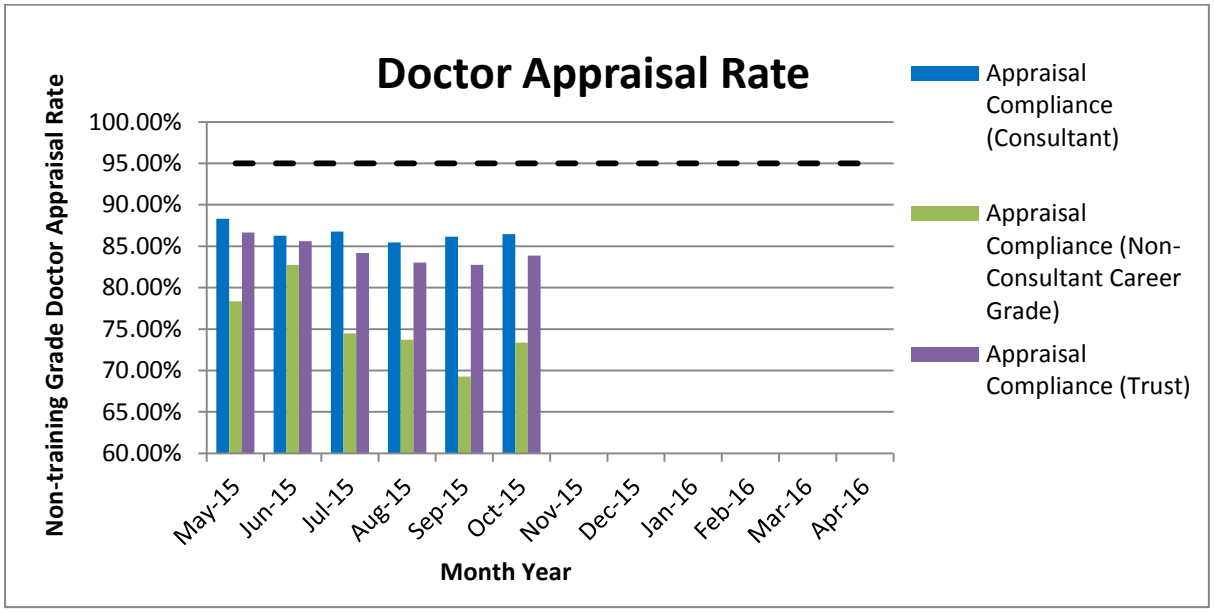


Figure 24 - Grade Doctor Appraisal Rates for the period May 2015 to April 2016

2.4.5 Well-Led: Performance Development Reviews (band 2 – 9 & VSM)

At the end of October, the PDR compliance rate for all of our non-medical staff was 91.57 per cent; against an expected compliance of 95.00 per cent. All of our non-medical staff were expected to have had a completed PDR by the end of September and Divisional and Corporate leads, with the support of the HR Business Partners, are working to ensure that remaining PDR's are scheduled, completed and recorded as soon as possible.

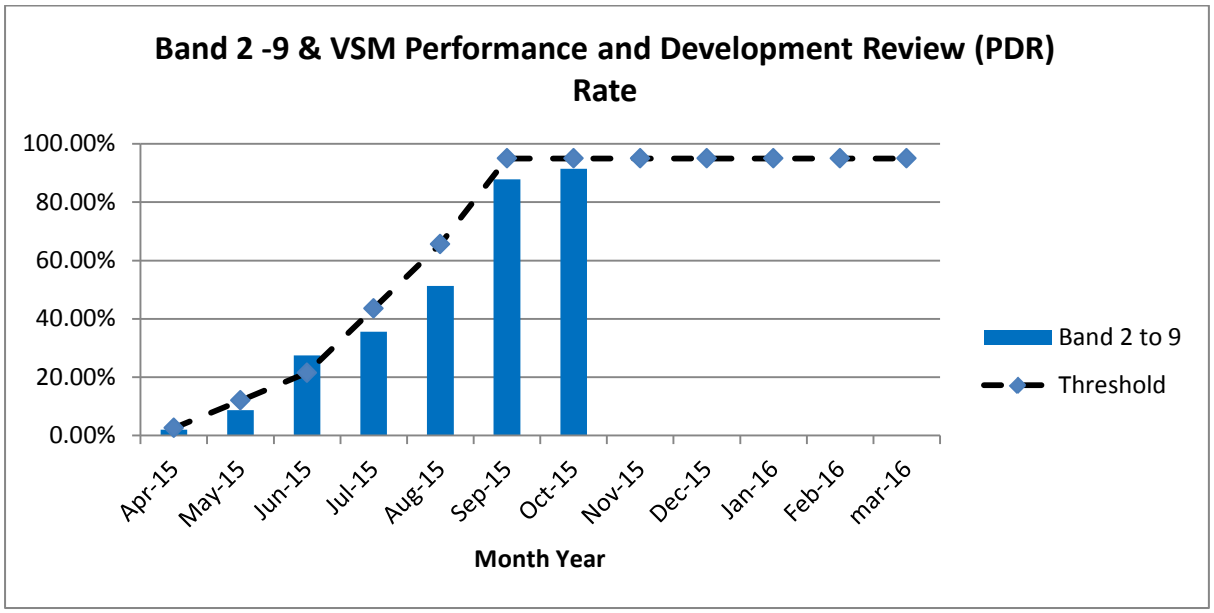


Figure 25 - Band 2 - 9 performance development review rates for the period April 2015 to October 2015

Professional Registration

In July it was brought to the Trust's attention that the registration had lapsed for a nurse. Action has being taken and this has been logged as a Serious Incident. This has led to an audit of all nurses registrations, the policy being reviewed for Professional Registration and a communication and briefing strategy being developed to ensure all staff and managers are aware of the responsibility they have to ensure their professional registration is current and what their respectively responsibilities are if a lapse occurs. As a result of the audit another four incidences of lapses were identified: two individuals are on maternity leave and the other two situations are being managed accordingly.

2.4.6 Well-Led: Health and Safety RIDDOR

Three reportable RIDDOR incidents occurred in October.

- One incident involved a staff member tripping on a portable gas cylinder frame and falling, resulting in a twisted leg and ankle and more than seven days off work.
- The second incident was a fall within a Trust vehicle by a wheelchair-bound patient who, when using the Trust's patient transport service, fell out of their wheelchair during the journey, sustaining injuries that, had the incident not occurred on the way to a hospital, would have resulted in her hospitalisation.
- The third incident was a trip and fall by a Trust visitor who tripped on steps, sustained bruises to his head and hospitalised as a result.

In the 12 months to 31 October 2015, there have been 30 RIDDOR reportable accidents of which 15 were slips, trips and falls and 5 were RIDDOR reportable dangerous occurrences.

Since April 2015, there have been 15 RIDDOR reportable accidents, 9 of which were 'slips, trips and falls/ collisions'. Consistently, the majority of all RIDDOR accidents are slips, trips and falls. The Health and Safety service is working with the Estates & Facilities service and its contractors to investigate ways of ensuring floors present a significantly lower risk of slipping.

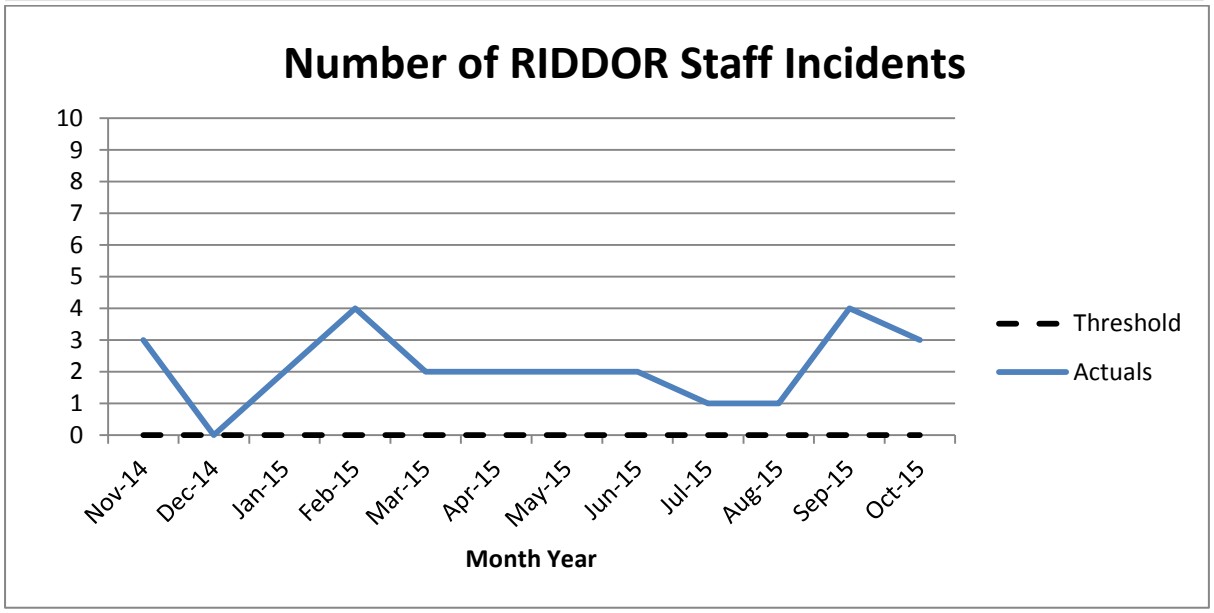


Figure 26 – RIDDOR Staff Incidents for the period November 2014 – October 2015

2.4.7 Well-Led: GMC NTS Actions

The 63 actions that were closed by HENWL in September meant that we could close 15 out of the 50 NTS red flags, leaving 35 still open.

There are 113 open actions, 96 of which were reviewed as part of the quality visit in November. The final report of the visit is due from HENWL in December; this should inform us as to whether we can close these actions.

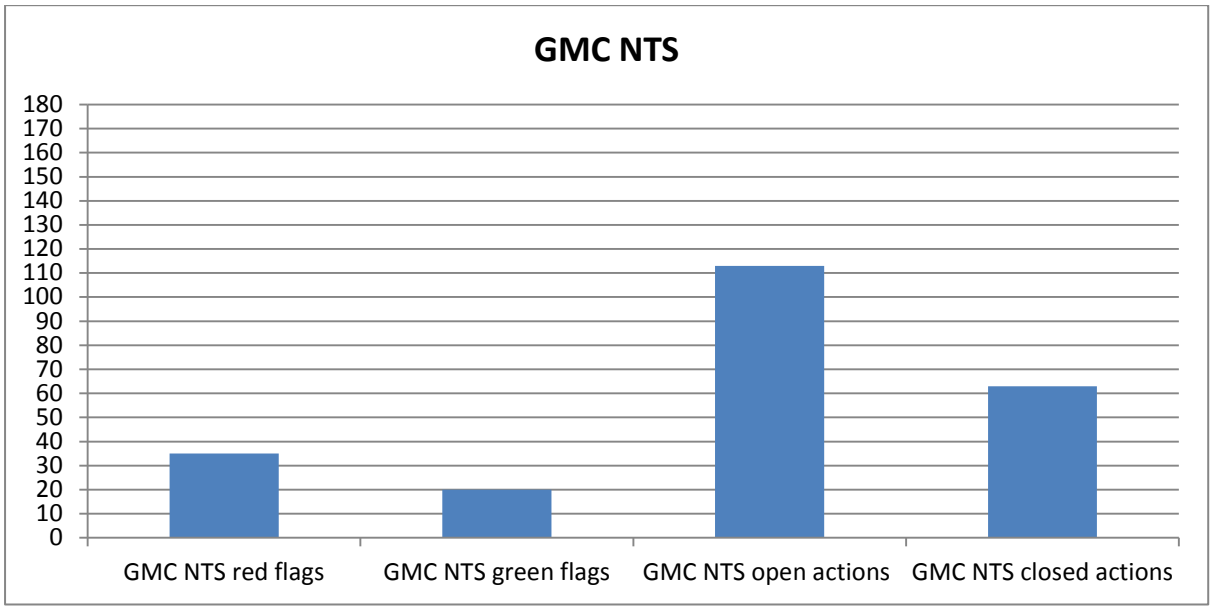


Figure 27 – GMC NTS action tracker, updated at the end of October 2015

2.4.8 Well-Led: Staff Engagement

The most recent engagement survey ran in July/August. This completed a two year cycle of quarterly engagement surveys. The response rate was 57 per cent and the engagement score was 44 per cent; these figures were the same as the previous quarterly survey in May.

Overall, we saw an improvement in both the response rate and engagement score measures in year two compared to year one. The combined response rate increased from 34 per cent to 54 per cent; the combined engagement score increased from 9 per cent to 42 per cent.

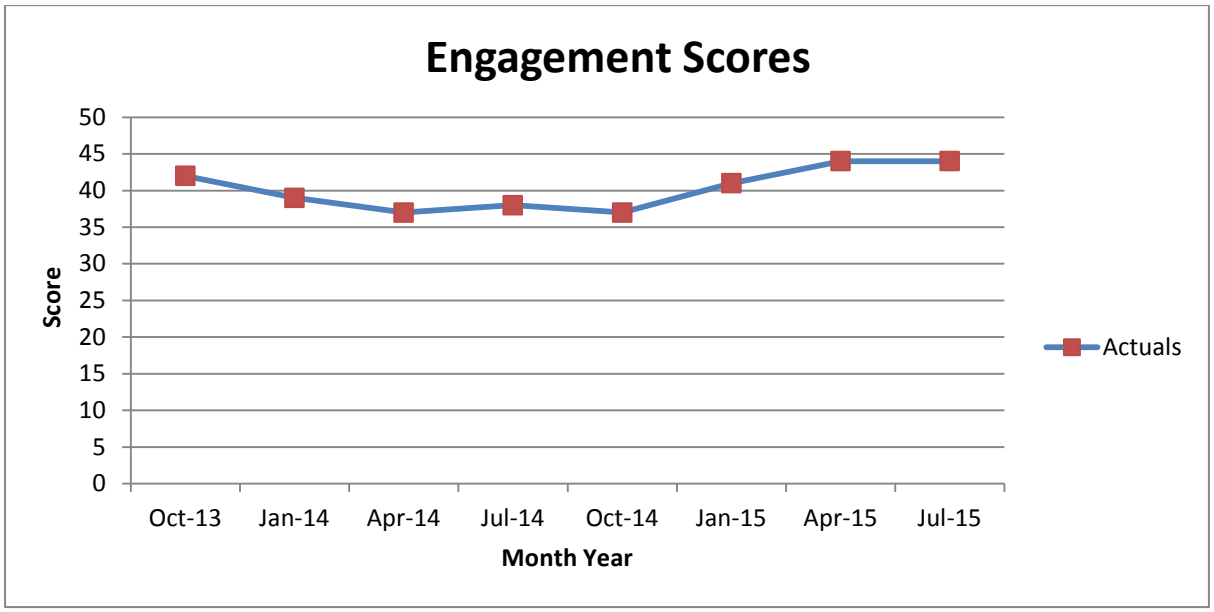


Figure 28 – Engagement scores for the period October 2013 – July 2015

2.5 Responsive

2.5.1 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.

The Trust performance for October was 90.87 per cent and therefore did not meet the 92 per cent incomplete standard. This was a slight worsening of the position from the previous month with an increase in the number of patients waiting over 18 weeks. This was as a result of a combination of individual capacity constraints at speciality level, and bed pressures, resulting in the need to cancel a small volume of elective surgery. Additional capacity is now in place in many specialities, and it is expected that performance submitted for November will show a reduction in the pathways over 18 weeks and achievement of the 92% standard.

The Trust had twelve patients in October who were waiting over 52 weeks for treatment. Five have now had their treatment, two will be treated in late November, one will be treated in early December and four patients are in the process of being booked for treatment.

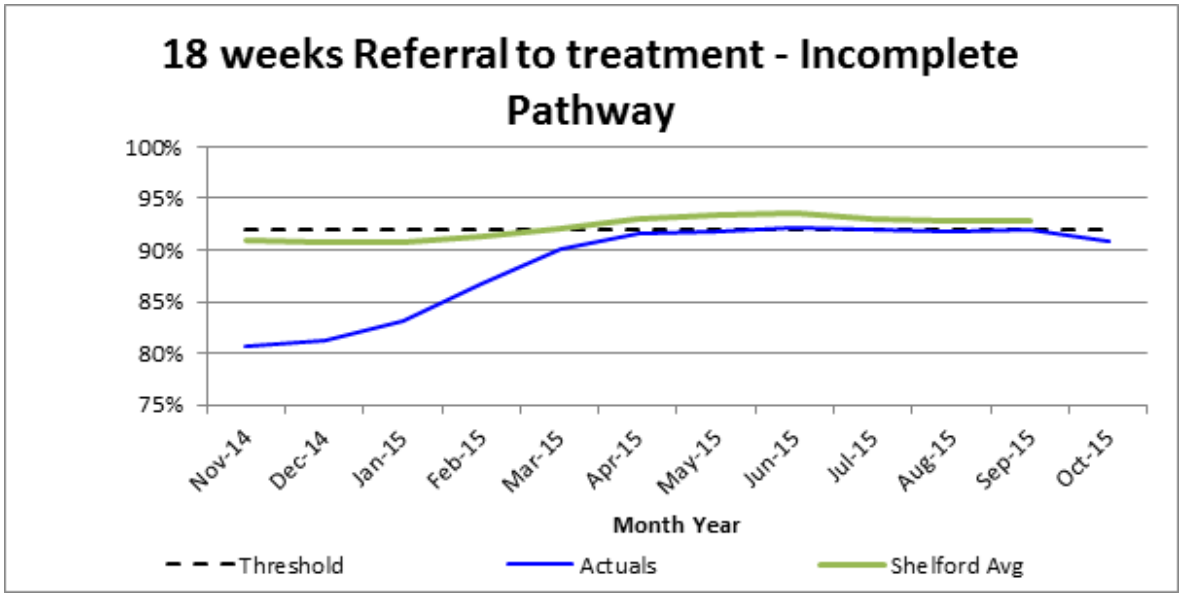


Figure 29 - RTT Incomplete Pathways for the period November 2014 – October 2015

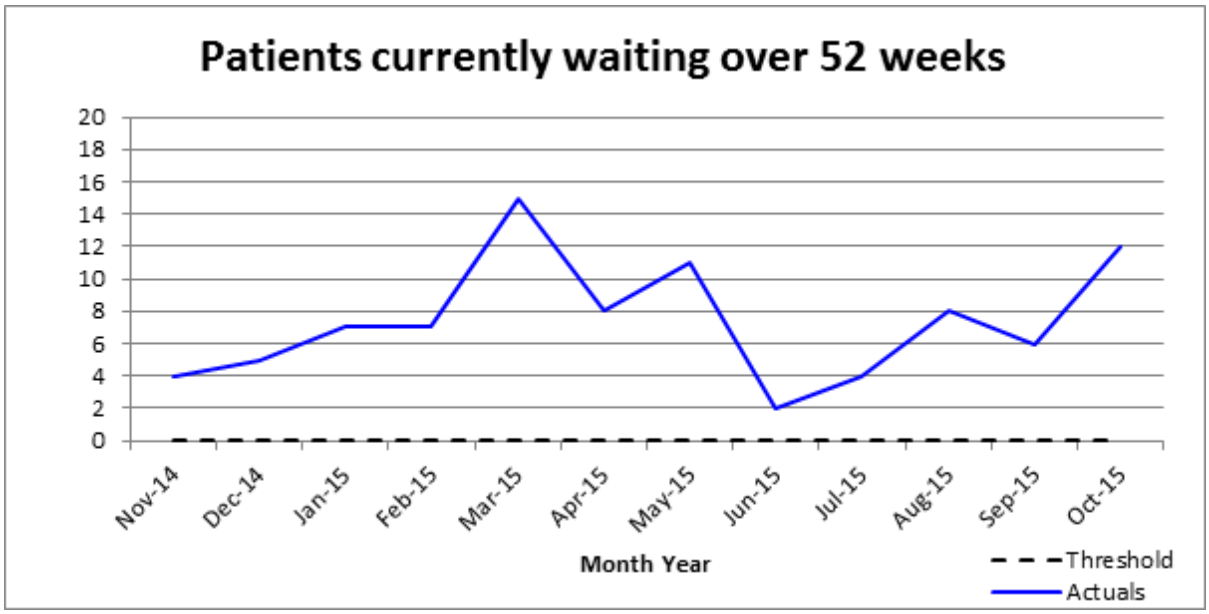


Figure 30 - Number of patients waiting over 52 weeks for the period October 2014 – October 2015

2.5.2 Responsive: Diagnostics

The Trust continued to meet the monthly 6 week diagnostic waiting time standard in October with 0.4% waiting over 6 weeks against the 1% tolerance. Additional capacity, in particular within imaging modalities, has contributed to the Trust improving performance within this standard.

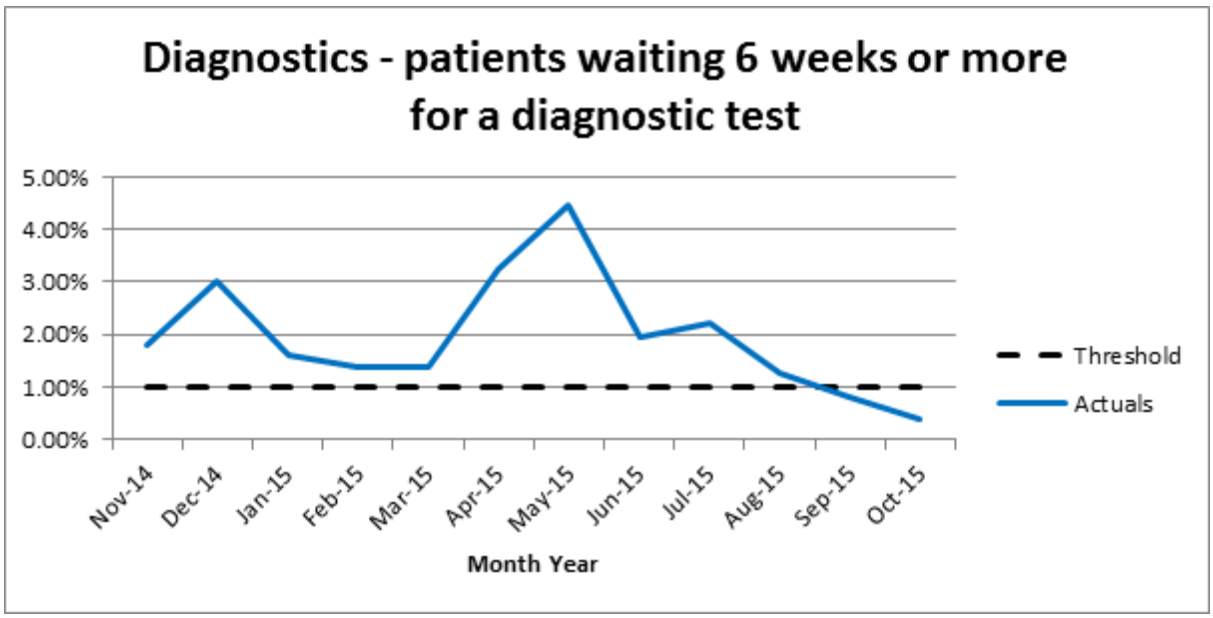


Figure 31 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period November 2014 – October 2015

2.5.3 Responsive: Accident and Emergency

Performance against the four hour access standard for patients attending Accident and Emergency remained below threshold at 92.07 per cent in October.

A number of initiatives to improve flow within the organisation are on-going. 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.

The Trust is also working with local Commissioners to ensure that patients who are awaiting social care, and don't need an acute bed, can be transferred in a timely way as appropriate.

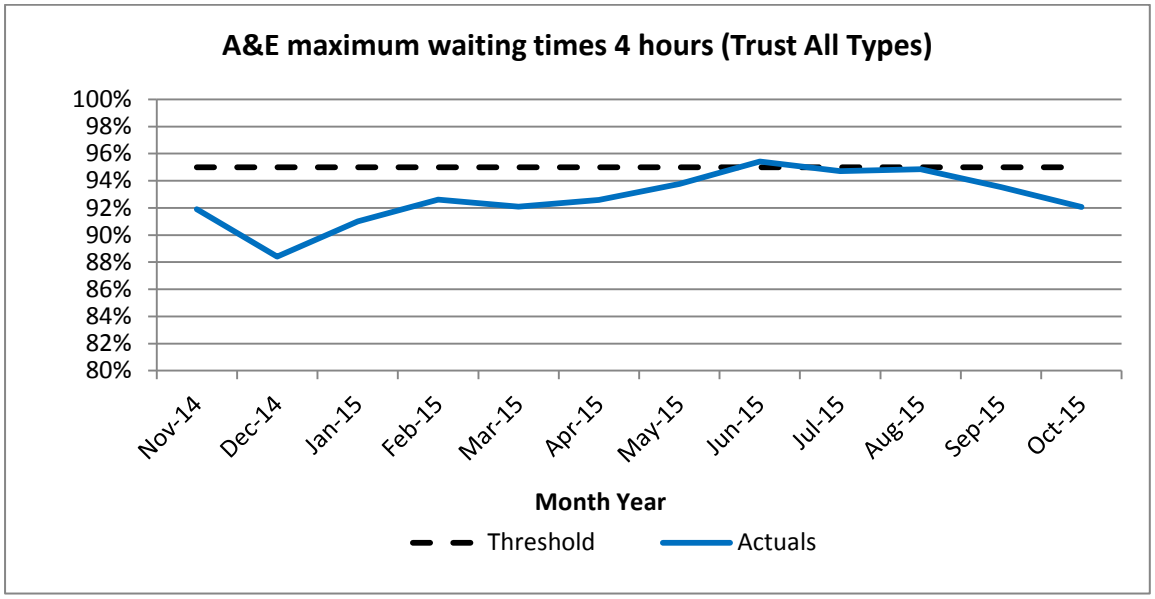


Figure 29 – A&E Maximum waiting times 4 hours (Trust All Types) for the period November 2014 – October 2015

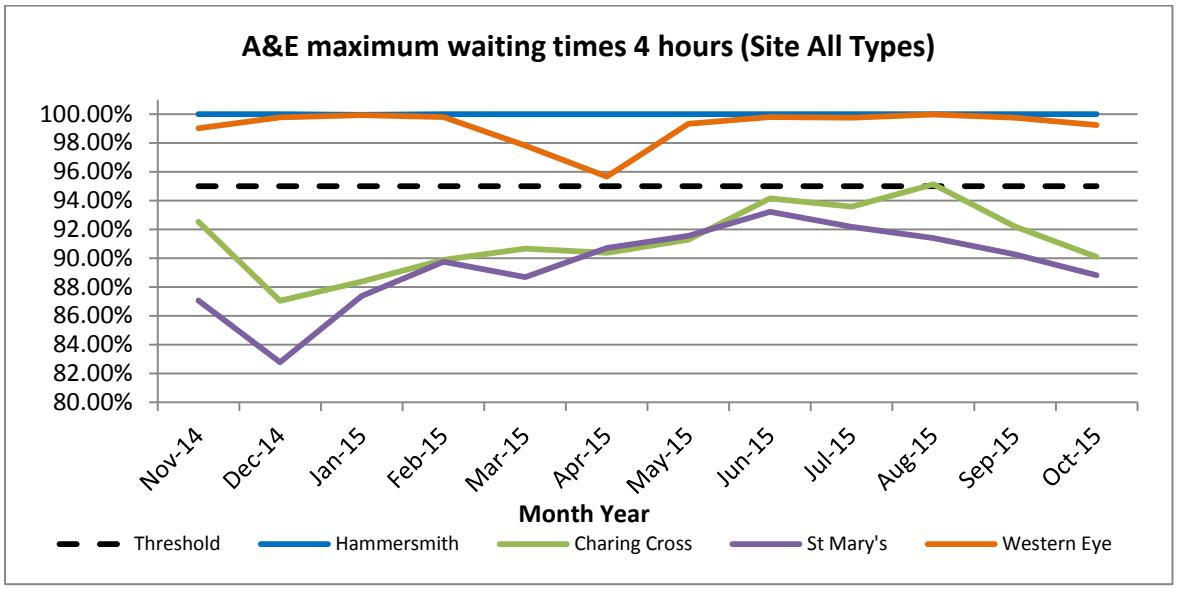


Figure 30 – A&E Maximum waiting times (Site All Types) 4 hours for the period November 2014 – October 2015

2.5.4 Responsive: Cancer

In November, performance is reported for the cancer waiting times standards in September and Quarter 2.

In Quarter 2, the Trust achieved all eight national cancer standards. This included recovery of the 62-day screening standard which the Trust failed to meet in Quarter 1.

In order to maintain the 62-day GP referral to first treatment standard in the winter months, the Trust has taken a number of actions. The IST have now provided their report to the Trust on suggested improvements on the GI diagnostic pathway. They have made several recommendations around improving the administration of diagnostic bookings, which the Trust will now work with them to implement. The Trust is also working with local GPs to improve education around what patients should expect when they are referred as new two week wait referrals to the Trust to help ensure that patients arrive with the understanding that they may require multiple investigations over a short period of time in order to confirm their diagnosis. We will be working closely with GPs and CCG colleagues over the coming months to mitigate the impact of patient choice delays across the Christmas period.

The breach reallocation policy for 62-day breaches shared between two organisations, negotiated by the Trust and included in all NWL contracts for 2015/16, is now being considered for rollout across London, and potentially nationally, by NHSE. The Trust is working closely with NHSE colleagues to ensure that the final policy is structured in such a way that it will give impetus to diagnostic pathway redesign work in all secondary centres and result in performance reporting that more fairly reflects the work of tertiary centres.

A new cancer waiting times target will be introduced as part of the five year national cancer strategy. The target will be to deliver diagnosis within 28 days of receipt of a GP two week wait referral. The CCGs are developing the metrics for this and the Trust has agreed to work with them by running shadow reporting from early 2016 to best prepare us for the formal implementation of the target in 2016/17.

In September, the Trust achieved seven of the eight national cancer standards. The Trust failed to meet the two week wait standard for first attendance after a GP referral. There were a high number of breaches relating to patient choice in September after the end of the summer period, which significantly contributed to the poor performance position. A demand and capacity exercise has been undertaken for all services receiving two week wait referrals from GPs to support capacity planning going into 2016/17. The actions with the CCGs outlined above will also support delivery of the standard.

The two week wait standard has been delivered in October, which will be reported in December. Performance against the other standards has remained strong and the Trust expects to report as delivering all eight national standard in October.

Indicator	Standard	Sep-15	Q2 15/16
Two week GP referral to 1st outpatient, cancer (%)	93.0%	90.5%	93.3%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	94.6%	94.1%
31 day wait from diagnosis to first treatment (%)	96.0%	96.4%	96.4%
31 day second or subsequent treatment (surgery) (%)	94.0%	96.2%	97.5%
31 day second or subsequent treatment (drug) (%)	98.0%	100%	100%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	99.0%	99.7%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	86.5%	85.3%
62 day urgent GP referral to treatment from screening (%)	90.0%	93.9%	94.3%

Table 1 - Performance against national cancer standards for September 2015 and Q2 15/16

2.5.5 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 appointment, they may be discharged back to their GP.

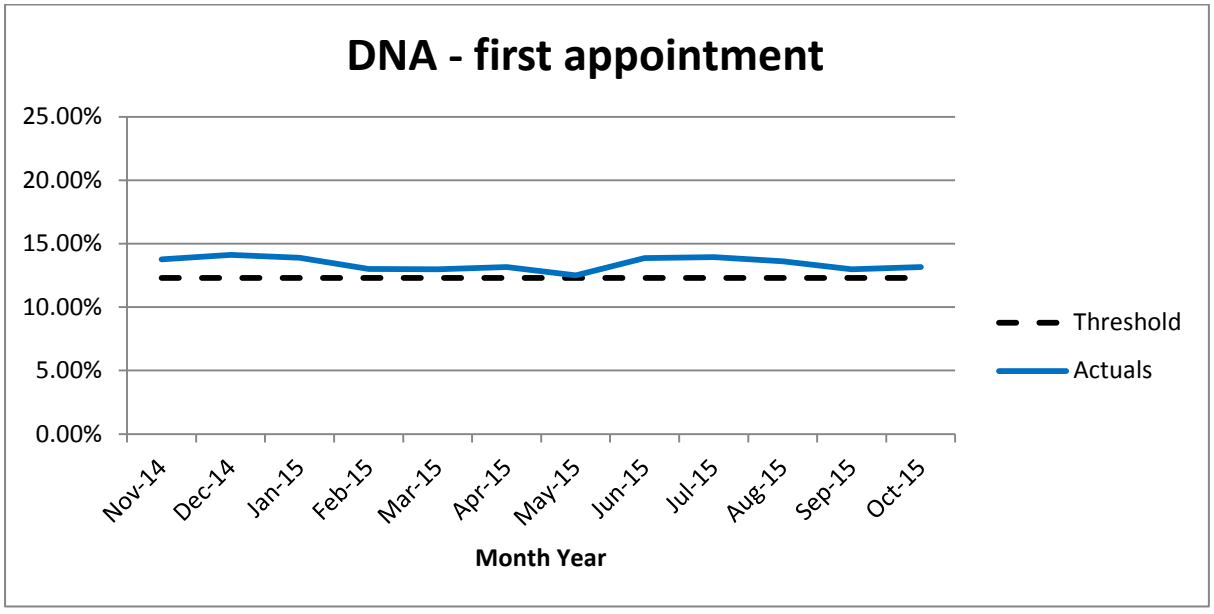


Figure 31 – First outpatient DNA rate for the period November 2014 – October 2015

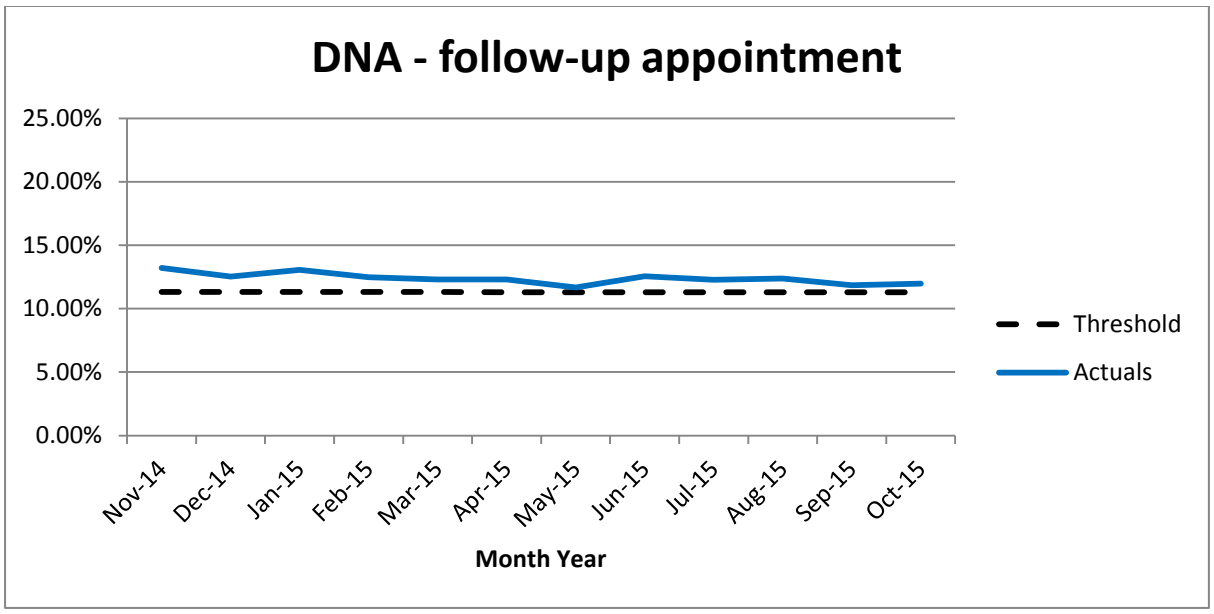


Figure 32 – Follow up outpatient DNA rate for the period November 2014 – October 2015

2.5.6 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.

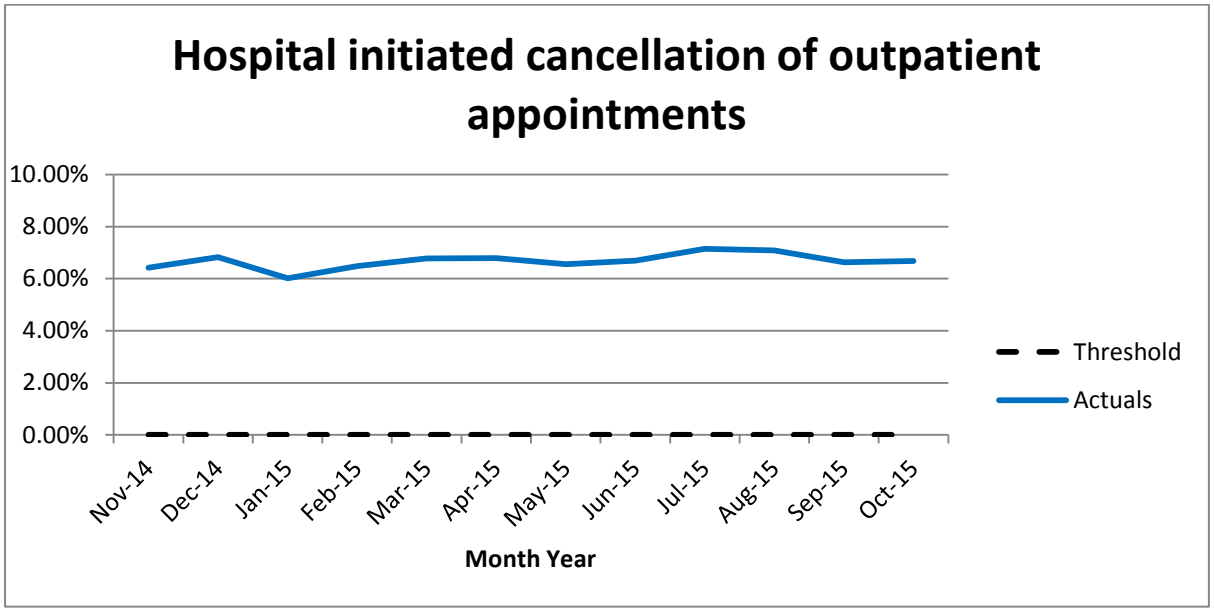


Figure 33 – Outpatient Hospital instigated cancellation rate for the period November 2014 – October 2015

3. Finance

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

Appendix 1

October 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	Roster Name	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	10 North	Charing Cross Hospital - RYJ02	10 North Ward	1905.5	1807.5	94.86%	529	494.5	93.48%	908.5	908.5	100.00%	493.5	493.5	100.00%
Medicine	11 South	Charing Cross Hospital - RYJ02	11 South Ward	2711	2543.5	93.82%	409.5	375	91.58%	2162	2075	95.98%	425.5	425.5	100.00%
Medicine	4 South	Charing Cross Hospital - RYJ02	4 South Ward	2126.166667	2038.67	95.88%	987	882	89.36%	1322.5	1276.5	96.52%	920	920	100.00%
Medicine	5 South	Charing Cross Hospital - RYJ02	5 South Ward	1867.5	1867.5	100.00%	103	103	100.00%	1794	1781.5	99.30%	115	115	100.00%
Medicine	5 West AMAU	Charing Cross Hospital - RYJ02	5 West Ward	2536.5	2302.5	90.77%	954.5	920	96.39%	1991.5	1922.5	96.54%	895.5	862.5	96.31%
Medicine	8 South	Charing Cross Hospital - RYJ02	8 South Ward	2117.5	2020.25	95.41%	1230.5	1130.5	91.87%	1322.5	1311	99.13%	828	828	100.00%
Medicine	8 West	Charing Cross Hospital - RYJ02	8 West Ward	1429.5	1418	99.20%	1269	1169	92.12%	1069.5	1069.5	100.00%	757	736.5	97.29%
Medicine	9 North HASU	Charing Cross Hospital - RYJ02	9 North Ward	2873	2480	86.32%	1012	941.5	93.03%	2162	2081.5	96.28%	448.5	437	97.44%
Medicine	7 West	Charing Cross Hospital - RYJ02	9 South Ward	2116.25	2013.25	95.13%	1150	1104	96.00%	1276.5	1219	95.50%	1263	1251.5	99.09%
Medicine	9 West ASU	Charing Cross Hospital - RYJ02	9 West Ward	1472	1424	96.74%	862.5	816.5	94.67%	724.5	724.5	100.00%	793.5	770.5	97.10%
Medicine	Rodney Porter & Almroth Wright	St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	2021	1952	96.59%	713	655.5	91.94%	1483.5	1460.5	98.45%	713	711	99.72%
Medicine	DAAU AMU	St Mary's Hospital (HQ) - RYJ01	AMU	1530.5	1513	98.86%	696.5	543.5	78.03%	1115.5	1092.5	97.94%	460	437	95.00%
Medicine	C8 Escalation ward	Hammersmith Hospital - RYJ03	C8 Ward	1804	1634	90.58%	737	701.5	95.18%	1644.5	1495	90.91%	724.5	701.5	96.83%
Medicine	Christopher Booth	Hammersmith Hospital - RYJ03	Christopher Booth Ward	1801	1778	98.72%	593.5	573.5	96.63%	1069.5	1069.5	100.00%	379.5	379.5	100.00%
Medicine	DAAU HDU	St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	1882.5	1770.67	94.06%	69	69	100.00%	1886	1794	95.12%	103.5	103.5	100.00%
Medicine	De Wardener	Hammersmith Hospital - RYJ03	Dewardener Ward	1486.5	1387.5	93.34%	0	0	100.00%	1437.5	1403	97.60%	322	310.5	96.43%
Medicine	Fraser Gamble	Hammersmith Hospital - RYJ03	Fraser Gamble Ward	1655.75	1595.75	96.38%	1127	1035	91.84%	1150	1139.5	99.09%	921	909.5	98.75%
Medicine	9 South ASU	St Mary's Hospital (HQ) - RYJ01	Grafton Ward	1199	1156	96.41%	736	701.5	95.31%	839.5	782	93.15%	678.5	667	98.31%
Medicine	Handfield Jones	Hammersmith Hospital - RYJ03	Handfield Jones Ward	1500.75	1418.75	94.54%	794	706	88.92%	1092.5	1069.5	97.89%	368	364	98.91%
Medicine	John Humphrey	Hammersmith Hospital - RYJ03	John Humphrey Ward	1426.5	1366.5	95.79%	830	735.5	88.61%	713	701.5	98.39%	816.5	805	98.59%
Medicine	DAAU Joseph Toynbee	St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	1300.5	1285.5	98.85%	565.5	522.75	92.44%	1173	1127	96.08%	483	471.5	97.62%
Medicine	Kerr Ward	Hammersmith Hospital - RYJ03	Kerr Ward	1373.5	1366	99.45%	998	926	92.79%	1058	1046.5	98.91%	504.75	504.75	100.00%
Medicine	Lady Skinner	Charing Cross Hospital - RYJ02	Lady Skinner Ward	1234.5	1209.5	97.97%	736	667.5	90.69%	713	713	100.00%	356.5	356.5	100.00%
Medicine	Manvers ward	St Mary's Hospital (HQ) - RYJ01	Manvers Ward	1424	1401	98.38%	713	713	100.00%	1426	1414.5	99.19%	713	713	100.00%
Medicine	Peters Ward	Hammersmith Hospital - RYJ03	Peters Ward	1142	1079	94.48%	724	699.5	96.62%	793.5	783	98.68%	368	368	100.00%
Medicine	SMH Lewis Lloyd	St Mary's Hospital (HQ) - RYJ01	Lewis Lloyd	1204.5	1193	99.05%	817.5	769.5	94.13%	713	713	100.00%	828	828	100.00%
Medicine	SMH Samuel Lane	St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	1845	1786.5	96.83%	736	690	93.75%	1357	1322.5	97.46%	356.5	356.5	100.00%
Medicine	Thistle	St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	1611	1515.5	94.07%	736	701.5	95.31%	1196	1173	98.08%	425.5	425.5	100.00%
Medicine	SMH Witherow Ward	St Mary's Hospital (HQ) - RYJ01	Witherow Ward	1234.5	1198.75	97.10%	782	769.5	98.40%	713	713	100.00%	977.5	966	98.82%
Surgery and Cancer/Clinical Haem	10 South Head & Neck	Charing Cross Hospital - RYJ02	10 South Ward	2129.5	2102.25	98.72%	772	684	88.60%	1460.5	1437.5	98.43%	80.5	80.5	100.00%
Surgery and Cancer/Clinical Haem	CXH 6 North	Charing Cross Hospital - RYJ02	6 North Ward	2207.25	2137.75	96.85%	719	696	96.80%	1069.5	1050.5	98.22%	989	989	100.00%
Surgery and Cancer/Clinical Haem	CXH 6 South	Charing Cross Hospital - RYJ02	6 South Ward	1584.5	1517.25	95.76%	652.5	652.5	100.00%	1023.5	968	94.58%	161	161	100.00%
Surgery and Cancer/Clinical Haem	7 North	Charing Cross Hospital - RYJ02	7 North Ward	2058.5	2012.5	97.77%	782.5	668.92	85.48%	1426	1399	98.11%	782	780.42	99.80%
Surgery and Cancer/Clinical Haem	7 South	Charing Cross Hospital - RYJ02	7 South Ward	2021.5	1984.5	98.17%	839	734.5	87.54%	1068.5	1055.67	98.80%	356.5	356.33	99.95%
Surgery and Cancer/Clinical Haem	A6 CICU	Hammersmith Hospital - RYJ03	A6 CICU	2933	2860.5	97.53%	408	408	100.00%	2909.5	2895.25	99.51%	207	207	100.00%
Surgery and Cancer/Clinical Haem	A7 Cardiology	Hammersmith Hospital - RYJ03	A7 Ward & CCU	2256.5	2113.5	93.66%	616.5	540.5	87.67%	1782.5	1759	98.68%	516.5	493.5	95.55%
Surgery and Cancer/Clinical Haem	A8	Hammersmith Hospital - RYJ03	A8 Ward	1735.67	1622.17	93.46%	713	701.5	98.39%	1081	1068.08	98.80%	184	161	87.50%
Surgery and Cancer/Clinical Haem	A9 Cardiothoracic	Hammersmith Hospital - RYJ03	A9 Ward	1411.5	1411.5	100.00%	421.25	421.25	100.00%	1081	1081	100.00%	437	437	100.00%
Surgery and Cancer/Clinical Haem	SMH Albert Ward	St Mary's Hospital (HQ) - RYJ01	Albert Ward	1877.5	1829.2	97.43%	965.5	931	96.43%	1069.5	1035	96.77%	793.5	782	98.55%
Surgery and Cancer/Clinical Haem	Charles Pannett ward	St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	2472	2365	95.67%	800.5	724.5	90.51%	1840	1817	98.75%	758	736	97.10%
Surgery and Cancer/Clinical Haem	D7	Hammersmith Hospital - RYJ03	D7 Ward	1435.5	1435.5	100.00%	345	345	100.00%	713	713	100.00%	356.5	356.5	100.00%
Surgery and Cancer/Clinical Haem	Dacie	Hammersmith Hospital - RYJ03	Dacie Ward	1711	1674.34	97.86%	222	218.5	98.42%	1069.5	1067.5	99.81%	137	137	100.00%
Surgery and Cancer/Clinical Haem	Intensive Care CXH	Charing Cross Hospital - RYJ02	Intensive Care CXH	5090.5	5029.5	98.80%	798	792	99.25%	5084.5	5045.5	99.23%	310.5	310.5	100.00%
Surgery and Cancer/Clinical Haem	Intensive care HH	Hammersmith Hospital - RYJ03	Intensive care HH	4843.5	4587	94.70%	621	609.5	98.15%	4889.5	4606	94.20%	253	218.5	86.36%
Surgery and Cancer/Clinical Haem	Intensive Care SMH	St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	5576.76	5576.76	100.00%	793.5	793.5	100.00%	5544.52	5492.5	99.06%	736	736	100.00%
Surgery and Cancer/Clinical Haem	Major Trauma Ward SMH	St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	1861.5	1811	97.29%	675.5	607	89.86%	1518	1506.5	99.24%	621	598	96.30%
Surgery and Cancer/Clinical Haem	Paterson Ward	St Mary's Hospital (HQ) - RYJ01	Patterson Ward	1363.5	1352	99.16%	402.5	390	96.89%	736	724.5	98.44%	379.5	379.5	100.00%
Surgery and Cancer/Clinical Haem	Riverside	Charing Cross Hospital - RYJ02	Riverside	2821.75	2522.75	89.40%	1547	1322.75	85.50%	1367.5	1321.5	96.64%	563.5	563.5	100.00%
Surgery and Cancer/Clinical Haem	Valentine Ellis	St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	2288.25	2161.25	94.45%	796	694.67	87.27%	1863	1840	98.77%	460	391	85.00%
Surgery and Cancer/Clinical Haem	Weston	Hammersmith Hospital - RYJ03	Weston Ward	1462.5	1433	97.98%	525.5	408	77.64%	1068.5	1057	98.92%	230	195.5	85.00%
Surgery and Cancer/Clinical Haem	Zachary Cope	St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	2547.75	2395.75	94.03%	1069.5	943	88.17%	1847	1656	89.66%	1067.5	1044.5	97.85%
Women and Children's	Alek Bourne 1&2	St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	5075	4766.66	93.92%	2030	1651	81.33%	4565.5	4369.25	95.70%	1426	1299	91.09%
Women and Children's	QCCH Birth Centre	Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	1219.5	1219.5	100.00%	271.5	271.5	100.00%	701.5	701.5	100.00%	333.5	333.5	100.00%
Women and Children's	SMH Birth Centre	St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	1069.5	1069.5	100.00%	57.5	52.5	91.30%	819.5	819.5	100.00%	241.5	241.5	100.00%
Women and Children's	Edith Dare	Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	2155.26	2072.76	96.17%	1069.5	999.25	93.43%	1483.5	1404.08	94.65%	1069.5	1036.5	96.91%
Women and Children's	Grand Union	St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	2071.5	2039	98.43%	0	0	100.00%	1943.5	1943.5	100.00%	0	0	100.00%
Women and Children's	GWE/PSSU	St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	2586	2553.17	98.73%	356.5	356.5	100.00%	2300	2288.5	99.50%	345	333.5	96.67%
Women and Children's	SMH Lillian Holland	St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	1163	1131.5	97.29%	669	669	100.00%	713	711	99.72%	356.5	356.5	100.00%
Women and Children's	Neo Natal	Queen Charlotte's Hospital - RYJ04	Neo Natal	4205	4182.5	99.46%	136	136	100.00%	3755.8	3744.3	99.69%	103.5	103.5	100.00%
Women and Children's	Winnicott Baby Unit	St Mary's Hospital (HQ) - RYJ01	NICU	2364	2231.25	94.38%	339.5	339.5	100.00%	2370	2271	95.82%	264.5	264.5	100.00%
Women and Children's	PCCS	St Mary's Hospital (HQ) - RYJ01	PICU	3143.25	2906.5	92.47%	0	0	100.00%	2990	2852	95.38%	0	0	100.00%
Women and Children's	QCCH Labour Ward	Queen Charlotte's Hospital - RYJ04	QCCH labour	4963.98	4609.83	92.87%	1049.25	934	89.02%	4385.5	4172	95.13%	1081	1069.5	98.94%
Women and Children's	QCCH Victor Bonney Ward & Day Unit	Hammersmith Hospital - RYJ03	Victor Bonney Ward	2169.5	1855.5	85.53%	851	754	88.60%	1046.5	989	94.51%	356.5	333.5	93.55%

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	2.4
Title	Financial report - 7 months ended 31 October 2015
Report for	Noting
Report Author	Richard Alexander, Chief financial officer
Responsible Executive Director	Richard Alexander, Chief financial officer

Executive summary:

This report provides a brief summary of the Trust's financial results for the 7 months ended 31 October 2015.

Recommendation:

The Trust board is asked to note this paper and the actions proposed to mitigate and address the position going forward.

Trust strategic objectives supported by this paper:

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

IMPERIAL COLLEGE HEALTHCARE NHS TRUST

FINANCE REPORT – 7 MONTHS ENDED 31 October 2015

1. Introduction

This report provides a brief summary of the Trust's financial results for the 7 months ended 31 October 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 seven months the Trust is reporting a deficit of £20.1m; an adverse variance to plan of £9.3m. This significant and concerning worsening in our position is driven to a large extent by a very disappointing Month 7 result – the drivers of this surprise and their implications are currently being worked through. 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	88,055	83,517	(4,538)	594,142	578,833	(15,309)
Total Expeniture	(83,385)	(85,735)	(2,350)	(577,776)	(572,177)	5,599
Earning Before Interest, Tax Depreciation and Amortisation	4,670	(2,218)	(6,888)	16,366	6,656	(9,710)
SURPLUs / (DEFICIT) including donated asset Treatment	756	(6,107)	(6,863)	(10,246)	(20,124)	(9,878)
SURPLU / (DEFICIT)	**738**	**(6,015)**	**(6,753)**	**(10,869)**	**(20,133)**	**(9,264)**

Whilst income is ahead of levels delivered at this point last year, the Trust is not achieving its ambitious growth targets in either NHS or Private income. NHS commissioners are challenging many elements of our activity and provisions have been made for this. Overall expenditure is below plan. The annual plan is for a deficit of £18.5m; the most recent forecast which takes account of the M7 result, indicates the Trust will be significantly adverse to this. The Executive have agreed a series of further actions, initially focussed on non-clinical headcount, to address this.

3. Revenue

The Appendix provides a summary of the position after 7 months.

3.1 NHS Activity and Income

The summary table shows the position by division.

Divisions	Year to Date (Activity)			Year to Date (Income)		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s
A - Medicine	1,490,296	1,164,484	(325,812)	175,222	174,897	(325)
B - Surgery and Cancer	781,432	828,385	46,953	179,908	179,725	(183)
C - Investigative Sciences and Clinical Support	1,228,360	1,306,112	77,752	19,609	20,340	731
D - Womens and Childrens	111,377	108,712	(2,665)	66,938	65,420	(1,517)
X/Z - Central Divisional Total	66,868	65,361	(1,506)	12,472	5,498	(6,974)
			0			
YTD OCTOBER's FORECAST ACTIVITY & INCOME	3,678,333	3,473,055	(205,278)	454,149	445,881	(8,268)

[Note: The Central division reports 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.]

Notably income from critical care (-10%) and elective (-2%) are below plan, whilst non-elective income is 3% ahead of plan. Within elective care day case activity is above plan whilst in-patient activity is behind plan with a switch of some activity to day case.

3.2 Private Care income

Private care income continues to underperform, by £4.2m at M7, although runrate improved in month 7 and income was £0.3m behind plan for the month. The division has agreed an ambitious revised plan for the remainder of the year and is on track to deliver this.

3.3 Expenditure

The devolved financial 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	1,003	264	(739)	7,135	7,625	490
	Pay	(11,796)	(12,147)	(351)	(82,500)	(84,253)	(1,753)
	Non Pay	(4,798)	(5,329)	(531)	(33,406)	(35,217)	(1,812)
Division Of Medicine Total		**(15,590)**	**(17,212)**	**(1,622)**	**(108,770)**	**(111,845)**	**(3,075)**
Division of Women and Children	Income	687	338	(348)	4,326	2,625	(1,701)
	Pay	(6,573)	(5,942)	631	(44,730)	(42,640)	2,090
	Non Pay	(1,261)	(1,163)	97	(8,607)	(7,575)	1,032
Division Of Women And Children Total		**(7,147)**	**(6,767)**	**380**	**(49,011)**	**(47,590)**	**1,421**
Investigative Sciences & C S	Income	2,251	1,850	(401)	15,751	15,407	(344)
	Pay	(7,446)	(7,444)	1	(52,748)	(52,131)	617
	Non Pay	(2,990)	(2,871)	119	(21,038)	(21,361)	(322)
Investigative Sciences & C S Total		**(8,185)**	**(8,466)**	**(281)**	**(58,035)**	**(58,084)**	**(49)**
Surg, Canc & Cardiovasc Div	Income	496	(1,229)	(1,725)	3,475	(239)	(3,715)
	Pay	(14,390)	(14,494)	(104)	(99,469)	(99,807)	(337)
	Non Pay	(4,755)	(4,990)	(235)	(33,430)	(32,432)	998
Surg, Canc & Cardiovasc Div Total		**(18,649)**	**(20,713)**	**(2,064)**	**(129,424)**	**(132,478)**	**(3,054)**
Private Patients Directorate	Income	3,439	2,987	(452)	24,072	18,327	(5,745)
	Pay	(1,128)	(986)	142	(7,896)	(6,962)	934
	Non Pay	(968)	(1,214)	(245)	(6,798)	(6,524)	274
Private Patients Directorate Total		**1,343**	**787**	**(555)**	**9,378**	**4,840**	**(4,537)**
		(48,228)	**(52,371)**	**(4,142)**	**(335,863)**	**(345,157)**	**(9,294)**

The Division of Medicine is £3.1m adverse to plan year to date driven by a combination of below plan activity and income, combined with overspends on nursing (primarily for "specialing"; for patients requiring 1:1 care). £0.5m of this position relates to drugs funded at cost which have offsetting variances in income.

The Surgery Division is £3.1m adverse to plan year to date due primarily to below plan performance against the NHS income plan, especially in recent months. This sudden and unexpected shortfall has been the major driver in the worsening of the Trust's financial position.

Private Health is adverse to plan year to date by £4.5m, £5.7m behind its income plan, partly offset by underspends on pay and non-pay.

4. Efficiency programme

CIP delivery in month 7 is showing an adverse in-month variance of £0.6m, at £2.7m against a plan of £3.3m, due to under achievement against both corporate and divisional schemes. YTD achievement of CIP has remained at 76% leading to a shortfall of £4.5m. The forecast position has worsened to 88% achievement of the £36.1 million target by year-end.

The position has deteriorated for Surgery, Cancer & Cardiovascular (forecast £1m worse than last month) and Women's & Children's (forecast £0.5m worse than last month). The underlying issues have been picked up and included in analysis of the overall performance for the divisions, and mitigating actions are being identified as part of the stretch programme and are actively monitored as part of the regular weekly / fortnightly meetings with the Divisions. We will continue to focus on CIP programme delivery in order and will carry out an urgent review to identify any further risks of slippage.

5. Cash

The cash balance at the end of the month was £51.5m; £6.3m above plan. Our assessment is that the cash position remains manageable for the remainder of the financial year.

6. Conclusion

The Trust is not meeting its financial and activity plans year to date and is forecasting that it will be extremely challenging to meet its full year plan. This is primarily due to the fact that the Trust is not meeting its ambitious growth targets for treating private patients, is overspending in Medicine Division and under-delivering activity in SC&C Div combined with much more challenge to the level of NHS activity from its commissioners. Whilst our NHS income levels are 4% above levels at this point last year, they remain lower than our plans.

The Executive is committed to recovering the financial position but based on more recent trends recognise this will be a challenge. The most recent forecast shows an adverse variance to plan and the Executive have agreed a series of actions to address this whilst maintaining safe and high quality care. These actions will support our long term sustainability.

The Trust Board is requested to note this report.

Appendix

Statement of Comprehensive Income – 7 months to 31st October 2015

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	69,113	63,731	(5,382)	463,914	456,194	(7,720)
Private Patients	4,320	4,028	(292)	27,872	23,626	(4,246)
Research & Development & Education	8,997	10,672	1,675	62,985	65,931	2,946
Other	5,625	5,086	(539)	39,371	33,082	(6,289)
TOTAL INCOME	**88,055**	**83,517**	**(4,538)**	**594,142**	**578,833**	**(15,309)**
Expenditure						
Pay - In post	(44,217)	(41,824)	2,393	(302,791)	(288,568)	14,223
Pay - Bank	(1,203)	(2,480)	(1,277)	(12,299)	(17,780)	(5,481)
Pay - Agency	(2,650)	(4,158)	(1,508)	(19,899)	(31,658)	(11,759)
Drugs & Clinical Supplies	(22,060)	(25,222)	(3,162)	(150,252)	(156,079)	(5,827)
General Supplies	(2,881)	(2,997)	(116)	(20,175)	(20,557)	(382)
Other	(10,374)	(9,054)	1,320	(72,360)	(57,535)	14,825
TOTAL EXPENDITURE	**(83,385)**	**(85,735)**	**(2,350)**	**(577,776)**	**(572,177)**	**5,599**
Earnings Before Interest, Tax, Depreciation & Amortisation	**4,670**	**(2,218)**	**(6,888)**	**16,366**	**6,656**	**(9,710)**
Financing Costs	(3,914)	(3,889)	25	(26,612)	(26,780)	(168)
SURPLUS / (DEFICIT) including donated asset treatment	**756**	**(6,107)**	**(6,863)**	**(10,246)**	**(20,124)**	**(9,878)**
Impairment of Assets	0	0	0	0	0	0
Donated Asset treatment	(18)	92	110	(623)	(9)	614
SURPLUS / (DEFICIT)	**738**	**(6,015)**	**(6,753)**	**(10,869)**	**(20,133)**	**(9,264)**

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	3.1
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.

The Trust board is asked to ratify the September 2015 submission (reviewed by the executive committee on 27 October) and to approve the October 2015 submission (reviewed by the executive committee on 24 November 2015). There are minor changes to the reports from previous submissions, including a weakening of statements 4 and 8.

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: September 2015, to be submitted 30/10/2015

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 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.** **The Executive has noted and discussed that under the new Financial Sustainability Risk Rating (FSSR) criteria the M6 results score a 2 and that delivering our current forecast to hit our budget we would remain at 2 - we have reported this as being "at increased risk of not having sufficient cash to pay our debts and liabilities". The Board will discuss this at its November meeting. The Audit, Risk & Governance Committee will discuss going concern in December in preparation for the 15/16 accounts advised by its external auditors. The Executive has circulated & discussed draft planning targets for 16/17 of a challenging CIP in the range of 6-8% aiming to significantly reduce the current deficit.**	Richard Alexander, 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).	Janice Sigsworth Director of nursing

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 good governance review have been identified and documented with appropriate actions in place to deliver.**	
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.* **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 has recently been received and is being reviewed 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 and Board Assurance 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.**	Janice Sigsworth Director of nursing
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. Recommendations from audits are followed up and the actions reported at each Audit, Risk & Governance Committee.**	Richard Alexander, 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 and submitted. Compliance with AGS will be monitored using the Trust's risk management and governance 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:** **Diagnostic waiting times:** The Trust has had significant challenges with diagnostic capacity in recent months. This was 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 met the 6-week diagnostic standard in September 2015. This is the first time the Trust has met the standard since May 2014. We have achieved the standard one month earlier than was in the trajectory that was submitted to the Trust Development Authority. **Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** No cases of MRSA BSI were allocated to the Trust in September. So far this year, 5 cases have been allocated to the Trust compared to 3 cases this time last year. A 6th case has been preliminlary attributed to the Trust but is currently in arbitration. **Clostridium difficile infections:** Three cases of *Clostridium difficile* were allocated to the Trust for September 2015. One of these cases has been identified as a potential lapse in care, pending the outcome of laboratory investigations. A total of 32 cases, 2 of which have been confirmed to be attributable to lapses in care, have been allocated to the Trust so far this year, compared to 41 this time last year. **Accident and Emergency:** Performance against the four hour access standard for patients attending Accident and Emergency remained below threshold at 93.54 per cent in September. A number of initiatives to improve flow within the organisation are on-going. 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. The Trust is also working with local Commissioners to ensure that patients who are awaiting social care, and don't need an acute bed, can be transferred in a timely way as appropriate. The A&E performance (all types) is presented at Trust level and split by site (CXH, HH, SMH, WEH). The CQC would assess our performance across four sites. The Trust is the in process of finalising the plan for delivery of services over the winter period. **Referral to treatment (RTT):** 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. The Trust	Steve McManus, Chief operating officer.

performance for September was 91.97 per cent and therefore did not meet the 92 per cent incomplete standard. However, there was a reduction of 99 patients waiting over 18 weeks (from backlog of 4,129 in August-15 to 4,030 in September-15). 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. The Trust had 6 patients waiting over 52 weeks in September. Three have now been treated and 3 have chosen to wait longer for their treatment and have dates over the next couple of months.	
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 regularly at Trust Board meetings.** **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.**	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.* **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.**	Karen Charman, Director of people and organisational development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: September 2015 Submitted 30/10/2015

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 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	Richard Alexander, 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:**	Richard Alexander, Chief financial officer
Q6. Condition P2 Provision of information to enable Monitor (for which read TDA) to undertake their functions. **ICHT Response: Yes** **Explanation:** All financial and activity reporting information required by TDA is provided to timetable	Richard Alexander, 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:** Provided as required to TDA	Richard Alexander, Chief financial officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Richard Alexander, Chief financial officer

Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes** **Explanation:**	Richard Alexander, 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:**	Richard Alexander, 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: October 2015, to be submitted 30/11/2015

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 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.** **The Executive has noted that under the new Financial Sustainability Risk Rating (FSSR) criteria the very disappointing M7 results score a 2 and that our latest updated internal forecast for the year would see us drop to a 1 – our updated cash forecast estimates sufficient funding only until Sept 2016. The Board will discuss this at its November meeting. The Audit, Risk & Governance Committee will discuss going concern in December in preparation for the 15/16 accounts advised by its external auditors. The Executive has circulated & discussed draft planning targets for 16/17 of a challenging CIP in the range of 6-8% aiming to significantly reduce the current deficit.**	Richard Alexander, 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.	Janice Sigsworth Director of nursing

Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the good governance review have been identified and documented with appropriate actions in place to deliver.	
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.* **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 has recently been received and is being reviewed 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 and Board Assurance 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.**	Janice Sigsworth Director of nursing
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. Recommendations from audits are followed up and the actions reported at each Audit, Risk & Governance Committee. The CFO has noted that the exceptional month 7 variance to plan calls into question the reliability of our income forecasting process.**	Richard Alexander, 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 and submitted. Compliance with AGS will be monitored using the Trust's risk management and governance 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:** **Diagnostic waiting times:** The Trust continued to meet the monthly 6 week diagnostic waiting time standard in October with 0.4% waiting over 6 weeks against the 1% tolerance. Additional capacity, in particular within imaging modalities, has contributed to the Trust improving performance within this standard. **Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** No cases of MRSA BSI were allocated to the Trust in October. So far this year, 5 cases have been allocated to the Trust compared to 3 cases this time last year. A 6th case has been preliminary attributed to the Trust but is currently in arbitration. **Clostridium difficile infections:** No cases of MRSA BSI were allocated to the Trust in October. So far this year, 5 cases have been allocated to the Trust compared to 3 cases this time last year. A 6th case has been preliminary attributed to the Trust but is currently in arbitration. **Accident and Emergency:** Performance against the four hour access standard for patients attending Accident and Emergency remained below threshold at 92.07 per cent in October. A number of initiatives to improve flow within the organisation are on-going. 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. The Trust is also working with local Commissioners to ensure that patients who are awaiting social care, and don't need an acute bed, can be transferred in a timely way as appropriate. **Referral to treatment (RTT):** The Trust performance for October was 90.87 per cent and therefore did not meet the 92 per cent incomplete standard. This was a slight worsening of the position from the previous month with an increase in the number of patients waiting over 18 weeks. This was as a result of a combination of individual capacity constraints at speciality level, and bed pressures, resulting in the need to cancel a small volume of elective surgery. Additional capacity is now in place in many specialities, and it is expected that performance submitted for November will show a reduction in the pathways over 18 weeks and achievement of the 92% standard. **Cancer** In November, performance is reported for the cancer waiting times standards in September and Quarter 2. In Quarter 2, the Trust achieved all eight national cancer standards. This included recovery of the 62-day screening standard which the Trust failed to meet in Quarter 1.	Steve McManus, Chief operating officer.

In September, the Trust achieved seven of the eight national cancer standards. The Trust failed to meet the two week wait standard for first attendance after a GP referral. There were a high number of breaches relating to patient choice in September after the end of the summer period, which significantly contributed to the poor performance position. A demand and capacity exercise has been undertaken for all services receiving two week wait referrals from GPs to support capacity planning going into 2016/17. The actions with the CCGs outlined above will also support delivery of the standard.	
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 regularly at Trust Board meetings.** **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.**	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.**	David Wells, 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.**	David Wells, Director of people and organisational development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: October 2015 Submitted 30/11/2015

1. Condition G4 – Fit and proper persons as ~~Governors and~~ Directors (also applicable to those performing equivalent or similar functions).
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6. Condition P2 – Provision of information.
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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 comply with the fit and proper persons requirements.	David Wells, Director of people and organisational development.
Q2. Condition G5 Having regard to Monitor guidance. **ICHT Response: Yes** **Explanation:** Where appropriate to NHS trusts	Richard Alexander, 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:**	Richard Alexander, Chief financial officer
Q6. Condition P2 Provision of information to enable Monitor (for which read TDA) to undertake their functions. **ICHT Response: Yes** **Explanation:** All financial and activity reporting information required by TDA is provided to timetable	Richard Alexander, 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:** Provided as required to TDA	Richard Alexander, Chief financial officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Richard Alexander, Chief financial officer

Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes** **Explanation:**	Richard Alexander, 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:**	Richard Alexander, 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.

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	3.2
Title	Redevelopment Committee
Report for	Approval
Report Author	Jan Aps, Trust company secretary
Responsible Executive Director	Tracey Batten, chief executive

Executive summary:

As noted at the Board seminar on 28 October, it is proposed to establish a board committee to undertake thorough and objective reviews of the redevelopment programme, including performance issues and financial issues, and to review investment requirements and risks associated with the overall redevelopment programme.

Recommendation to the Board:

The Board is asked to approve:

- the setting up of the Redevelopment Committee as a board committee
- the terms of reference attached
- non-executive members of the Committee being Sir Richard Sykes, Dr Andreas Raffel, and Jeremy Isaacs.

Trust strategic objectives supported by this paper:

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

REDEVELOPMENT COMMITTEE

Terms of reference

Role

The Redevelopment Programme Committee will be established, as a board committee, to undertake thorough and objective reviews of the redevelopment programme, performance issues, financial issues, including investment and risks associated with the overall redevelopment programme.

The Committee will identify the key issues and risks requiring discussion or decision by the Trust board and will advise accordingly.

Definitions
"the Trust" means Imperial College Healthcare NHS Trust
"the Committee" means the Redevelopment Programme Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the Committee shall be appointed by the Trust board. The Committee shall be made up of three Non-Executive Directors, the Chief Executive, Chief Financial Officer, Chief Operating Officer, Medical Director and Director of Nursing.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the Committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of four scheduled meetings.

- Director of Strategy & Redevelopment
- Director of Planning & Redevelopment
- Clinical lead.

2 Secretary

2.1 The Trust Company Secretary or their nominee shall act as the secretary of the Committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be four members, one of which is a Non-Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4 Frequency of meetings and attendance requirements

4.1 The Committee will normally meet quarterly at appropriate times in the reporting cycle and otherwise as required.

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The secretary of the Committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the Committee may be called by the secretary of the Committee at the

request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend and all other non-executive directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

6.3 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust Board unless a conflict of interest exists.

7 Annual General Meeting

7.1 The chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

8 Duties

The Committee should carry out the following duties for the Trust:

8.1 Redevelopment programme assurance

The Committee shall make recommendations to the Trust board on the programme, performance issues, financial issues, including investment and risks associated with the overall redevelopment programme.

Specifically the Committee shall:

- review the redevelopment programme and identify key issues with progress and assess the impact on the trust business that requires discussion or decision by the Trust Board;
- review partnership arrangements between trust and key stakeholders and advise the trust board of impact and issues that require discussion or decision by the Trust Board;
- review quality of the healthcare facilities being developed to ensure trust objectives are being met and that requires discussion or decision by the Trust Board;
- review the redevelopment programme risk register and identify the key issues and risks requiring discussion or decision by the Trust Board;
- ensure the redevelopment programme operates a comprehensive budgetary control;

8.2 Redevelopment programme management and reporting

The Committee shall review and recommend to the Trust Board:

- the Trust's Investment Strategy in so far as this is relevant to the redevelopment of the Trust sites, including:
- establish the overall methodology, processes and controls which govern the approach to site redevelopment;
- evaluate, scrutinise and monitor investment relating to site redevelopment; prepare post project evaluations for capital projects and for revenue projects related to redevelopment which have a whole life contract value of £5 million and above;
- review and recommend to Trust board the Trust's estate strategies;
- within limits set out in the Standing Orders, Standing Financial Instructions, Scheme of Delegation and matters reserved to the Trust Board, the Committee

shall approve, evaluate and scrutinise the financial and commercial validity of relevant individual investment decisions, including the review of Outline and Final Business Cases. The current delegated limit for the Trust is £5million.

9 Reporting responsibilities

9.1 The Committee will report to the Trust board on its proceedings after each meeting.

9.2 The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The Committee will produce an annual report to the Trust board.

10 Other matters

The Committee will:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

10.3 give due consideration to laws and regulations;

10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

11 Authority

11.1 The Committee is a Committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Company Secretary;
- to call any employee to be questioned at a meeting of the Committee as and when required.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the chair of the Committee might provide.

12.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

12.3 The secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the Committee will be reported in the annual report.

Imperial College Healthcare NHS
NHS Trust

Redevelopment Committee Membership 2015-16

CHAIRMAN – AN INDEPENDENT NON EXECUTIVE DIRECTOR	Sir Richard Sykes
TWO OTHER NON EXECUTIVE DIRECTORS	Jeremy Isaacs
	Dr Andreas Raffel

EXECUTIVE DIRECTORS

Chief Executive	Dr Tracey Batten
Chief Operating Officer	Steve McManus
Director of Nursing	Janice Sigsworth
Medical Director	Chris Harrison
Chief Financial Officer	Richard Alexander

Standing attendees

Director of Strategy & Redevelopment	(interim) Chris O'Boyle
Director of Planning & Redevelopment	Michelle Wheeler
Clinical lead	TBC

Secretary

Trust Company Secretary	Jan Aps

QUORUM

- The quorum necessary for the transaction of business shall be four members including one Non Executive.
- Only members of the Committee have the right to attend and vote at Committee meetings.

Imperial College Healthcare NHS Trust

Trust board – public

Agenda Item	4.1
Title	CQC Update Report
Report for	Noting
Report Author	Priya Rathod, Deputy Director of Quality Governance
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary

The following report provides an update to the Trust Board in relation to: the Trust's Care Quality Commission (CQC) registration for quarter 2 (Q2) of 2015/16, the implementation of the compliance and improvement framework and progress against the CQC action plan.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

CQC update report

1 Purpose

The following report provides an update to the Trust Board in relation to; the Trust's Care Quality Commission (CQC) registration for quarter 2 (Q2) of 2015/16, the implementation of the compliance and improvement framework, progress against the CQC action plan and inspection preparation.

2 Quarter 2 (2015/16) update in relation to the Trust's CQC registration

2.1 Registration Status

- The Trust continues to be registered at each site without any conditions.

2.2 Intelligent Monitoring

- An update on the latest CQC Intelligent Monitoring report for the trust was presented at the Trust Board meeting on 30th September 2015.
- On 25 August 2015 the Trust received notification from the CQC that the Trust was an outlier for the maternity indicator of puerperal sepsis and / or other puerperal infections within 42 days of delivery. The Trust has responded to the CQC and is currently awaiting a response.
- The CQC confirmed in November 2015 that they will no longer develop and publish intelligent monitoring reports going forward and instead, will be working on a new data analysis tool known as 'CQC Insight'.

2.3 Complaints and whistleblowing alerts made to the CQC

No complaints or whistleblowing alerts were made to the CQC about the Trust in Q2.

2.4 CQC Inspections/reviews of the Trust

- The trust was not inspected by the CQC in Q2.
    - The CQC have published their inspections through to the end of March 2016 and the trust has not been identified. This means that the earliest the trust will be re-inspected will be April 2016.

2.4.1 Thematic review of integrated care for older people

- The trust was copied on a notification that during November 2015 the CQC will carry out a thematic review of integrated care for older people which includes the area served by the Hammersmith and Fulham Health and Well-being Board. This is not an inspection of the Trust, but the trust may be visited as part of the field work undertaken for the review.

2.4.2 Information security review

- The CQC undertook a national Information Governance review on 16 November 2015 and visited St. Mary's Hospital. The visit was led by the Health and Social Care Information Centre (HSCIC) on behalf of the CQC. This was not an inspection of the trust, and no inspection report or rating will be published about the trust. The report on the national review is expected to be published by the CQC in January 2016. The report will not identify the trust unless it is to highlight good or outstanding practice.

2.5 Display of CQC Ratings

- The CQC requires providers to display their CQC ratings at all locations where services are delivered. The Trust's ratings posters are on the Trust's website and in the main entrances of

St. Mary's, Charing Cross, Hammersmith, QCCH and the Western Eye hospitals. Over the coming month, ratings will be displayed in the following areas; private healthcare , community clinics and satellite units

2.6 New CQC Strategy for 2016-2021

- On 28 October 2015 the CQC published a 'discussion document' which sets out its proposed five year approach to regulation from April 2016 and can be accessed using the following link: *Building on strong foundations: Shaping the future of health and care quality regulation*.
- In January 2016 the CQC will publish its formal consultation document.
    - The corporate nursing team will also manage the trust's response to this consultation.
- The new strategy will be implemented from April 2016.

3 Update on the Implementation of the Compliance and Improvement Framework

The Board will recall that a trust-wide Compliance and Improvement Framework has been developed to ensure the Trust is compliant with CQC regulations and to drive improvement in the quality of care delivered. The framework comprises of the following components:

3.1 Internal reviews

3.1.1 Deep dive reviews

- During 2015/16, internal audit are conducting a series of deep dive reviews for areas that were rated as 'good' by the CQC.
- Since the last Trust Board meeting, the findings of the following reviews have been finalised:

    - *Critical Care (St. Mary's)*
        - Based on the key findings, the service appears to be continuing to provide a 'Good', service although work is underway to improve medical cover and management as well as some outstanding estates issues.
    - *Children and young people (St. Marys)*
        - It is likely at this time that the service overall would continue to be rated as 'Good' based on the review findings.
    - *End of life care (St. Marys)*
        - It is likely at this time that the service overall would continue to be rated as 'Good' based on the review findings although some issues in relation to staff training capacity and acting on audit outcomes were identified.

- The final reports and recommendations are currently being awaited for the following reviews that were undertaken in late October/November 2015:
    - *Renal satellite units*
    - *End of life care (Charing Cross and Hammersmith)*
    - *A&E (Charing Cross)*
- The outcomes of these reviews will be shared with divisional colleagues for any action required and the findings will be presented to the Executive Quality Committee and to the Quality Committee in December 2015 and January 2016.
- A deep dive review of the Western Eye hospital is planned for February 2016.

3.1.2 Core Service Reviews

- The Board will recall from its meeting in September that the first set of core service reviews for outpatients and A&E at the St. Mary's site were undertaken in June 2015.

- The second set of core service reviews for areas rated overall as 'Inadequate' or 'Requires improvement' were carried out in mid-September 2015.

  - ***Medical care, including older peoples' care (all sites)***
  - The review found that good improvement was being made under the 'Well led' domain at the Charing Cross and Hammersmith sites. It also identified good practice regarding incident management and a strong awareness of patients who may be vulnerable/at risk.
  - Further work is still required to ensure standardisation of medicines management practices and in managing nursing vacancies.

  - ***Surgery (all sites)***
  - The review found that this core service continues to generally do well in relation to managing incidents, safe staffing, medicines management, infection prevention and control and in handling patient records.
  - A good level of improvement has been made in relation to use / completion of the WHO checklist for all surgical procedures, although work is still underway to ensure practice is embedded and improved compliance sustained.

  - ***Critical care (Charing Cross and Hammersmith)***
  - The final report for this core service review is pending. Key findings and conclusions will be reported to the Executive Quality Committee at its meeting in December 2015.

- The outcomes of these reviews have been shared with divisional colleagues for any action required and the findings have been presented to the Executive Quality Committee and Quality Committee.
- The final and third set of core service reviews will take place for; maternity and gynaecology, children's and young people and neonatal services in January/February 2016.

4 Progress against the 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			
Status of actions	**Sep**	**Oct**	**Trend**
Actions completed on time	36	36	⬆
Actions on track	2	2	⬇
Actions completed late	10	11	⬆
Actions off track	0	0	⟷
Actions not completed	7	6	⬇

CQC 'Must-do' Actions Overview			
Status of actions	**Sep**	**Oct**	**Trend**
Actions completed on time	24	24	⟷
Actions on track	1	1	⟷
Actions completed late	8	8	⟷
Actions off track	0	0	⟷
Actions not completed	4	4	⟷
Total	**37**	**37**	

Total	**55**	**55**	

CQC 'Should-do' Actions Overview	
Status of actions	**Number**
Actions completed on time	14
Actions on track	0
Actions completed late	4
Actions off track	0
Actions not completed	2
Total	**20**

- The exceptions relate to the following areas:
  - The review, ratification and dissemination of Trust cleaning and decontamination policies
  - Reducing DNAs and resolving the issues associated with the administration of outpatient appointments.
  - The implementation of a 24/7 anaesthetic rota with anaesthetists who have recent obstetrics experience.
  - Non-achievement of the target of 95% for completion of statutory and mandatory training.
  - Standardisation of morbidity and mortality reviews in the divisions of Medicine and Surgery
  - Review and re-launch of the 'nil by mouth' policy
- All exceptions have revised completion dates in place and progress towards achieving these are monitored by the Executive Quality Committee.

5 Having quality conversations

Taking into account the learning from the Trust's previous inspection preparation and also considering best practice from other organisations, it is paramount that staff are engaged and can describe what 'good' and 'outstanding' looks like under each CQC domain, for their areas, as well as what would constitute 'inadequate' and 'requires improvement'. To this end, it was agreed at the Executive Quality Committee on in October 2015 that a communications and engagement programme to focus on raising awareness with staff from ward to board about the key lines of enquiry (KLOE) and the CQC ratings, is introduced.

Teams at all organisational levels will be asked to undertake a self-assessment against the KLOEs under each CQC domain. A toolkit has been developed to help in this exercise and in developing quality conversations about areas of 'good' and 'outstanding' practice as well as areas that require further work.

It has also been agreed that Director Leads for each CQC domain will undertake a trust-wide self-assessment and to this end, the Trust's Chief Executive presented the outputs of this against the 'Well led' domain to the Executive Quality Committee in November 2015.

The outcomes of the assessments will be collated Spring 2016 and presented at the leadership forum in March 2016. The deep dive and core service reviews will continue as planned to determine the levels of improvements made since the last CQC inspection.

6 Next steps

- Undertake the scheduled deep dive and core service reviews
- Launch the 'Having quality conversations' programme

- Complete implementation of the CQC action plan.

Imperial College Healthcare NHS
NHS Trust

Trust board - public

Agenda Item	4.2
Title	Corporate risk register
Report for	Noting
Report Author	Priya Rathod, Deputy Director of Quality Governance
Responsible Executive Director	Janice Sigsworth, Director of Nursing
Freedom of Information Status	Public

Executive Summary

The Trust Board reviewed the corporate risk register at its meeting in May 2015 as part of the agreed six-monthly review process. The following report provides an update on the Trust's key risks. Please refer to **Appendix 1** for a copy of the Trust's corporate risk register.

At present there are 18 corporate risks within the risk register of which 12 are identified as operational and 6 as strategic. The highest risks are scored as 20 and the lowest as 9. Two risks (from the 18 risks) have been removed from the corporate risk register as they are commercial in confidence.

Key themes include:

- Workforce
- Operational performance
- Financial sustainability
- Clinical site strategy
- Regulation and compliance
- Delivery of care

Since the last update to the Trust Board, and through discussion at the Executive Committee and Audit, Risk and Governance Committee, the following changes have been made:

1. **New risks escalated onto the corporate risk register since May 2015**

Four new risks have been escalated onto the corporate risk register as follows:

- **Risk 89:** *Risk of increased waiting times and length of stay for patients as well as failure to meet access targets due to equipment failure*
- **Risk 88:** *Risk of spread of organisms such as CPE (Carbapenam-Producing Enterobacteriaceae)*
- **Risk 87***: Failure to deliver outpatient improvement plan*
- **Risk 75:** *Failure to provide safe emergency surgery at the Charing Cross site*

2. **Amalgamation of risks**

The following risks have been amalgamated to avoid duplication:

- **Risk 68:** '*Insufficient support for key aspects of our clinical strategy from one or more key audiences/stakeholders'* has been merged with Risk 74 and the content updated.
- The revised risk description is:
  Risk 74: '*Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration'.*
- The risk score is currently 12.

- **Risk 79: '***Mismatch in capacity and demand increasing the risk of not achieving 95% A&E target'* has been merged with Risk 7 and the content updated.
- The revised risk description is:
- **Risk 7:** '*Failure to maintain key operational performance standards'.*
- The risk score is currently: 15

In light of these changes, the following risks have therefore been removed from the corporate risk register:

- Risk 68
- Risk 79

Due to the timing of the Trust Board meeting, there will be further discussion at the Executive Committee on 24th November 2015 where it will be proposed that the risks outlined below are merged**.** A verbal update will be given at the Board meeting on the outcome of that discussion.

- **Risk 83:** *Failure to meet recommended vacancy rates across all areas of the organization and* **Risk 85:** *Failure to recruit to substantive nursing posts on some medical wards.*
- It is likely that only Risk 83 will remain.

- **Risk 55:** *Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks* and **Risk 89:** *Risk of increased waiting times and LOS for patients as well as failure to meet access targets due to frequent equipment failure.*
- It is likely that only Risk 55 will remain.

3. Amendment to risk description

- **Risk 73:** The risk description has been modified from;
- *'Failure to deliver transformational integrated, personalised and systematised models of care to achieve long term sustainability'*

to

- '*Failure to deliver the clinical strategy implementation programme to achieve long terms sustainability, enhance acute services and support out of hospital care'.*

4. Change to risk score

- Since the last update to the Trust Board in May 2015, the score for the following risk has increased from 12 to 16:
- **Risk 83:** *Failure to meet required or recommended vacancy rates across all areas of the organisation.*
- The score for all the remaining risks have stayed the same.
- The above changes are summarised by the arrows in the 'movement' column within the risk register.

The following risks are scored as 20 due to the likelihood of the risk occurring and the consequence the risk would have:

- **Risk 48:** ***Failure to achieve financial sustainability***
  Please refer to the 'finance report' agenda item for further information.

- **Risk 55:** ***Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks***
  A number of actions have been undertaken to mitigate this risk including; prioritising the work plan to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out as quickly as possible. The capital programme has been reviewed and decision making for investment has been based on robust risk assessments.

- **Risk 89:** ***Risk of increased waiting times and length of stay for patients as well as failure to meet access targets due to frequent equipment failure.***
  Interim arrangements have been put in place to mitigate loss of capacity such as ad-hoc additional sessions, a mobile MRI unit and the outsourcing of diagnostics. Referrals are clinically prioritized and waiting times monitored.

The following governance process for risk management is in place:

- **Divisional risk register;** this is discussed and approved at monthly divisional quality meetings, at the Quality Committee and at the Executive Committee each quarter.
- **Director risk register;** each corporate director has their own risk register which is discussed and approved at the Executive Committee quarterly.
- **Corporate risk register:** This is discussed and approved monthly at the Executive Committee, quarterly at the Audit, Risk and Governance Committee and six-monthly at the Trust Board.

Recommendations to the Board:

- Note the changes to the corporate risk register
- Note the corporate risk register

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
NHS Trust

Corporate Risk Register

Trust Board

25th November 2015

Scoring matrix:

To calculate the risk placement on the matrix,
it is necessary to consider both the likelihood of the risk happening and the consequence of it happening as described below:

			Likelihood				
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Consequence	**Severity**		1	2	3	4	5
	Negligible	1	1	2	3	4	5
	Minor	2	2	4	6	8	10
	Moderate	3	3	6	9	12	15
	Major	4	4	8	12	16	20
	Catastrophic	5	5	10	15	20	25

Key:

Risk Source: The source of the risk / where or how the risk was identified, for example strategic planning

Initial Score: The score of the risk when first identified

Current Score: The current risk score including key controls to mitigate this risk

Movement: Arrow to show if the risk has increased ↑ decreased ↓ or remained the same ↔ since the last update to the Trust Board

Target Score: Target of the risk once all future and current actions have been completed and implemented

Contingency Plans: Predefined action plans that would be initiated should the risk materialise

Corporate Risk Register Dash Board November 2015

Risk ID	Page No.		Lead Director	*Initial Score*	Date risk identified	≤6	8	9	10	12	15	16	≥20	Date to achieve target risk score
STRATEGIC RISKS														
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion														
48	Page 3	Failure to maintain financial sustainability	Chief Financial Officer	*20*	Mar-12						●		♦	Review Feb 16
81	Page 4	Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target	Director of Nursing	*16*	Dec-14		●			♦				Mar-16
83	Page 5	Failure to meet required or recommended vacancy rates across all areas of the organisation	Director of People & Organisation Development	*12*	Jan-15					→		♦		Jul-16
85	Page 6	Failure to recruit to substantive nursing posts on some medical wards *(*under 'operational risks' on page 4 risk profile but co-located with Risk 83)*	Chief Operating Officer	*15*	Jan-15	●					♦			Mar-16
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement														
67	Page 7	Failure to achieve benchmark levels of workforce engagement	Director of People & Organisation Development	*9*	Oct-13	●		♦						Oct-16
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve														
74	Page 8	Failure to gain approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Acting Director of Strategy and Redevelopment	*12*	Oct-14		●			♦				Mar-16
73	Page 9	Failure to deliver the Clinical Strategy Implementation programme to achieve long term sustainability, enhance acute services and support out of hospital care.	Medical Director	*16*	Oct-14	●		♦						Mar-16
OPERATIONAL RISKS														
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion														
55	Page 10	Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Acting Director of Strategy and Redevelopment	*20*	Mar-11						●		♦	Mar-16
89	Page 11	**NEW since last update to the Trust Board* Risk of increased waiting times and length of stay for patients as well as failure to meet access targets due to equipment failure.	Chief Operating Officer	*New*	Jul-15		●						♦	Jul-16
88	Page 12	**NEW since last update to the Trust Board* Risk of Spread of Organisms such as CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director	*New*	Jul-15		●					♦		Mar-16
71	Page 13	Failure to deliver safe and effective care	Medical Director	*12*	Oct-14		●			♦				Jun-16
87	Page 14	**NEW since last update to the Trust Board* Failure to deliver the outpatient improvement plan.	Chief Operating Officer	*New*	Jul-15		●					♦		Jul-16
75	Page 15	**NEW since last update to the Trust Board* Failure to provide safe Emergency Surgery at Charing Cross site	Chief Operating Officer	*New*	Oct-14		●					♦		Jul-16
7	Page 16	Failure to maintain key operational performance standards	Chief Operating Officer	*15*	Jun-07	●					♦			Dec-15
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement														
65	Page 17	Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors	Medical Director	*12*	Feb-14		●					♦		Dec-15
72	Page 18	Failure to assess the risks to the health, safety, and wellbeing of employees, workers, students, and visitors	Director of People & Organisation Development	*12*	Oct-13	●				♦				Jan-16

Key:

→ Indicates movement in score since last update to the Trust Board

♦ Diamond indicates current score

● Circle indicates target risk score

Strategic Risks

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
48 / Datix 1597	Chief Financial Officer	Risk Assessment / Operational Risk	1	March 2012	**Failure to maintain financial sustainability** **Cause:** • CCG reductions / changes in commissioned activity, insufficient funding • Changes to specialist commissioning regime • Risk of failing to deliver a surplus with consequent effect on liquidity resulting in a failure to maintain a CoS risk rating of 3 • Non-delivery of expected efficiencies and cost improvement plans • Loss of DH/NHS England Project Diamond income and market forces factor in respect of additional specialist care and R&D costs • Adverse impact of tariff deflator greater than planned. Currently we are on DTR (Default Tariff Rollover) with no deflator but loss of CQUIN • Failure to maintain and / or increase private patient market share • Failure to secure funding for the redevelopment of our site **Effect:** • Could undermine Trust's critical mass to provide high end secondary and tertiary services with increased pressures on A&E, other services, etc and the potential to lose key services • Reputational risk - not engaging with wider healthcare community, inability to engage with Monitor pricing and external benchmarking exercises, in tariff setting and reviews. Inability to deliver a recurrent surplus to enable planned investments in estate and quality initiatives with consequent risk to service viability **Impacts:** • Potential to incur penalties and / or fines: Contractual, CQUIN. Enforcement notice • Potential loss of revenue: NHS income, research and education income, other income • Potential to increase costs: bank and agency, reactive and inefficient ways of working, increased length of stay • Reputational with adverse revenue impact: reduction in market share, service decommissioned, failure to gain FT status - impact on capital plan and strategy, compromise future re-designation of BRC and AHSC • Lack of resources to support strategic investment	4 x 5 20		• Contract Negotiating Team engages with Divisions via Service Agreement Steering Group and reports progress on contracts via ExCo to FIC • Feedback on consultation on national tariff. Active cash management and reports to FIC and Board. Monthly financial reporting and performance reviews. Divisional performance meetings to review spend and income against budget and progress in delivering savings. Regular meetings with Commissioners and TDA to review contract performance • QuEST governance structure, monthly financial reporting, weekly divisional performance meetings to review spend and income against budget and progress in delivering savings. Pro-actively work with the Shelford group and Project Diamond group to influence national tariff to guarantee adequate reimbursed for provision of complex activity. Ensure PLICS systems are materially accurate to reflect the costs of treating patients	4 x 5 20		Current	**In-year actions:** • Contracts with main commissioners now agreed • Intensive action throughout July / August / September to reforecast in-year, understand risks and opportunities and agree actions accordingly (discussed at FIC on 23 September) to drive back to budget • Increased organisational focus on income / contribution through: o Devolvement of income responsibilities to divisions (from August 15) o Project on income maximisation (September to February; CFO as SRO) • Continuation of weekly / monthly / quarterly divisional performance reviews which have focused on financial positions (income and expenditure) • Detailed discussion taken place at the Executive Committee on 17th November and at the Finance and Investment Committee on 18th November. **Longer term:** • Trust wide engagement in SAHF programme (including consideration of long term financial modelling, sustainability and site strategy) • Exco considering organisation structure to support long term efficiency programme (discussions throughout August and September) (Target risk score date: Review February 2016)	⟷	3 x 5 15		• Intensive action being undertaken to reforecast in-year, understand risks and opportunities and agree actions accordingly.

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
81 / Datix 1599	Director of Nursing	Strategic Planning / Strategic risk	1	Dec 14	**Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target following the inspection** **Cause**: • Systems not in place which enable the Trust to achieve regulatory compliance • Failure of staff to comply with practice governance (i.e. policies, procedures, guidelines, etc.) and the compliance and improvement framework (implementation of the framework is due to begin in April 2015) • Lack of resource within the nursing directorate to effectively manage on going compliance **Effect**: • Greater number of incidents of poor patient experience and potentially greater severity • Reduction in the quality and safety of patient care • Poor reputation • Potential for financial penalties • Potential for criminal prosecution • Potential restriction on individuals' ability to practice and / or of the Trust's services imposed by the CQC in response to on-going regulatory breaches **Impact**: • Potential loss of ability to practice or deliver a service at one or all sites. • Potential loss of revenue: NHS Income (as result of inability to deliver service from one or all sites) and reduced revenue from Imperial Private Healthcare as a result of capacity issues • Potential to increase costs :Reactive and inefficient ways of working.(arising from services being stopped on one or more sites) • Threaten FT application • Poor Monitor Governance Risk Rating • Potential to increase costs of Bank & Agency staff arising from inability to retain and recruited staff • Potential to incur penalties/fines imposed by the CQC • Potential to increase costs: i.e. claims and litigation impact on CNST payment	4	4 16	• Implementation of a compliance and improvement framework to manage compliance with regulatory requirements and drive related quality improvements began in April 2015 • The framework includes a variety of quality activities, including delivery of the CQC action plan • Progress towards implementation of the framework and delivery of the CQC action plan are reported to ExCo on a monthly basis • CQC Intelligent Monitoring (IM) is published twice per year by the CQC and identifies what the CQC considers the current key risks to be, and presents an overall risk rating for the Trust. IM reports are incorporated into risk registers, and are presented to the Executive Committee, Quality Committee and Trust board when they are produced by the CQC • A Patient Safety and Service Quality report is presented quarterly to the Trust board • The compliance and improvement framework is a component of the Trust's quality strategy.	3	4 12	Current	• The procedure underpinning the framework was ratified by the Executive Committee on 28 July • Delivery of the current CQC inspection action plan is on-going o Performance is now being monitored to gain assurance that completed actions are achieving the desired outcomes o Should-do actions are also now being monitored with updates to the Executive Committee from November • A programme of work has been agreed with the Trust's Internal Audit (IA) team for 2015/16 to support quality activities with in the new compliance and improvement framework o Core service reviews for areas rated as 'Inadequate' or 'Requires will be completed by mid-January 2016 o Deep dives of areas rated as 'Good' will be completed by mid-December 2015 o Action plans resulting from these reviews may be managed locally or by the corporate nursing team, with updates provided to the Executive Committee • A communications plan has been developed with the communications team which is adapted as appropriate while the framework is implemented. It is aligned with communications about other Trust initiatives, such as the quality strategy. • Ward accreditation (a nursing peer review methodology) has been completed for all ward areas. • Corporate and divisional preparations for the next inspection are being developed and will be implemented over the coming months. (Target risk score date: March 2016)	⇔	2	4 8	• Prioritise and utilise internal expertise (external additional support may be required) and undertake site wide quality and safety reviews and assessment to identify key risks and provide a Trust action plan to mitigate any issues • Commission external review and support

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
83/ Datix 1600	Director of People & Organisation Development	Staff engagement surveys / Strategic Risk	1	Jan 15	**Failure to meet required or recommended vacancy rates across all areas of the organisation** **Cause:** • Mis-match of staff establishment requirements and / or rostering • National Shortage of clinical / non clinical staff • Not enough training commissioned • Conflicting operations priorities slowing down recruitment process. • Competition from neighbouring trusts attracting potential employees • Trust not employing 'the right people in the right posts', • Reduction in funding from HENWL • Tier 2 visa requirements • Agency spend 5% cap **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence • Increased bank and agency usage • Poor patient experience • Poor organisational performance • Inability to recruit high quality candidates **Impact:** • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	3 x 4 12		• Associate Director of HR Operations • Restructure and new admin support now in place to reduce the total time to hire. New Resourcing Manager now in place to support, additional checks being monitored daily to increase the pace & quality of activity • Additional resource identified for E-Rostering implementation • Business case for midwifery recruitment agreed • Recruitment open days being held (nursing and midwifery) • All current vacancies for nursing in key areas advertised • Monthly strategic people planning meetings with divisions • Safe staffing on wards monitored through monthly fill rate reports for nursing by division.	4 x 4 16		Current	• Recruiting to 5% vacancy level for bands 2- 6 • Vacancy levels for bands 2 to 6 reviewed monthly at divisional performance reviews (on-going) • Attain bank fill of 90% by improving management of requests. • New e-rostering policy which includes key indicators has been developed and training rolling out • Frequency of centralised recruitment open days increased from monthly to weekly. • Campaign underway using social media to increase the profile of the Trust and attract more candidates. • Associate Director of HR Operations and Resourcing working with Business Partners to monitor vacancy levels. • Auto-rostering project has been completed and all rosters can now auto-roster. Monthly reports are circulated to DDNs and DDOs on performance against targets • Ongoing review of divisional resourcing plans with particular consideration given to hard to recruit areas against vacancy factor • Implementation of midwifery staffing plan underway • Desktop review of vacancies • Disaggregation of True vacancies, Maternity vacancies, service changes • Retention analysis • Student Nurses and Midwife retention • Review of resourcing team • Case for additional staff • Targeted campaigns underway for hard to recruit areas • Band 5-6 campaign underway to recruit an additional 200 nurses (Target risk score : For review July 2016)	↑	2 x 4 8	• Continue to monitor impact of changes and implement further corrective measures as needed • Use of Bank & Agency staff • Reduction in activity

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85 / Datix 1611	Chief Operating Officer	Divisional Risk Register / Operational Risk	1	January 15	**Failure to recruit to substantive nursing posts on some medical wards.** **(previously as an 'operational' risk)* **Cause:** • The increase in emergency activity has resulted in additional capacity which requires the recruitment of staff. • Additional beds opened • Lack of available / suitable specialist nursing staff **Effect:** Potential reduction in staff morale /increased staff turnover /Increased rates of sick absence • Increased bank and agency usage • Potential for poor patient experience • Inability to recruit high quality candidates • Potentially increased incidents **Impact:** • A potential impact on the delivery of care • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	3 x 5 15		• Divisional performance review meetings monitoring vacancy rates • Bank and agency support available • Recruitment open days taking place with a rolling programme of recruitment. • Review of trust recruitment processes to streamline process and ensure rapid turnaround of offer letters • Monthly exception reports now produced for Divisional Quality and Safety Committee	3 x 5 15		Current	• Additional recruiting staff employed to speed up recruitment process and manage increased volume and work load. • Divisional recruitment and vacancy reduction trajectory to achieve less than 5% rate to be set. • Agreement to involvement in international recruitment • Continue with Divisional plan for reduction in vacancies through open days and over-recruitment. • On trajectory for the recruitment plan however due to the addition of new posts into plan the current vacancy rate is 14%. • International recruitment took place in July with projection of October starts for staff recruited through this process. • The Neuro-Rehab service posts will come into the divisional numbers but it is uncertain how many vacancies there will following the TUPE process (Consultation with UCLH). • The trajectory of HCA's is on target for August September and for Band 5 vacancies for November. (Target risk score date: March 2016)	⇔	1 x 5 5		• Review of bed capacity • Escalation of staffing issues through divisional management structure and site team • Early identification of staffing issues with shifts put out to bank and agency,

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

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67/ Datix 1601	Director of People & Organisation Development	Staff engagement surveys / Strategic Risk	2	Oct 13	**Failure to achieve benchmark levels of workforce engagement** **Cause:** • Disruption due to implementation and roll out of Cerner project • Change in Director level leadership • Senior leaders fail to empower/inspire staff • Job not regarded as good for health • Organisation not seen to be taking positive action on health & wellbeing • Opinions thought not to count • Managers not undertaking PDR's • Trust not employing 'the right people in the right posts', **Effect:** • Reduced staff morale/increased staff turnover/ Increased rates of sick absence / bank and agency usage • Lack of engagement • Poor patient experience /Poor organisational performance • Increased safety risk to patients • Inability to recruit high quality candidates • Staff sickness **Impact:** • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working	3	3	• Trust surveys (quarterly) covering all staff annually • NHS survey • Communications events – Open Forum, Divisional Forums Newsletters • Exit surveys • Joiners surveys • Engagement on Clinical Strategy • Source communications • Monitoring at Executive Committee • Monitoring at Quality Committee & Trust Board • Discussed at Divisional reviews • Director of P&OD attends Quality Committee • Health and Wellbeing Strategy developed • People strategy • Make a Difference people recognition scheme • Monitoring of any 'hot spot' lack of engagement areas • My Benefits launched Nov 14 • Current PDR compliance rate 94%	3	3	On-going	• Trust quarterly surveys held and 7th survey showing best engagement scores and response rates in the history of the survey • Better than average staff engagement scores in national staff survey compared with other UK acute Trusts. • Specific action plans developed by Corporate & Divisional Directors • People strategy 2015-2019 (which includes; Culture & Engagement, Organisation Development, Talent Development and Health & Wellbeing) has been refreshed • Standing item on Quality Committee • Monthly reporting to Executive Committee • Board Seminar ran April 2015 (Target risk score date: October 2016)	⇔	2	3	• Continue to monitor impact of changes and implement further corrective measures as needed • Any identified hot spots to be directly addressed with tailored action plan

Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
74 / Datix 1602	Acting Director of Strategy and Redevelopment	Risk Workshop / Strategic Risk	4	Oct 2014	**Failure to gain approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration.** **Cause**: • Case for change not sufficiently clear and/or compelling therefore insufficient support for key aspects of our clinical strategy from stakeholders. • Delays to obtaining planning permissions • Technical design and build issues lead to unanticipated challenges and project creep • Increase in costs beyond currently expected levels through indexation, due to delays in business case. • Inability to obtain sufficient and timely funding • Insufficient organisational capacity to capitalise on strategic and commercial opportunities. • Failure to achieve support for key aspects of our clinical transformation, especially service reconfiguration and estate redevelopment from one or more key audiences / stakeholders • Lack of internal resources allocated to deliver the programme **Effect**: • Poor organisational performance – inefficient pathway management • Poor reputation with regulatory bodies • Failure/delays in implementing new clinical models and new ways of working • Deteriorating and / or inadequate estate • Failure of critical equipment and facilities that prejudices trust operations • Reduced staff morale and staff engagement • Reduced confidence in our services/public concern about their services • Difficulty in programming interim capital projects **Impact**: • Potential loss of income • Increased staff turnover • Reduction in patient experience and satisfaction • Potential increase in clinical incidents • Potential increase in staff health and safety incidents • Potential reputational impact with stakeholders - Loss of market share • Potential to impact upon securing FT status	3 x 4 12		• Regular meetings with NHSE, TDA, CCG partners for early identification of potential issues/changes in requirements • Reports to Trust Board and ExCo • Regular meetings with Council planners • Active management of backlog maintenance. • Active ways of engaging clinicians through models of care work • Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation • Active internal communications plan, including CEO open sessions • Internal and external resource and expertise in place.	3 x 4 12		One to six months	• Draft Implementation Business Case complete and submitted to NHSE March 2015 • Trust ImBC refresh draft actions completed, including update of activity modelling, enhancement of design, update of capital costs of the preferred option. • Further revision of ImBC to be prepared with option 2a in the main text and 4a in the critical estate chapter. Likely date for submission Jan 2016 • Appointment of Healthcare planning resource • Technical team &Town planning activities funded within 2015/16 capital programme. • Active engagement with developers of adjoining sites. • Redevelopment programme board established (first meeting 22/10/2015) • In the process of procuring strategic estates advisors. • Internal and external stakeholder engagement strategy to manage relationships. • Work has commenced with CCGs and NHS England in relation to the North West business case, with implementation for January 2016 • Formal submission to NHS England by March 2016, with expected final decision by the end of 2016 • Submission and approval of final business case prior to commencement of redevelopment work. (Target risk score date: March 2016)	⇔	2 x 4 8		• Develop site based redevelopment solutions • Maintain flexibility to respond to any changes in demand as required • Identify and develop alternative options • Increase priority of stakeholder engagement activities

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73 / / Datix 11606	Medical Director	Risk Workshop / Strategic Risk	4	October -14	**Failure to deliver the Clinical Strategy Implementation programme to achieve long term sustainability, enhance acute services and support out of hospital care.** **Cause:** • Failure to set up an adequately resourced and skilled programme group • Lack of engagement with clinical and managerial staff • Lack of support from commissioning colleagues • Lack of engagement from external stakeholders • Unknown / changing economic landscape effecting health care needs • Modelling assumptions for services are based on incorrect or inappropriate data • Clinical leads do not have capacity to deliver workstreams • External stakeholders and public consultations do not support the proposed changes • Lack of finance and information capacity **Effect:** • Capacity at SMH remains constrained • Clinical services are not configured appropriately to optimise the space available in the new hospital building at SMH • Unable to move to a 24/7 model of care • Unable to deliver highest possible quality of care • Failure to improve patient experience • Failure to meet efficiency KPI • Failure to grasp opportunities in development of personalised medicine • Inability to support out of hospital care **Impact:** • Poor patient experience and clinical care as not responding to changes in clinical practice and advances in clinical care • Potential to incur contractual penalties (due to higher demand for trust services impacting upon waiting time) • Potential for loss of NHS income • Potential for increased costs as result of reactive and inefficient ways of working • Failure to meet Trust strategic objectives • Failure to maintain high calibre employees • Potential to incur penalties and/or fines: Contractual and Enforcement notices (Financial penalties resulting from non-compliance) • Loss of reputation with commissioners and public Financial loss due to amendments to build of new hospital at SMH	4 x 4 16		• Deputy Medical Director responsible for management of project • Clinical strategy in place • Estates strategy in place • Initial programme plan approved including phase one workstreams • Governance structure defined • Links with Estates Redevelopment Programme established – Deputy Medical Director is clinical lead • Initial scoping work completed by MD & COO • Programme Director appointed • Links to quality strategy and CQC action plan • CSIP programme committee established – first meeting held on 21st September • Clinical leads appointed for each workstream • Executive Transformation Committee established	3 x 3 9		Current	• Recruitment to key CSIP posts commenced • Programme Plan to be completed with workstreams for phase 2 Year 1 (2015/16) and for Year 2 and beyond defined – report to ExTra in November • Programme management documentation to be established, including risk registers for all workstreams • All workstreams are underway with monthly reporting to ExTra (Target risk score date: March 2016)	⇔	1 x 3 3		• Process to be managed through the Medical Director's office with nominated clinical leads

Operational Risks

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55 / Datix 1607	Acting Director of Strategy & Redevelopment	Strategic planning / Operational Risk	1	Mar 11	**Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks** **Cause:** • Historic under investment • Obsolescence of the estate • Availability of capital and revenue funding • Delay in approval of the medical equipment capital replacement programme • Inability to retain core competencies within the workforce • Delay in delivering NWL reconfiguration plans **Effect:** • Possible short-notice closure of facilities due to equipment failures and breakdowns (e.g. lift breakdowns, chiller plant failures) • Obsolete installations that do not meet current standards • Key medical equipment being off line • Inability to keep up with repair requests and minor improvements for operational / clinical benefit • Reduced staff morale leading to higher turnover and increased rates of sickness absence • Loss of reputation and reduced confidence from key stakeholders **Impact:** • Potential to incur penalties /fines: Enforcement Notices • Inability to effect changes to estate in order to achieve transformation of clinical services • Potential to increase costs: Reactive & inefficient ways of working • Potential reputational Impact: Loss of market share • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential to increase costs: Bank & Agency staff	4 x5 20		• Statutory and regulatory inspections are now in place to pick up risks to continued safe operation of the Trust • The new PPM concept database is operational and generating planned work schedules • The ExCo approved Backlog maintenance programme is targeted to risks 16 or above and capital funding, and managed through risk assessment directed at addressing these high risk categories • 2015/16 capital programme £14 million allocated to deal with 16 and above risks. • Formal reviews of operational performance are conducted monthly both internally and with ops team to continually review performance • PLACE (Patient-Led Assessment of the Care Environment) is run by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works • Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services • Estates & Facilities H&S, Fire and Compliance committee has been established to monitor compliance • Quarterly reporting to ExCo • Monitoring of incidents • The 2015/16 backlog maintenance capital programme is targeting the highest risk areas £14 million has been allocated.	4 x 5 20		Current	• All policies and procedures have been reviewed, rewritten were necessary and approved in order to ensure statutory regulatory compliance • A risk analysis workshop has been held and the action plan prioritised to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out as quickly as possible within the constraints of available resources • Planned preventative maintenance scheduling is in place to reduce the risk of key equipment failures together with regular testing of equipment and systems. • Procurement options being tested to secure additional labour force to deliver planned activity. Currently with procurement as part of a Facilities Management Gateway Review • A full condition survey has been commissioned and 6 facet survey commenced May 2015, to help identify and update the future investment priorities. • Review schedule for 22 October 2015 to assist with Capital Backlog Maintenance programme 20106/17 and 5 years on. • Capital Backlog Maintenance programme on target with planned expenditure of £13.2m following revised Capital Investment Programme (Target risk score date: Review for March 2016)	⇔	3 x 5 15	• Plans for future years assume that NWL reconfiguration will provide the necessary funding for the long term solution which will address a large proportion of the backlog maintenance issues • If NWL reconfiguration funding is not approved then the Capital Programme will need to continue to increase, reflecting the degree of depreciation that is attributable to estates buildings and equipment and will continue to be targeted on the highest risks. • Assets register to be utilised to share in house equipment and rental of medical devices available if required • Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Business continuity plan • NHSLA insurance cover • Estates Strategy with contingency plans agreed.

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89 / Datix 1608	Chief Operating Officer	Incidents /Operational risk	1	July -15	***NEW** **Risk of increased waiting times and length of stay for patients as well as failure to meet access targets due to equipment failure.** **Frequent failure of key equipment including PET_CT CT, MRI scanners and gamma cameras due to failure of chiller units and equipment having reached its nominal life, increasing waiting times and breach of diagnostic targets** **Cause:** • Trust infrastructure is old e.g. chillers which fail to maintain required temperatures • Imaging equipment is very sensitive to changes in temperatures an overheats when chillers fail • Significant proportion of departmental scanning equipment past life cycle • Equipment no longer suitable for repair • Insufficient funding for replacement of equipment • Sustained upward growth in demand for CT / MRI • Vacancy rates **Effect:** • Increased wait for PET-CT, CT and MRI for both NHS and Private patients • Breach of diagnostic targets / failure to meet access targets • Increased length of stay for patients • Loss of private income • Suspension of service on one site **Impacts:** • Increase costs – increased length of stay • Penalties / fines - contractual • Penalties / fines – litigation / compensation • Revenue loss – other income	New		• Planned preventative maintenance cycle • Capital replacement programme • Outsourcing activity • Capital Risk Assessment budget • Temporary chiller unit • Mobile scanner • Weekly monitoring of waiting times and the turnaround of reporting times • Prioritisation f patients by clinical urgency • Activity diverted to other sites	5 x 4 20		Current	• Capital replacement programme • Recruitment strategy • Additional ad hoc sessions • Prioritisation and management of referrals • Risk reviewed and increased due to nuclear medicine service at HH suspended due to failure of gamma cameras (Target risk score date: July 2016)	NEW	2 x 4 8		• Lease equipment • Outsourcing activity

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88 / Datix 1644	Medical Director	Incidents /Operational risk	1	July -15	***NEW** **Risk of spread of organisms such as CPE (Carbapenem-Producing Enterobacteriaceae)** **The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust.** **Cause:** • CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, and environmental hygiene. • Also, the use of antibiotics will drive the CPE problem. • Easy transmission from patient to patient if correct IPC procedures are not followed. • Certain specialties (e.g. ICU, renal and vascular) at higher risk of transmission. • Current isolation capacity insufficient to implement the PHE toolkit recommendations. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotics and ultimately worse outcomes. • Increased demand for isolation facilities, potentially beyond available capacity. • Resource impact. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. **Impacts:** • Increase costs - Reactive / inefficient working, • Penalties / fines - Enforcement notice.	New		• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship. • The Trust has a CPE Policy in place, and has patient and staff information available on the Source. • Flagging system on CERNER for identifying readmissions of positive patients. • Serious Incident investigation following ward closures resulting in increased emphasis on hand hygiene, environmental improvements and cleaning. • There are regular meetings with the Medical Directors Office and Divisional Directors to address the strategic response to CPE, in addition to regular infection control meetings and a weekly conference call with external agencies.	4 x 4 16		Current	• Measuring and improving compliance with admission screening. Electronic system to measure admission screening compliance is now in place and being used to address areas with low compliance. • a system for tracking where patients have had 3 screens to be introduced to provide assurance • Plans under development to improve single room capacity, and to plan for cohorting on a bay or ward basis. Cohorting plan has been agreed with the Divisions. • Clear triggers for escalation of response being identified • Time to isolation of affected patients is being reviewed and monitored on a case-by-case basis • Each CPE patient is reviewed in detail to identify any potential lapses in care that may have led to the spread of CPE. • A review of deaths of patients with the outbreak strain of CPE has been performed – no patient has died from CPE. Each death will be reviewed in this way. (Target risk score date: March 2016)	NEW	2 x 4 8		• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality.

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71 / Datix 1609	Medical Director	NHSLA / CQC / Operational Risk	1	October 2014	**Failure to deliver safe and effective care in respect of:** • **Incident reporting, including Serious Incidents and Never Events** • **HSMR, SHMI and mortality alerts** • **Infection Prevention & Control** • **CAS alerts** • **NICE guidance and standards** • **National audits** • **Clinical audit programmes** • **Quality assurance of data submissions** • **Clinical guidelines** **Cause:** • Appropriate governance process not in place • Visibility of current compliance not available or known • Insufficient resource in place to manage the process • Non-compliance with Trust policies and procedures • Continued change in HCAI landscape • Increasing incidence of antimicrobial resistance **Effect:** • Unable to demonstrate that practice is evidence based • Limited oversight of externally reported data • Inability to demonstrate any or adequate audit trail • Unable to benchmark care against peers • Increase in SIs and Never Events • Increased mortality rates • Increased potential for Healthcare Acquired Infection (HCAI) **Impact:** • Potential to incur penalties and/or fines: Contractual and Enforcement notices (Financial penalties resulting from non-compliance) • Limited understanding of performance benchmarks • Potential loss of reputation and reduction in market share as a result of Negative media coverage • Non-compliance with CQC regulation • Potential to increase costs: i.e. claims and litigation impact on CNST payment	3 x 4 12		• Associate Medical Directors for Safety & Effectiveness and Infection Prevention & Control appointed • Executive responsibility for clinical governance revised • Compliance and improvement monitoring governance process through the Executive Quality Committee in place • Trustwide reports including performance data in place • Root cause analysis and learning from incidents • Weekly incident review meeting with Medical Director • SI policy updated to streamline process • Being Open policy reviewed to include duty of candour, training undertaken within divisions, divisional duty of candour advisors in place • Quality Accounts published 30th June 2015 – aligned with Quality Strategy • Quarterly IPC report to TB in place • Safety Improvement Programme with focused improvement projects in key areas – quarterly reporting to ExQu • Updated invasive procedures policy published – mandates briefing and debriefing stages of '5 steps to safer surgery' • Quality Strategy published and QI programme launched	3x4 12		current	• Business case for resource expansion approved – recruitment commenced. Full team anticipated to be in place by December 2015 • Corporate clinical audit programme developed to enable directing of efforts to areas most in need of improvement – quarterly reports to ExQu • All consultant anaesthetists and surgeons were to have completed invasive procedures mandatory online training programme by 30th Sept 2015. Non-compliance has been escalated to the divisions for action. • Programme of invasive procedures simulation commenced • Programme of observational audits of WHO checklist compliance underway to look at leadership and team function – results reported in the quality report • Never Event declared August 2015 – investigation complete and action plan in progress: ➢ All staff should be reminded of the process for checking all implants prior to insertion – complete ➢ Circulation of the Standard Operating Procedure for checking implants - complete ➢ Training regarding the use of the equipment by the manufacturer, specifically the types of nails, and associated equipment - 31/10/15 • 4 high profile incidents in the last year due to 'failure to act on abnormal results - task & finish group established to improve the process. Regular reports will be provided to ExQu (Target risk score date: June 2016)	⟷	2 x 4 8		• Process to be managed through the Medical Director's office with nominated clinical leads

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87 / Datix 1171	Chief Operating Officer	CQC inspection /Operational risk	1	July -15	***NEW** **Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver the Outpatient improvement plan.** **Cause:** • Lack of robust processes • Failure of staff to comply with Trust policies, processes and standards • Lack of visible leadership • Lack of robust key performance indicators • Impact from transition to Cerner • Multi management facets • Lack of clarity and consistency between centralised and decentralised OPD departments **Effect:** • Poor patient experience • Poor reputation of OPD services • Potential negative reputational impact • Potential failure to meet key Trust access targets • Potential to remain rated as inadequate by the CQC **Impacts:** • Increase costs - Reactive / inefficient working, • Penalties / fines - Enforcement notice	New		• Service Level Agreement • Outpatient improvement steering group • Periodic progress reports from Divisions and programme workstreams • Outpatient Improvement monthly performance dashboard • Leadership walkrounds • Weekly patients referral triage management • Referral tracking indicators for OPD booking office • OPD scorecard	4 x 4 16		Current	• Adoption of Service level Agreement • Outpatient improvement programme plan with terms of reference and clear milestones agreed for each workstream • Fortnightly meeting of outpatient improvement steering group and workstreams • Further development of outpatient improvement monthly performance dashboard, including the setting of improvement trajectories. • Weekly review of letters awaiting triage • Visits to other outpatient service to learn better practice • Introduction of leadership walkrounds by Chief Operating Officer and recording of key findings/actions. • Additional staff/capacity being sourced including seconded project and admin support and new Director of OPD. • Patient Services Centre - business case approved by Trust Board (Sept 2015) and being mobilised • Charitable funds granted for improvement work to outpatient's environment, totalling £3million. Phrases 1 of £2.3 million agreed and work progressing. • Customer service training planned for start of November covering all OP staff. • All site staff engagement events have commenced during October regarding OP improvement. (Target risk score date: July 2016)	NEW	2 x 4 8		• May have to invest in additional resources including senior nurse and general manager leadership overseeing the outpatient clinics at each site • May have to reduce activity

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75 / Datix ID 1338	Chief Operating Officer	Risk Workshop / Operational Risk	1	October -14	***NEW*** **Failure to provide safe Emergency Surgery at Charing Cross site** **Cause:** • Lack of Consultant cover at CX. • Difficulty to recruit junior doctors in surgery at CX. **Effect:** • Potential clinical risk to emergency surgery patients admitted to Charing Cross. **Impact:** *Potential Impacts:* • Increase costs – Reactive / inefficient working • Revenue loss – NHS income • Potential for loss of NHS income (as result of cancellations of elective activity) • Reputation impacting revenue – Reduced market share • Potential Reputational with adverse revenue impact: results in reduction in market share • Reputation impacting revenue – Service decommissioned • Potential for service to be decommissioned • Penalties / fines – Litigation / compensation • Potential to increase costs: i.e. claims and litigation impact on CNST payment as result of patient safety breaches • Penalties / fines – Enforcement notice • Potential for enforcement notices and costs through CQC • Penalties / fines – Contractual • Potential to incur contractual penalties through non delivery of quality standards.	New		• Non GI Consultant surgeons removed from rota) • Cover from SMH GI Consultant Surgeons – Consultant surgical rota supplied from SMH consultant body. • Consultant of the Week model set up at CX to provide NCEPOD operating and review emergency patients. • Chief of Service discussions with Consultant surgeons to ensure continued short term support for contingency measures while long term solutions put into place. • Surgical clinical fellows attached to Academic surgical unit providing clinical cover at CX re-advertised to support junior rota. • Moved to Consultant of the week system from Sep 2014. • Recent increase in transfers of surgical patients from St Mary's to Charing Cross, where resident surgical cover is less robust mitigated by policy of no cross site transfers after 8pm. (On-going discussions with senior team about what the long term model will look like. RISK LINKS TO DIV C RISK #14.) • ANP covering former FY1 posts. Dedicated surgical SNP cover for out of hours.	4 x 4 16		Current	• Investment in clinical nurse specialist, trust fellows, additional consultants. • Surgical Nurse Practitioners appointed • Additional consultant appointments made. First new appointments due to start end Oct 2015. • Out of hours and at weekends the Site Team will provide SNP cover • Extended SHO cover for 6 months due to delay in recruiting SpRs. • Surgical task force created; Divisional Team meeting with Surgical Leads to address a number of issues, including those related to emergency surgery cover. • This action remains on-going: Chief of Service discussions with Consultant surgeons to ensure continued short term support for contingency measures while long term solutions put into place. Surgical clinical fellows attached to Academic surgical unit providing clinical cover at CX re-advertised to support junior rota. • June15 Update: Number of transfers had reduced for Approx 6 months, but has increased again in last month. • August15 Update: ANP covering former FY1 posts. Dedicated surgical SNP cover for out of hours. • September15 Update: SHO/SpR level cover at CX is very low, escalated to Divisional Director due to risk to patient safety. Transfers of acute surgical patients from SMH to CXH to be stopped. DDN has cascaded to the surgical nursing teams, HoS to weekend medical teams, and GM to the site team. Risk Re-upgraded. (Target risk score date: July 2016)	NEW	2 x 4 8		• Consultant surgical rota supplied from SMH consultant body. • Chief of Service discussions with Consultant surgeons to ensure continued short term support for contingency measures while long term solutions put into place. Surgical clinical fellows attached to Academic surgical unit providing clinical cover at CX re-advertised to support junior rota.

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
7 / Datix 1610	Chief Operating Officer	Risk Assessment / Operational Risk	1	June 2007	**Failure to maintain key operational performance standards including – ED target, Cancer waiting target and RTT target** **Cause**: • Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes. • Mismatch of capacity and demand • Financial challenges • Bed capacity across site • Volatility of non-elective demand • Increased requirements for elective RTT activity • Late discharges / delayed review by speciality doctors • Potential infection outbreak **Effect**: • Reduced patient experience / staff morale • Increased operational inefficiencies • Failure to meet contractual / regulatory / performance requirements • Loss of reputation and reduced confidence from key stakeholders • Delays to accessing services • Elective patients on the waiting list have to be cancelled. • Delayed step downs from critical care. • Transfer of patients between sites impacting on patient experience **Impact**: • Poor quality of care • Potential increased costs: Reactive & Inefficient ways of working • Potential to incur penalties and/or fines • Potential reputational Impact: Loss of market share • Potential for increased lengths of stay	5 x 3 15	• Elective Patients: Weekly clinical risk assessment of all patients on the waiting list to triage those most at risk. • Daily ED Performance Reports • Local level scorecards and monitoring forums • Tri-borough urgent care board to oversee improvements in ED performance and urgent care pathway • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool) • Business Continuity and Emergency Plans in place and tested regularly • Senior input into site operations • Clinical transformation plan includes Urgent Care Board and Weekly operational delivery group • Funded opening of additional acute medical beds • Extended opening hours in UCC • Increased senior medical staff input into A&E • information per review • 3 year MOU and funding agreement with Macmillan into cancer services • Ambulatory emergency capacity on 3 sites • Recruit additional 6 ED consultants to St Marys • Monthly RTT delivery plan for admission pathways • Non-elective patients: Decision to transfer patients to CXH made by an SpR or Cons. and only clinically appropriate cases are transferred. • Theatre utilisation mtgs • Review meetings for all inpatients with a length of stay longer than 10 days • Clear escalation plans • Daily circulation of Trust SITREP • 3x daily site calls to manage capacity • Participation in weekly sector operations executive • Development and implementation of site/clinical strategy	5 x 3 15	Current	• For Surgical Patients: Ensure daily sub-specialty Cons. ward rounds, and implementation of abscess pathway where patients are booked onto emergency list and sent home. • Re-location of current UCC location to SMH site releasing space in main ED (Feb 15) • Remedial action plan for ED performance developed in response to sub 95% standard in September • Operations team restructured • New Head of service for emergency medicine • Increased escalation and visibility of DTOC within the sector • Discharge lounge opened • Implemented internal validation process for cancer pathways • On-going negotiations with commissioners regarding demand management. • On-going work with DGH in relation to timeliness of cancer pathway referrals • Range of meetings in place to manage issues • Implemented internal validation process for cancer peer review • On-going work to move discharges forward to before 12.00. • On-going validation of out-patient waiting list status (June 15) (Target risk score date: December 2015)	⇔	3 x 2 6	• Agreed remedial action plan with commissioners for RTT and choose and book. • Formal review re ED performance via ECIST with improvement action plan • Additional trauma lists • Increased therapy support • ED recovery plan • Additional elective activity focused on CXH / HH sites • Additional step down beds (18 CLCH) at CXH • Increased senior (executive) scrutiny of the emergency pathway and in patient discharge planning • Weekly review by CEO at ExCo

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
65 / Datix 1613	Medical Director	Divisional risk register / Operational risk	2	Feb 2014	**Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors, resulting in suspension of training.** **Cause**: • Inadequate training and education programmes • Failure to address allegations of bullying and undermining • Poor engagement and supervision • Poor access to and transparency of educational resources • Failure to be able to deliver safe patient care due to reduced doctor cover as an immediate consequence of trainee reduction (training suspension) • Failure to ensure that trainee doctors are able to progress in their training programme **Effect**: • Failure to deliver high quality training • Reduction in student and training places commissioned by Imperial College or HE NWL • Damage to reputation as a world class medical education provider • Withdrawal/Suspension of ST1 Training • Gaps on ward cover and out of hours on call rota causing pressure on existing workforce • Risk of trainees being removed **Impact**: • Potential loss of revenue: Research and education income (Failure to maintain medical education income) • Undermines mission of AHSC by failing to provide medical education integrated with research and service provision • Reputational with adverse revenue impact: Compromises future re-designation of AHSC • Potential to increase costs: Bank & Agency staff as result of being unable to recruit and retain medical staff at all levels • Potential to increase costs: i.e. claims and litigation impact on CNST payment due to poorly trained staff and potential for harm. • Reputational with adverse revenue impact: Service decommissioned and withdrawal of medical student places • Possible increase of complaints / incidents due to lack of continuity of medical staff/gaps in rotas • Potential Cost implications of locum requirements, service pressures and impact of future removal of funding for training posts	3 x 4 12	• Education transformation programme launched • New management structure in place • Anti-bullying strategy implemented • Revised governance structure implemented • Proactive management of recruitment and rotas, with locums filling shifts and escalation process in place in neurosurgery • Safety panel monitoring incidents weekly – chaired by MD • National trainer census complete – meets required standards • Formal process for the management of education action plans in place • Neurosurgery and ophthalmology action plans submitted to HENWL with supporting evidence - awaiting confirmation of closure of actions and date for return of students • Trust Education Committee established • Trust Steering Group established • Project to identify income streams and use of educational funds, including transparency of consultant job plans completed – funds accrued and process for monitoring expenditure introduced • Successful identification and creation of community and psychiatry posts to implement the Broadening the Foundation Programme requirements • Annual programme of specialty reviews chaired by the medical director established.	4 x 4 16	On-going	• Education strategy in development – consultation commenced. Strategy to be published in December 2015. • Bullying and undermining project continues including resilience training programme to counteract negative behaviour/undermining reports. • Progress on team job planning and inclusion of Educational PAs in consultant job planning – increase to 5.8% of total PAs for education • GEMV visit - action plan in place, update reviewed at ExCo 070715. Additional teaching fellows recruited (13 undergraduate and postgraduate). Action plan to be updated prior to interim GEMV in November • 12priority workstreams established following specialty reviews (reported to ExQu in September) • GMC trainee survey 2015 published – shows increase in red flags to 50 – actions plan developed in response – closure of actions to be monitored through trust scorecard • Local Faculty Group meetings established in 95% of specialties – actions in place to improve content and attendance • 3 trainees withdrawn from ophthalmology – safety risk assessment complete, recruitment of locums to fill gaps in rota, action plans developed to improve educational experience of remaining trainees – weekly meeting chaired by AMD to review progress established • Consolidation of all actions (GMC survey, GEMV and quality visits, SOLE, specialty and trainee review meetings) underway to ensure cohesion • HENWL quality visit due 2nd-3rd November – project plan to ensure readiness established (Target risk score date: December 2015)	⇔	2 x 4 8	• Recruitment of locums to fill gaps in rotas due to suspension of training • Increase scope of CIP programme due to loss of income

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Movement since last update to the Board	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
72/ Datix 1614	Director of People & Organisation Development	Strategic Planning / Operational risk	2	Oct 13	**Failure to implement, manage and maintain an effective health and safety management system including:** - **Appropriate health and safety policies, procedures and safe systems of work** - **Risk assessments and risk control measures** - **Information, instruction, training, support and supervision** - **Monitoring, measuring and auditing** - **Governance and assurance arrangements** **in order to protect the health, safety, and wellbeing of employees, contractors, students, patients and visitors whilst at or on behalf of the Trust.** **Cause:** • Lack of appropriate and effective H&S management structures • Lack of appropriate H&S information and guidance – including policies, procedures and safe system of work • Lack of induction, job specific and refresher training • Lack of management ownership and accountability • Poor employee engagement, awareness and culture • Lack of competent H&S advice and resources • Failure to report and investigate accidents/incidents/near misses **Effect:** • Increase in accidents, incidents and ill health • Damage to property and equipment • Impact on business continuity • Reduced morale, quality & productivity • Increased rates of sickness absence due to injuries and ill health • Poor patient experience • Poor reputation with regulatory bodies such as HSE and CQC **Impact:** • Potential to incur criminal penalties and/or fines: • Contractual and Enforcement Notices • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential loss of revenue : NHS Income as a result of Increased incidents to staff and patients • Management time to investigate accidents/incidents and implement corrective/preventative action • Training & retraining costs • Reputational risks	3 x 4 12		• Fully staffed Health and Safety Service • Strategic Health and Safety Committee • Division/Corporate Functions Health and Safety Committees • Divisional Health and Safety Leads • Departmental Safety Coordinators • Trust wide health and safety action plan, including a Trust risk profile • Divisional health and safety action plans • Accident/incident reporting via DATIX • H&S risk assessments undertaken and recorded on assessnet • Health and Safety dashboards • Health and safety training, including Health and Safety e-learning, Manual handling training, Fire Safety training • E-learning H&S module • Periodic updates to ExCo and Quality Committee • Health and Safety gap analysis undertaken • Readily accessible H&S information e.g. webpages on Source	3 x 4 12		Current	• New health and safety policies continue to be produced (several have been produced already i.e. COSHH and Manual Handling) • Increase profile of health and safety and employee engagement via blended comms programmes e.g. electronic, mailshots, noticeboards and face to face • Ensure there is a clear strategy for making suitable periodic Trust-wide communications on health and safety • Further develop suitable Trust health and safety performance indicators and set suitable performance standards • Further develop the Trust-wide dashboard and consider developing Division-level dashboards • Consider devising additional health and safety training for different levels of management i.e. over and above the statutory and mandatory H&S e-learning • Increased complement and training of Department Safety Coordinators (DSCs), Fire Wardens and First Aiders required • Consider the use of Health and safety audits (from April 2016) for service areas. Latterly audits will be carried out on divisions, directorates and sites • Ensure there is close working with the other Trust-wide services that influence H&S significantly (e.g. Estates and Facilities, Occupational Health) (Target risk score date: Jan 2016)	⇔	1 x 4 4	• Prioritise and utilise internal H&S expertise e.g. DSCs, Security, Trade Union Reps (external additional support may be required) • Monitor effectiveness of health and safety action plan

Acronyms

AHSC – Academic Health Science Centre

BRC – Biomedical Research Centre

CCG – Clinical Commissioning Group

CE – Chief Executive

CFO – Chief Financial Officer

CNST – Clinical Negligence Scheme for Trusts

COO – Chief Operating Officer

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation

CXH – Charing Cross Hospital

ECIST – Emergency Care Intensive Support Team

ED – Emergency Department

ExCo – Executive Committee

FBC – Full Business Case

FIC – Finance Investment Centre

FT – Foundation Trust

HCAI – Healthcare Associated Infections

HSE – Health and Safety Executive

MD – Medical Director

NWL – North West London

PLACE – Patient Led Assessment of the Care Environment

PMO – Project Management Office

PPM – Planned Preventative Maintenance

R&D – Research and Development

RTT – Referral to Treatment

TDA – Trust Development Authority

UCC – Urgent Care Centre

Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	4.3
Title	Proposal for a joint Trust and Charity patient and public involvement strategy
Report for	Discussion and feedback
Report authors	Michelle Dixon, director of communications Dr Bob Klaber, associate medical director Ian Lush, chief executive, Imperial College Healthcare Charity
Responsible Executive Director	Michelle Dixon, Director of communications

Executive summary

This papers sets out a proposed strategic approach to increasing and improving the use of patient and public involvement in the delivery and development of care and services across Imperial College Healthcare NHS Trust and Imperial College Charity. By patient and public involvement, we mean the active participation of citizens, patients, their carers and their representatives in the development of health services and as partners in their own care. This includes the planning, designing, delivery and improvement of health services and covers activities such as experience based co-design, patient representatives on boards and committees, fundraising and volunteering.

It makes the case for a more systematic and co-ordinated approach in terms of living our values and improving quality and efficiency at all levels of the organisation.

Specifically, we propose a semi-devolved model for delivering effective patient and public engagement as we need to balance the need for a more systematic and co-ordinated approach with the need to ensure it is owned and championed throughout the organisation, and to reflect that there is already much good work at a local level. The proposed model is set out, covering:

- 'recruiting' patients and citizens
- contact data management and building involvement
- support and training
- policy and oversight
- development and sharing of insight.

The Board is asked to support the proposed strategic approach.

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

This papers sets out a proposed strategic approach to increasing and improving the use of patient and public involvement in the delivery and development of care and services across Imperial College Healthcare NHS Trust and Imperial College Charity.

By patient and public involvement, we mean the active participation of citizens, patients, their carers and their representatives in the development of health services and as partners in their own care. This includes the planning, designing, delivery and improvement of health services.

The approach is intended to improve ways of working throughout the Trust. In particular, it will produce further synergies between five key functional areas with distinct but overlapping drivers for achieving improvements in our approach to patient and public involvement:

- quality improvement hub team – seeking to create a culture of continuous improvement and embedding experience based co-design as a standard QI approach
- patient experience team – gathering and analysing data and feedback, and leading developments, to drive improvements in patient experience
- communications and marketing team – seeking to build awareness, understanding and advocacy for change; seeking to support the development of services and initiatives that recognise and reflect individual patient needs and preferences
- governance team – seeking to improve our governance and help ensure the organisation is well-led
- Imperial College Healthcare Charity – seeking to build support.

2 The case for effective patient and public involvement

Whilst the importance of patient and public engagement in the NHS has been recognised in the NHS for several years, a recent focus has been driven by findings from a number of key reviews relating to failures of care in the NHS, including Berwick, Francis and Keogh. Most recently, NHS England's *Five Year Forward View* devotes a chapter to engaging patients and communities and makes the case for a radical change to the relationship the NHS has with patients and communities.

The Francis inquiry into failures at Mid Staffs NHS Foundation Trust highlighted particular problems around patient and public engagement and scrutiny bodies. The inquiry recommended the need for a mature approach to patient and public involvement, with multiple channels of engagement and a range of roles, from support to challenge.

The Berwick review into patient safety recommended that patients and their carers should be 'present, powerful, and involved at all levels of healthcare organisations from wards to boards' and be listened to and involved in every organisational process and every step of their care. Berwick argues for a bold level of engagement of patients in the processes of design, regulation and scrutiny of the system, not just activation of patients in the individual clinician/patient relationship.

At an individual level, when patients and their families and carers feel involved in their care, listened to and informed, they are more likely to be satisfied with their care and have less anxiety, greater understanding of their own needs, improved trust and better relationships with their healthcare professionals.

Increasing effective volunteering, fundraising and participation in clinical trials has very tangible, additional benefits for our organisation and our staff, as well as a positive impact on individual and community health and wellbeing more generally.

Example of effective patient and public involvement in NHS trusts

Great Ormond Street NHS Foundation Trust – has developed an integrated patient and public involvement and patient experience strategy with three levels of engagement:

- *Level 1* - Relates to the quality of the relationships and communications between patients, their parents/carers and staff (includes using a film made by patients in staff induction and junior doctor training; parent stories at staff induction; ward and outpatients surveys; semi-structured interviews at discharge; use of parent support volunteers on the ward; parent open days).
- *Level 2* - Relates to improvements or changes in services at speciality or unit level (includes recruiting parents on to management boards; involving patients in ward redesign or service improvement projects; focus groups; executive safety walkaround; parents on recruitment panels; use of volunteers to support improvement projects; parent input on reference groups on clinical outcomes and website work).
- *Level 3* - relates to engagement in Trust-wide strategic issues (includes parent story at Trust Board; Members' Council; listening events; focus groups to inform strategy; consulting parent and lay reps on Trust strategies and corporate plans).

3 Patient and public involvement at Imperial College Healthcare

There are many examples of how the involvement of patients and local people has produced real benefits, including in shaping improvements at Clinic 8 at Charing Cross Hospital, the co-design of GP child health hubs as part of Connecting Care for Children, community volunteering and fundraising projects, and informing the redevelopment of our new website. Many of our services, especially those providing care for long-term conditions, have active patient groups.

Example of effective patient and public involvement at Imperial College Healthcare

Connecting Care for Children - is an innovative programme of integrated child health that was co-designed with children, young people and their families, alongside a broad group of professionals from across our local communities. Central to the GP child health hubs that have been established is the development of 'practice champions'. Young people and their carers are recruited as practice champions, volunteering their time to lead patient engagement and co-production, enabling peer support and self-management, and ensuring GPs, acute clinicians and patients work together. Through training, they are empowered to be equal partners with the primary care team.

However, our current approach is inconsistent and uncoordinated. There are significant gaps, particularly in terms of involvement in more strategic aspects of our work. Staff who do want to involve patients and the public often don't have the skills, experience or confidence to make it happen. We don't monitor or have any oversight of the effectiveness of involvement, including whether or not we are providing a positive and meaningful experience for patients and local people. There's no clear process for inviting and supporting patients and local people to take up involvement opportunities, so that it tends to be the same relatively few individuals invited on to multiple project groups.

An entirely *ad hoc* approach to patient and public involvement also means we don't make the connections or see the bigger picture – we are missing the opportunity to build and share powerful insight about the needs and views of our patients and local communities, especially if this was co-ordinated with our patient experience monitoring. Overall, we could achieve much more – for our

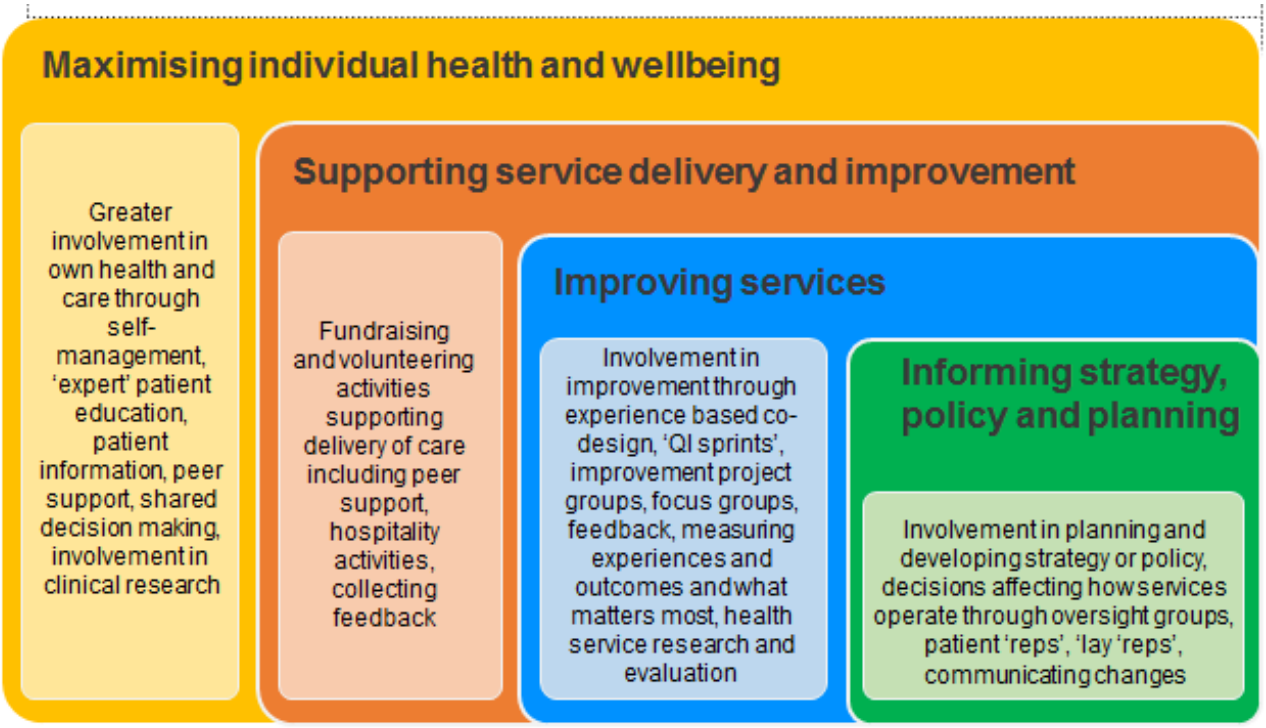
patients, our staff and the NHS – if we had a strategic approach to actively identifying, supporting and building involvement, making it easy for patients – and staff – to identify appropriate involvement opportunities. The Trust has over a million patient contacts each year. There are around 2 million people in the local population we serve.

Strategic developments at the Trust and the Charity, linked to wider organisational transformation and culture change, are amplifying the opportunities that a more strategic approach to patient and public involvement would bring, as well as the risks of continuing on our current course. These include:

- Our new ethos and values – setting out how we're part of a wider health community, that partnerships are key, and that collaboration is a core value.
- Establishment of a trustwide QI approach – built on evidence that small tests of change, and experience based co-design of improvements is the most successful approach.
- Clinical strategy improvement programme – developing new models of care and reconfiguring key services will require input from the very start from a range of stakeholders, not least patients and their families, if we want to get the best solutions and for those solutions to be owned and understood.
- Integrated care – connections and relationships are key to the development of integrated care pathways that reach beyond the walls of the hospital.
- Estates redevelopment – we have a once in a generation opportunity to redevelop our hospitals, and the involvement of patients and local communities will be essential.
- A more ambitious and strategic approach to fundraising and community support within the Charity, and a shared commitment to closer working between the Trust and the Charity.

4 A proposed framework for patient and public involvement at Imperial College Healthcare

We have developed the following framework for patient and public involvement within Imperial College Healthcare. The four elements relate to the primary intended outcome of the involvement but there would clearly be overlaps between them.



Using these categories, we can begin to systematise and tailor our approach to 'recruitment', development and support of patients and citizens, and understand key connections to other developments and strategies.

	Maximising individual health and wellbeing	**Supporting service delivery and improvement**	**Improving services**	**Informing strategy, policy and planning**
The involvement offer	Patient education and information to support self-management Shared decision making Clinical trials Peer support	Volunteering Fundraising Donating	Co-design – one-off sessions and project-based General and focused feedback	Representative on a major programme, project or committee
'Real' examples	Long- term condition management data-sharing pilot	Being a support-for-families or way-finding volunteer	Taking part in an outpatient improvement co-design event	Representative on estates redevelopment board or research ethics committee
What's the likely motivation?	Directly improving own health and wellbeing Learning and development	Giving something back; wanting to be part of an organisation that helps people and that has a big impact on the health and wellbeing of the wider community Learning and development	Making good use of personal experience and insight to improve a service for self and others	Making good use of broader skills and experience to influence decisions and planning Learning and development
Who are they?	Patients and carers, particularly relating to long-term conditions or where we are caring for population 'cohorts'	Patients, carers and families from our wider communities	Users of services – past and present Patients, careers and families from our wider communities	Recruit more formally, through public notice and networks – Healthwatch etc
Key links	Care information exchange Community independence service Partnership with Macmillan Long term conditions groups Imperial College	Other volunteering groups and charities (eg Friends and COSMIC)	Quality improvement programme and projects Clinical strategy improvement programme Service change policy – formal consultation	Healthwatch CCG/commissioner lay representative fora Service change policy – formal consultation
Co-ordinating 'team'(s)	TBC	Charity/Volunteering	Quality improvement/ QI hub	Communications

5 An integrated approach to delivering patient and public involvement

We propose that we move towards a semi-devolved model for delivering effective patient and public engagement as we need to balance the need for a more systematic and co-ordinated approach with the need to ensure it is owned and championed throughout the organisation, and to reflect that there is already much good work at a local level.

The centrally co-ordinated or supported elements would include:

5.1 'Recruiting' patients and citizens

We would look to offer all of our patient contacts – and increasingly local citizens – the opportunity to be part of a community of members – or partners – to help the Trust provide better care and services. For patients, and their families and carers, we would do this systematically in an early stage of their patient journey. As we move towards digital communications with our patients as standard, we would want to ask for relevant permissions to contact them at the point that they give us their email address.

We currently have around 4,000 individuals (patients, local people and staff) who have signed up to become shadow foundation trust members. We would look to develop a membership offer that reflects our wider patient and public involvement aspirations and that could also include the specific needs of FT membership – such as the election of governors - if and when that becomes a requirement .

5.2 Contact data management and building involvement

We would look to develop an integrated contact relationship management (CRM) system to include all of our contacts interested in helping us improve our care and services.

Specific involvement contact would continue to be managed by the relevant team or service (s) – for example, donors would remain managed as donors by the charity and a service-specific user group would continue to liaise with that service's clinicians. But the CRM would allow us to have a single overview of each individual in terms of their preferences and interests and what they have and are involved in. This would allow us to build up a picture of how we can evolve and deepen our relationship with them in response to their needs, skills and interests. We would be moving from 'competing' for, and essentially 'capturing', individuals to creating and co-ordinating an open range of involvement opportunities that best suit them.

On a practical level, an integrated CRM would also allow us to improve co-ordination and administration. We would be able to combine and schedule contact from different parts of our organisations that put the member/partner first and prevents them from being bombarded with siloed requests and information.

By consolidating CRM centrally, we can also improve the quality of our general membership – or partner - communications and engagement, keeping our contacts up to date with developments and feeding back the positive impact of their contribution. This would include a newsletter/magazine, digital space, special events. The goal would be to create the sense of a membership – or partner – community that is a core part of the Trust.

5.3 Support and training

Patients, carers and citizens who want to get involved should expect and will need support – and, in some cases, training – to help them make their full contribution. Staff also need support and guidance to ensure we make the best use of individuals' time and contributions. A significant body of good practice has been developed in relation to this aspect of involvement, including by national policy bodies such as The Health Foundation, The King's Fund and Citizens UK, and also by specialist teams within Imperial College and our own academic health sciences network, Imperial College Partners, and CLAHRC.

We would work collaboratively wherever possible, making best use of existing resources and toolkits, to provide the following types of support:

- developing skills for patients and citizens involved in governance and shaping policy and strategy
- understanding and skills development for experience-based co-design and 'community organising' approaches
- volunteering skills development and guidance
- fundraising skills development and guidance
- 'expert' patient and self-management support and training
- awareness raising, support and guidance for staff, including facilitation skills development.

5.4 Policy and oversight

We need to develop consistent approaches in a number of areas that support fair and effective patient and public involvement. Most pressing is an agreed policy on expenses and recognition for patients and citizens who give their time. We also need to develop monitoring, evaluation and oversight processes that reflect the semi-devolved model. We need to ensure best practice wherever or whoever is leading on a patient and public involvement opportunity.

5.5 Development and sharing of insight

We propose that there is an ongoing and systematic gathering and analysis of learning from patient and public involvement activities, supported by the co-ordination and insight enabled by an integrated CRM. If this is combined with learning from other forms of feedback, especially those led by the patient experience team, such as friends and family test, complaints, PALS – and potentially increasingly from social media approaches supported by our new website, we can create very powerful insight. Working in partnership with the patient experience team, the central patient and public involvement function would be able to extract key learning and share across the whole organisation in order to support continuous improvement.

6 Next steps

- A project team has been established with representatives from across the five key functional areas involved to take forward the strategy development and implementation.
- The project team will propose new ways of working and team structures to deliver the elements of the new approach that we recommend are centrally co-ordinated or supported, and will feed this into business planning for 2016/17.
- We are establishing a strategic lay forum in 'shadow form' from December, initially to provide guidance and oversight to the project team in developing and implementing our patient and public involvement strategy and related policies. The forum is also intended to provide feedback and guidance on other strategic developments across the Trust, as required, influencing in particular how these developments are genuinely informed by wider patient and public involvement. The co-chair of North West London whole systems integrated care lay partners advisory group and the director of the tri-borough Healthwatch are kindly advising us on this initiative.
- Progress work within the charity and communications team to develop a small scale pilot to gauge the proposed approach to recruitment, making use of the integrated 'get involved' section on the new website.

7 Recommendation

The Trust Board is asked to support the proposed strategic approach set out in this paper.

Imperial College Healthcare NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Wednesday 8 July 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 (Item 1.5 and from part of item 3.1 onwards)
Sarika Patel	Non-Executive Director
In Attendance:	
Jan Aps	Trust Company Secretary
Dr Tracey Batten	Chief Executive
Claire Broster	Risk/Projects Manager (item 4.3 – 5.2 only)
Ian Garlington	Director of Strategy and Development
Alan Goldsman	Interim Chief Financial Officer
Paul Grady	Director, TIAA
Kevin Jarrold	Chief Information Officer (item 3.1 onwards)
Prof Naresh Kikkeri	Divisional Director ISCS (item 4.3 – 5.2)
Philip Lazenby	Director of Audit, TIAA
Leigh Lloyd-Thomas	Partner / Public Sector Assurance, BDO LLP
Steve McManus	Chief Operating Officer (item 5.2 onwards)
Arti Patel	Senior Counter Fraud Specialist
Prof Julian Redhead	on behalf of Prof Chris Harrison
Prof Janice Sigsworth	Director of Nursing
Dr Nicola Strickland	Consultant – Radiology (item 4.1– 5.2 only)
Tracy Walsh	Committee Clerk (minutes)

1	GENERAL BUSINESS	Action
1.1	**Chair's opening remarks and apologies for absence** The Chair welcomed everyone to the meeting. Apologies for absence were received from Prof Chris Harrison, Dr Andreas Raffel and Ian Sharp.	
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 27 May 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: • Patient transport – a deep dive taking into consideration any new tender would be presented to the Committee meeting in October.	**IG**
1.5	**Amendments to terms of reference** Jan Aps introduced the paper. The Committee considered the proposed terms of reference and agreed that the amendment to 12.3 'by reviewing the minutes of those Committees' would not be included in the revised terms of reference. The Committee confirmed that the terms of reference accurately reflected the activity undertaken by the Committee. The Committee recommended the revised terms of reference for approval by Trust board.	

1.6	**Annual Committee report to the Trust board** Jan Aps presented the paper. The Committee reviewed and discussed the Committee's annual report for submission to the Trust board. The report was approved subject to minor amendments.	
PART I AUDIT		
2	**EXTERNAL AUDIT BUSINESS**	
3	**INTERNAL AUDIT BUSINESS**	
3.1	**Internal audit and counter fraud progress report** Philip Lazenby presented the paper that provided an update on progress with the 2015/16 plan. The Committee noted that Mr McManus had concerns as to the accuracy of some sections in the initial cancer wait times report. The revised report was being reviewed by the performance and information team to ensure that an appropriate methodology had been used. Mr Lazenby highlighted items in the following audits: • IVF recharges – it was clarified that IVF-H are a totally separate company independent of the Trust. There were currently no processes and procedures in place or formal agreement with IVF-H; this may result in the Trust not securing appropriate levels of income. Dr Batten advised the Trust would seek legal advice on how to revise contract arrangements; an update would be provided to the Committee later in the year. • 18 week RTT – TIAA had finalised the report without having received comments from the responsible director. Dr Batten asked TIAA to contact her directly where management responses were not forthcoming following completion of an audit. • Safeguarding adults and Do not attempt resuscitation (DNAR) audits were outstanding; Dr Redhead advised he would follow this up on behalf of the Medical Director. • CQC service review and deep dives – Prof Sigsworth would advise whether this needed to be reported to the Committee as it was being reported extensively to the Quality Committee. Arti Patel reported that a new investigation had commenced into a member of staff working elsewhere while being on sick leave from the Trust. She also highlighted that in the case PAA 6416 - Illegal Worker, the individual had been given a suspended prison sentence. The Committee noted the update.	**SM** **JR/CH**
4	**FINANCIAL & OTHER BUSINESS**	
4.1	**Draft Capital programme for FY15/16** Ian Garlington presented the paper and reported that £14 million had been allocated to risks rated 16 or above in relation to backlog maintenance. Negotiations continued with Imperial Charity regarding increasing funding for the capital programme; the option of borrowing or servicing debt was also being considered. Dr Batten noted that the Charity had confirmed they would fund some of the outpatient improvements. The Committee noted the paper recognising that the plan would be reviewed by Finance and Investment Committee at their meeting 22 July.	
4.2	**Tender waivers report 2014/15** Mr Goldsman introduced the paper and assured the Committee that goods and services were being procured using the most appropriate methods, and that, in addition to being scrutinised by the procurement team, he personally reviewed the waivers. The Committee noted the paper.	

4.3	**Losses and special payments register Q4 2014/15** Mr Goldsman presented the paper. Sir Gerry Acher asked whether the likely cost of individual private patient procedures could be pre-assessed, and charged to them prior to treatment. Mr Goldsman would consider this proposal, and ask for a paper on the opportunity for implementing such an approach to be presented in October. The Committee were concerned at the level of overpayments being incurred by the Trust, and asked that management raised awareness of the importance of completing staff leaver notifications in a timely manner to mitigate unnecessary losses. The Chief Financial Officer would provide a brief on overpayments of salaries in October. Mr Goldsman reported that overseas visitors' write-offs had been reviewed on an individual basis, involving joint working with the Departments of Health and Immigration; these were very challenging cases and unlikely to be resolved. The Committee noted the paper.	**AG** **AG**
6	**ANY OTHER BUSINESS** This being the last Committee meeting for the interim Chief Financial Officer, Alan Goldsman, Sir Acher thanked Mr Goldsman for significant contribution to the Trust.	
7	**DATE OF NEXT MEETING** Wednesday 7 October 2015, 10.00am – 12.30pm, Clarence Wing Boardroom, SMH.	

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust board**

Report from: **Quality Committee (11 November 2015)**

KEY ITEMS TO NOTE

Frequency of Quality committee meetings
The committee agreed to revert to monthly meetings from January 2016; this would be reviewed in June 2016.

Divisional Director's risk register update
The committee reviewed the divisional risks; it was noted that there was difficulty in filling all the medical registrar vacancies at Hammersmith Hospital, partially due to a national shortage of trainees. Actions were being taken to review whether the service could be accommodated on either the Charing Cross or St Mary's sites. Issues identified in the senior medical cover for HDU at St Mary's were being addressed.

Quality report
The committee noted that the Trust's incident reporting rate (40.51 per 1,000 bed days) was above the peer group average (35.10), a positive position given the overall low harm. Enhanced WHO checklist audits were now in place that included a safety and effectiveness check.

Diagnostics review: update on imaging challenges
The committee received a report as to the investigation of, and actions taken to mitigate imaging and reporting backlogs. The number of breaches had been reduced significantly due to extra lists and staff working overtime voluntarily to provide extra capacity during the day. There had been a small improvement in recruitment to the radiography team and the division was working with HR to develop more effective recruitment campaigns and retention strategies. There were on-going challenges due to the age of the equipment, discussions were currently taking place with Finance and Facilities re arrangements for future replacement of aged equipment.

Fire safety assurance report
The fire enforcement division of the London Fire Brigade had visited the Trust in October. The LFB responded positively to the Trust's six year fire safety compliance plan (which had been agreed by the Executive Committee); this would be formalised in a memorandum of understanding.

RECOMMENDATION:

The Trust board is requested to:

- Note the report

Report from: Prof Anthony Newman Taylor, Chairman, Quality Committee
Report author: Tracy Walsh, Committee clerk
Next meeting: 13 January 2016

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Finance & Investment Committee (18 November 2015)**

KEY ITEMS TO NOTE

Finance report

Mr Richard Alexander reported that at month 7, the Trust was reporting a deficit of £20.1m, £9.3m behind the planned year-to-date position. The committee expressed significant concern at the worsening situation. Mr Alexander and his deputy finance directors outlined details of the position, particularly noting the lower than planned income and higher than expected CCG challenges. The proposed action plan was discussed, as were further actions to reduce expenditure which may be considered. The committee will now receive weekly finance updates.

Business planning framework

Mr Alexander reported that the NHS England planning framework for the next financial year would be issued on 23 December. This was likely to seek pan-sector (west London) planning. In advance of this the Trust had started work on developing plans based to ensure that robust and integrated plans were developed; this was integral to the continuing work on the cost improvement. The Committee noted the difficulties of reducing services as a means of reducing costs.

NWL Pathology update

The Committee, noting their concerns about the unanimous vote required for approval of annual business plans, recommended to the Trust board for approval the joint working agreement, side letter, ITFF loan agreement and LIMS contract.

Tenders and business cases

The Committee:

- considered that further information was required in relation to the tendering for the 'hard facilities management contract before recommending this for approval to the Trust board. An extra-ordinary Committee meeting would be arranged to consider this after it has been further developed.
- supported the recommendation from the Medicine Division that the Trust submit a tender for the Urgent Care Centre at St Mary's in partnership with another provider, and agreed for the details to come back to the Committee to consider the pricing and margins by email for approval..
- noted the forthcoming tender in relation to sector genetic services.
- recommended for approval by the Trust board the proposal to extend the existing patient transport contract by two years, but with a six-month break clause to provide an opportunity for improved performance whilst the Trust considers longer term options.
- approved progressing with the capital request to the CCGs (£1.3m) in relation to the paediatric emergency department. The capital and revenue proposals relating to reconfiguration of the adult emergency department would be subject to further review and discussed further at the extra-ordinary Committee meeting.

Imperial College Healthcare NHS Trust

The Committee requested that it be provided with earlier notice of major contract renewals to ensure more effective input into the procurement and approval process.

Estates backlog maintenance

The Committee noted the scale of the backlog maintenance requirements across the Trust sites, the risks associated with this and the mitigations in place to manage the risks, confirming that this would be discussed further by the Committee in January as part of the wider capital planning for 2016/17. The committee recommended that this paper be circulated to the Audit, Risk and Governance Committee for information. It should also be an agenda item at that committee when further details of the report are available to discuss risks and mitigation.

Action requested by Trust board

The Trust board is requested to

- Note the report

Report from: Sarika Patel, Chair, Finance & Investment Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 20 January 2016 (Extra ordinary meeting to be arranged December 2015)