Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
25 May 2016
12.15 – 14.00
W12 Hammersmith Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	12.15	Oral
1.2	Board member's declarations of interests	Chairman		1
1.3	Minutes of the meeting held on 6 April 2016	Chairman		2
1.4	Record of items discussed at Part II board meeting 6 April 2016	Chairman		3
1.5	Action Log	Chairman		4
1.6	Annual report of the use of the Trust seal	Trust company sec		5
2	**Operational items**			
2.1	Staff story – Venetia Wynter-Blyth	Director of nursing	12.25	6
2.2	Patient story stocktake	Director of nursing		7
2.3	Chief Executive's report	Chief executive		8
2.4	Operational report & scorecard (Month 1)	Director leads for each domain		9
2.5	Month 12 2015/16 Finance report	Chief financial officer		10
2.6	Operational plan 2016/17	Chief financial officer		11
3	**Items for decision or approval**			
3.1	Clinical service improvement - proposed pathway for chest pain and acute medicine patients	Medical director/ Deputy medical direct'r	13.00	12
4	**Items for discussion**			
4.1	Sustainability & Transformation Plan	Chief executive	13.15	13
4.2	Safeguarding children – annual report	Director of nursing		14
4.3	Safeguarding adults – annual report	Director of nursing		15
4.4	Improving the quality of care CQC report	Director of nursing		16
4.5	Nursing and Midwifery establishments review and safe staffing update	Director of nursing		17
5	**Board committee reports**			
5.1	Audit, risk & governance committee (20 April)	Committee chair	13.45	18
5.2	Quality committee (13 April & 11 May)	Committee chair		19
5.3	Finance and investment committee (18 May)	Committee chair		20
5.4	Redevelopment committee (27 April 2016)	Committee chair		21
6	**Items for information**			
6.1	Responsible Officer report	Medical director	13.50	22
6.2	Ealing Hospital – changes to children's services	Chief executive		23
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			13.55	
9	**Date of next meeting**			
	27 July 2016, New boardroom, Charing Cross Hospital			

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 6 April 2016
11.30 – 13.00
Clarence Wing boardroom, St Mary's Hospital

Present:	
Sir Gerry Acher	Deputy Chairman (chair of meeting)
Dr Rodney Eastwood	Non-executive director
Jeremy Isaacs	Non-executive director
Professor Sir Anthony Newman Taylor	Non-executive director
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Jan Aps	Trust company secretary (minutes)
Dr Julian Redhead	Medical Director
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Dr William Oldfield	Deputy Medical Director
Stephanie Harrison-White	Head of patient experience

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** Sir Gerry Acher, chairing, welcomed members, attendees and members of the public to the meeting. He noted apologies from Sir Richard Sykes, Dr Julian Redhead, and Michelle Dixon.	
1.2	**Board members' declarations of interests** There were no declarations of interest made for the meeting.	
1.3	**Minutes of the meeting held on 27 January 2016** The Trust board accepted the minutes of 27 January 2016 as an accurate record of the meeting.	
1.4	**Record of items discussed at Part II board meeting 27 January 2016** The Trust board noted the record of items discussed.	
1.5	**Action Log** The Trust board noted that there were no outstanding actions on the action log	
1.6	**Review of Trust board declarations of interest** The Trust board noted the latest statement of Trust board members' declarations of interests, and that members were requested to inform the Trust company secretary of any updates in year.	
2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth introduced the patient story, welcoming Mrs Bruce, and members of staff accompanying her. Mrs Bruce thanked the Trust board for the invitation, and commented that she had always been, and remained, proud to have St	

	Mary's as her local hospital. In reviewing the care that she had received, Mrs Bruce was very complimentary of the medical care, but reflected that nursing care, communications and maintenance of her dignity had been far more variable. Describing distressing personal incidents, she commented how unhappy she had become at the lack of concern displayed at times, noting the measurable difference between treatment received on different wards and from different teams. Discharge arrangements had also been particularly poor. Staff did not appear aware of how disoriented, shocked and frightened patients are on being admitted to hospital. Mrs Bruce also described some real high points, how individual staff had made her feel particularly welcomed or cared for. Sir Gerry Acher thanked Mrs Bruce for being brave and taking the Trust board on her journey, and apologised for her experience. Prof Sigsworth, noting that the assessment was a challenging environment, commented that there had been no excuse for providing Mrs Bruce with such a poor experience. Prof Orchard welcomed the feedback, both positive and negative, and noted that more general patient feedback in that area had identified issues; these had been addressed and the area had been noted as one of the most improved areas. Dr Tracey Batten highlighted the need for all staff to remember simple acts of kindness and to treat every patient as an individual. In response to a query from Sarika Patel, Mrs Bruce commented that she had not felt able to complain, and responding to Richard Alexander, she noted that, to address loneliness and fear, patients should not be left alone when waiting for diagnostic tests, but acknowledged that volunteers may not be able to respond to patients' questions. Dr Andreas, noting that the Trust board had received a number of patient story presentations, requested a 'look back' to check on the lessons learned. In closing the session, Sir Gerry Acher commented that embedding the Trust values remained a priority, as did bringing more timely improvement where shortcomings were identified. The Trust board noted the patient story and asked that for the next meeting, a look back be presented with reviewed actions taken and lessons learned from the experiences presented.	
2.2	**Chief executive's report** Dr Tracey Batten introduced her verbal report, noting: • the completion of the roll out of Cerner Clindocs • the completion of phase I of the re-organisation following Trust board agreement of the proposals in January 2016 • that the TDA had approved the capital cost of the PICU development • that the Imperial College Healthcare Charity had completed arrangements to become a fully independent charity. A robust series of arrangements existed between the Trust and the Charity, and the Trust would have three trustees on the Charity board (Dr Redhead, Michelle Dixon, and an executive yet to be confirmed). The Trust board noted the chief executive's report	
2.3	**Operational report & scorecard** In introducing performance on 'safe' metrics, Dr William Oldfield noted that there had been a total of 108 reported serious incidents in 2015/16, against a total of 130 in 2015/16; he considered there to be a clear focus on patient safety across the Trust, robust investigations and embedded learning. One of the in-month cases of C difficile had exposed a lapse of care which was being addressed; at the end of February, there had been a total of 68 cases against a full year threshold of 69. Mortality ratio for the Trust remained particularly good; with effectively and well-managed recruitment of patients into research trials; improvements being achieved in both 30 day readmission rates and length of stay, reflecting improvement in pathway management, seven day services (reducing waits for tests) and more effective discharge arrangements. Leading on 'caring' metrics, Prof Janice Sigsworth was pleased to note the improvement in the Friends and family test response rate, where teams had been working to increase the number of patients providing feedback; level of satisfaction	

	remained positive. Following the restructuring of how patient complaints were dealt with by the Trust, the backlog had been much reduced, and patients tended to receive a phone call to discuss their concerns which was being positively received; there was a clearer understanding of the themes where improvement was needed supporting more timely improvement. David Wells highlighted a number of the 'well-led' metrics: improvement in reducing vacancies focused on reducing time to recruit and a rolling recruitment programme for nursing staff; staff mandatory training compliance was much improved (a new process for mandatory training for junior doctors would show improvement in these areas shortly). The engagement survey which had been showing continued improvement had been adversely affected by the restructuring noted in the chief executive update, but this was an area which would receive further attention. The divisional directors, Profs Mayet, Orchard and Teoh introduced the responsive metrics, and key points were: • Referral to treatment (RTT): validation had identified further patients who remained waiting for treatment - improvements continued to be sought to identify such issues earlier (issues related to interpreting the challenging data set). The target would remain challenged for some months, and the Trust projected maintained achievement from the summer months. • Cancer: good performance continued overall, although two targets had not been achieved in month - screening (where patients may choose to delay their own treatment) and 62 treatment commencement target (which was challenged where patients were transferred from initial care elsewhere). Dr Andreas Raffel expressed concern that any patients were waiting 52 weeks for treatment; Dr Batten concurred that this was not a position that the Trust would wish to continue. • Diagnostics: the targets were being achieved, but the Trust board noted that the target may not be achieved in May and June during the introduction of the new computer reporting and archiving system. • Outpatients: some outpatient clinics were yet to be rationalised into the patient service centre arrangements; those that had been were showing improving metrics. Whilst those clinics at Western Eye remained particularly challenged, improvements could be seen following the recent attention paid to the site. • A&E: the emergency department remained challenged, particularly at Charing Cross, with activity increase of 13.5% in a year (St Mary's had experienced 5% growth); capacity increase was progressed at both sites, with the business case at St Mary's having been approved by the Charity. The submitted recovery trajectory for the A&E targets showed achievement in March 2017. The Trust board noted the operational report	
2.4	**Finance report – month 11** Richard Alexander introduced the report, noting that despite an improved in-month position, the Trust was forecasting a £30m deficit position; the executive team remained focused on improving both the short-term and medium term position. Cash support was being sought from the Department of Health. The Trust board noted the financial report with continuing concern	
3	**Items for decision or approval**	
3.1	**Shaping a Healthier Future paediatric service transition – letter of assurance** Prof Teoh reported that an extra 1000 emergency department attendances and 400 admissions had been planned as a result of the closure of the paediatric facility at Ealing Hospital. As for the maternity transfer, the Trust was required to submit a letter of assurance stating that the Trust was in a position to safely accept the transfer. Responding to Dr Raffel's concern that the Trust may be increasing its risk by accepting this activity, Dr Batten, commented that this was part of acting as a partner in the wider health economy needs, in enabling the closures at Ealing Hospital. The Trust board approved the submission of the letter of assurance, but requested that	

	a further paragraph be added to reflect the concerns and potential financial impact resulting from planned activity levels not having resulted from the transition of maternity activity	
4	**Items for Discussion**	
4.1	**Proposal to consolidate stroke and neuro-rehabilitation bed base at Charing Cross Hospital** Prof Tim Orchard introduced the Proposal to consolidate the stroke and neuro-rehabilitation bed base at Charing Cross Hospital, noting that the particularly effective care previously provided at St Mary's had further improved care at Charing Cross when the services had been transferred. This would further enable appropriate care for a wider cohort of patients with similar needs; both internal and external stakeholders had been engaged in the plan changes. The Trust board noted the consolidation and ring-fencing of beds for stroke and neuro-rehabilitation services	
4.2	**Improving the quality of care – CQC update report** In introducing the report, Prof Sigsworth reiterated the comprehensive compliance and improvement framework which had been introduced; both core service reviews and deep dive reviews continued and areas of improvement identified and acted upon; using self-assessment to review services was being introduced which reflected the approach likely to be developed by the CQC in its developing approach to inspection. The outcome of such self-assessments would be presented to the Trust board. Seven actions remained outstanding in relation to the CQC action plan; most of these were expected to be completed by the end of April 2016; Trust-wide groups, attended by the chief executive were addressing the remaining challenges, and progress would continue to be reported to the quality committee and Trust board. The Trust board noted the update report	
4.3	**Quality accounts – update** Dr William Oldfield introduced the update as to progress in producing the annual quality account, and the proposed quality strategy targets for 2016/17. He reported that the final document would be approved by the Quality Committee in April, and presented to the Trust board in May. Responding to a query from Prof Sir Anthony Newman Taylor, he would consider whether, noting the surgical never events in 2015/16, it was appropriate to include a target reflecting the WHO surgical checklist. The Trust board noted the report	
5	**Board Committee reports**	
5.1	**Audit, Risk & Governance Committee - Part I minutes (2 December) and report (16 March)** The Trust board noted the report	
5.2	**Quality Committee report (9 March)** Prof Sir Anthony Newman Taylor highlighted that the committee had also received assurance that the Trust's apparent outlier status in relation to palliative care coding was not a clinical issue. The Trust board noted the report	
5.3	**Finance and investment committee report (23 March)** Dr Andreas Raffel reflected that 2016/17 would be an ever more challenging year for the Trust. The Trust board noted the report	
5.4	**Redevelopment Committee report (24 February and 23 March)** The Trust board noted the report	
6	**Items for information**	

	There were no items for information.	
7	**Any other business**	
	There was no other business.	
8	**Questions from the public relating to agenda items** In responding to questions from the public, the following key points were made by Trust board members: • confirmation that emergency department services would only be down-graded when it was considered safe to do so • the Trust had not submitted a formal response to the planning authority given the withdrawal of the Sellar planning application. It was the responsibility of the planning authority (Westminster City Council) to consider the requirement for affordable housing; the Trust would consider whether to mention this in any future response to planning applications.	
9	**Date of next meeting** 25 May 2016, W12, Hammersmith Hospital	

Imperial College Healthcare NHS Trust

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

Record of items discussed at the confidential Trust board on 6 April 2016

Executive summary:

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

Issues of note and decisions taken at the Trust board's confidential meetings held on 6 April 2016:

- **Business planning**: the Trust board discussed the draft business plan, noting that whilst the Trust would not wish to submit a deficit budget, the NHS systems would be facing unprecedented financial pressures in 2016/17. The Trust board agreed to delegate authority to the chief executive and chief financial officer to finalise the position to be presented to the TDA and the accompanying narrative. The narrative for publication would be presented to the public Trust board in May. An application for a Revolving Working Capital Facility (RWCF).
- **Draft NWL sustainability and transformation plan (STP)**: the board noted the progress being made on developing the STP, noting that further work would be required. The plan would be presented to the public board at an appropriate time.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Jan Aps, Trust Company Secretary	Tracey Batten, Chief Executive

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
Patient and public involvement strategy Regular reports would be provided	25 November 15	Michelle Dixon	In progress	Report will be brought in July 2016

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

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

Annual report of use of the Trust seal

Executive summary:

The Trust standing orders required that the use of the Trust seal is report to the Trust board on a n annual basis.

Quality impact:

n/a

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse.

Recommendation to the Trust board:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Jan Aps Trust company secretary	Dr Tracey Batten Chief executive	13 May 2016

Use of the Trust common seal June 2015- May 2016

This table is a record of the use of the Trust seal as required by the Trust Standing Orders

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
141	Dr Matthew Berry, Imperial Innovations and Professor Robert Wilkinson	Deed of assignment	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	18/06/2015
142	Dr Matthew Berry, Imperial Innovations	Deed of assignment	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	18/06/2015
143	ICHT and GE Healthcare	Managed maintenance services of Trust imaging and biomedical equipment	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	30/07/2015
144	Westminster City Council	Genito-Urinary Medicines Services	Steve McManus, Deputy Chief Executive Richard Alexander, Chief Financial Officer	27/08/2015
145	Lloyds Bank PLC	ATM at Charing Cross Hospital	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	21/10/2015
146	Medical Illustration UK Ltd	Technical Medical Illustration Services	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	28/10/2015
147	Carestream Health UK Ltd	ICT Services	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	25/11/2015
148	UK Broadband Ltd	Lease for aerial cabin Charing Cross Hospital	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	02/12/2015
149	Imperial Innovations and Dr Nick Oliver	Deed of assignment	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	17/12/2015
150	Synergy Health	Linen and laundry services for all Trust sites	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	07/01/2016

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
151	Imperial College	Revised JWA for AHSC Academic Health Sciences Centre	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	03/02/2016
152	Imperial Innovations	Deed of amendment to a Revenue Sharing Agreement (26/7113) re Dr Prapa Kanagaratnam and Dr Nicholas Linton and Darrel Francis	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	25/02/2016
153	Imperial College Healthcare Charity	MoU Deed of Understanding on transfer to independent status	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	25/02/2016
154	Cornerstone Telecomms Infrastructure Ltd	Lease on aerial cabin	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	08/03/2016
155	Xerox UK Ltd	Hybrid mail service	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	09/03/2016
156	Deep Mind Technologies	MoU for 'Hark' mobile application	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	09/03/2016
157	Becton, Dickinson UK Ltd	Bacteriology Laboratory Automation Equipment	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	17/03/2016
158	CBRE Managed Services Ltd	Maintenance of Hard FM Facilities	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	24/03/2016
159	Alliance Medical	Mobile MRI St Mary's	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	06/04/2016
160	Medical Research Council	TRI application for transfer of registered title at Hammersmith Hospital	Dr Julian Redhead, acting Chief Executive/medical director Jan Aps, Trust Company Secretary	26/04/2016
161	Dharmesh and Bhavini Yadav	Lease renewal – lift lobby Charing Cross Hospital	Dr Julian Redhead, acting Chief Executive/medical director Jan Aps, Trust Company Secretary	26/04/2016
162	TIAA Ltd (internal audit provider)	Lease of occupation – 2nd floor Hammersmith Hospital	Dr Julian Redhead, acting Chief Executive/medical director Jan Aps, Trust Company Secretary	26/04/2016

Imperial College Healthcare NHS Trust

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

Staff story

Executive summary:

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

This month the Trust board is receiving a review of the Trust Patient Story approach and therefore a patient will not be attending. However, members will hear a staff story from a nurse specialist who has not only delivered innovative improvements for patients undergoing surgery, but has also won this year's Royal College of Nursing, Nurse of the Year award.

Quality impact:

The Trust board will hear how staff adopting innovative approaches to care results in improved patient care and outcomes This activity is relevant to the safe and caring CQC domains.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

None

Recommendation to the Trust board:

The Trust board is asked to note the paper

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young Deputy Director of Patient Experience	Janice Sigsworth Director of Nursing	18 May 2016

Patient Story

1. Background

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

The perceived benefits of patient stories are:

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

2. Venetia's story

Venetia Wynter-Blyth was recently awarded the Nurse of the Year 2016 by the Royal College of Nursing (RCN) in recognition of her innovative work in preparing patients to be both physically and psychologically fit for surgery.

Since 2003, Venetia has worked as an upper gastro-intestinal cancer nurse specialist at a number of specialist centres including St George's NHS Trust, Brighton and Sussex NHS Trust. She has been the lead upper gastrointestinal clinical nurse specialist at ICHT since 2011.

Venetia and her team developed the PREPARE for surgery programme, using a multimodal and multi-professional peri-operative programme of support. In the past two years 80 patients have used this programme, 50 of whom have seen dramatic improvements in their outcome including a reduction in their length of stay.

The PREPARE programme stands for: physical activity; removal of bad habits; eat well; psychological wellbeing; ask about medications; respiratory exercises; enhanced recovery. This innovative programme was also won the RCN innovation award.

Venetia recently wrote a trust blog that provides more detail about the PREPARE programme which can be found here.

There is also a very interesting YouTube film about the programme

Venetia will discuss how the awards came about and what they have meant to her and the team.

Imperial College Healthcare NHS Trust

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

Patient Story Stocktake (including update on learning disabilities)

Executive summary:

In July 2014 the Trust Board approved an approach to bringing patient stories to the Board. Since then, ten stories have been presented and it is timely to take stock of the approach and for the Board to decide if any changes are required.

The paper summarises the themes arising from the stories so far and actions that have resulted from them. Following up on a Board action from the January Board, this paper also contains an update on learning disability activity in the Trust.

Quality impact:

Patients are given the opportunity to feedback directly to the Trust Board. This activity is relevant to the caring and responsive CQC domains.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

None

Recommendation(s) to the Trust board:

The Trust board is asked to note the paper

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young Deputy Director for Patient Experience	Janice Sigsworth Director of Nursing	17 May 2016

Patient Story Stocktake (including update on learning disabilities)

1. Background

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

In March 2014 the Trust had its first 'in-person' patient story to the Board. This was well received and, following a review of other organisations approaches, the Director of Nursing presented a paper to the Board in July 2014 outlining various approaches to patient stories, which the Board approved. This has by and large been very successful, but it seems reasonable almost two years on to review this approach and consider whether any changes are required.

This paper will also highlight some of the themes arising from the stories presented to the Board and actions that have arisen. In addition, a story presented to the Board in January 2016 raised questions about the management of patients with learning disabilities and an update on these is given at the end of the paper.

2. Patient story methods

In the July 2014 paper a number of methods were proposed for how stories might be presented, these were:

- Patients coming to the board to tell their story in person
- Video or audio presentations of patients telling their stories
- Divisional, clinical or patient experience staff telling a story on the patient's behalf
- An executive director, usually the Director of Nursing, telling the story about a patient's experience
- Weaving the details of the impact on a patient resulting from a serious incident or complaint

The Board agreed that all methods had their merits and that a multi-method approach would be adopted. In practice the majority of stories have been told by the patients themselves or by a relative or friend. This seems to have worked well and brings immediacy and impact to the story. It has also, importantly, given Board members an opportunity to ask questions. This has proved to be very valuable not only for the Board, but also for the person presenting their story. Feedback from participants has been that they felt very pleased to have been able to tell their story, that they felt listened to, taken seriously and that their story would somehow make a difference.

There have been no audio or video presentations, nor have there been any division led stories. A number of the stories have been based around complaints, indeed that is how they have been brought to the Trust's attention, but there has not been a story related to a serious incident. One story, related to the national *Hellomynameis#* campaign was told by a member of staff, but was linked to the trust cancer patient experience improvement plan.

People who tell their stories are supported and coached by members of the patient experience team in order to help them tell their stories in the most effective way possible and to ensure that they get their key messages across. But, in all other senses, the stories the Board hear are the real experiences of the patients and families.

3. Summary of emergent themes

Since July 2014, ten stories have been told at the public board meetings. Inevitably the focus of the majority of the stories has been the experience of patients or their families and this has been both good and bad. Key themes and outcomes from these stories are shown below.

Clinical care and caring

The stories have highlighted the extremes of care related patient experience. There have been examples of excellent standards of care delivered with warmth and compassion, such as MB's story in which she was critical of the processes of getting an appointment, but very complimentary about the clinical care and thoughtfulness with which her potential cancer diagnosis was discussed. AF, having described an awful experience on one ward went on to describe the outstanding and compassionate care she received on another. NH's father praised the support and care than his son had received from the paediatric diabetic team. LT told the board how the development of a drop-in sickle cell clinic had transformed her life. K's mother described how the Trust had gone the 'extra-mile' to make sure her severely disabled daughter got the care she needed.

But it was often the poor experiences of care and compassion that often stood out. AF's distressing experience following major cancer surgery where her pain was not managed and she wasn't listened to. A profoundly deaf patient, CB, being told that the ward would ring him when they were ready to see him, despite him asking for them to text him. GS left feeling vulnerable in outpatients because nobody communicated with her. And, most recently, HB's experience of having drinks left out of reach, being shouted at and having her dignity compromised when using the toilet.

Communication

The majority of patient stories have highlighted communication, in one form or another, to be a critical factor in the experience of patients. Consistent and clear communication, or the lack of it, was often cited in the stories. NH had a model experience where communication was regular, clear and in the form that best suited him as someone with a learning disability. MD, on the other hand, received a lot of written communication but it was full of inaccuracies, which caused frustration and a lack of confidence in the service. The Trust failed to provide CB with a sign language interpreter which meant he was unable to consent to a procedure, which then had to be postponed. HB described how poor communication deeply affected her experience of one of the wards and how conversely, a smile and an introduction on another ward set up a completely different experience.

Consistency

One of the most striking things common to all the stories is the lack of consistency of experience as they move through the Trust. It is acknowledged that someone coming to the Board to report their experience is likely to be driven by either a strongly positive or negative experience, but there has not been a single story that is entirely positive or entirely negative; all have reported different experiences at different times. A clear challenge for the Trust is to ensure consistency of high quality care.

4. Actions arising from stories

An important aspect of patient stories is for the Board to hear first-hand the experience of our patients and in that regard the approach has been successful. Stories also provide assurance to the Board that the quality of care is, in many areas, extremely high and

consistent with the Trust's values. However, there are of course situations where the experience fell below the standards expected and the Board want to see that things have changed as a result. Below is a summary of some of the actions and outcomes resulting from patient stories:

- MB's story (Sept 2014) prompted an urgent review of letters being sent out from the outpatient booking team and corrections were made to contact details and opening times.
- AF's story (Nov 2014) directly influenced the cancer patient experience improvement plan. Her positive comments about the effective handling of her formal complaint, helped to inform the design of the new complaints process and drive its implementation.
- The *Hellomynameis#* story (March 2015) gained support for a new style name badge and change to the dress code policy that help to make sure that patients know who is caring for them
- The John's Campaign story (July 2015) told by Julia Jones helped to drive the implementation of the carers passport and involvement of carers in the care of patients.
- CB's story (Sept 2015) told by his friend resulted in changes to the translation policy and the process for sourcing British sign language interpreters. CB's friend actively worked with the Trust to help secure improvements.
- K's story (Jan 2016) told by her mother has led to a strengthening of the support available to patients with a learning disability (this is described in more detail below)
- HB's story (March 2016) raised a number of issues about caring and compassion. As a result the Trust is now developing a video of her story that will be utilised in structured training sessions related to caring both during the induction of new starters and in programmes for existing staff, such as the *Caring Matters* programme.

5. Learning disability update

Following K's story in January of this year, the Board asked for an update to outline details of actions taken to ensure systematic access to support patients with learning disabilities. These are shown below:

- '*Mail Margaret'* posters have been distributed and displayed throughout the Trust requesting information of any patients with learning disabilities or similar be sent to Inclusion and Vulnerability Officer (IVO). A noticable increase in referrals has been seen. All new notifications result in the patient record being flagged for future information. (Margaret is the IVO who came to the Board meeting with K's mother in January)
- The IVO has met with ward managers and matrons to discuss how she can help them and has identified rooms suitable for carers to stay overnight.
- The IVO now regulary meets patients in outpatients and pre-assessment to raise her profile in these areas. At these appointments she is checking "patient passports" and ensuring staff are aware of them and their use.
- The IVO has developed and is piloting a learning disability communication aid folder in A&E at SMH and CXH and some wards at SMH. It contains tips on stress factors, reasonable adjustments and communication aids such as picture boards, symbols, BSL alphabet, Makaton signs
- A *'Purple Pathway'* is being developed for patients with LD accessing the Trust via the emergency department. This will involve detailing all processes and procedures necessary to make the journey better.
- Extensive collaboration with tri-borough and community LD organisations is taking place to ensure that they are encouraging support workers to attend hospital with the patient and the use of the patient passports

- Imperial will be a pilot site for new Mencap training that is currently being evaluated to be included in medical and nursing training. Ward managers and an identified LD champion from each ward/department are being targeted for this training as are doctors and patient facing admin staff.

6. Summary

The current approach to patient stories has been a feature of Trust Board meetings for almost two years. Overall this seems to have been very successful.

The Board however, is asked to consider, whether any changes are required to this approach.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board	25 May 2016

Chief Executive's Report

Executive summary:

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

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Tracey Batten, Chief Executive	Tracey Batten, Chief Executive	19 May 2016

Chief Executive's report

Key Strategic Priorities

1. Financial performance

Operationally, the Trust ended 2015/16, as forecast since December, with a financial deficit of £30.1m, which was £11.5m behind plan. In addition, there was an £18m increase in provision for a technical adjustment, bringing our total year end position to a deficit of £47.9m This adjustment is primarily to reflect a reassessment of the state of our estate. As previously noted, the biggest factors creating the additional deficit in 2015/16 were below plan NHS income, partly due to increased levels of fines and commissioner challenges, significantly less growth than expected in our private health division and above plan medical staffing costs.

Our financial plan for 2016/17 submitted to NHS Improvement shows a deficit of £52m. This compares with an underlying £54.2m deficit position (excluding one off benefits) at the end of 2015/16. The plan includes new 2016/17 cost improvement plans totalling £46.0m. A further £34.3m of CIPs would have been required for us to be eligible for our allocation of £24.1m from the central sustainability and transformation fund.

Discussions with the Trust's commissioners continue and the Trust expects to agree contracts with NWL CCGs and NHSE before the end of May.

2. Financial improvement programme

The Trust has joined a new voluntary financial improvement programme being run by NHS Improvement, to help identify and deliver cost savings.

The Financial Improvement Programme (FIP) is aimed at saving the NHS tens of millions of pounds by supporting trusts to make immediate, appropriate savings. 80 trusts volunteered to be in the FIP with 16 selected to take part because NHS Improvement believes they will benefit most from the programme.

Improving the financial position and returning to a balanced budget, sustainably, is a top priority for Imperial College Healthcare NHS Trust. Through the FIP, the Trust is working in partnership with PwC, to develop and accelerate our current programme of activities to identify and deliver savings. It will also help the Trust to build skills and capacity to drive efficiencies in the long-term and improve cost management at an organisation overall.

The Trust will maintain its focus on the safety and quality of services throughout the programme.

3. Operational Performance

Cancer: In May 2016, performance is reported for March 2016 and Quarter 4 2015/16. In both March and Quarter 4, the Trust achieved six of the eight national cancer standards. The Trust underperformed against the 62 day standard for urgent GP referral to treatment and the 62 day screening standard. This was a consequence of three main factors which are being addressed: issues with urology rapid access pathways, issues with gastrointestinal diagnostic pathways and an increase in late referrals from other North West London trusts. The Trust also underperformed against the 62-day screening standard in March due to late referrals from other screening services.

Accident and Emergency: Performance against the four hour access standard for patients attending Accident and Emergency was 89 per cent in April 2016 against a national standard of 95 per cent. This is a three per cent improvement on the March performance. The Trust continues to work closely with partners across the local health system on the

detailed improvement plan, which is due to ensure we deliver the 95 per cent standard sustainably by March 2017. One key element of our improvement plan is the expansion of capacity at St Mary's A&E department (see item 4 below for details).
Referral to treatment (RTT): The performance for March 2016 was 89.2 per cent (April 2016 performance is still being finalised) against a standard of 92 per cent of patients being treated within 18 weeks of referral. We have identified issues with our RTT data in a number of areas and we are putting in place additional actions to help us remain on track to delivering the national standard sustainably from August 2016 (see Trust board paper 2.4 Operational report and scorecard for details)
Diagnostic waiting times: In March 2016, 0.3 per cent of patients were waiting over six weeks against a tolerance of 1 per cent (April performance is still being finalised).

4. Stakeholder engagement
The Trust was pleased to host a joint visit to Charing Cross Hospital for the respective Mayors of the local boroughs of Hammersmith & Fulham and Kensington and Chelsea in early April. This visit focused on the specialised services for elderly patients in the Frailty Unit and Older Person Rapid Access Clinic.

Together with local commissioners, the Trust attended the April meeting of Westminster City Council's Adults, Health and Public Protection Policy & Scrutiny Committee to discuss the 'Shaping a Healthier Future' transformation programme across the NHS in North West London and the Trust's clinical strategy and estates redevelopment programme.

Regular update discussions have been held with Hammersmith & Fulham councillors who are responsible for health and care services and local Members of Parliament for Westminster constituencies.

The Trust's strategic lay forum met in April which is supporting the establishment of a vision for effective patient and public involvement at the Trust and guiding the further development and implementation of the strategy.

The bi-monthly electronic newsletters for stakeholders, GPs and shadow foundation trust membership were also published.

5. Refurbishment of St Mary's Emergency Department
Meeting the national standard for at least 95 per cent of Emergency Department patients to be assessed, treated and discharged or admitted within 4 hours is a 'must do' for the Trust in 2016/17.

Like many NHS Trusts, we have struggled to meet this standard over the past year. The reasons for this are complex including: an increase in the number of emergency patients coming to our hospitals, an increase in the acuity of these patients and an increase in the number of patients presenting with co-morbidities and complexities.

To improve patient experience and to achieve our target we have agreed a detailed improvement plan for our Emergency Department services with NHS Improvement and local CCGs. This sees us meeting the standard consistently by March 2017.

In support of this plan, a programme of work to refurbish the Emergency Department at St Mary's Hospital will start on Monday 6 June. The work has been commissioned in recognition that the current layout and design of the Emergency Department at St Mary's Hospital no longer meets the demands of the service.

The refurbishment has been supported by a £3.2 million grant from Imperial College Healthcare Charity and is expected to take about eight months. The Emergency Department

will remain open and operational throughout the refurbishment, although capacity will be reduced during some phases of the work. Patients and will be kept up to date with this work and how it may impact on them, as it progresses

The refurbishment of St Mary's Emergency Department will:

- increase the number of resuscitation bays at St Mary's Emergency Department from four to six
- create a four-bed paediatric assessment unit at St Mary's children's Emergency Department
- create a new 'Combined Assessment Space' for ambulance and self-presenting patients
- improve patients' experience and the quality of their clinical care by improving the environment in which it is delivered;
- increase staffing levels to accommodate increased demand
- improve the staff experience of delivering care and enable them to provide a better service to patients and clinician stakeholders.

6. Estate strategy

The Trust's Estate strategy has been updated for the period 2016-2026 in line with the new guidance on estates strategies which reflects the following changes:

- Six facet survey
- Backlog maintenance
- Redevelopment plans

The strategy was reviewed and recommended for approval by the Executive Operational Performance Committee on 17 May 2016 and will be presented to appropriate committees and the Trust board for consideration in July 2016.

7. Management reorganisation

Following the implementation of phase one of the revised management structure, proposals were launched for consultation and further input on phase two on 11 May 2016.

The proposals follow wide-ranging, pre-consultation discussions in February 2016 to get staff views on how best to ensure clinical directorates have the authority and support to act as the accountable business units for delivering transformation, as well as operational and financial targets. The proposals are intended to be implemented from July 2016 onwards.
The key aims of the new management structure are to:

- simplify and minimise the reporting layers between the ward and the board to help speed up decision making and the escalation of issues.
- devolve and clarify accountabilities for delivering operational, quality and financial targets.
- establish clinical directorates as the key organisational units for driving and leading improvement and ensure their leaders and staff are sufficiently empowered, informed and resourced to deliver effectively.
- strengthen site-based control while maintaining the integrity of specific services and patient pathways that often span two or more sites.

The first phase of the restructure, which resulted in changes to the structure of the executive management team and the move from five clinical divisions to three, took effect from 1 April 2016.

The phase two consultation will run from 11 May to 6 June, with divisional and directorate sessions held to answer questions and discuss feedback and a round of CEO sessions held

immediately after the consultation to discuss the process. Decisions resulting from the consultation and interviews for all affected staff will take place by 23 June 2016 to enable implementation from July 2016 onwards.

8. Junior Doctor industrial action

There were no major issues reported during the two days of industrial action by Junior Doctors on 26 and 27 April. The Consultant cover ensured safe patient care across our emergency departments and ward areas. We ran an incident control room on each of our sites and with quick escalation to our site management team or our additional site nurse practitioners, any problems were rapidly resolved.

Due to the full withdrawal of labour by the Junior Doctors more outpatient appointments and elective procedures were cancelled than previous strike days to ensure Consultant colleagues could run the emergency services and in patient ward areas safely. The Trust where possible ensured that patients on a two week cancer pathway were seen appropriately so as not to hold up their care

Since the industrial action, negotiations between the government and the British Medical Association (BMA) have restarted and it was confirmed on Wednesday 18 May that Ministers and the BMA had successfully reached an agreement. The offer will now be put to a referendum of BMA members.

Key Strategic Issues

1. St Mary's redevelopment

The Trust has continued the work that covers the redevelopment and refurbishment programme for the St Mary's Hospital site. This is a major initiative which involves a significant programme of work to develop our plans and deliver the much needed improvements and benefits for our patients and staff.

It is widely recognised that we have to modernise the St Mary's Hospital site in order to ensure we continue to provide safe and efficient care as well as an excellent patient experience. Our approach is based on creating a modern hospital site that supports the highest quality of healthcare, education and research through a combination of redeveloping parts of the existing estate at St Mary's, using land more efficiently, and building a number of brand new facilities. As part of our redevelopment programme we are exploring ideas to take forward plans for St Mary's Hospital in a phased approach, including undertaking more detailed work on potential new outpatients facilities, which would require planning permission, to form an early phase of our overall estate redevelopment.

Wider investment in the area local to St Mary's Hospital is obviously very welcome. We recognise the need to ensure that potential neighbouring development proposals, such as those for the former Royal Mail/Post Office building on London Street, blend with our own emerging plans and meet our priority of maintaining a fully operational, safe, major acute hospital.

Imperial College Healthcare NHS Trust

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

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key operational headlines that relate to the reporting month of April 2016 (month 1).

Recommendation to the Trust board:

The Trust board is asked to note this report.

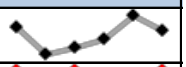
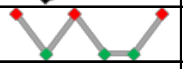
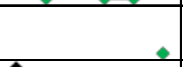
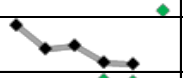
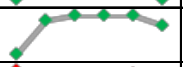
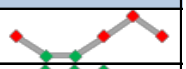
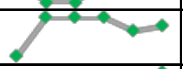
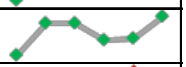
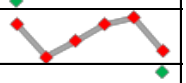
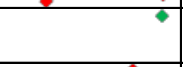
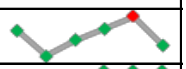
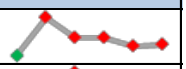
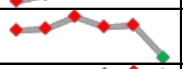
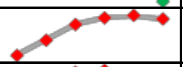
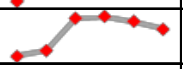
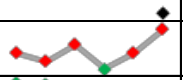
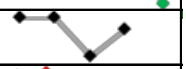
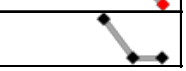
Trust strategic objectives supported by this paper:

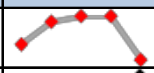
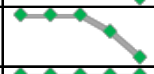
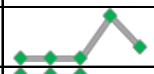
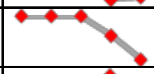
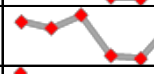
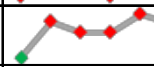
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director
Terence Lacey (Performance Manager) Ruth Holland (Acting Head of Performance)	Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Jamil Mayet (Divisional Director) Tim Orchard (Divisional Director) Tg Teoh (Divisional Director)

Contents

1. Scorecard summary

Key indicator	Executive Lead	Period	Standard	Performance	Direction of Travel
Safe					
Serious Incidents	Julian Redhead	Apr-16	-	**16**	
MRSA	Julian Redhead	Apr-16	0	**1**	
Clostridium Difficile (Cumulative YTD)	Julian Redhead	Apr-16	7	**5**	
Staffing Fill Rates	Janice Sigsworth	Apr-16	tbc	**95.8%**	
Harm Free Care (Safety Thermometer)	Janice Sigsworth	Apr-16	90.0%	**97.6%**	
Effective					
Hospital Standardised Mortality Ratio (HSMR)	Julian Redhead	Dec-15	100	**61**	
Clinical Trials - Recruit 1st patient within 70 days	Julian Redhead	Qtr 4 15/16	70.0%	**93.7%**	
Average Length of Stay (elective) (days)	Jamil Mayet	Apr-16	3.4	**3.5**	
Average Length of Stay (non-elective) (days)	Tim Orchard	Apr-16	4.5	**4.5**	
Caring					
Mixed-Sex Accommodation (Number)	Janice Sigsworth	Apr-16	0	**1**	
Friends and Family Test: Inpatients (% Recommended)	Janice Sigsworth	Apr-16	95.0%	**96.8%**	
Friends and Family Test: A&E (% Recommended)	Janice Sigsworth	Apr-16	85.0%	**96.5%**	
Friends and Family Test: Maternity (% Recommended)	Janice Sigsworth	Mar-16	95.0%	**92.4%**	
Friends and Family Test: Outpatients (% Recommended)	Janice Sigsworth	Apr-16	94.0%	**96.8%**	
Complaints: Total number received	Janice Sigsworth	Apr-16	100	**85**	
Complaints: Responded to within timeframe (%)	Janice Sigsworth	Apr-16	95%	**100.0%**	
Well Led					
Vacancy Rate (%)	David Wells	Apr-16	10.0%	**10.3%**	
Voluntary Turnover Rate (%) 12-month rolling position	David Wells	Apr-16	10.0%	**10.1%**	
Sickness Absence Rate (%)	David Wells	Apr-16	3.1%	**3.0%**	
StatMand excl. doctors in training / Trust grades (%)	David Wells	Apr-16	90.0%	**86.4%**	
StatMand - doctors in training / Trust grades (%)	David Wells	Apr-16	90.0%	**62.6%**	
Band 2-9 & VSM PDR rate (%)	David Wells	Apr-16	95.0%	**3.5%**	
Health and Safety RIDDOR	David Wells	Apr-16	0	**5**	
Bank and Agency Spend (%)	David Wells	Apr-16	9.2%	**3.1%**	
Staff Engagement Score	David Wells	Jan-16	-	**43**	
Consultant Appraisal Rate (%)	Julian Redhead	Apr-16	95.0%	**82.2%**	
Education Open Actions	Julian Redhead	Apr-16	-	**129**	

Key indicator	Executive Lead	Period	Standard	Performance	Direction of Travel
Responsive					
RTT: 18 Weeks Incomplete (%)	Jamil Mayet	Mar-16	92.0%	**89.2%**	
RTT: 18 weeks Incomplete Breaches (Number)	Jamil Mayet	Mar-16	-	**5,992**	
RTT: 52 Weeks Waits (Number)	Jamil Mayet	Mar-16	0	**47**	
Cancer: 2-week GP referral to 1st outpatient - cancer (%)	Jamil Mayet	Mar-16	93.0%	**93.2%**	
Cancer: Two week GP referral to 1st outpatient – breast symptoms (%)	Jamil Mayet	Mar-16	93.0%	**93.3%**	
Cancer: 31 day wait from diagnosis to first treatment (%)	Jamil Mayet	Mar-16	96.0%	**96.4%**	
Cancer: 31 day second or subsequent treatment (surgery) (%)	Jamil Mayet	Mar-16	94.0%	**95.2%**	
Cancer: 31 day second or subsequent treatment (drug) (%)	Jamil Mayet	Mar-16	98.0%	**100.0%**	
Cancer: 31 day second or subsequent treatment (radiotherapy) (%)	Jamil Mayet	Mar-16	94.0%	**97.9%**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Jamil Mayet	Mar-16	85.0%	**79.5%**	
Cancer: 62 day urgent GP referral to treatment from screening (%)	Jamil Mayet	Mar-16	90.0%	**70.6%**	
Cancelled operations as % of elective activity	Jamil Mayet	Apr-16	0.8%	**0.7%**	
28 day breaches as % of cancellations	Jamil Mayet	Mar-16	5.0%	**13.3%**	
A&E Type 1 Performance (%)	Tim Orchard	Apr-16	95.0%	**74.0%**	
A&E All Types Performance (%)	Tim Orchard	Apr-16	95.0%	**88.8%**	
Diagnostic tests waiting longer than 6 weeks (%)	Tg Teoh	Mar-16	1.0%	**0.3%**	
Hospital initiated outpatient cancellation rate (less than 6 weeks notice) (%)	Tg Teoh	Apr-16	8.5%	**10.8%**	
Antenatal booking: 12 weeks and 6 days excluding late referrals	Tg Teoh	Apr-16	95.0%	**95.0%**	
% DNAs: First appointments	Tg Teoh	Apr-16	11%	**12.7%**	
% DNAs: Follow up appointments	Tg Teoh	Apr-16	11%	**11.9%**	

2. Key indicator overviews

2.1 Safety

2.1.1 Safety: Serious incidents (SIs)

Sixteen serious incidents were reported in April 2016. All cases are investigated using the Trust's standard approach for managing incidents.

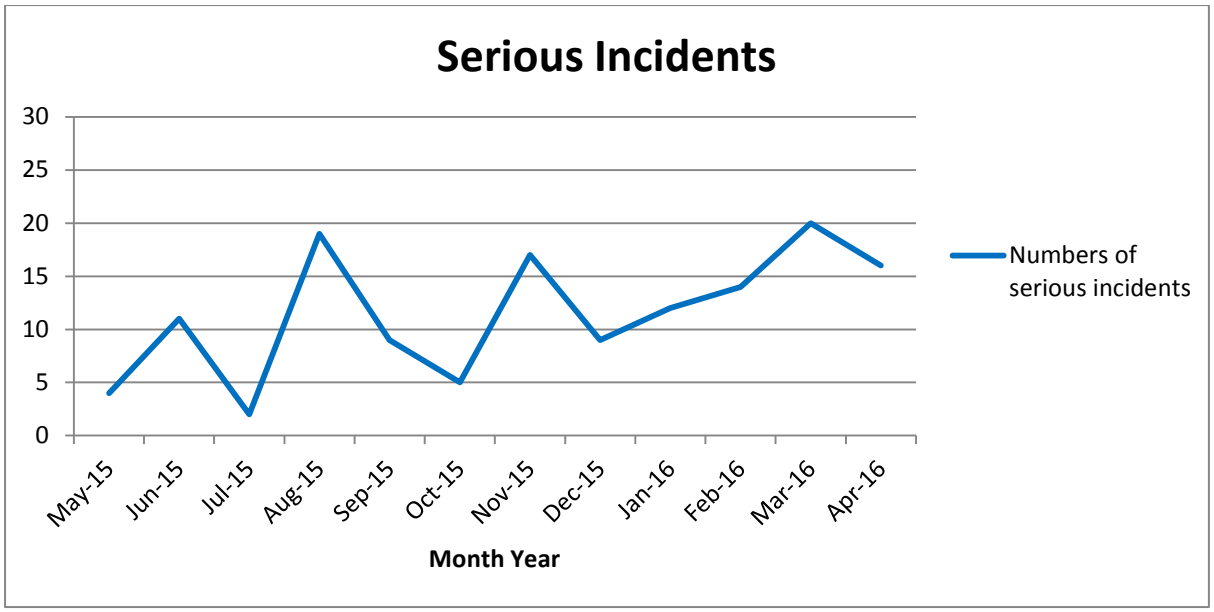


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period May 2015 – April 2016

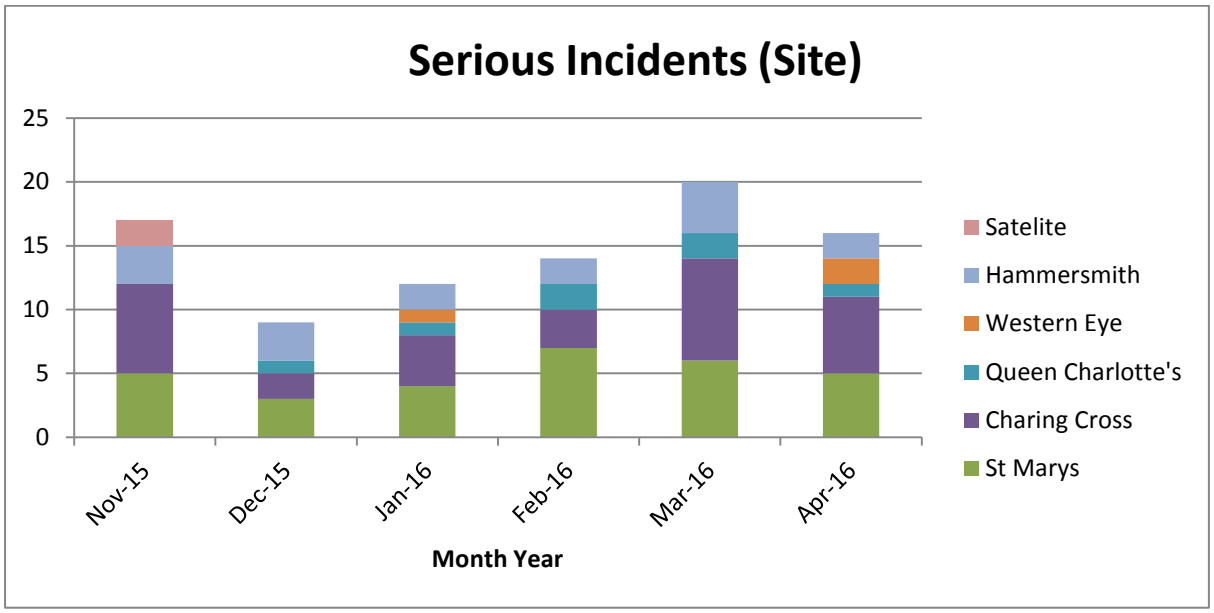


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period November 2015 – April 2016

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

Two cases of MRSA BSI have been identified at the Trust in 2016/17, as follows:

- 1 has been allocated as non-Trust.
- 1 case is awaiting final allocation. The initial allocation for this case is to the Trust.

Each case is reviewed by a multi-disciplinary team. Themes are identified and contributory factors are addressed with the clinical divisions via the taskforce group meetings.

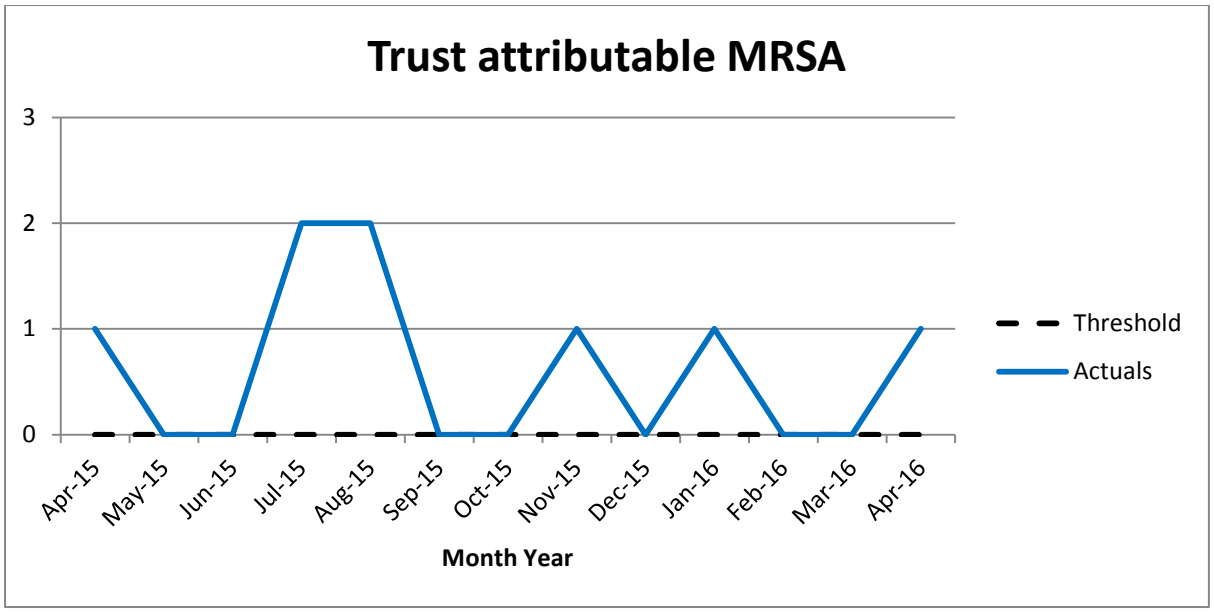


Figure 3 - Number of MRSA (b) infections by month for the period April 2015 – April 2016

2.1.3 Safety: Clostridium difficile

Five cases of Clostridium difficile were allocated to the Trust for April 2016 against the threshold of 7 for the month. No lapses in care were identified following the standard review of each case by a multi-disciplinary team.

A total of five cases have therefore been allocated to the Trust so far in 2016/17 and the annual target remains 69 cases or less.

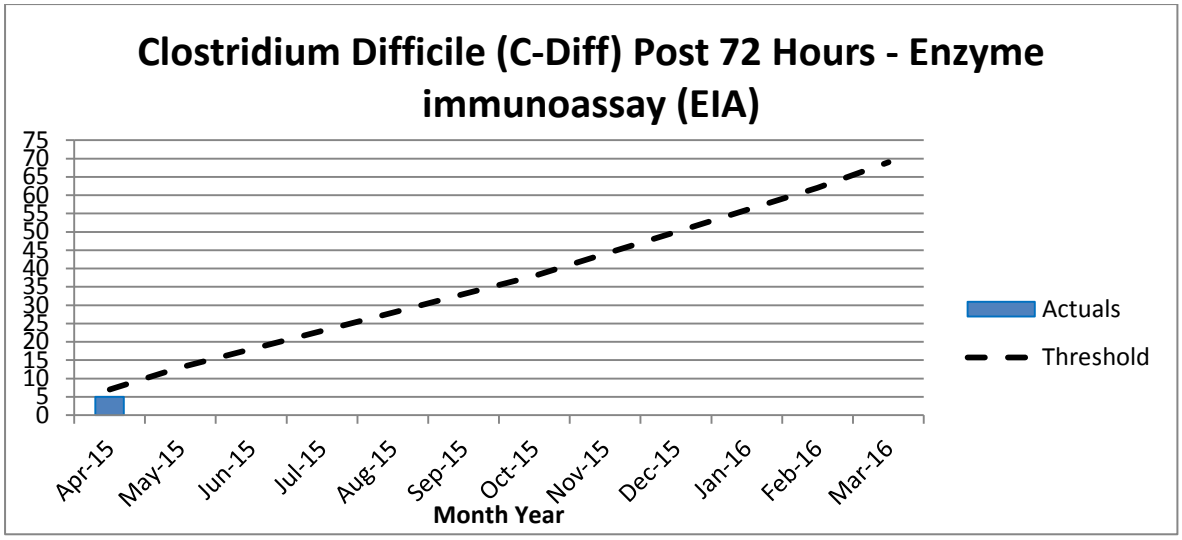


Figure 4 - Number of Clostridium Difficile infections against cumulative plan by month for the period April 2015 – March 2016

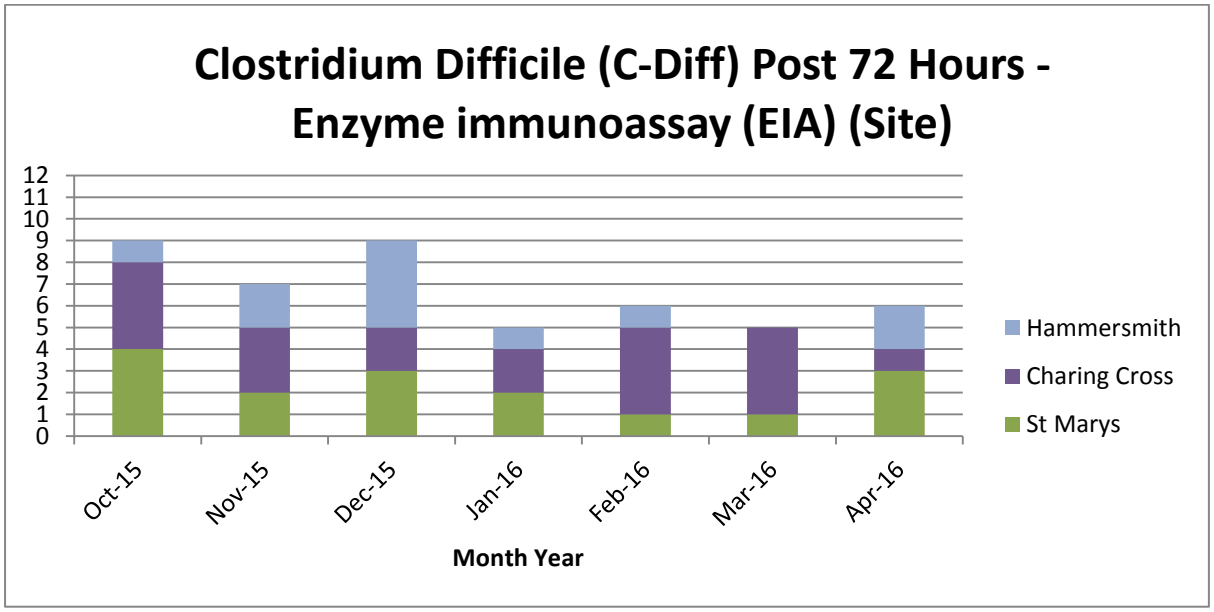


Figure 5 - Number of Clostridium Difficile infections by site and by month for the period October 2015 – April 2016

2.1.4 Safety: Nurse / Midwife staffing levels

In April 2016 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night.

The average staffing fill rate for April 2016 by hospital site was as follows:

Site Name	Day		Night	
	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff
Charing Cross	93.95%	88.85%	97.11%	95.78%
Hammersmith	96.47%	88.02%	98.39%	97.01%
Queen Charlotte's	97.21%	96.63%	95.53%	97.73%
St. Mary's	95.64%	92.06%	97.41%	97.71%

The fill rate was below 85 per cent for care staff for a number of clinical areas, particularly on day shifts. Reasons include an increased number of patients assessed as having enhanced support needs (specialling) due to increased acuity, prevention of harm from falls and a higher level of confusion.

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

- Using the workforce flexibly across floors and clinical areas and in some circumstances between the three hospital sites.
- Deploying post graduate student nurses to take a clinical case load in renal.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

Each Divisional Director of Nursing has confirmed to the Director of Nursing that the staffing levels in April 2016 were safe and appropriate for the clinical case mix. Further, they have advised that the vacancy rates for bands 2 to 6 are decreasing in the Women's and Children's and Surgical services with improved fill from the Bank.

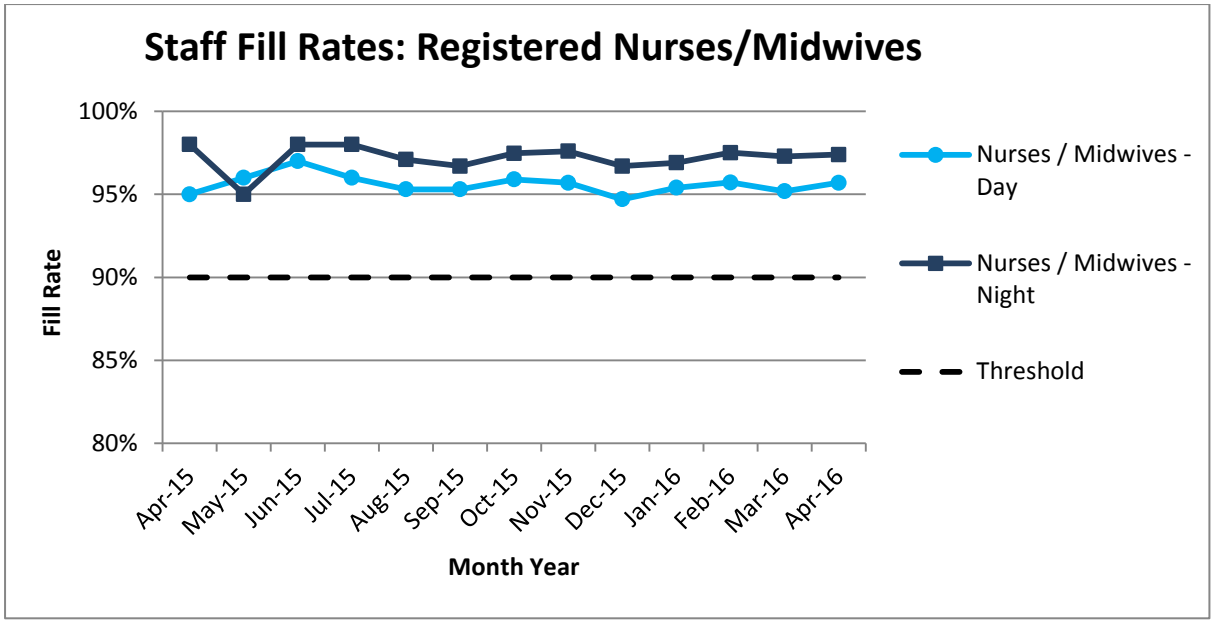


Figure 6 - Monthly fill rates (RNs/RMs) for NHS patients by month (April 2015 – March 2016)

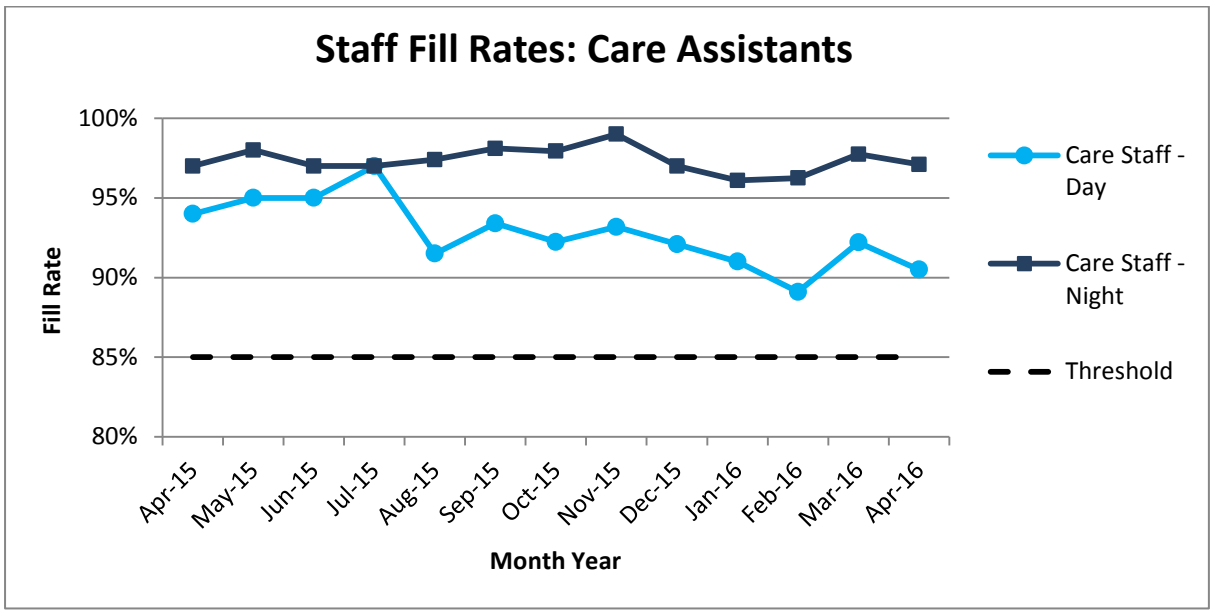


Figure 7 - Monthly fill rates (care assistants) for NHS patients by month (April 2015 – March 2016)

2.1.5 Safety: National Safety Thermometer – Harm Free Care Score

The latest scores for April 2016 are being finalised and are not yet available.

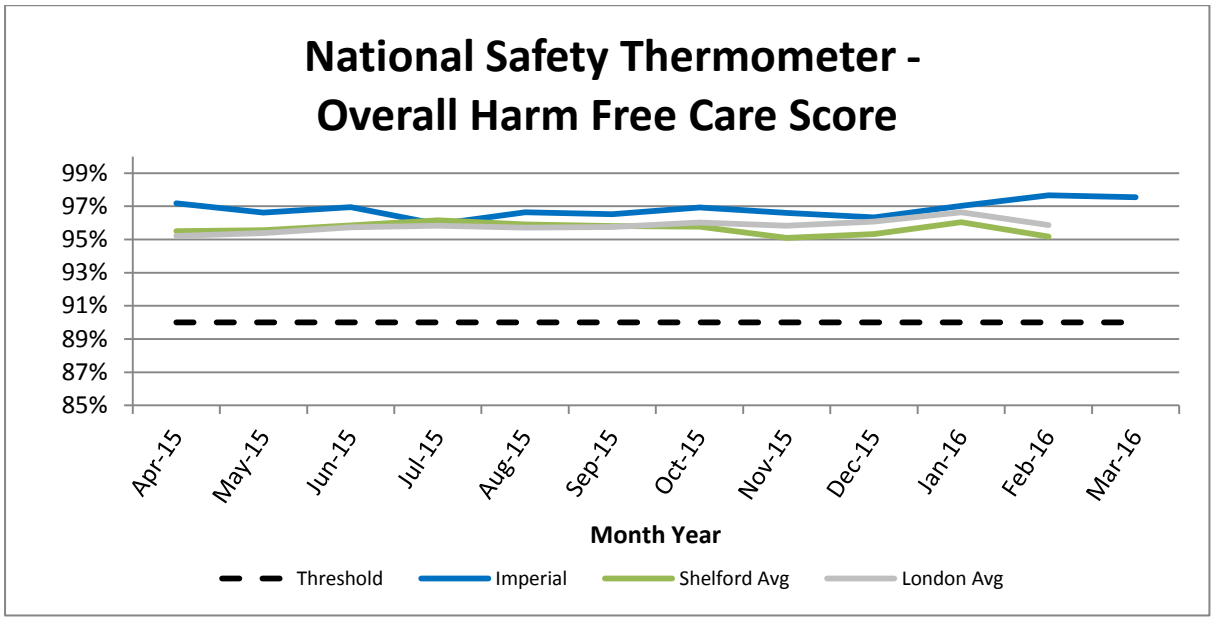


Figure 8 – Harm Free Care (Safety Thermometer) Apr 2015 – March 2016

2.2 Effectiveness

2.2.1 Effectiveness: Mortality data

The most recent monthly figure for the Hospital Standardised Mortality Ratio (HSMR) is 61 for December 2015. Across the last year of available data (January 2015 – December 2015), the Trust has the second lowest HSMR for acute non-specialist trusts nationally and the third lowest in the Shelford Group. The Trust has the third lowest Summary Hospital-Level Mortality Indicator (SHMI) of all non-specialist providers in England for quarter 3 2014/15 to quarter 3 2015/16.

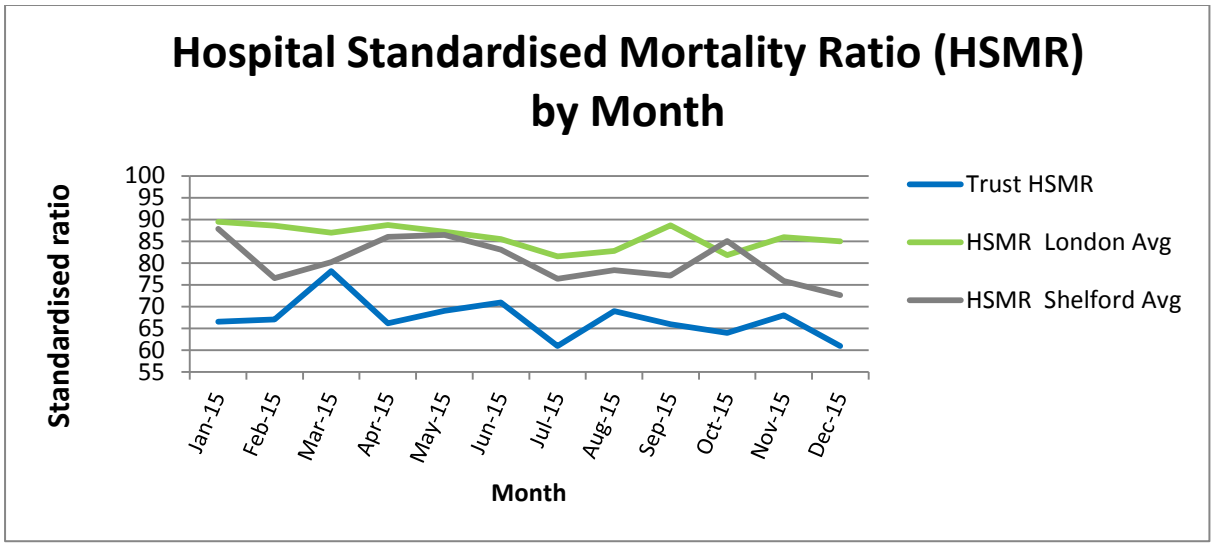


Figure 9 - Hospital Standardised Mortality Ratios for the period January 2015 – December 2015

2.2.2 Effectiveness: Recruitment of patients into interventional studies

The forecast for quarter 4 2016/17 is that 93.7 per cent of clinical trials will have recruited their first patient within 70 days of Valid Research Application, against the target of 70 per cent. This is subject to final verification from the National Institute for Health Research.

As part of the 2016/17 quality strategy, the target is for 90 per cent of clinical trials to recruit their first patient within 70 days.

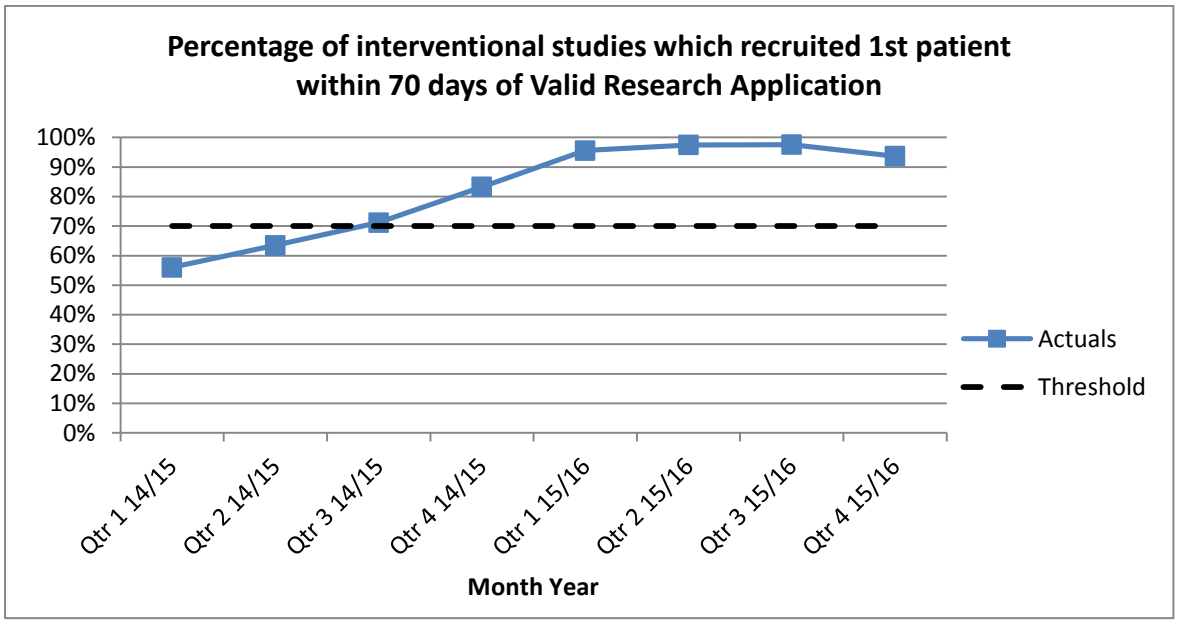


Figure 10 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q4 2015/16

2.2.3 Effectiveness: Average Length of Stay

Figures for the Trust length of stay (Elective and Non Elective admissions) are relatively stable.

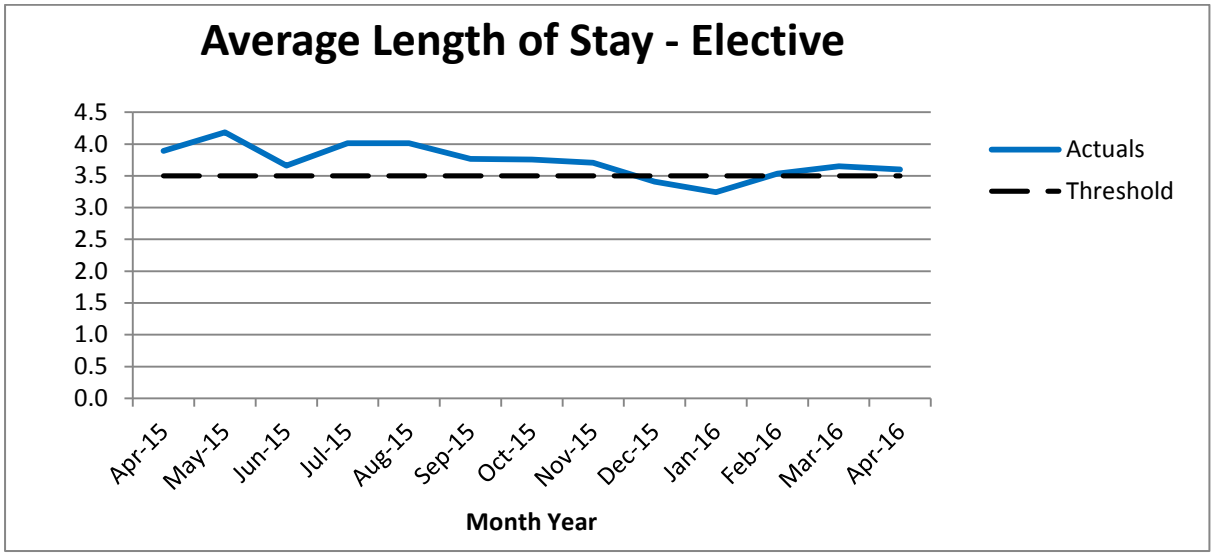


Figure 11 – Average Length of Stay – Elective for the period April 2015 – April 2016

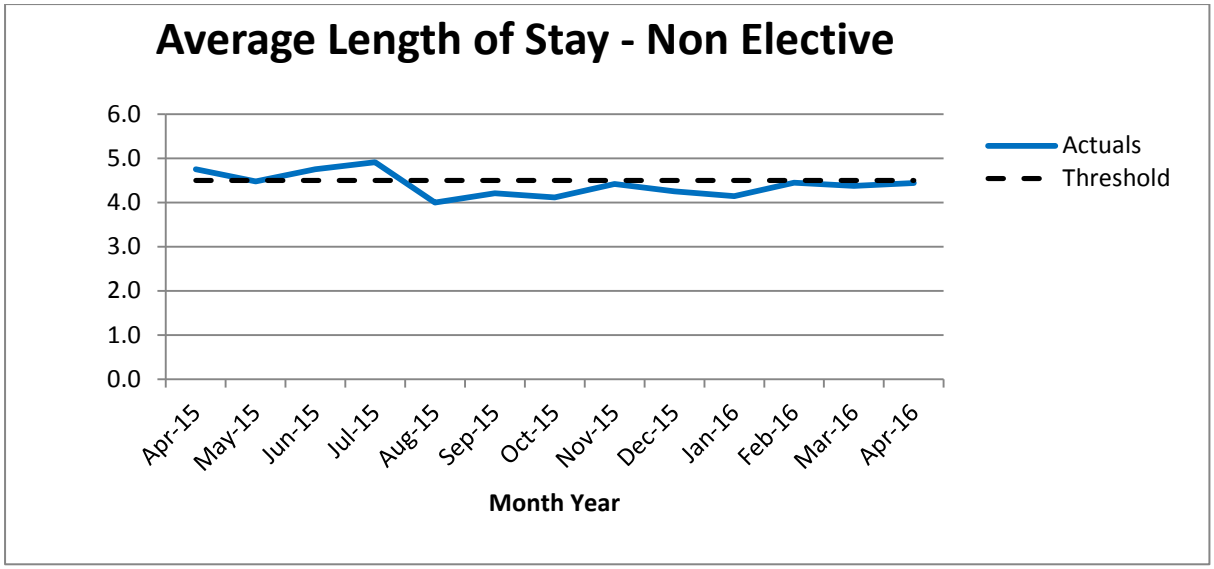


Figure 12 – Average Length of Stay – Non-Elective for the period April 2015 – April 2016

2.3 Caring

2.3.1 Caring: Eliminating mixed sex accommodation

The Trust reported one instance of a mixed-sex accommodation breach during April 2016 relating to delay in step down from critical care.

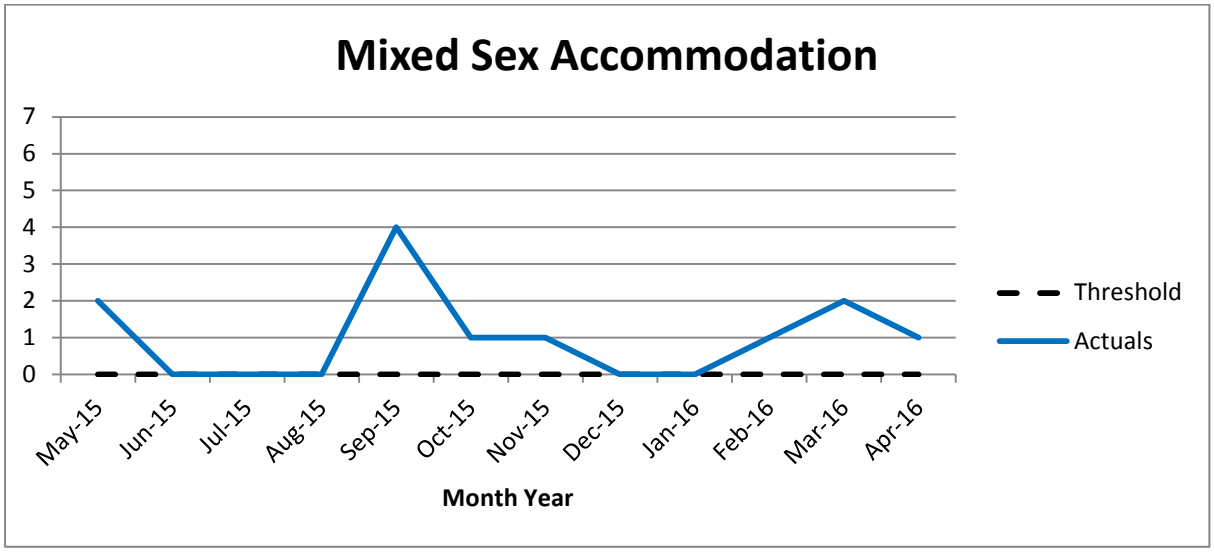


Figure 13 - Mixed Sex Accommodation breaches by month for the period April 2015 – April 2016

2.3.2 Caring: Friends and Family Test

The willingness to recommend across all surveys continues to be high and response rates are holding up. At 17 per cent the response rate within Accident & Emergency is the best since the Trust began collecting the data and is indicative of the efforts by the departments and the patient experience team to increase it.

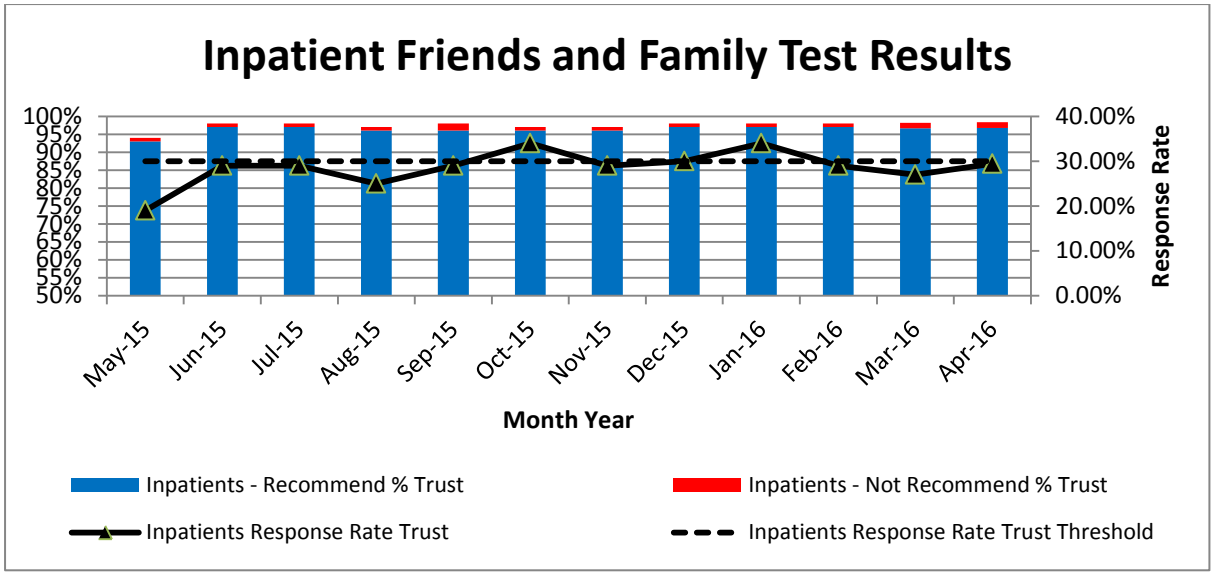


Figure 14 - Friends and Family: Percentage who would recommend ICHT Inpatients for the period April 2015 – April 2016

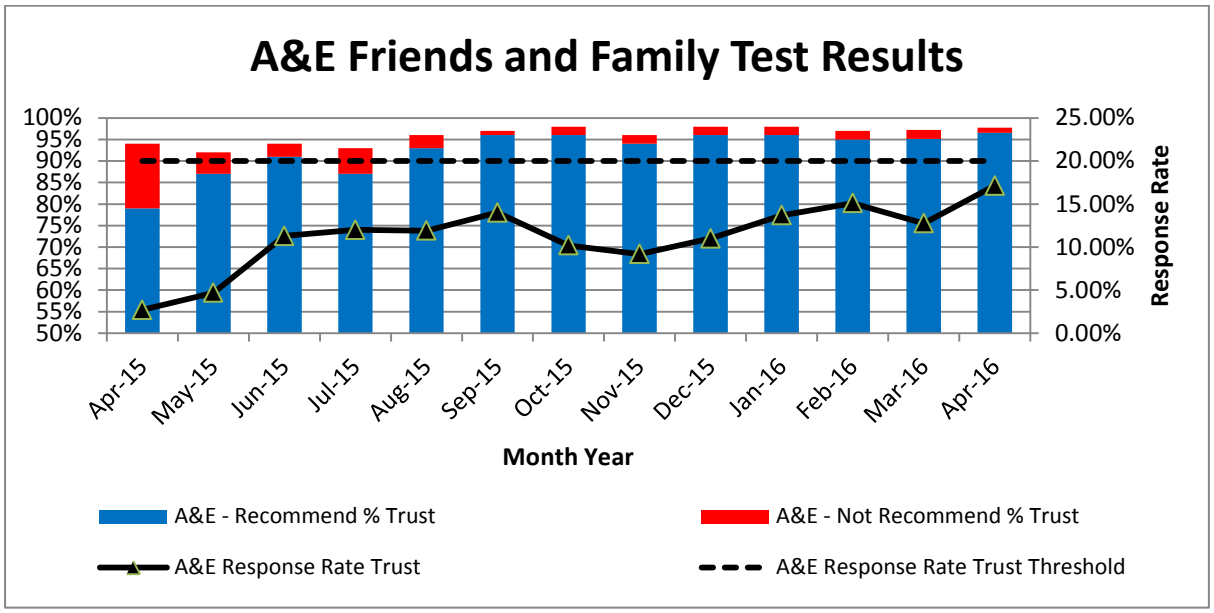


Figure 15 - Friends and Family: Percentage who would recommend ICHT Accident and Emergency for the period April 2015 – March 2016

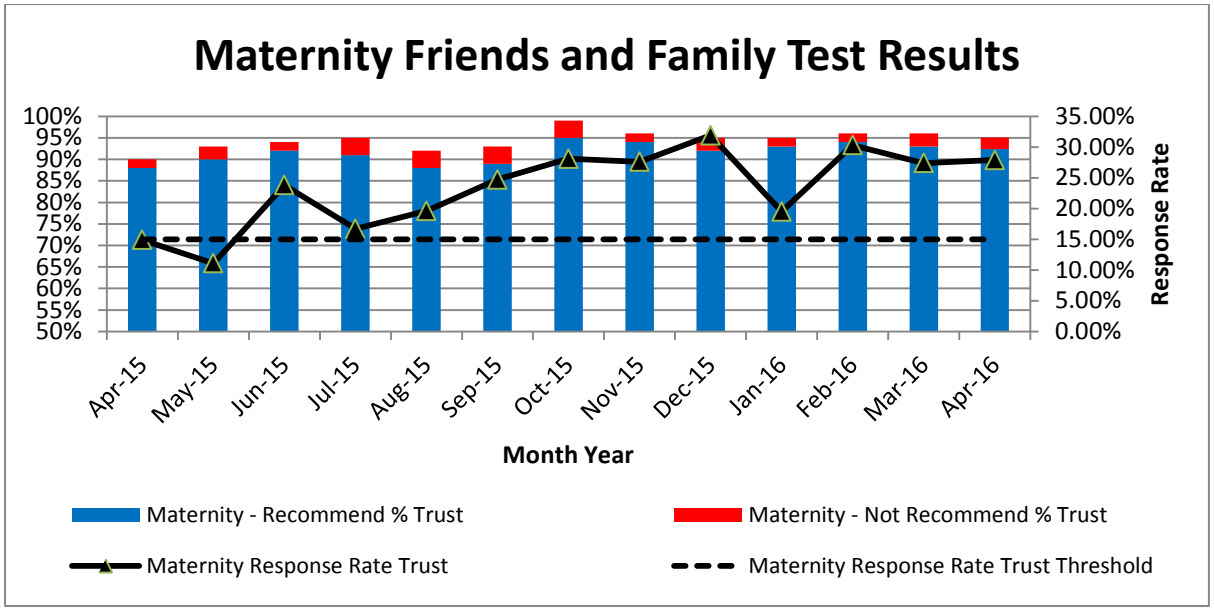


Figure 16 - Friends and Family: Percentage who would recommend Maternity for the period April 2015 – March 2016

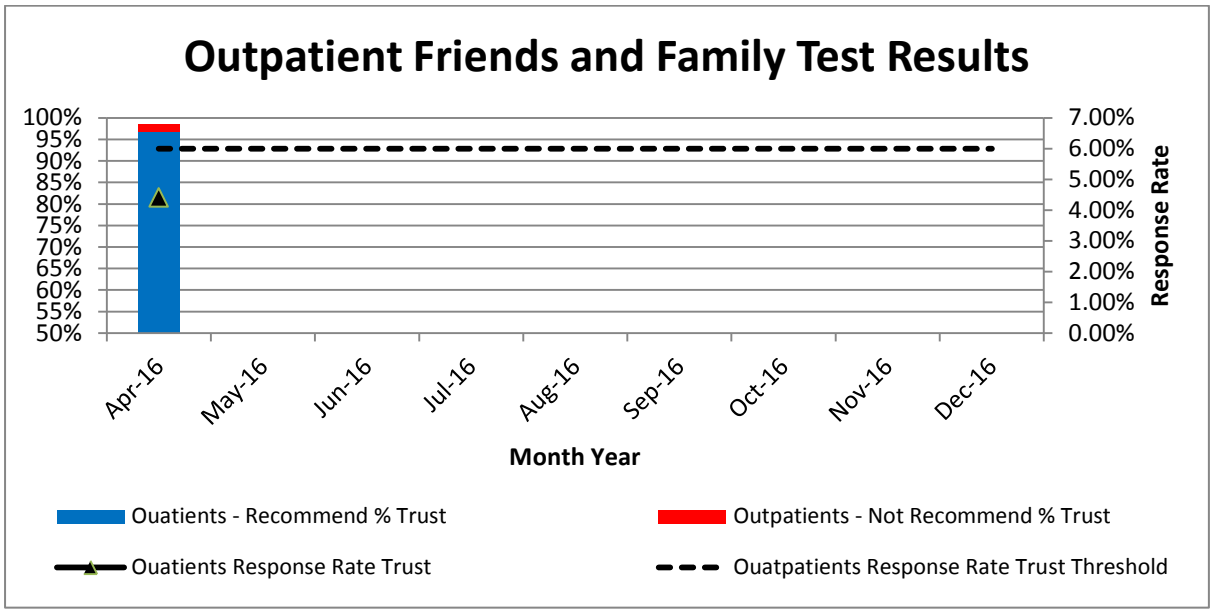


Figure 17 - Friends and Family: Percentage who would recommend Outpatients for the period April 2015

2.3.3 Caring: Complaints

The number of formal complaints fell in April; there is no particular area that accounts for this. The response rate performance remains good.

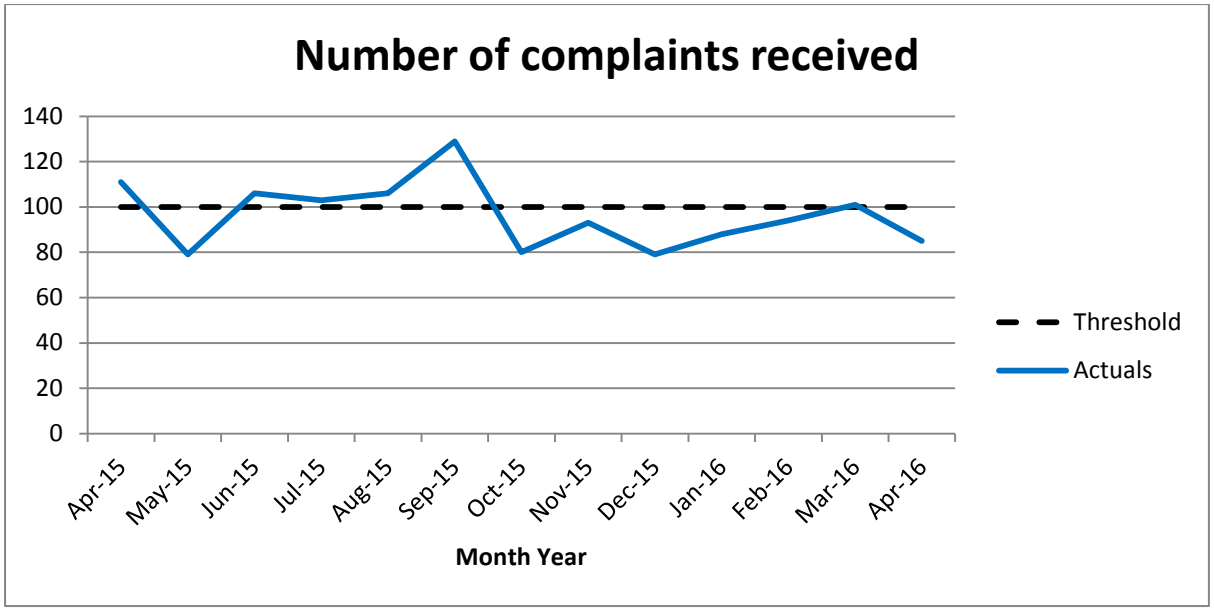


Figure 18 – Number of complaints received for the period April 2015 – April 2016

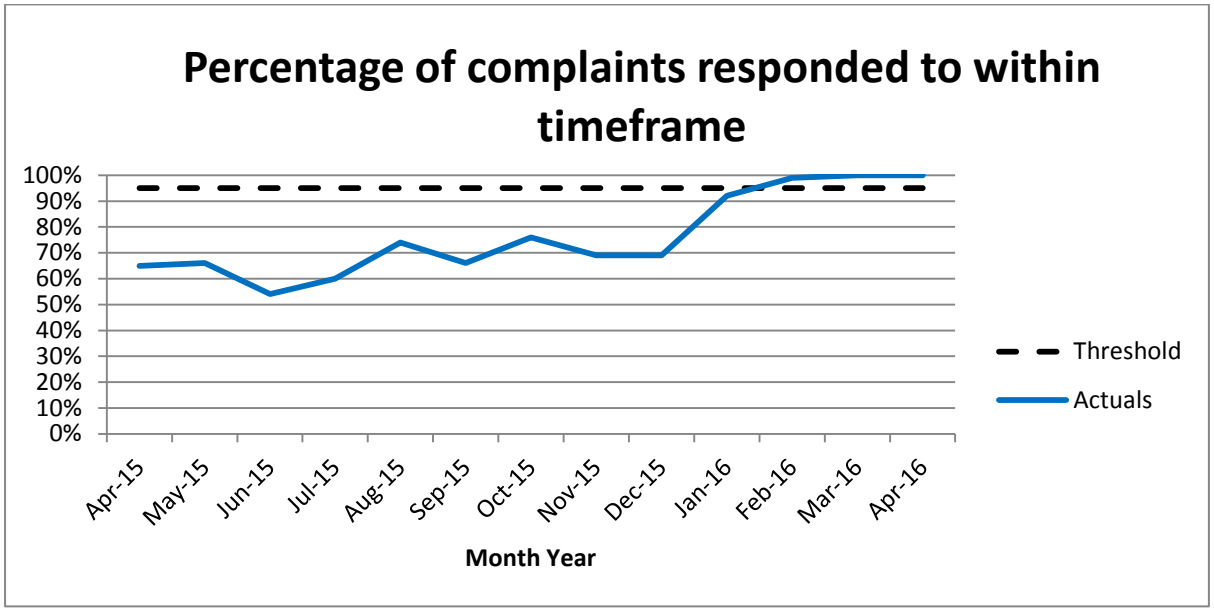


Figure 19 – Percentage of complaints responded to within the period April 2015 – April 2016

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At the end of April, we directly employed 9,627 WTE (whole time equivalent) members of staff across our Clinical and Corporate Divisions and Research & Development areas. There were a total of 180 WTE new joiners and 120 WTE leavers during April giving a contracted vacancy rate of 10.28 per cent; representative of 1,103 WTE vacancies.

The Trusts voluntary turnover rate (rolling 12 month position) is 10.13 per cent and one of the lowest amongst all London Acute Teaching Trusts. Work continues to explore the numbers of leavers we see and to put in place appropriate retention strategies.

Bespoke and generic recruitment campaigns continue to support the reduction of vacancies with 372 WTE pipeline candidates waiting to join us over the coming months (across all occupational groups). The *attraction strategy* is being revised for 2016/2017 to broaden the pipeline, to find more efficient and cost effective ways of attracting and recruiting candidates, including social media and branding.

Bands 2~6 Nursing & Midwifery on Wards

Across the Trusts wards, the band 2-6 Nursing & Midwifery contractual vacancy rate at the end of April was 14.27 per cent, 349 WTE vacancies, and there are currently 125 WTE candidates waiting to fill these ward vacancies whom we expect to join over the coming months. This is marginally lower than the 14.59 per cent vacancy rate reported at the end of March.

Over the coming weeks, the ward establishments on the electronic staff record will be adjusted to reflect the plans for 2016/17.

The turnover rate for ward based band 2 – 6 staff is currently at 19 per cent; reflective of an average 35 WTE leavers each month. A Trust project group has been established to develop the *retention strategy* for this occupational group.

Rolling advertisements continue along with a range of focused activity. The team are exploring more generic recruitment events for Band 5 roles to manage our high volume of generic vacancies. Internal transfers and rotations are also being explored. An *assessment and selection strategy* is being developed to define how we assess and select people across the Trust to enable us to recruit and retain the right candidates. We are considering the role of Strengths Based Recruitment, already done with Band 7 ward nurses, for Band 6 nursing and midwifery staff.

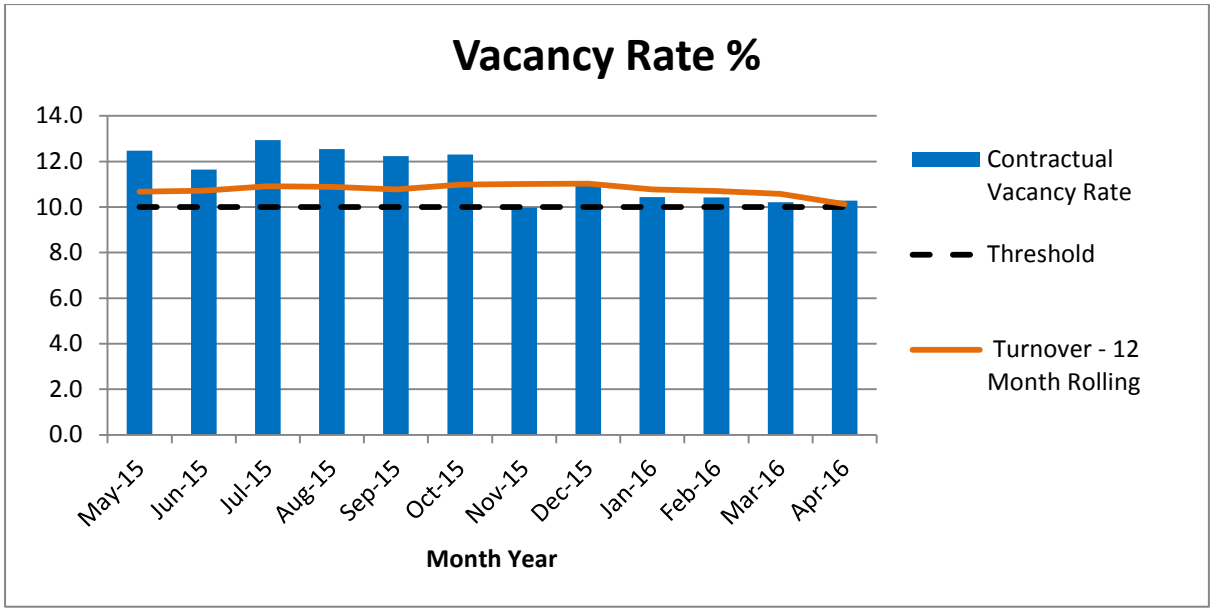


Figure 20 - Vacancy rates for the period March 2015 – March 2016

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence continues to reduce and during April fell to 3.02 per cent; similar to levels recorded in April 2015. This brings the rolling 12 month sickness position to 3.21 per cent with the Trust aiming to reach a full-year position of 3.10 per cent or lower by March 2017. Across the other London Acute Teaching Trusts, the average rolling 12 month sickness position ranges from 2.8 to 3.8 per cent.

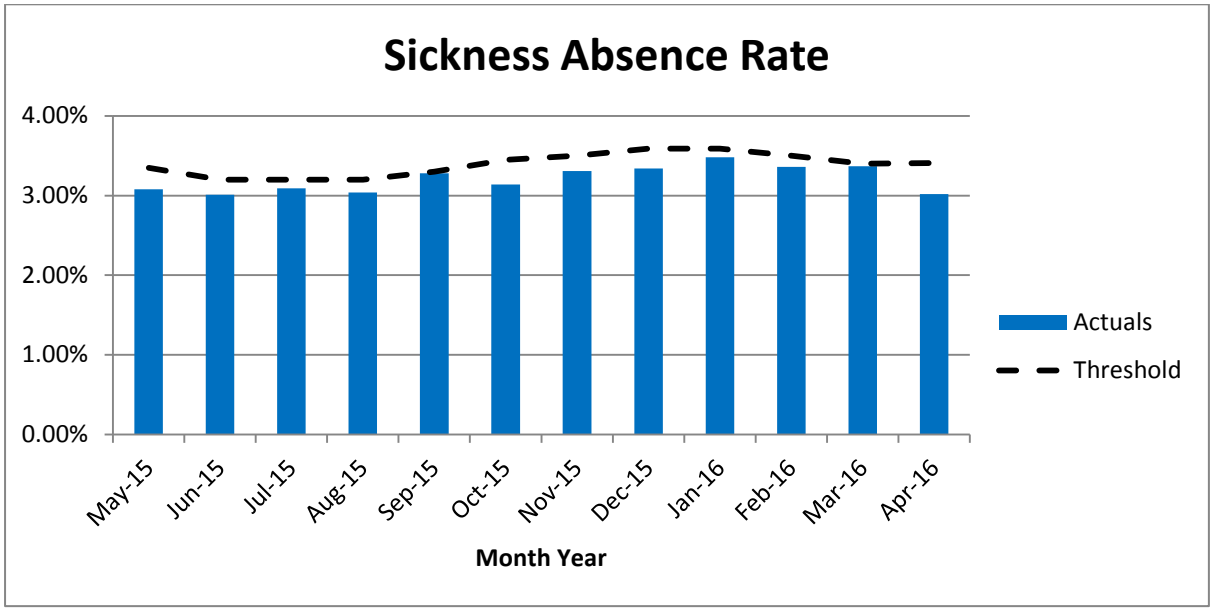


Figure 21 - Sickness absence rates for the period March 2015 – March 2016

2.4.3 Well-Led: Statutory and mandatory training

Core Skills (excl. doctors in training / trust grade)

Overall compliance has stabilised at 86.38 per cent in April which is the highest compliance to date, from 69 per cent in March 2015. Work continues to drive up compliance in the topics and departments where it is below target.

From April 1 2016, the target has been changed to 90 per cent.

Core Skills for doctors in training / trust grade

A new intake of junior doctors arrived in April 2016 and a range of changes have been made in Induction to maximise compliance for the new doctors coming in.

Corporate Welcome and Clinical Induction

New Staff are able to attend Corporate Welcome and Clinical induction sooner after commencing work at the Trust by increasing places. Compliance for Corporate Welcome attendance is now at 93 per cent.

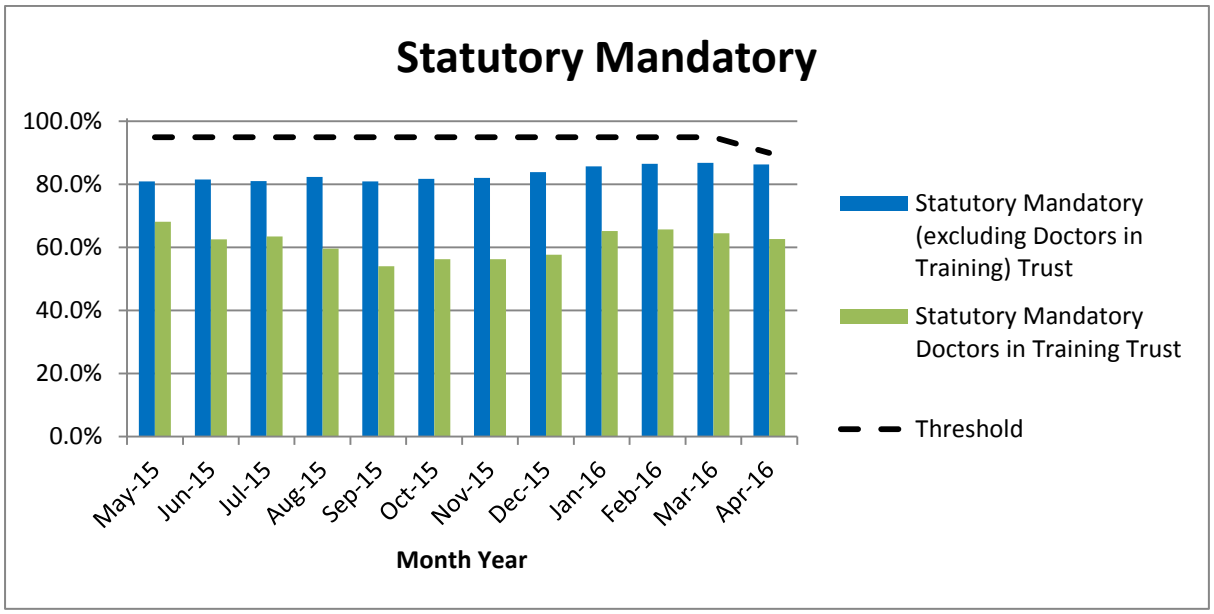


Figure 22 - Statutory and mandatory training for the period May 2015 – April 2016

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

The new personal development review (PDR) cycle began on 1 April 2016. We expect all of our non-medical staff at bands 7 to 9 to have a completed PDR with their line manager by the end of June 2016; the current completion rate for this staff group is 7 per cent.

The PDR cycle will close at the end of September when all non-medical staff must have a completed PDR.

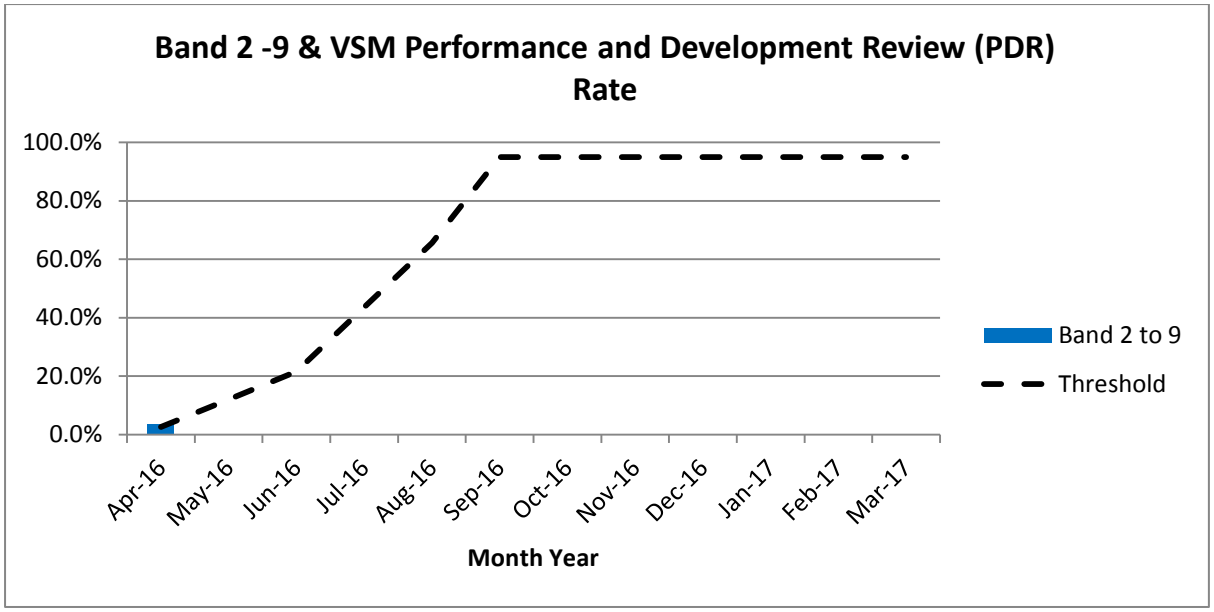


Figure 23 - Band 2 - 9 performance development review rates for the period April 2016 to March 2015

2.4.5 Well-Led: Health and Safety RIDDOR

There were five RIDDOR-reportable incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) in April 2016.

- The first incident involved a scrub nurse who received a sharps injury from an instrument used on an HIV positive patient; this is a reportable dangerous occurrence.
- The second incident was a tissue culture in the microbiology lab confirmed as *Brucella melitensis* which had not been previously indicated on clinical details; staff were exposed to the samples and this is a reportable dangerous occurrence.
- The third incident involved a nurse who was using a ladder and fell; this resulted in a broken wrist.
- The fourth incident involved a nurse who received a sharps injury from an insulin needle used on a Hepatitis C positive patient; this is a reportable dangerous occurrence.
- The fifth incident involved a staff member tripping and fracturing their little finger; this resulted in an absence from work of more than 7 days.

In the 12 months to 30 April 2016, there have been 32 RIDDOR-reportable incidents of which 14 were slips, trips and falls. The Health and Safety service is continuing to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

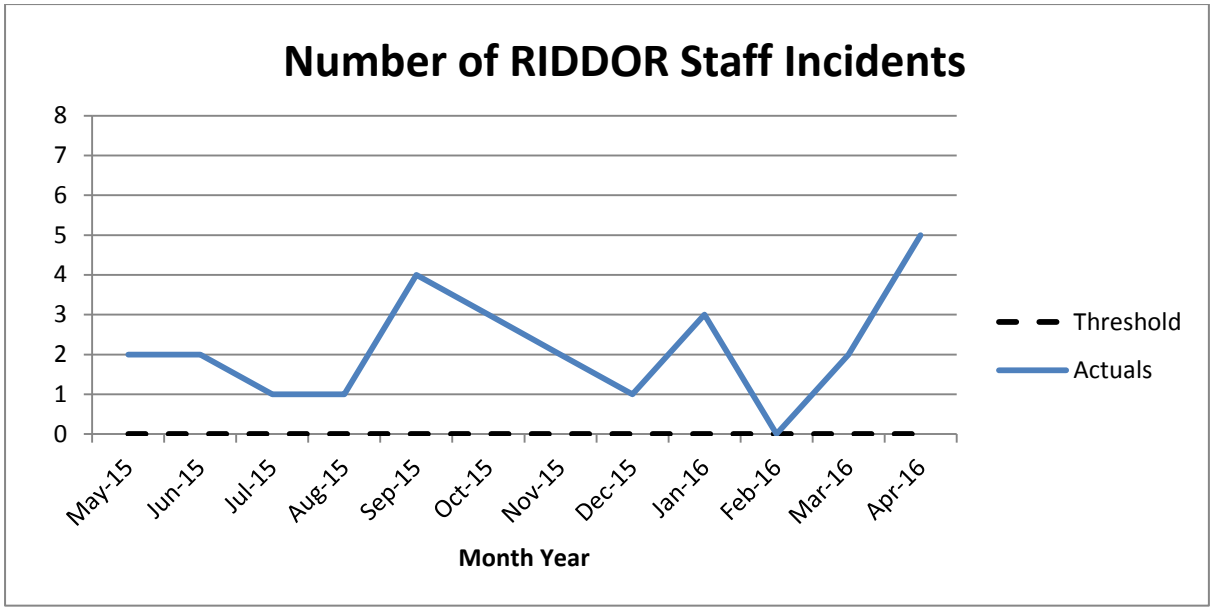


Figure 24 – RIDDOR Staff Incidents for the period May 2015 – April 2016

2.4.6 Well-Led: Staff Engagement

The latest survey was carried out in January and February 2016. The survey had a 43 per cent response rate and the overall engagement score increased by 2 per cent to 43 per cent.

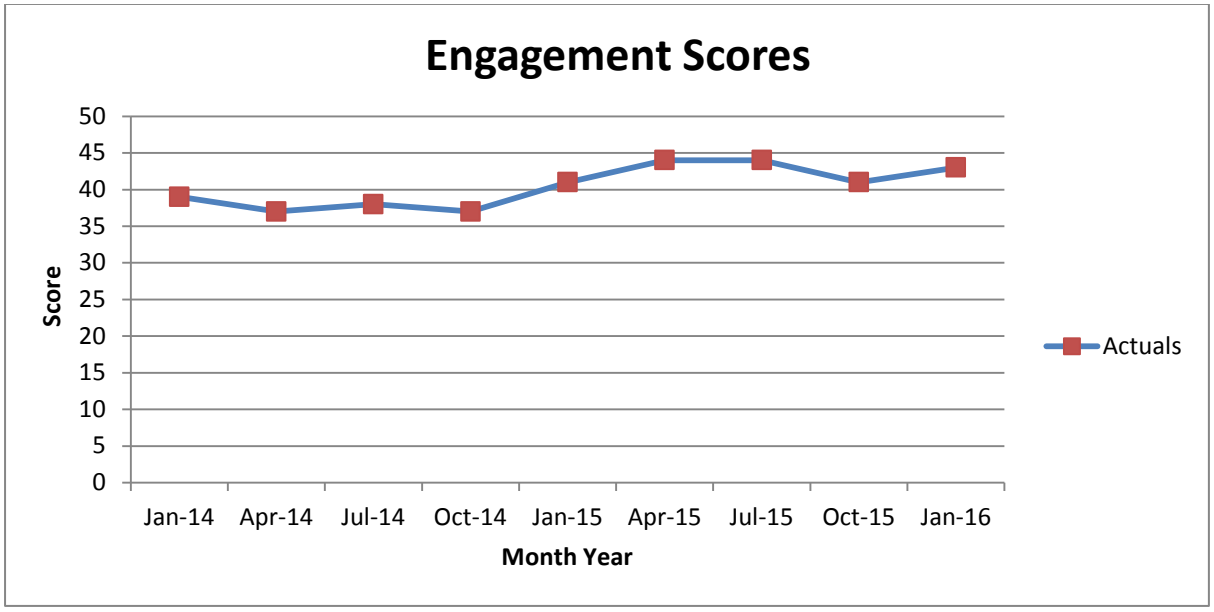


Figure 25 – Engagement scores for the period January 2014 – January 2016

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

Appraisal rates have fallen slightly, from 83.3 per cent in March 2016 to 82.2 per cent in April 2016. This is attributed to a higher than average number of new starters requiring revalidation and also a higher number of doctors due an appraisal. The

appraisal compliance if these new starters are excluded is 85.2 per cent, a 3.0 per cent increase on the reported figure last month.

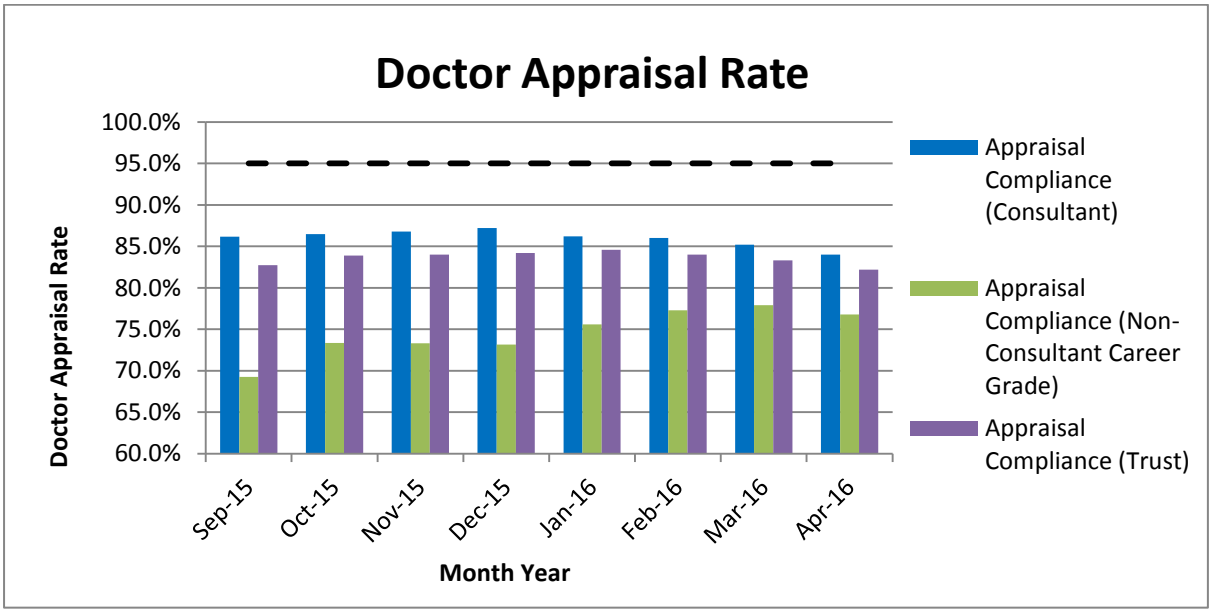


Figure 26 - Grade Doctor Appraisal Rates for the period September 2015 to April 2016

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

The 2016 General Medical Council National Training Survey (GMC NTS) went live on 22 March and closes on 11 May 2016. In the last month we have improved the survey rate from 38 per cent to 91 per cent of our trainees completing the survey.

So far we have only received 2 Immediate Mandatory Responses which were both around patient safety and which were submitted 12 May 2016.

The most recent action plan submission date was 29 April through which we responded to 100 quality visit actions and the 2 remaining NTS red flag actions.

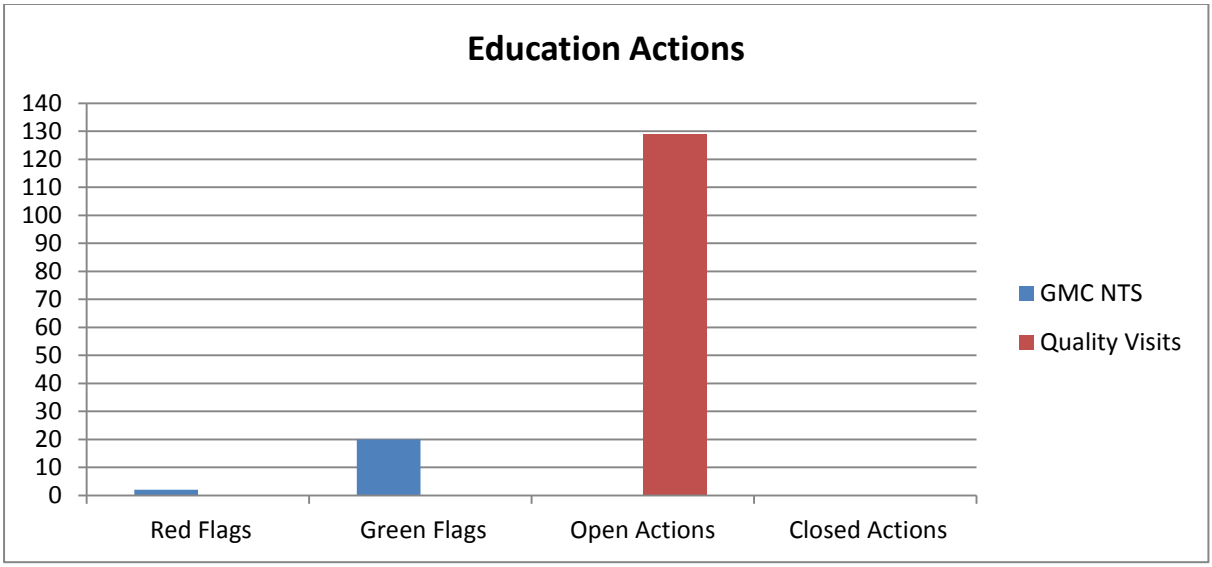


Figure 27 – General Medical Council - National Training Survey action tracker, updated at the end of April 2016

2.5 Responsive

2.5.1 Consultant-led Referral to Treatment Waiting Times - 18 weeks

The performance for March 2016 was 89.2% of patients on an incomplete pathway waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92 per cent.

The reasons for this disappointing performance relates to capacity in some specialties, to changes in our validation processes and better accuracy of our reports, and to the impact of industrial action by junior doctors in January, February and March.

The specialties with the most significant challenges include:

- Orthopaedics (validation processes have highlighted incorrect application of detailed RTT rules for some patients, so the waiting list is longer than we had previously reported);
- Neurology and neurosurgery (a combination of staffing, estates and validation issues); and
- General surgery (validation processes have highlighted incorrect closure of pathways after diagnostic investigations).

Performance in April is not expected to improve on March, because of the extended junior doctor's industrial action in April, and because orthopaedics and general surgery are still completing detailed validation resulting in further patients being added to the waiting list.

Our plans for 2016/17 include a detailed improvement plan and trajectory agreed with Commissioners and NHS Improvement which will deliver the 92 per cent standard from August 2016.

The following steps have been taken or are being put in place:

- We are finalising plans to use a mobile operating theatre on the Charing Cross Hospital site to provide additional capacity for patients waiting 20 weeks or more, from early June. Mobile operating theatres are routinely used in the NHS to boost capacity. Our own consultants would work extra sessions to undertake the surgery and we would need to bring in additional theatre staff. This extra capacity would coincide with the planned refurbishment of the short-stay, planned surgery unit at Charing Cross, Riverside theatres. There is already a plan being put in place to re-provide the normal Riverside capacity at Hammersmith Hospital for the period of the refurbishment, so this mobile theatre will provide additional capacity to reduce our waiting lists.
- We have also asked the NHS Intensive Support Team to review our waiting lists and RTT processes and this review will report at the end of May. This will help us to fully understand our RTT challenge and design improved processes for managing waiting lists in order to ensure that we meet the 92 per cent target

sustainably in future, with much more emphasis on getting the administrative processes right first time, and much less reliance on intensive validation processes after the event.

- These steps include specific plans for additional staff and clinics in many different specialties.

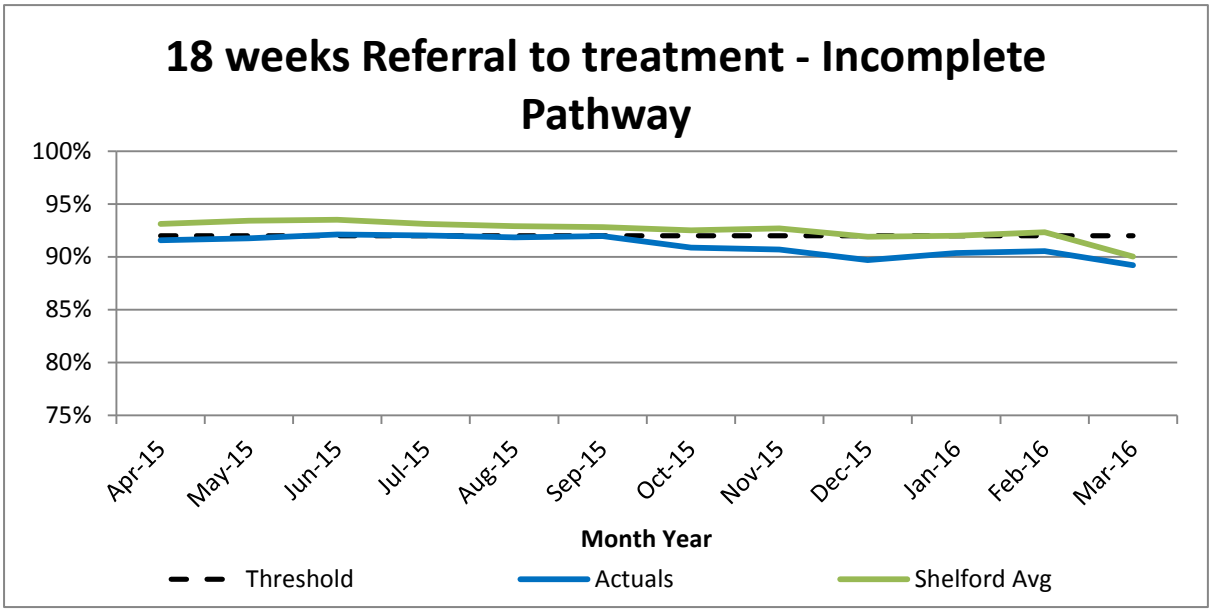


Figure 28 - RTT Incomplete Pathways for the period April 2015 – March 2016

2.5.2 Consultant-led Referral to Treatment Waiting Times – 52 weeks

At the end of March, there were 47 patients who had waited over 52 weeks for their treatment since referral from their GP, significantly more than the 14 patients reported at end February. A minority of these 47 patients are patients whom we had been reviewing regularly, but whose treatment took longer than it should have done because of capacity problems and in some cases also because patients had chosen to postpone appointments or operations. However, the majority of the 47 patients waiting over 52 weeks are patients whom we had not been tracking consistently. This is because we had applied RTT rules incorrectly at an earlier stage of the patient's treatment pathway.

Improvements to our RTT processes will mean that we then avoid this situation arising again.

A clinical review has been conducted on each of the 47 patients waiting over 52 weeks and all now have a treatment plan in place. In none of these 47 patients has the delay to their treatment resulted in any significant clinical harm to the patient.

A similar number of patients are expected to be reported as waiting over 52 weeks at the end of April when the validation process is complete. Many of these are the

same patients as were waiting at the end of March, whose cases have been reviewed clinically and who now have treatment plans in place. Clinical reviews and treatments plans are currently being completed on the new patients waiting over 52 weeks at end April.

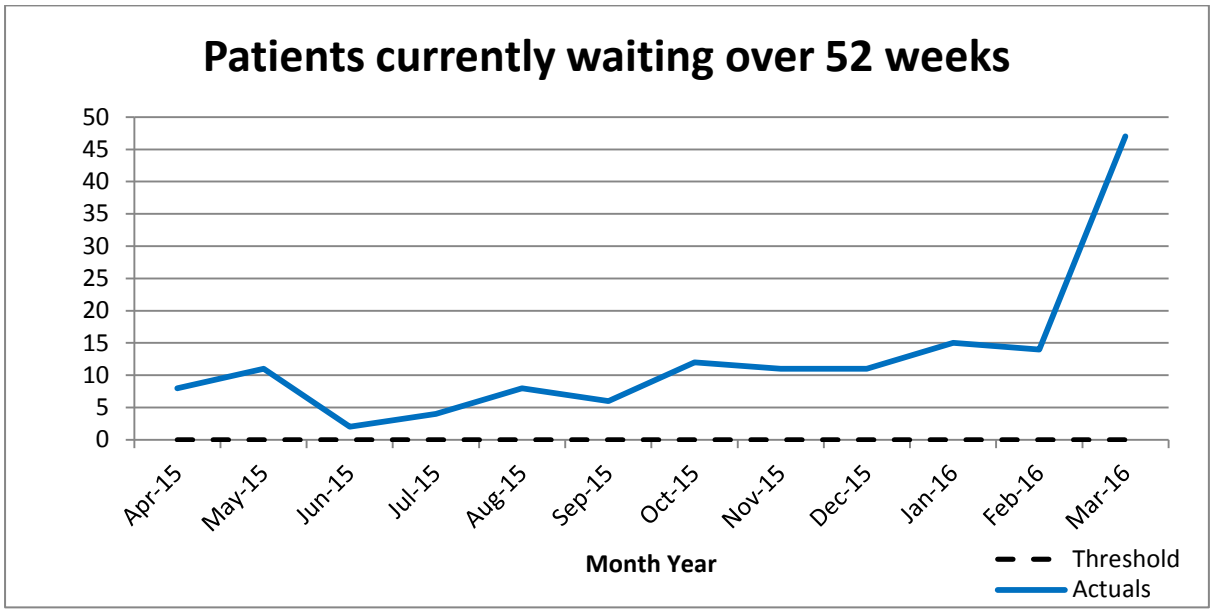


Figure 29 - Number of patients waiting over 52 weeks for the period April 2015 – March 2016

2.5.3 Cancer

In May 2016, performance is reported for Cancer waiting times standards for March 2016 and for Quarter 4 2015/16.

In both March and Quarter 4, the Trust achieved six of the eight national cancer standards. The Trust underperformed against the 62 day standard for urgent GP referral to treatment and the 62 day screening standard.

Non-delivery of the 62 day GP referral to treatment standard was a consequence of three main factors which are being addressed, as outlined below.

- Issues with the urology rapid access pathways resulted in patients not receiving bundled diagnostics. Mitigations against this are now taking effect.
- Gastrointestinal diagnostic pathways remain slow while endoscopy additional capacity is arranged. Limited protected capacity for cancer patients has been introduced.
- Late referrals from other North West London sites have increased. The Trust is working with local CCGs to manage partner organisations to improve this.

The Trust also underperformed against the 62-day screening standard due to late referrals from other screening services for surgical treatment at Charing Cross Hospital. The corporate cancer team is continuing to work with the screening service to improve the management of patient choice delays ahead of the first outpatient appointment following screening scans to reduce internal breaches.

Indicator	Standard	Mar-16	Q4 15/16
Two week from GP referral to 1st outpatient – all urgent referrals (%)	93.0%	93.2%	93.0%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.3%	93.1%
31 day wait from diagnosis to first treatment (%)	96.0%	96.4%	96.9%
31 day second or subsequent treatment (surgery) (%)	94.0%	95.2%	98.1%
31 day second or subsequent treatment (drug) (%)	98.0%	100.0%	99.5%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	97.9%	98.4%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	79.5%	81.6%
62 day urgent GP referral to treatment from screening (%)	90.0%	70.6%	76.7%

Table 1 - Performance against national cancer standards for March 2016 and Quarter 4 2015/16

2.5.4 Elective operations cancelled for non-clinical reasons

In April 2016, a total of 60 elective operations were cancelled on the day for non-clinical reasons, representing 0.6 per cent of all elective activity. This is within the national tolerance of 0.8 per cent.

The most recent fully validated performance for the 28 day rebooking target is for March 2016. A total of 16 patients (13 per cent of cancellations) were not rescheduled for treatment within the 28 day target, against a 5 per cent tolerance. The main specialities were neurosurgery, general surgery, vascular surgery and cardiac surgery.

The root causes are being investigated, a review is being carried out into how potential breaches are recorded and reported and a cross divisional working group is being established. Performance is expected to return to within at least 95 per cent of cancellations rescheduled within the 28 day standard by October 2016, subject to further review of the themes/factors impacting on performance.

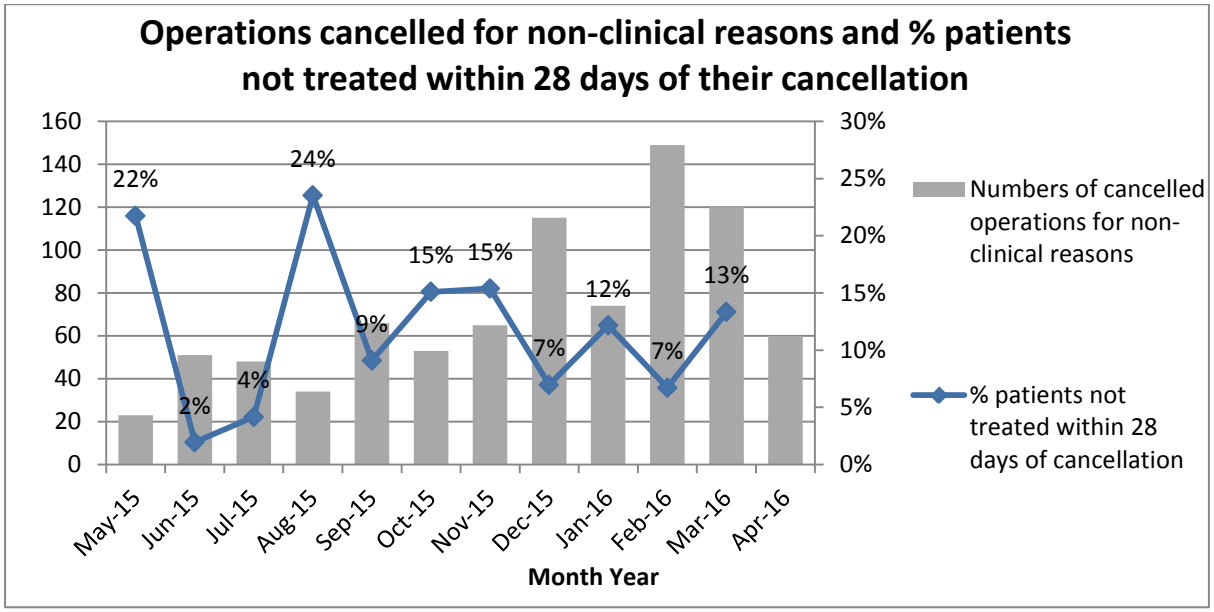


Figure 30 - Elective operations cancelled at the last minute for non-clinical reasons and % patients not treated within 28 days of their cancellation for the period May 2015 – April 2015

2.5.5 Accident and Emergency

Performance against the four hour access standard for patients attending Accident and Emergency was 89 per cent in April 2016. This is a 3 percentage point improvement on the March performance. A poor start to the month meant that the Trust missed the performance trajectory for April by 1.04 percentage points. However there was continuous improvement throughout with performance of 91.38 per cent for the last week of April against a trajectory of 89.88 per cent.

The Trust continues to work closely with the local health system to develop and implement detailed site based action plans and has agreed performance trajectories with local Commissioners. Due to on-going increases in demand and challenges with capacity it is anticipated that the Trust will achieve the 4-hour access standard in March 2017.

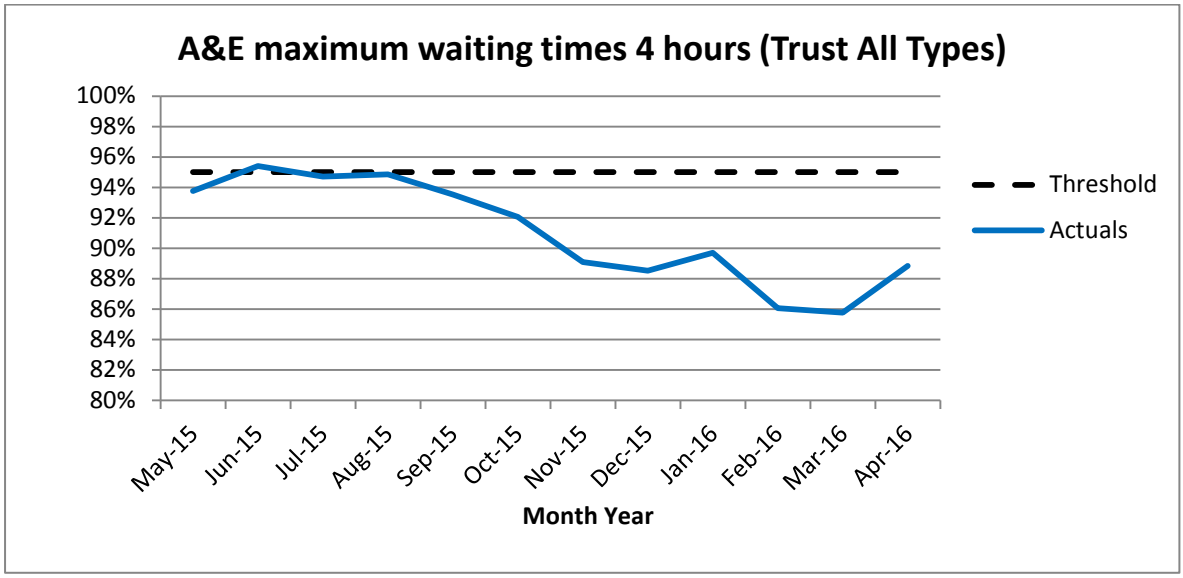


Figure 31 – A&E Maximum waiting times 4 hours (Trust All Types) for the period May 2015 – April 2016

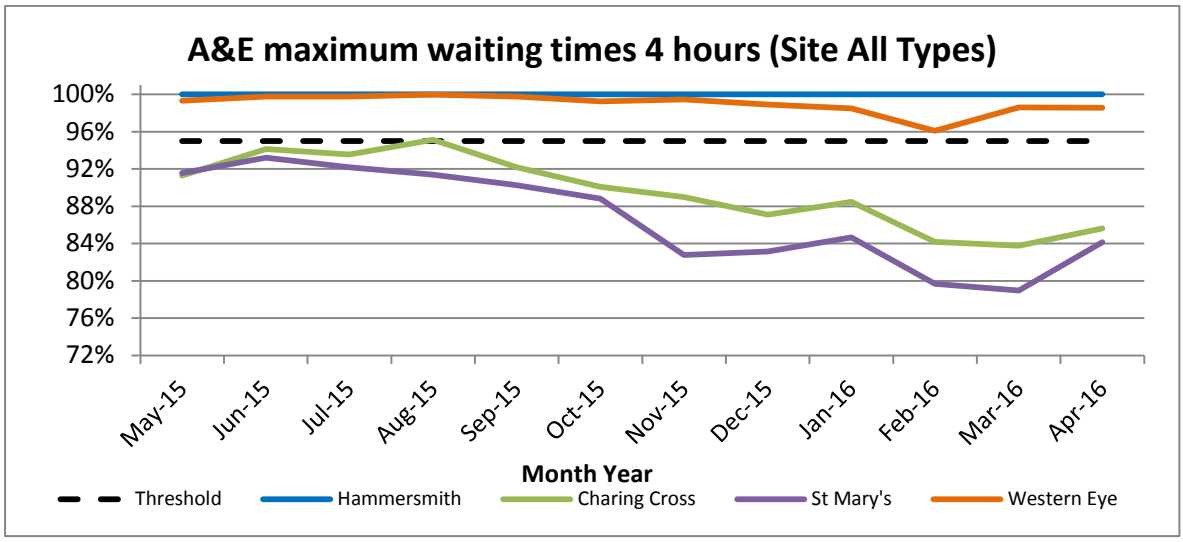


Figure 32 – A&E Maximum waiting times (Site All Types) 4 hours for the period May 2015 – April 2016

2.5.6 Diagnostics

The finalised performance for April 2016 for diagnostics will be submitted on Wednesday 18 May.

Throughout the last quarter of 2015/16 the Trust achieved good performance in the monthly diagnostic waiting time standard of less than one per cent of patients waiting over six weeks. It is projected that the Trust will not achieve the standard for a 2-month period in May and June (2016/17) when the Trust goes live with RIS PACS (Radiology Information System picture archiving and communications system). An extraordinary meeting will be scheduled to support mitigation plans within imaging during implementation of the new system.

Following the organisational restructure, a due diligence exercise is being conducted by the Women's, Children's and Clinical Support Division on activity capture and operational reporting processes for the diagnostic standard. This will be completed in time for Month 2 reporting.

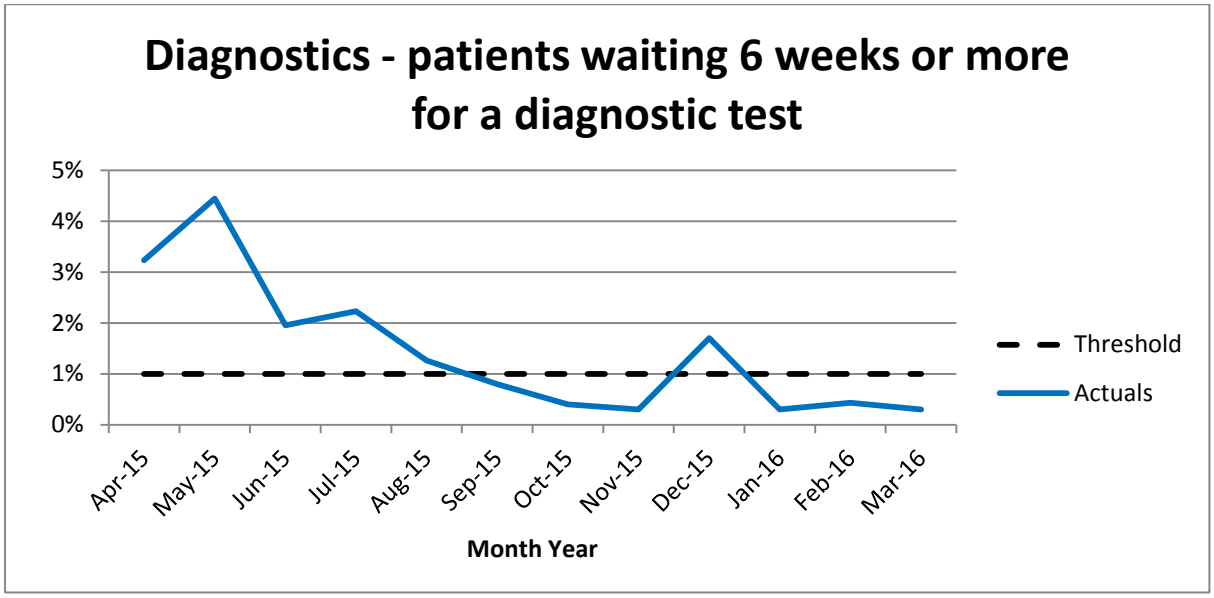


Figure 33 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period April 2015 – March 2016

2.5.7 Patient attendance rates at outpatient appointments

In April 2016, 12.7 per cent of new appointments and 11.9 per cent of follow up appointments resulted in a patient Did Not Attend. This compares favourably to performance for March which was 13 per cent for new appointments and 12.3 per cent for follow ups.

Whilst the overall Trust position has shown some improvement over the last year, the second phase of the Outpatient Improvement Programme will revisit and refocus on seven of the highest activity areas namely, Cardiology, Dermatology, ENT, Gynaecology, Midwife Episode, Neurology and Ophthalmology, which combined account for almost 40 per cent of all DNAs across the Trust.

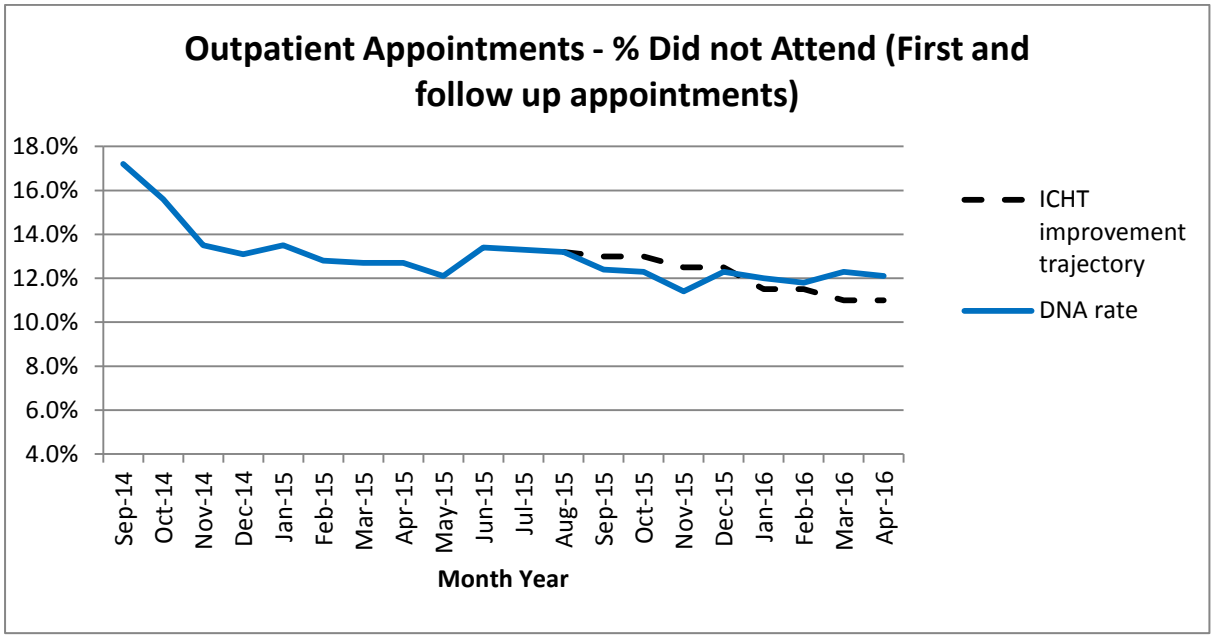


Figure 34 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period September 2014 – April 2016

2.5.8 Outpatient appointments cancelled by the Trust

In April 2016, 10.8 per cent of outpatient appointments were cancelled by the Trust with less than 6 weeks' notice. This equates to around 19,000 appointments in month and an increase on last month's performance of 9.8 per cent for March.

A closer look at the data reveals a 15 per cent to 50 per cent increase in cancellations over four days, likely correlating with planned cancellations in response to the junior doctors' strike. However, new cancellation reason codes introduced into the Trust's Cerner patient administration system during the same reporting period - an intervention initiated by the Outpatient Improvement Programme - will allow more in depth analysis of root causes on release of Month 2 (May) results.

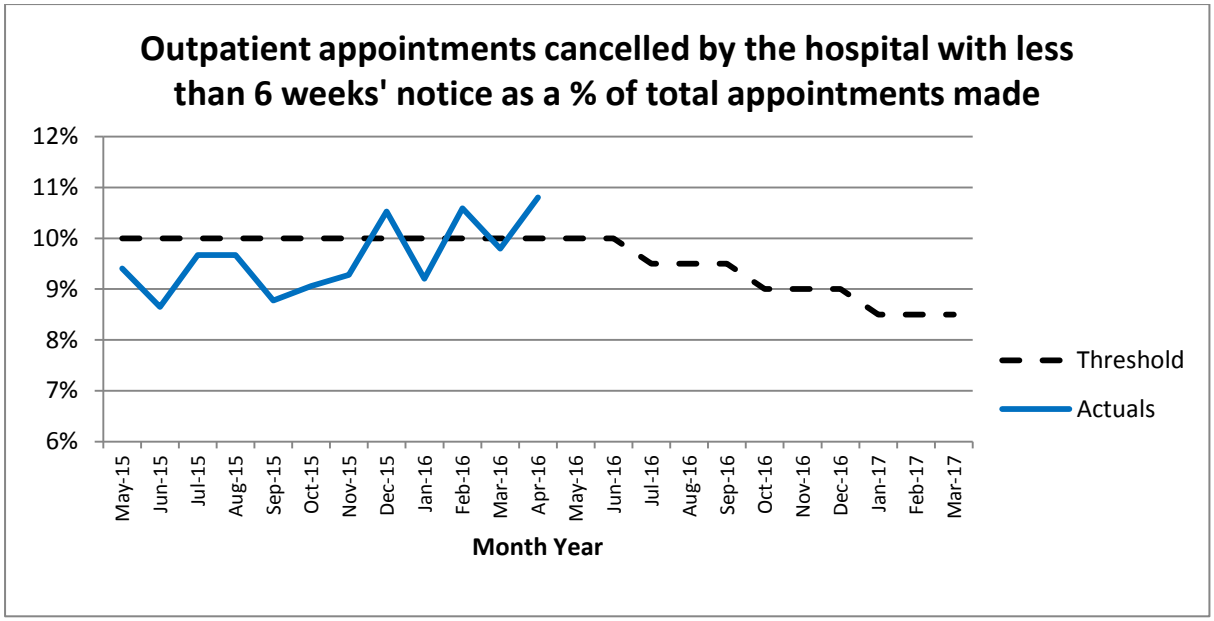


Figure 35 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period May 2015 – April 2016

2.5.9 Access to antenatal care – booking appointment

In April 2016, 95 per cent of pregnant women accessing antenatal care services completed their booking appointment by 12 weeks and 6 days (excluding late referrals), against the target of 95 per cent or more. The Trust is expected to continue to achieve this access standard during 2016/17.

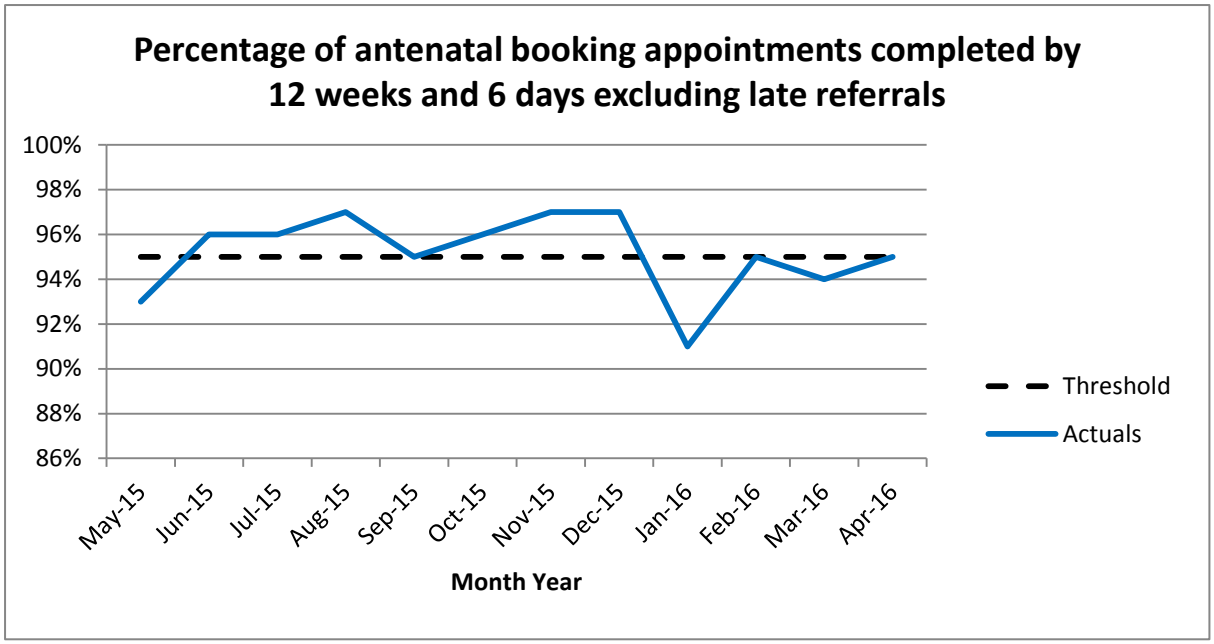


Figure 36 – Percentage of antenatal booking appointments completed by 12 weeks and 6 days excluding late referrals for the period May 2015 – April 2016

3. Finance

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

Imperial College Healthcare NHS Trust

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

Month 12 2015/16 finance report

Executive summary:

The Trust is reporting an operational deficit of £30.1m; an adverse variance to plan of £11.5m, in addition there was an additional provision relating to the condition of our estate of £17.8m bringing the overall position to a deficit of £47.9m. The operational deficit was broadly in line with forecast. 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	86,588	91,213	4,625	1,018,262	1,012,296	(5,966)
Total Expenditure	(83,032)	(107,873)	(24,841)	(990,336)	(1,014,684)	(24,348)
Earning Before Interest, Tax Depreciation and Amortisation	3,556	(16,660)	(20,216)	27,926	(2,388)	(30,314)
SURPLUS / (DEFICIT) including donated asset Treatment	4,322	(19,683)	(24,005)	(10,611)	(30,192)	(19,581)
SURPLUS / (DEFICIT)	**(246)**	**(20,303)**	**(20,057)**	**(18,623)**	**(47,883)**	**(29,260)**

Whilst NHS activity grew significantly, affordability constraints from commissioners resulted in a significantly higher level of challenges and fines being levied significantly reducing our NHS income. Additionally the Trust failed to achieve its ambitious growth targets in Private income, especially in the first half of the year Expenditure necessary to deliver the activity was also above plan.

Quality impact:

n/a

Financial impact:

See executive summary above

Risk impact:

Financial risks for 2016/17 have been highlighted in the business plan and controls and mitigations are being developed to address.

Recommendation to the Trust board:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Janice Stephens	Richard Alexander CFO	19 May 2016

Introduction

This report provides a brief summary of the Trust's financial results for the 12 months ended 31 March 2016. The Trust Board is asked to note this paper.

Summary

The Trust is reporting an operational deficit of £30.1m; an adverse variance to plan of £11.5m, in addition there was an additional provision relating to the condition of our estate of £17.8m bringing the overall position to a deficit of £47.9m. The operational deficit was broadly in line with forecast. The table below provides a summary of the income and expenditure position.

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Revenue

The Appendix provides a summary of the position after 12 months.

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	2,980,073	1,997,884	(982,188)	299,257	302,402	3,145
B - Surgery and Cancer	1,331,775	1,419,584	88,500	309,502	309,649	146
C - Investigative Sciences and Clinical Support	2,090,765	2,213,916	123,150	33,305	35,124	1,819
D - Womens and Childrens	196,169	191,595	(4,574)	116,520	113,114	(3,406)
X/Z - Central Divisional Total	119,083	111,766	(7,317)	21,416	9,783	(11,633)
			0			
FULL YEAR's ACTIVITY & INCOME	6,717,865	5,934,745	(782,430)	780,000	770,072	(9,928)

[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 (-15%) and elective (-3%) 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.

Private Care income

Private care income continues to improve, and is £4.8m behind plan year-to-date at M12, a slight deterioration on last month. The run-rate improvement first noted at M7 has been maintained and for the last six months income has been on average £4.1m each month, whereas in the first six months of the year the average was £3.2m.

Clinical Divisions

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	2,024	1,020	12,151	15,151	2,999
	Pay	(12,053)	(12,370)	(317)	(142,364)	(145,497)	(3,133)
	Non Pay	(3,815)	(4,719)	(904)	(43,828)	(46,729)	(2,902)
Division Of Medicine Total		**(14,865)**	**(15,065)**	**(200)**	**(174,040)**	**(177,076)**	**(3,036)**
Division of Women and Children	Income	677	842	165	7,724	5,029	(2,695)
	Pay	(6,565)	(6,558)	7	(77,564)	(74,187)	3,376
	Non Pay	(1,260)	(1,527)	(267)	(14,909)	(14,007)	901
Division Of Women And Children Total		**(7,148)**	**(7,243)**	**(95)**	**(84,748)**	**(83,166)**	**1,583**
Investigative Sciences & C S	Income	2,251	2,821	570	27,005	27,386	381
	Pay	(7,619)	(7,748)	(129)	(90,745)	(89,996)	749
	Non Pay	(2,986)	(3,480)	(494)	(35,981)	(37,107)	(1,126)
Investigative Sciences & C S Total		**(8,354)**	**(8,407)**	**(53)**	**(99,721)**	**(99,717)**	**4**
Surg, Canc & Cardiovasc Div	Income	496	705	209	5,958	2,244	(3,714)
	Pay	(14,268)	(14,761)	(493)	(170,793)	(171,592)	(799)
	Non Pay	(4,752)	(5,679)	(927)	(57,201)	(56,796)	405
Surg, Canc & Cardiovasc Div Total		**(18,523)**	**(19,735)**	**(1,211)**	**(222,036)**	**(226,144)**	**(4,108)**
Private Patients Directorate	Income	3,439	3,427	(12)	41,266	34,555	(6,712)
	Pay	(1,128)	(1,077)	51	(13,536)	(12,232)	1,304
	Non Pay	(968)	(951)	17	(11,639)	(11,171)	469
Private Patients Directorate Total		**1,343**	**1,399**	**56**	**16,091**	**11,152**	**(4,939)**
		(47,548)	**(49,051)**	**(1,503)**	**(564,455)**	**(574,951)**	**(10,496)**

The Division of Medicine is £3.0m 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).
The Division of Women and Children is favourable to plan by £1.6m, this is driven by underspends in expenditure relating partly to lower than expected transfers from Ealing for maternity
The Surgery Division is £4.1m adverse to plan year to date due primarily to below plan performance against the NHS income plan.
Private Health is adverse to plan year to date by £4.9m, £6.7m behind its income plan, partly offset by underspends on pay and non-pay.

Efficiency programme

CIP delivery in month 12 is showing an adverse in-month variance of £0.1m, at £3.4m against a plan of £3.5m, due to under achievement against both corporate and divisional schemes. YTD achievement of CIP has improved to 80% leading to a shortfall of £7.1m, which is in line with recent forecasts.

Cash

The cash balance at the end of the month was £24.2m; £11.9m below plan.

Conclusion

The Trust did not meet its financial plans in the year. This is primarily due to the fact that the Trust did not meet its ambitious growth targets for treating private patients, overspent in Medicine Division and under-delivered activity in SC&C Division combined with much more challenge to the level of NHS activity which commissioners are prepared to remunerate.

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

The Trust Board is requested to note this report.

Appendix

Statement of Comprehensive Income – 12 months to 31st March 2016

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	67,536	72,989	5,453	793,562	796,890	3,328
Private Patients	4,456	4,334	(122)	49,254	44,444	(4,810)
Research & Development & Education	8,995	9,920	925	107,964	113,983	6,019
Other	5,601	3,970	(1,631)	67,482	56,979	(10,503)
TOTAL INCOME	**86,588**	**91,213**	**4,625**	**1,018,262**	**1,012,296**	**(5,966)**
Expenditure						
Pay - In post	(44,189)	(42,462)	1,727	(524,008)	(498,749)	25,259
Pay - Bank	(1,199)	(3,330)	(2,131)	(18,310)	(32,519)	(14,209)
Pay - Agency	(2,768)	(4,338)	(1,570)	(33,267)	(51,402)	(18,135)
Drugs & Clinical Supplies	(21,625)	(29,084)	(7,459)	(255,949)	(275,413)	(19,464)
General Supplies	(2,882)	(21,756)	(18,874)	(34,580)	(53,443)	(18,863)
Other	(10,369)	(6,903)	3,466	(124,222)	(103,158)	21,064
TOTAL EXPENDITURE	**(83,032)**	**(107,873)**	**(24,841)**	**(990,336)**	**(1,014,684)**	**(24,348)**
Earnings Before Interest, Tax, Depreciation & Amortisation	**3,556**	**(16,660)**	**(20,216)**	**27,926**	**(2,388)**	**(30,314)**
Financing Costs	766	(3,023)	(3,789)	(38,537)	(27,804)	10,733
SURPLUS / (DEFICIT) including donated asset treatment	**4,322**	**(19,683)**	**(24,005)**	**(10,611)**	**(30,192)**	**(19,581)**
Donated Asset treatment	(4,568)	(620)	3,948	(8,012)	(2,158)	5,854
Impairment of Assets	0	0	-	0	(15,533)	(15,533)
SURPLUS / (DEFICIT)	**(246)**	**(20,303)**	**(20,057)**	**(18,623)**	**(47,883)**	**(29,260)**

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - private	25 May 2016

Operational plan 2016/17

Executive summary:

The 2016/17 operational plan describes the next steps the Trust is taking to:

1. Maintain the highest levels of patient safety and quality of care
2. Make purposeful steps towards implementing our clinical strategy and developing the north west London sustainability and transformation plan
3. Deliver our promise of Better health, for life

Quality impact:

The Trust's quality strategy will be delivered through the following quality goals: Safe; Effective; Caring; Responsive; Well-led. These goals are supported by specific annual targets and associated improvement programmes. The targets are reviewed annually and are described in our Quality account. Alongside the quality goals and targets, we have developed structured improvement projects to drive change in our priority areas.

Financial impact:

This plan has been prepared in the context of considerable financial challenge, under-achievement of a deficit plan during 2015/16 and the need for large-scale productivity improvement and transformational redesign to achieve a sustainable position. There are a number of further financial challenges in 2016/17 that add to the underlying deficit of £54 million from 2015/16. These include nationally driven pressures, such as a 2 per cent efficiency target (£16 million) and a reduction in education and training income (£4 million). They also include local issues, such as the loss of income due to the transfer of the St Mary's Hospital Urgent Care Centre to another provider.

Against these challenges, the Trust has a cost improvement programme aiming to deliver £54.1m of savings in the year. Taking the challenges and savings together, the 2016/17 plan has been set at a £52m deficit.

Risk impact:

The risks associated with the operational plan have been reviewed and included on appropriate risk registers

Recommendation to the Trust board:

The Trust board is asked to note the public-facing plan.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Communications team	Richard Alexander, CFO	19 May 2016

Imperial College Healthcare NHS
NHS Trust

Operational plan 2016/17

Delivering our promise: Better health, for life

Our 2016/17 operational plan describes the next steps we are taking to:

1. Maintain the highest levels of patient safety and quality of care
2. Make purposeful steps towards implementing our clinical strategy and developing the north west London sustainability and transformation plan
3. Deliver our promise of *Better health, for life*

CONTEXT

This plan has been prepared in the context of considerable financial challenge, under-achievement of a deficit plan during 2015/16 and the need for large-scale productivity improvement and transformational redesign to achieve a sustainable position.

Addressing the financial position is essential, as well as maintaining the highest levels of patient safety and building on progress against our Care Quality Commission (CQC) action plan. In addition we must:

- support major strategic change planned across north west London (NWL), including the forthcoming Sustainability and Transformation Plan (STP).
- coordinate a range of large-scale initiatives working across the Trust, including those related to quality improvement, clinical strategy implementation, estates and capital, health informatics and workforce.
- tackle long-standing pressures meeting targets such as A&E and referral to treatment times (RTT), related to issues around demand, capacity and patient flow, both inside and outside the Trust.
- address substantial and increasing risk associated with backlog maintenance and equipment replacement costs and timescales.

CLINICAL STRATEGY

Our clinical strategy and estates programme aim to:

Create more local and integrated services to improve access, helping keep people healthy and out of hospital	**Concentrate specialist services where necessary, to increase quality and safety**	**Ensure better organised care, to improve patient care and clinical outcomes**	**Develop more personalised medicine, capitalising on advances in genetics and molecular medicine**

The clinical strategy will be supported by reconfiguration of services across our three main sites as well as in local health centres, in line with *Shaping a healthier future* and the anticipated NWL STP.

DELIVERING OUR PROMISE: BETTER HEALTH, FOR LIFE

Our estates proposals support wider delivery of place-based care and enable our hospitals to make their own distinctive, but interdependent offers:

- **Charing Cross** evolving to become a local hospital with planned, integrated and rehabilitation care
- **Hammersmith and Queen Charlotte's & Chelsea** extending their role as specialist hospitals
- **St Mary's**, with a co-located **Western Eye Hospital,** as the major acute hospital for the area
- Plus a growing range of **services provided in community** settings, alone and in **partnership**.

Our operational plan describes next steps for delivering our promise, which will be achieved through delivering our core and supporting strategies and progressing our key initiatives for 2016/17:

Key initiatives for 2016/17:

Organisational structure and ways of working review	**Estates redevelopment programme**	**Clinical strategy implementation programme** (including four existing work streams and a new project on 'flow')	**Quality improvement programme** (including partnering with CSIP on 'flow' project)
Outpatient improvement programme / patient service centre	**Patient and public involvement strategy implementation**	**Accountable care strategy development**	**Digital strategy development** (including care information exchange)
Compliance and improvement framework (including preparation for likely CQC inspection)	**Safety improvement programme**	**West London Genomic Medicine Centre**	**North West London Pathology**

Approach to activity planning

Activity modelling
Activity plans have been developed using an open book approach with commissioners, ensuring a shared understanding of the opening 2016/17 baseline. We have included adjustments for:

- full year effects from 2015/16 growth
- demographic and non-demographic growth
- anticipated service changes shared with commissioners.

Care has been taken to ensure consistency across activity, performance, revenue, capital and workforce plans.

Operational performance
The impact of activity assumptions on performance trajectories has been shared and discussed with commissioners and discussed in detail at the Audit, Risk & Governance Committee. In summary, the Trust:

- will continue work with CCGs and the system resilience group and regulators to improve on current **A&E 4 hour wait performance** aiming to achieve the standard Trust-wide by March 2017. This is **dependent on** a number of projects including emergency department expansions and performance of St Mary's new urgent care centre (UCC).
- will continue to meet **quarterly cancer performance standards**. This is **dependent on** the growth in context of new GP referral guidelines, yet to be modelled and activity increases following re-commissioning of some pathways.
- will meet **RTT performance standards** from September 2016 (excluding gender reassignment). This is **dependent on** a number of things including any impact of any further industrial action, planned improvements to theatres at Charing Cross Hospital and further outsourcing, as well as additional imaging capacity
- fully support NHS England's decision to prioritise additional investment for patients on **gender reassignment pathways**. In 2015, we agreed with NHS England it would take 2-3 years to clear the backlog of patients waiting for this specialist surgery, to this end we are working with a national taskforce. During 2015/16, we recruited an experienced urological surgeon who has now been trained in this highly specialised subspecialty increasing capacity.

Approach to quality planning

Our new Quality strategy 2015-18 sets out our definition of quality under the CQC domains of safe, caring, effective, responsive and well-led, and describes our vision and direction, with quality as our number-one priority. The strategy is designed to ensure we are providing safe, high-quality care and can achieve a 'good' rating in our next CQC inspection, while striving for outstanding.

We work closely with our commissioners throughout the year to monitor our performance against the strategy, and develop the quality account and priorities for the next year through the clinical quality group and quality steering group.

A compliance and improvement framework was implemented in April 2015, to ensure we are compliant with regulatory requirements, and to drive improvements to help services deliver 'good' or 'outstanding' care. Key components of the framework and activities undertaken include: delivery of the CQC inspection action plan, developed following the Trust's inspection in September 2014. The framework will be re-developed for 2016/17 to reflect lessons learned and evaluations of 2015/16, and in response to the CQC's new regulatory strategy, which is currently under consultation and will take effect from April 2016.

Approach to quality improvement
The Trust's quality strategy will be delivered through the following quality goals:

Safe	Effective	Caring	Responsive	Well-led
To eliminate avoidable harm to patients in our care, showing a reduction in the number of incidents causing severe and extreme harm	To be in the top quartile for all national clinical audit outcomes	To provide our patients with the best possible experience by increasing the % of inpatients (to 95%) and A&E patients (to 85%) who would recommend our Trust to friends and family if they needed similar care or treatment	To consistently meet all national access standards through responsive patient pathways	To increase the percentage of our people who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis

These goals are supported by specific annual targets and associated improvement programmes. The targets are reviewed annually and are described in our Quality account. Alongside the quality goals and targets, we have developed structured improvement projects to drive change in our priority areas.

These projects include:

- **Safety improvement programme**: reinforcing our commitment to patient safety.
- **Mortality review programme**: an online module developed throughout 2015-16 to enable a standardised mortality review; launched on 1 February 2016.
- **Outpatient improvement programme**: a coordinated overarching programme aligned to issues identified by the CQC and subsequent must-do compliance actions.
- **Quality improvement (QI) programme:** Provides staff with the necessary skills and tools to enable and empower them to lead QI projects in their work areas. Read more about QI at the Trust on our website.

Risks to quality of care are managed through the Trust's risk register. The corporate risk register is reported to the executive committee and then to the Board. Each risk is reviewed on a monthly basis, with an action plan in place for mitigation.

Quality governance and indicators
The governance arrangements for clinical quality and safety in the organisation are led by the medical director.

An integrated operational and quality performance scorecard is reported to the executive operational committee and the Board on a monthly basis alongside a finance report, which includes information on income and expenditure and the cost improvement plan.

A process to 'triangulate' or bring together, quality, workforce and financial indicators on at least a six-monthly basis as required by NHS Improvement, is currently under review.

Key indicators reported on include:

- **Safe:** Serious incidents, safe staffing levels, infection prevention and control
- **Effectiveness:** Mortality data (SHMI and HSMR), and readmissions
- **Caring:** Friends and Family Test, mixed-sex accommodation, complaints;
- **Responsive:** National access standards, RTT
- **Well-led:** Staff engagement, vacancy rates, statutory and mandatory training.

Seven day services

Responsibility for the delivery of appropriate seven day services at the Trust sits with the deputy medical director.

An action plan is being developed with CCGs to explore how the Trust can further implement seven day services, subject to affordability. This includes consultation processes with staff to review the possibility of providing diagnostic services seven days a week.

In addition to existing seven day services, the areas prioritised for 2016/17 are discharge improvement, radiology and diagnostics, interventions and the inpatient model of care. This implementation of full seven day services at the Trust is supported by the newly-established Clinical strategy implementation programme (CSIP).

CSIP focuses on sustainable improvement in specific pathways or service areas, contributing to achieving our clinical vision and delivery of high quality services, seven days a week. Phase one of the programme began in September 2015 and focused on:

- a review of vascular surgery services
- developing the ambulatory care strategy
- streamlining the pathway for patients with chest pain
- a review of acute medical services on all three sites.

In February 2016, phase two of CSIP was approved and will focus on improving how our patients flow through and experience our care pathways.

Approach to workforce planning

The draft 2016/17 workforce plan is a representation of our agreed investment programme showing a decrease in staffing of 130 WTE (working time equivalent):

- bank temporary staffing, decrease of 192 WTE
- agency temporary staffing, decrease of 330 WTE
- substantive staffing, increase of 392 WTE.

The main contributors to the staffing changes can be themed as:

- cost improvement schemes
- transfer of staff out due to contracting out of Hard FM services and loss of the UCC contract
- additional staffing to support planned income, growth and expansion of services
- reducing our vacancy rate for ward based band 2 – 6 staffing to 10 per cent.

The Trust has established a workforce transformation committee to identify the workforce requirements of the Trust in five years' time, to meet the growing need for people to work in integrated care settings. The output of this group will be a clear direction of travel in terms of the types and number of people we need to attract in the future and the development opportunities we provide our employees. The Trust has also developed a strategy to promote health and wellbeing of its people.

Approach to financial planning

2015/16 context
The Trust's financial goal when submitting its 2015/16 plan was to allow a one year of deficit of £18.5 million (largely driven by the removal of the subsidy for complex specialist care) before returning to surplus and long-term financial sustainability. During the year it became clear that the financial position of the trust had deteriorated further – analysis suggesting an underlying deficit in the region of £54 million.

Following a period of intensive work during November to January, a re-organisation proposal was taken to our Board as the first step of turnaround. The 2016/17 plan therefore represents year one of a recovery plan for the Trust, towards its goal of a return to surplus and financial sustainability, and should be viewed in this light.

National and local pressures
There are a number of further financial challenges in 2016/17 that add to the underlying deficit of £54 million from 2015/16. These include nationally driven pressures, such as a 2 per cent efficiency target (£16 million) and a reduction in education and training income (£4 million). They also include local issues, such as the loss of income due to the transfer of the St Mary's Hospital Urgent Care Centre to another provider.

Against these challenges, the Trust has a cost improvement programme aiming to deliver £54.1m of savings in the year. Taking the challenges and savings together, the 2016/17 plan has been set at a £52m deficit.

Efficiency savings for 2016/17

Approach to productivity planning
The Trust continuously works to identify opportunities to improve productivity and, over the 2015 summer, developed an updated outline five-year programme following a review undertaken by the medical director and deputy chief executive.

This work, which also resulted in the new *Clinical strategy implementation programme*, was informed by analysis covering national productivity benchmarking, as well as detailed information on costing and profitability drawn from the Trust's service line reporting and patient level costing systems. The programme was also informed by benchmarking and identification of best practice from sector-wide work related to the *Shaping a healthier future* programme.

The Trust is part of a patient cost benchmarking group made of 72 NHS trusts, which enables us to compare admitted patient costs with a selected peer or the peer average.

2016/17 Cost improvement plans
A CIP programme of £54.1m has so far been built into divisional and directorate plans for 2016/17 with £39.0m relating to new schemes for the coming year, £8.1m comprising full-year effect from schemes started towards the end of 2015/16, and £7.1m relating to further opportunities for which specific schemes will be worked up during 2016/17. In summary the programme includes:

- **£1.1m related to pathway management**, including streamlining theatre lists
- **£12.0m related to cost management**, including procurement savings
- **£26.0m of income schemes**, including community tender schemes awarded to the Trust and growth in private work
- **£6.4m of corporate and clinical back-office reconfiguration,** including savings from reduced agency usage
- **£1.3m from workforce productivity**, including imaging, maternity and community services
- **£0.2m from asset productivity**, largely related to rental income.
- **£7.1m of further opportunities,** for which specific schemes will be worked up during 2016/17.

Non-pay and Lord Carter's report
We are fully-committed to learning from and implementing the recommendations of Lord Carter's report on productivity and efficiency. The Trust is actively involved in piloting many of the recommendations, and is exploring more detailed benchmarking against product price indices and performance in similar Trusts.
Procurement
We will continue to be represented at and work with the original Carter cohort of 32 trusts to support and drive through national initiatives aimed at delivering greater value and optimising collaboration. As part of this, the Trust:

- is committed to report to NHS Improvement on spend and other defined data for performance metrics, to assist with the development and implementation of a new national reporting and price benchmarking system.
- has agreed to be a pilot site with Lord Carter's team to assess the best way to collect data on NHS top 100 items, and be pathfinder on data collection.
- will assist in creating tactics or strategies to reduce unit price to best in market from the data received (as analysis is received from NHS Improvement).
- will work with Shelford trusts to assess a common catalogue and E-Procurement system, a "Carter Pathway" project already underway and supported by the Carter team.

Capital planning
The proposed 2016/17 capital programme comes to £51million (including £12 million Imperial College Healthcare Charity-funded schemes, and £1m in interest free government loan funding for energy efficiency schemes). Further prioritisation is required in some areas, but our provisional allocations at this stage include:

- Patient services centre and outpatient redevelopment
- St Mary's A&E refurbishment and expansion
- Riverside theatres refurbishment
- Diagnostic equipment schemes
- Rolling theatre programme and other schemes such as tri-borough neuro-rehabilitation developments
- Backlog maintenance, medical equipment replacement and enabling
- ICT infrastructure essential schemes
- Site redevelopment
- Investment in transformational projects.

Sustainability and transformation plan (STP)

In north west London (NWL) we are proud of our history of joint working and collaboration, which has delivered better outcomes, care and services for people in NWL and committed to working in a more integrated way across NHS and local government to tackle our shared challenges across the whole system. We are using the STP process to strengthen and broaden collaborations, to work better together for the benefit of local residents, a population of 2 million.

Leadership at all levels across the whole system is important to galvanise aspiration, hold commitment to change and set the right culture for successful delivery and quality. Our collaboration is across eight boroughs at different levels of 'place'. There is a NWL Strategic Planning Group (SPG) comprising of place based representatives from the CCGs and local authorities, and key partners such as providers and patient representatives. The Trust chief executive is the STP provider lead.

The NWL STP vision is consistent with the Trust's plans, with its commitment to delivering support, care and health services that are:

- Personalised enabling people to manage their own care;

- Localised allowing for a wider variety of services closer to home;
- Integrated covering all aspects of a person's wellbeing, health and needs;
- Specialised for those with conditions that require specific services.

The emerging priorities which were included in the April first submission to NHS England included:

- tackling inequalities;
- planning and delivering services for population health gains;
- how can service development/improvement impact on life expectancy;
- better alignment of physical and mental health;
- promoting/enhancing self-care;
- reviewing our estates on a partnership basis and delivering reconfiguration.

Work continues to develop the final submission in June, and to further engage staff and stakeholders in the process and in co-designing the implementation plan.

We welcome the opportunity to play a more active role in the development of the Tri-borough Health and Wellbeing Strategy for 2016 and in identifying how we can integrate early intervention and prevention initiatives into secondary care services so that every consultation counts as a learning opportunity. We look forward to building on work already begun, with some key developments and work streams for the coming year being led by the Trust briefly highlighted below.

HEALTH INFORMATICS

The Trust digital strategy, *Towards the Digital Health Community* for 2015/20 will be a critical enabler for more productive working both internally and across the local health system. The immediate internal priority is to move from paper records towards digital data capture and processing, and by the start of this operational planning period, the following supporting projects will have been completed:

- Digital workflows for patient administration
- Digital clinical notes in inpatient and outpatient settings
- Electronic prescribing and medication administration records
- Digital ordering and reporting of diagnostic tests and procedures.

More widely, the Trust is leading work in north west London to create a comprehensive, aggregated patient electronic record that will be accessible across health and social care providers and to patients and their carers to improve patient engagement and self-management.

INTEGRATED CARE

Based on a growing track record in design and delivery of integrated health and care services, we are gradually developing our reputation as a collaborative partner in system leadership through our role as lead health provider for the tri-borough community independence service in 2015/16 and other innovative and successful programmes such as Connecting Care for Children.

In support of the *Five Year Forward View* and *Delivering the Forward View*, our plans prioritise building internal capacity and capability to work with local commissioners and lay

partners to progress the Integrated Care agenda in NWL.

In December 2015, the Trust and the Hammersmith & Fulham GP Federation signed a Memorandum of Understanding describing our shared commitment to develop a sustainable model of integrated care for the population, potentially through an Accountable care partnership and learning from experience in the UK and abroad.

PATIENT SERVICES CENTRE

Our patient services centre (PSC) improvement programme will create a single, streamlined, straightforward and centralised point of contact for patients in the elective pathway. Based at Charing Cross Hospital, the programme will deliver improved services and £6m in cost savings over the coming five-year period.

The PSC will significantly improve the quality and experience of administrative care for patients, external stakeholders, clinicians and staff. In January 2016 work began to improve the services provided, with a target for this improvement work to be completed prior to transfer to the new location, resulting in at least 97 per cent of calls being answered and 95 per cent of referrals booked within five days.

From October 2016 through to July 2017, there will be a phased transfer of services into the central PSC, with the aim that the PSC should have sufficient expertise to resolve the vast majority of patient queries directly; (the remaining more complex enquiries will be forwarded to the specialty area to resolve).

NORTH WEST LONDON PATHOLOGY

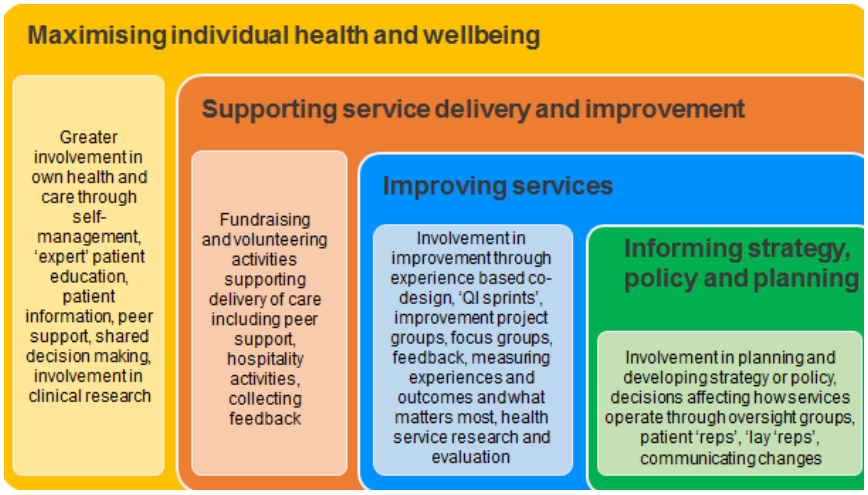
As outlined in the North West London Pathology full business case the objective is to set up a consolidated pathology service provider, providing a full range of services in a collaborative venture between the Trust, Chelsea and Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust.

The configuration will be a hub and spoke model, with a large centralised hub for most work, plus smaller 24-hour ‘hot lab’ spokes at each site for urgent work.

Significant savings are anticipated – in the order of £90m net, over a c.10 year period. However, there is some uncertainty around timing as further regulatory requirements are navigated and an alternative solution requiring no further capital spend is explored.

PATIENT AND PUBLIC INVOLVEMENT

The Trust Board agreed a new strategy in November 2015 to expand and enhance patient and public involvement (PPI) at all levels of the Trust. The four key areas for PPI development relate to a specific set of intended outcomes as shown.



We are developing a work plan to progress PPI in all four areas, using a semi-devolved approach, as we need to balance the need for a more systematic and co-ordinated approach led by an overarching central resource, with the need to ensure PPI is owned and championed throughout the organisation, and to reflect that there is already much good work taking place at a local level. A strategic lay forum meets regularly to grow and shape this work.

Imperial College Healthcare NHS Trust

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

Proposals for Acute Medicine and Chest Pain Pathways

Both these related service change proposals aim to ensure patients see the right physician and receive the right care and treatment in the right facilities first time.

Acute Medicine
The changes to the acute medicine patient pathway at Hammersmith Hospital are being proposed as it has become clear that the current pathway is not working as the effective access point to the site's specialist teams. In fact, for many patients, it is acting as an additional, unnecessary stage in their care pathway.

Currently, acute medical patients at Hammersmith Hospital can wait for a significant amount of time for a specialist care bed which delays their diagnosis, treatment, transfer or discharge.

As Hammersmith Hospital builds its role as a specialist hospital further, it has become clear that the acute medical pathway is not providing the quick and seamless access to specialist teams which it was intended to and should be replaced by a new patient pathway.

An important strand of this work has involved our clinicians looking at how to enable faster direct access to specialist services at Hammersmith Hospital for long-term patients - primarily renal, haematology and cardiology services.

This will require that a specialist unit be established on Hammersmith Hospital to accommodate the direct access renal and haematology patients who currently make up the main proportion of acute medicine activity.

Chest Pain
Currently, many patients who need specialist chest pain expertise are first admitted for assessment to Charing Cross or St Mary's hospitals through their emergency departments, before accessing the specialist cardiology team based in our Heart Assessment Centre at Hammersmith Hospital.

These, patients frequently comment on the number of different hospitals and wards they visit before accessing the cardiology team and do not understand why this happens.

Our clinicians have been working with London Ambulance Service and other partners to explore how we could build capacity and pathways at Hammersmith Hospital so that more patients with chest pain are able to go to the Heart Assessment Centre directly.

Communications and engagement
Trust Board approval is sought for the communications and engagement plan for the proposed changes to the acute medicine and chest pain pathways.

Further approval is sought to return to the July public meeting of the Trust Board with a report on the feedback from the engagement process with a view to making a recommendation about implementing the new pathways.

Quality impact:

The quality impact of the two projects are:

Acute Medicine Pathway
The recommended option for the acute medicine pathway:

- Removes the acute medicine take at Hammersmith Hospital
- Creates a Renal/Haematology specialist unit to replace Specialist Medical Assessment Centre
- Introduces a new chest pain patient pathway
- Expands acute medicine services at Charing Cross and St Mary's hospitals

From the options considered the preferred option which forms this proposal delivers the best value for money and the following quality benefits:

- Direct access to specialist ward
- Streamlined pathways for specialty medical patients
- Fewer transfers and waste associated with waiting for transfer
- Reduced length of stay
- Improved staff rota
- Enhanced training

Chest Pain Pathway
The recommended option for the chest pain pathway:

- Implements a new chest pain pathway and redesigns flow within Heart Assessment Centre
- Utilises Ward C8 to provide additional cardiology capacity of 10-15 beds
- Offers cardiology services (e.g. Cath labs, echocardiography, etc.) 7 days per week

From the options considered the preferred option which forms the proposal delivers the best value for money and the following quality benefits:

- A rapid 3-hour acute coronary syndrome assessment pathway which works for patients across the Trust
- Aim for correct physician first time
- Improve flow from diagnosis to investigation/treatment and transfer/discharge
- Co-location of services
- Do today's work today (i.e. not creating backlogs)
- Clear on-going pathways to reduce unnecessary follow up and investigation
- A 7-day service
- Clear pathways for patients needing to change service (e.g. elderly patients, post cardiac procedure/treatment who require moving to an elderly care bed)
- Improving patient and staff satisfaction
- No delays awaiting investigations.

Communications and engagement
Delivering an effective communications and engagement programme on these proposals is an important part of the process for achieving effective service change and delivering

benefits to patients.

The communications and engagement programme should help ensure the projects will benefit from patient, carer, local authority and local commissioner, and wider community feedback, so that the quality of the new pathways is as high as possible.

Financial impact:

The financial impact of the combined cases has been reviewed by the finance team with the delegated authority of the Chief Financial Officer. The Trust Executive Committee has accommodated, within the approved 2016/17 capital plan, the required capital investment of £318,000. It is noted that £207,000 of the capital requested is for lift improvement works required for the chest pain pathway proposal.

It should also be noted that the Imperial College Healthcare Charity has kindly committed to making a generous contribution of £108,000 to fund key pieces of equipment required to implement the chest pain pathway.

The combined cases are anticipated to deliver savings of approximately £282,000 for financial year 2016/17, £690,000 for 2017/18, £781,000 recurrent full year saving in future years and total projected discounted savings (adjusted time value of money) through to 2021/22 totalling £3.2m.

Risk impact:

Risks around the communications and engagement plan relate to:

1. process (requires support of the relevant CCGs and Local Authority Health Overview and Scrutiny Committees), and;
2. engaging effectively with the public, patients and key stakeholders to ensure that all relevant points of view are heard within the required timeframe.

The main tools to manage these risks are:

- to agree the appropriate level of communications and engagement on the proposals with local commissioners and local authorities, and;
- to design a communications and engagement plan to capture comments and feedback from stakeholders and the wider system in a timely manner for the Trust Board to consider before reaching a decision.

Recommendation to the Trust board:

To approve that communication and engagement on the proposals for acute medicine and chest pain pathways proceeds followed by a further report for consideration by the Trust board on the outcomes of this process before making a final decision on implementation of the new pathways.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Nick Lawrance (CSIP) /Mick Fisher (Communications)	Dr William Oldfield	20 May 2016

Proposals for Acute Medicine and Chest Pain Pathways

1. Purpose of report

This report sets out the case for change and the proposals developed by Trust clinicians for improving the current acute medicine and chest pain patient pathways.

Trust Board approval is sought for the communications and engagement plan for the proposed changes to the acute medicine and chest pain pathways.

Further approval is sought to return to the July public meeting of the Trust Board with a report on the feedback from the engagement process with a view to making a recommendation about implementing the new pathways from August 2016.

2. Introduction

2.1. Imperial College Healthcare Trust's Clinical Strategy

The Trust's Clinical Strategy sees our three main hospital sites building on their own distinctive, but interdependent, focus:

- **Charing Cross Hospital**: evolving to become a new type of local hospital, with planned, integrated and rehabilitation care
- **Hammersmith Hospital and Queen Charlotte's & Chelsea Hospital**: extending their role as specialist hospitals
- **St Mary's Hospital with a co-located Western Eye Hospital**: being the major acute hospital for the area.

2.2. Clinical Strategy Implementation Programme

The Clinical Strategy Implementation Programme (CSIP) develops the detailed plans to deliver end state on each site, leading a core of changes every year to 2020 and beyond. It will also help shape redevelopments on each site, help set out how we achieve standards for seven day services, the workforce strategy for the Trust and our approach to achieving financial sustainability.

Four work-streams were developed in September 2015 as 'phase one' of CSIP. These were selected by the Trust's executive committee with the aim of addressing the issue of in-patient capacity at St Mary's Hospital and stabilising acute medical services, whilst continuing to support the overall aims of the Clinical Strategy, through the identification of new clinical models, service changes and efficiencies.

The CSIP phase one work-streams were as follows:

- Developing the ambulatory care strategy
- Review of Vascular Surgical services
- Streamlining the pathway for non-elective patients presenting with chest pain
- Review of Acute Medical Services.

Strategic Outline Cases for acute medicine and chest pain patients' pathways were presented to the Executive Committee in February 2015, following which Full Business Cases were developed and put forward for approval in April 2015. These presented the case for change and preferred options for both these work-streams, as the proposals are interlinked and need to be considered together.

2.3 Patient pathways

'Patient pathway' is a term which hospitals use to describe the route that a patient will take from their first contact with the NHS – usually starting with an appointment with their GP, or presenting themselves to an urgent care centre or emergency department or being conveyed by ambulance to hospital - through referral, to the completion of their treatment and discharge.

It can be thought of as a timeline - on which every event relating to an individual patient's care can be entered. Events such as consultations, diagnosis, treatment, medication, assessment, and preparing for discharge from the hospital can all be mapped on this timeline.

3. The case for change

3.1 Acute medicine pathway

Acute medicine is the part of general medicine concerned with the immediate and early specialist management of adult patients who present to, or from within, hospitals as urgencies or emergencies. Acute medical emergencies are the most common reason for admission to an acute hospital.

Acute medicine hospital services see patients presenting with a wide range of acute medical problems, but common problems treated include:

- heart problems
- asthma, chest infection and other respiratory conditions
- gastrointestinal bleeding
- drug and alcohol problems
- acute illness in the elderly
- diabetic complications
- acute infections and sepsis
- complications of drug and alcohol misuse

Acute medicine is closely linked to emergency medicine and critical care. Acute physicians manage the hospital intake of adult medical patients and lead the development of acute care pathways for a wide variety of clinical conditions.

Our Trust provides acute medicine services for adult patients at its three main sites: Charing Cross, Hammersmith and St Mary's hospitals.

The current acute medicine service at Hammersmith Hospital was reviewed and re-organised as part of the arrangements to manage the safe closure of the emergency unit and the expansion of the urgent care centre to a 24/7 service in September 2014.

Acute medicine at Hammersmith Hospital is provided through the Specialist Medical Assessment Centre and Ward C8. The patient case mix is mainly cardiology, renal and haematology and short-stay acute medicine. A telephone-based resource staffed by nurses offers advice and referral assistance for local GPs.

As Hammersmith Hospital builds its role as a specialist hospital further, it has become clear that the acute medical pathway is not providing the quick and seamless access to specialist teams which it was intended to, and, for many patients, is acting as an additional,

unnecessary stage in their care pathway.

The proposed change to the way acute medical services are delivered has a number of drivers, high among which are patient safety, improved quality of clinical care and experience, and the need to train within the specialty.

Acutely ill patients require rapid access to the right senior clinical decision makers who can provide clinical assessment and illness management.

Currently, patients can wait for a significant amount of time for a specialist care bed which delays their diagnosis, treatment, transfer or discharge.

Too many patients are simply waiting for a specialist bed which is something these proposals are set to change by providing direct access to specialties to address poor care and inappropriate use of resources.

There is therefore a clear need to improve how our acute medicine services are organised to provide more effective and efficient patient access to acute care - whenever that need arises.

3.2 Chest pain pathway

Currently, patients in West London who the London Ambulance Service suspect are having a heart attack are conveyed directly to the Heart Assessment Centre at Hammersmith Hospital. These proposals are not related to this patient pathway which will remain unchanged.

Many other patients who need specialist chest pain expertise will first be admitted for assessment to Charing Cross or St Mary's hospitals through their emergency departments before being transferred to the Heart Assessment Centre at Hammersmith Hospital. This way of working adds an additional, unnecessary stage to the patient's care pathway.

These patients frequently comment on the number of different hospitals and wards they visit before arriving at the Heart Assessment Centre at Hammersmith Hospital and do not understand why this happens.

After being assessed at Charing Cross or St Mary's hospitals, patients must wait for a bed to become available in the Heart Assessment Centre and then for transport to be arranged to Hammersmith Hospital. Upon arrival at the Heart Assessment Centre, patients are then assessed again.

Our data shows that 73 per cent of patients requiring a cardiology procedure directly admitted to Hammersmith Hospital have their procedure within 72 hours - while only 49 per cent of those coming from other hospitals - including St Mary's and Charing Cross hospitals - have their procedure within 72 hours.

These 'bottlenecks' in the flow of chest pain patients have led to prolonged admission times, longer average length of hospital stays, reduced quality of care and poor patient and staff experience.

The bottlenecks also result in patients occupying beds on our St Mary's and Charing Cross hospital sites which could be more usefully used by other patients who need them.

4. Proposed improvements to acute medicine and chest pain pathways

4.1 Proposal for acute medicine pathway

Our clinicians have worked up a detailed proposal for enabling faster direct access to specialist services at Hammersmith Hospital for long-term patients - primarily renal, haematology and cardiology services - when required, while boosting acute medicine provision for patients using our emergency departments at Charing Cross and St Mary's hospitals.

The Specialist Medical Assessment Centre and Ward C8 at Hammersmith Hospital are often used for patients waiting for a bed on a specialist ward. These proposals would provide direct access to specialist wards, for both patients admitted through our emergency departments or for long-term patients with whom we have established protocols for managing any deterioration in their conditions.

The proposal includes the following developments:

- new arrangements for receiving emergency renal and haematology patients through a specialist unit, providing a safe direct access pathway for patients into these specialties and a reduction in inter-hospital transfers

- expansion of acute medicine services at Charing Cross Hospital and St Mary's Hospital

- introduction of an improved chest pain patient pathway - see below.

This proposal is also designed to help us continue to make improvements in junior doctor training and staffing.

It has been increasingly difficult over recent years to staff the junior doctor rotas that provide the acute medicine service at Hammersmith Hospital, especially out-of-hours. Our doctors in training need to have a good breadth of experience on their acute medicine rotation and the specialist focus of the Hammersmith Hospital site means that is difficult to provide.

Consolidating our acute medicine rotas at Charing Cross and St Mary's hospitals will provide junior doctors with a better training experience and reduce reliance on expensive locum staff.

4.2 Proposal for chest pain pathway

The second related proposal developed by Trust clinicians is designed to improve care for patients with chest pain, building on the major advances in outcomes achieved by consolidating care for patients with suspected heart attacks and other very serious, acute heart conditions at the Heart Assessment Centre at Hammersmith Hospital.

There are many potential causes of chest pain which is not always caused by a problem with the heart, but it can sometimes be a symptom of:

- angina – where the blood supply to the muscles of the heart is restricted
- heart attack – where the blood supply to part of the heart is suddenly blocked

Most chest pain is not heart-related and is not a sign of a life-threatening problem. Some common causes of chest pain include:

- Gastro-oesophageal reflux disease
- Bone or muscle problems
- Anxiety and panic attacks
- Lung conditions

Other possible causes include:

- shingles
- mastitis
- acute cholecystitis
- stomach ulcers
- a pulmonary embolism
- pericarditis

The appropriate hospital specialty or service which will eventually provide patient care and treatment therefore depends on the outcome of the diagnosis of an individual patient's chest pain.

Our clinicians have been working with London Ambulance Service and other partners to explore how we could build capacity and pathways at Hammersmith Hospital so that more patients with chest pain are able to go to the Heart Assessment Centre directly.

The proposal includes the following developments:

- phase 1 - patients presenting at St Mary's or Charing Cross hospitals' emergency departments with chest pain presumed to be of cardiac origin (i.e not respiratory or gastro-related) to be transferred directly to the Heart Assessment Centre at Hammersmith Hospital

- phase 2 - patients who present to London Ambulance Service with chest pain which is presumed to be of cardiac origin (i.e. not respiratory or gastro-related) and who previously would have been conveyed to Charing Cross or St Mary's hospitals' emergency departments, to be conveyed directly to the Heart Assessment Centre at Hammersmith Hospital

- improved facilities at the Heart Assessment Centre to create a better, more private environment for patients

- an additional 10-15 cardiology beds at Hammersmith Hospital where patients can recuperate after their treatment in the Heart Assessment Centre and provide the capacity to accept patients more quickly.

- closer working between cardiology and other clinical teams - such as medicine for the elderly - to ensure patients who, post assessment and/or procedure, do not require further specialist cardiology care are either quickly referred to another specialist service, if required, or safely discharged.

As stated above, patients in West London who the London Ambulance Service suspect are having a heart attack and are currently conveyed directly to the Heart Assessment Centre at Hammersmith Hospital. These proposals are not related to this patient pathway which will remain unchanged.

4.3 Potential timescales

The proposal is for these changes to take place from August 2016, subject to the outcomes of the engagement process and further consideration of these by the Trust Board before reaching a decision.

4.4 Benefits of the proposed changes

We believe that the proposed changes will bring significant benefits for patients, their families and carers, and our staff, through:

- Patients seeing the right physician and receiving the right care and treatment in the right facilities first time
- Improved outcomes for patients
- Reduced patient transfers between hospitals
- Better patient experience
- Reduced average length of stay for patients
- Patients who need specialist chest pain expertise being able to directly access our cardiology team at the Heart Assessment Centre at Hammersmith Hospital
- Improved facilities at the Heart Assessment Centre to create a better, more private environment for patients and improve patient flow through the department
- Additional 10-15 cardiology beds at Hammersmith Hospital where patients can recuperate after their treatment in the Heart Assessment Centre
- Improved, direct access to specialist renal and haematology services at Hammersmith Hospital
- Expanded acute medicine services at Charing Cross Hospital and St Mary's Hospital
- Supporting Hammersmith Hospital as the centre of excellence for specialist services, focused on meeting the needs of patients with cardiac, cancer, renal and haematological disease.

5. Legal obligations and guidance for communications and engagement

There is a range of legal and policy requirements on NHS organisations that directly impact on the duty of the NHS to communicate with patients and the wider public. NHS bodies are required to comply with this legislation and policy. In summary these include:

- Section 11 of the Health and Social Care Act 2001
- The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
- Section 242 and Section 242 of the NHS Act 2006
- Department of Health 'Real Involvement' guidance, October 2008
- Coalition Government 'Equity and Excellence: Liberating the NHS', July 2010
- Department of Health four reconfiguration tests, August 2010
- Health and Social Care Act 2012, sections 13Q and 14Z2
- NHS England 'Transforming Participation in Health and Care', September 2013
- NHS England 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', December 2013
- NHS England 'Planning and delivering service changes for patients', December 2013
- Local Authority Health Scrutiny, June 2014

There is a clear duty on NHS organisations to involve patients and the public whether or not a service change proposal constitutes a 'substantial variation' or 'substantial development'.

All service change proposals need commissioner ownership, support and where appropriate leadership - even if the change is initiated by the Trust as an NHS provider of services.

In the case of 'substantial developments' or 'substantial variations' to services which are the commissioning responsibility of clinical commissioning groups (CCGs) or NHS England, consultation is to be led by NHS commissioners rather than providers i.e. by the relevant CCG or NHS England.

In terms of the health scrutiny regulations, NHS commissioners must consult relevant local authorities where there is a 'substantial development of the health service', or 'a substantial variation in the provision of such a service'.

The Trust has already begun to engage with local commissioners and the relevant local authority Health Overview and Scrutiny Committees (OSC) to establish whether these proposed service changes would require a full formal consultation or if a local engagement programme is appropriate.

6. Benefits of information, engagement and consultation

There are many benefits to proactive provision of information and engagement and, where appropriate, consultation for an NHS organisation, including:

- developing a patient focused service
- allowing greater public participation
- developing services that meet the needs of local people
- improving relationships
- generating new ideas
- increasing public awareness and education about NHS services
- achieving cost efficiency and value for money
- helping to plan, prioritise and deliver better services.

7. Communications assessment of acute medicine and chest pain proposals

Each proposal (or combined proposals in this case) for a service change needs to be considered and assessed on a case-by-case basis. The legal framework and associated regulations and guidelines are not definitive as to what constitutes a major or 'substantial' change to a service and whether formal consultation is required or if engagement or information is appropriate.

Based on an assessment of the business case reports prepared by the CSIP team, it is recommended that the Trust Board approves an engagement programme for the combined service change proposals.

If given the go ahead by the Trust Board, this communications plan for the acute medicine and chest pain proposals would feature an engagement programme (or 'informal consultation') lasting at least four week in the June/July period to explain our plans and to seek feedback from local residents and patients, local authorities and commissioners, and other stakeholders.

However, as stated above, the Trust does not decide by itself which is the appropriate level of communication on a service change proposal. The relevant local authorities for the boroughs of Hammersmith & Fulham and Westminster respectively, and NHS Hammersmith & Fulham CCG (on behalf of all North West London CCGs) have been notified about the

forthcoming proposals in recent meetings and via email correspondence to elicit their views on the appropriate level of patient and public engagement.

Local commissioners at NHS Hammersmith & Fulham Clinical Commissioning Group have taken the initial view that in principle an engagement programme on these proposals would be appropriate. Further meetings with the CCG where the proposals will be subject to further discussion are scheduled to follow immediately after the May Trust Board meeting.

The response received from the chair of the Health OSC for Westminster City Council has raised no objections to the proposed engagement approach. At the time of preparing this report we are awaiting the response of Hammersmith & Fulham Council's Health OSC.

8. Audiences and communications channels

8.1 Audiences

The main audiences for the engagement programme can be considered in three main categories:

Internal audiences:
- Staff actively involved in delivering the service
- Staff representatives (e.g. trade unions)
- Staff in adjacent clinical services
- All other Trust staff

Patients and communities:
- Patients and families/carers
- Service user groups e.g. West London Kidney Patients Association, Hammersmith Hospital Red Cell Patient User Group
- Trust strategic lay forum
- Healthwatch and patient user groups/representatives
- CCG patient reference groups
- Shadow FT members
- Local communities and the public

Stakeholders and partners:
- NWL CCGs
- NHS England (London)
- Elected representatives: primarily local authority scrutiny committee/s and cabinet member for health (and officers), MPs, London Assembly Members, MEPs
- NWL GPs
- NHS Improvement
- Other NHS providers and organisations
- Education bodies
- Professional bodies
- London Ambulance Service NHS Trust

8.2 Communications channels

The engagement period will feature a publication setting out the case for change and the proposals to explain why and how the Trust wants to improve the acute medicine and chest pain patient pathways. The proposals document will clearly state that the Trust wishes to engage as widely as possible on the proposals and how comments and feedback can be

provided during the engagement period.

Audiences	Communications channels
Staff	Staff team meetings, Clinical division staff meetings, CEO staff sessions, weekly In Brief, Trust intranet
Patients	Users' group meetings, Healthwatch, CCG patient reference group, Trust website
Shadow FT members	Dedicated email/letter; Membership update newsletter, Trust website
Stakeholder organisations and representatives	Face-to-face meetings, speaking engagements/existing meetings, personalised letters/emails, Partner Update newsletter, GP Bulletin newsletter
Community organisations	Speaking engagements/existing meetings, personalised emails/letters
General public	Trust website
Media	News releases
Social media	Trust Facebook page, Twitter

9. Timelines for engagement

9.1 Public engagement

The communications and CSIP teams are working together to plan an engagement programme according to a timeline which concludes with reporting feedback to the Trust Board's public meeting at the end of July for their consideration and decision.

This plan would feature an engagement programme (or 'informal consultation') lasting at least four weeks in the early summer (June/July) to make the case for change and explain our proposals and to seek feedback from local residents and patients, local authorities and commissioners, and other stakeholders.

Some communication and engagement has already been undertaken through key stakeholder meetings and email correspondence and our regular newsletters to GPs and shadow foundation trust membership.

The engagement period will feature a publication on the proposals to explain why and how the Trust wants to improve the acute medicine and chest pain patient pathways. All stakeholders and interested parties will have the opportunity to make any comments or raise questions about the proposals.

9.2 Trust staff engagement

Once timelines are defined, the formal consultation process with Trust staff directly affected by the proposals would be organised and delivered in accordance with Trust policy.

10. Recommendation to the Trust board

To approve that communication and engagement on the proposals for acute medicine and chest pain pathways proceeds followed by a further report for consideration by the Trust Board on the outcomes of this process before making a final decision on implementation of the new pathways.

Imperial College Healthcare NHS Trust

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

Sustainability and Transformation Plan (STP)

Executive summary:

STPs are 'place based', five-year plans built around the needs of local populations and which support the implementation of the NHS England's Five Year Forward View (FYFV) and NHS Planning Guidance for 2016/17–2020/21.

STPs are of great importance as they describe the multi-agency strategic direction agreed by all partners in the local health and care system necessary to develop high quality sustainable healthcare and, from next year, will determine access to the NHS Sustainability and Transformation Fund (STF) which will total £3.4bn by 2020/21.

To develop the STP, the 8 boroughs in North West London (NWL) have agreed to work together co-ordinated through a Strategic Planning Group (SPG) chaired by Dr Mohini Parmar. Our Trust chief executive Dr Tracey Batten is the provider sector lead for the group, which comprises senior executives from commissioning, health and wellbeing, Local Authorities, public health, mental health and other stakeholders. The SPG reports to the existing statutory bodies in NWL and has no decision-making powers.

A first draft of the NWL STP was submitted to NHS England in April 2016. The draft STP builds on the existing NWL vision of care and quality that is personalised, localised, co-ordinated and specialised where necessary. Three themes of prevention, integration, technology and innovation are identified to address the gaps in the FYFV.

Membership of the Local Integration and Collaboration Groups is the mechanism through which organisations across the NWL engage with and help to shape the STP.

Plans are being developed for sharing and seeking feedback on the draft STP from staff, patients, GPs, local citizens and other stakeholders across north west London during the first three weeks of June, prior to finalising the plan for submission on 30 June 2016.

Quality impact:

Financial impact:

Risk impact:

Recommendation(s) to the Committee:

To note the progress report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Anne Mottram, Director of Strategy	Dr Tracey Batten, Chief Executive Officer	19 May 2016

North West London (NWL) Sustainability and Transformation Plan (STP)

May 2016

1. Introduction

1.1 The Five Year Forward View (FYFV) set out the vision to galvanise all stakeholders working across the system to collaboratively bring about transformational change, notably to reduce variation in care, return the NHS to aggregate financial balance and to address three key gaps:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

1.2 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17– 2020/21', identified the steps that local organisations should follow to deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

The planning guidance also introduced a new Sustainability and Transformation Fund (STF) available to organisations able to meet the required DH conditions. The STF seeks to support financial balance, the delivery of the Five Year Forward View, and enable new investment in key priorities. The STP Fund is expected to rise to £3.4 billion by 2020/21.

2. Sustainability and Transformation Plans (STP)

STPs are 'place based', five-year plans built around the needs of local populations and focus on enabling people to be well and to live healthy, empowered lives.

STPs are of great importance as they will set out the multi-agency strategic direction to build sustainable healthcare, address the wider social determinants of health and provide future access to the STF.

To deliver the STPs NHS providers, Clinical Commissioning Groups (CCGs), local authorities, public health and other health and care services have come together to form 44 STP 'footprints' or geographic areas where they will work together to develop plans to transform the way that health and care is planned and delivered for local populations. The footprints are of a scale which should enable transformative change and takes into account: Geography, patient flow, travels links and how people use services, fit with existing change programmes/relationships, financial sustainability of organisations in an area and leadership capacity and capability to support change.

Figure 1 and table 1 show the boundaries and population size of the footprints.

Diagram1. The 44 STP Footprints

Table 1. Size of Footprints

NHS region	Total STP footprints	Average CCGs per footprint	Average footprint population m
England	**44**	**4.8**	**1.2**
North	9	7.4	1.7
Midlands & East	17	3.6	1.0
London*	5	6.4	1.7
South	13	3.8	1.1

*The footprints for London comprise: North West London (Population 2.0), North Central London (1.4) North East London (1.9), South East London (1.7), South West London (1.5).

3. NWL STP

3.1 Governance and Leadership

The eight boroughs in North West London (NWL) have agreed to work together to develop the NWL STP and the necessary programme arrangements.

The STP Leadership team (shown in table 2) comprises senior representatives from stakeholders and provides the mechanism through which the local integration and collaboration forums engage with and input into the development of the STP.

The Strategic Planning Group (table 3) comprises a wider group of stakeholders and oversees the STP development; it has no decision-making powers with organisations reporting to their own statutory bodies.

Table 2. NWL STP Leadership Team

Stakeholder Group	Representative
System Leader (Chair)	Dr Mohini Parmar, Ealing CCG Chair
Joint NHS Commissioner SRO	Clare Parker Chief Officer, Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCG
Joint NHS Commissioner SRO	Rob Larkman Chief Officer, Brent, Harrow, Hillingdon CCGs
Provider Lead	Dr Tracey Batten Chief Executive, Imperial College Healthcare Trust
Local Authority lead	Carolyn Downs Chief Executive, Brent Council
STP Programme Director	Matt Hannant, CCG Director Strategy & Transformation

Table 3. NWL STP Strategic Planning Group

Stakeholder Group	Representative
System Leader (Chair)	• Dr Mohini Parmar, Ealing CCG Chair
Eight Boroughs	• Local Authorities • CCGs
Acute Trusts	• ICHT • Chelsea & Westminster • London North West Hospitals • Hillingdon Hospitals • Royal Brompton Hospital • Royal Marsden
Mental Health Trusts	• Central & North West London • West London Mental Health Trust
Community Trusts	• Central London Community Trust • Hounslow & Richmond Community Healthcare
Others	• Lay Partners • London Ambulance Service • HENWL • Specialised Commissioning • Imperial College Health Partners • West London Alliance

3.2 NWL Draft STP

The draft STP submitted to NHS England for the April deadline builds on the existing NWL vision of care and quality that is - personalised, localised, co-ordinated and specialised where necessary. Three themes of prevention, integration, technology and innovation are identified to address the gaps in the FYFV and to understand the local needs, population based segmentation was used to identify nine emerging priorities for the April draft STP:

1. Support people who are mostly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Reduce social isolation
3. Improve children's mental and physical health and well-being
4. Ensure people access the right care in the right place at the right time
5. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population
6. Improve the overall quality pf care for people in their last phase of life and enabling them to die in their place of choice
7. Improve consistency in patient outcomes and experiences regardless of the day of the week that services are accessed
8. Reducing unwarranted variation in the management of long term conditions – diabetes, cardiovascular disease and respiratory disease
9. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart disease and respiratory illness

It should be noted that as the STP plans develop and as communication and engagement initiatives gain momentum there may be further iterations of the April draft priorities for the final STP submission.

Appendix 1 is a summary of the draft April STP submitted to NHS England.

3.3 Communication and Engagement

Plans are being developed for sharing and seeking feedback on the draft STP from staff, patients, GPs, local citizens and other stakeholders across north west London during the first three weeks of June, prior to finalising the plan for submission on 30th June 2016.

4. Milestones

The final NWL STP is due to be submitted to NHS England on the 30th June 2016.

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

Summary of the 15 April 2016 submission to NHS England

DRAFT, NOT FINAL
Created May 2016

North West London – proud to be London

The North West London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospital trusts

2 mental health trusts

2 community health trusts

North West London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford, which include landmarks such as Big Ben, Oxford Street, Heathrow Airport and Wembley Stadium.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in North West London (NW London) – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- There is a 17-year difference in the life expectancy between the wealthiest and poorest parts of our boroughs
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average
- If we do nothing, there will be a £1bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the broader determinants of health and wellbeing such as housing and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs.** In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

Understanding our population – the health and wellbeing of NW London

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (above 50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- High proportions living in **poverty and overcrowded households**
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**
- State primary school **children with high levels of obesity**
- **19% of our population are unhealthy**

Mostly healthy

- 1.65m people in NW London are mostly healthy
- 81% of the total population
- 37% of care spend in NW London

In 2030:
- 4.3% more people in this segment
- 31% more +65s

One or more long-term conditions

- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030
- 35% more adults in this segment
- 37% more spend in NW London

Cancer

- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4.5% of care spend in NW London

In 2030:
- 53% more adults in this segment
- 20% more spend in 2030 on adults

Serious and long term mental health needs

- 15,000 adults in NW London have serious and long term mental health needs
- 0.7% of population
- 7.5% of care spend

In 2030:
- 27% more adults in this segment
- 21% more spend in 2030 on adults

Learning disability

- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8.2% of care spend in NW London

In 2030:
- 29% more adults in this segment
- 35% more spend in 2030 on adults

Severe physical disability

- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults in this segment
- 26% more spend in 2030 on adults

Advanced dementia / Alzheimer's

- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults in this segment
- 45% more spend in 2030 on adults

The NW London segmentation framework was coproduced by the sector, including lay partners, based on common need, and a regression analysis of cost based on a variety of factors i.e. age. Validation was carried out on a linked data set from H&F. These factors drive considerable need for services and rising costs.

Sources: ONS (2014/15 estimates and 2011 census), HSCIC, Public Health England 2014/15, Greater London Authority, London Health Commissioning Framework

Our ambitions for NW London – helping people to be well and live well

We want people in NW London to **be well and live well,** enabled to live as healthy and full a part of London life as possible. We want to create a truly sustainable health and care system, paying its way as part of the London economic powerhouse. We are on a journey to achieve this, as described below, but realise there is more to do.

This STP is part of our continuing journey of collaboration and transformation

2011	NHS in NW London agreed its 'Case for Change', describing how care, quality and financial sustainability within the NHS could be transformed.
2013	Local NHS sub-regional NW London Programme Board agrees *Shaping a Healthier Future* (SaHF) Decision Making Business Case clinical strategy setting out a vision to localise, centralise and integrate care and reconfigure acute services – endorsed by Secretary of State. Eight clinical commissioning groups form NW London Collaborative.
2014	'Whole Systems Integrated Care' strategy setting out vision for person centered, proactive and coordinated care agreed by NW London Partnership Board of NW London Collaborative and local government – publishes 'the toolkit'. NW London becomes a National Pioneer in Integrated Care with ten Early Adopters implementing new models of care. Better Care Fund established across all Boroughs with pooled budgets to support local joint commissioning. In 2015/16 pooled budgets across eight boroughs is £168m Healthcare Commission publishes 'Better Health for London', ten priorities supported by all stakeholders in NW London.
2015	NW London Programme Board oversees implementation of first phase SaHF service changes: A&E and maternity improvements, plans for pediatric improvements. NW London becomes a Seven Day Services Early Adopter.
2016	NW London agrees 'Like Minded' mental health and wellbeing Case for Change and vision. NW London agrees to be part of 'London Health and Care Collaboration Agreement' and forms Strategic Planning Group of 31 organisations. First established accountable care partnership

Improvements delivered

- Pilot established for multi disciplinary teams in managing the care of selected over 65s, implemented care planning and recruited care navigators.
- Integrated delivery teams for community care.
- 1.9m have access to weekend primary care appointments, supported by Prime Minister's Challenge Fund.
- 280,000 patients have access to web-based consultations.
- Primary Care is working at scale. All eight CCGs have federation population coverage of above 75%.
- Improved maternity pathway including 100 extra midwives.
- Increased maternity consultant cover from 108 to 122 hours per week.
- Paediatric Assessment Units in all major hospitals by end of 2016/17.
- Single points of access for urgent care and mental heath crisis.
- Psychiatric liaison in all A&Es and UCCs in NW London.
- New eating disorder services and perinatal mental health services.
- Single hospital discharge process across health and social care will be piloted across NW London.
- Working together, all of our local organisations published borough-level health and wellbeing strategies.
- Pooled BCF budget of £168m in 15/16, with increased focus on nursing care, rehabilitation and reablement and third sector commissioning.
- Significant social care efficiencies made to protect social care budgets through working at scale across NW London boroughs.
- One emergent Accountable Care Provider in Hillingdon, building on the work of the WSIC Pioneer programme.

Shaping a Healthier Future sets out how we could improve quality of care, save 130 lives a year and address a growing financial challenge through a significant shift of activity into the community from hospital settings and the reconfiguration of acute services to attain the London quality standards. In addition there are a wide range of other areas where we are working closely together to improve care and health in the areas set out in the planning guidance.

We see the STP as an opportunity to create a transformational step change in areas such as prevention, integration and digitisation, and to align our shared objectives and priorities as we collaboratively develop a delivery-focused plan that addresses the big challenges for people in NW London.

Whilst SaHF does not address the full set of challenges described in the Five Year Forward View, and there is not full support for reconfiguration plans, we intend to work together on areas where there is joint agreement and to move forward locally in delivering a health and care system that improves health and wellbeing, care and quality and closes the productivity and financial gap for the whole system.

Building on our strong history of joint working, and as part of the transformational step change set out in our STP plan, we believe that we are well placed to take on additional responsibilities at a local level through a Devolution Deal for NW London. The specific areas of focus that we will be seeking to devolve will be further refined in the final plan.

Working together to address a new challenge

To enable people to be well and live well, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities:

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

Leadership and collaboration

NW London has meaningful leadership and robust governance to drive transformational change

There is a history of collaboration at a sub-regional level in NW London across both health and local authorities. To help us work most effectively we have in place a robust governance structure and leadership arrangements.

NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership.

With the development of the STP, we have strengthened our ways of working. We will use the Strategic Planning Group as the initial governance forums for the plan's development. The pan-NW London governance structure will be set up to mirror the local governance arrangements. Local governance will retain sovereignty over decisions in line with the London Devolution Deal.

Underpinning all leadership and governance is our partnership with our service users and our workforce

We continue to ensure that people's voices drive our decision-making:

In NW London we collaborate with people, service users and patients at all stages of the commissioning, mobilisation and delivery cycle; **co-production with service users is fundamental to our culture** and we have been recognised for our 130 strong Lay Partner Forum and its approach to co-production, which includes significant engagement with other patient groups including Healthwatch and Patient and Public Participation Groups. The NW London Self-Care Task and Finish Group, whose membership includes voluntary and community group members, lay members, service users, commissioners and providers, has co-developed and continues to support the embedding of the self-care commissioning framework. The Triborough's Community Champion Programme uses a dynamic community engagement process to co-produce local health campaigns and neighbourhood services.

To date we have engaged extensively as we developed our Health and Wellbeing Strategies, Shaping a Healthier Future, and Like Minded. We will be continuing these conversations with people in NW London during the development of the STP, and during its implementation.

We are investing in our workforce and ensuring they are supported throughout all changes:

We have great people working in support, care and health organisations in NW London and a clear vision for change developed with those people. We also understand that the people who live in NW London are a huge part of the 'informal workforce' and also need support.

To deliver our vision we need to make sure that **all our professionals are engaged in the process of change, own that change and then receive the training and development they need to implement those changes**.

STP Leadership Team

The STP is led by the appointed STP System Leadership Team, which meets weekly and includes representation from all of the key stakeholder groups in our system:

Dr Mohini Parmar *System Leader*
(Ealing CCG Chair)

Carolyn Downs *Local Authority Lead*
(Chief Executive, Brent Council)

Clare Parker *Joint NHS Commissioner SRO*
(Chief Officer CWHHE CCGs)

Dr Tracey Batten *Provider Lead*
(Chief Executive, Imperial College Healthcare Trust)

Rob Larkman *Joint NHS Commissioner SRO*
(Chief Officer BHH CCGs)

Matt Hannant *STP Programme Director*
(CCG Director of Strategy & Transformation)

Understanding people's needs

Understanding our people's needs is vital for planning local and NW London wide services and initiatives. Our segmentation approach supports the development of new models of care

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease

- **Brent**, the most densely populated London Borough, is ranked amongst the top 15% most-deprived areas in the country
- Between 2011 and 2021 the population aged 85+ is expected to grow by 72%
- Brent is ethnically diverse with 65% from BME groups
- There was a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13
- Brent children have worse than average levels of obesity – 11% of children aged 4-5, 24% of children aged 10-11 years

- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 19.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- BME communities, including individuals of mixed ethnicity, made up 46% of the Ealing's total population in 2012
- The main causes of death are cardiovascular disease accounting for 31% of all deaths
- The mortality rate from respiratory disease is 45% higher in Ealing than the NW London average

- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2012, Westminster had the seventh highest reported acute Sexually Transmitted Infections (STI) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 262,000 people, the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

- **Hammersmith & Fulham** is a small, but a densely populated borough with 179,000 resident with one in four born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD
- Mental health is the most common reason for long term sickness absence

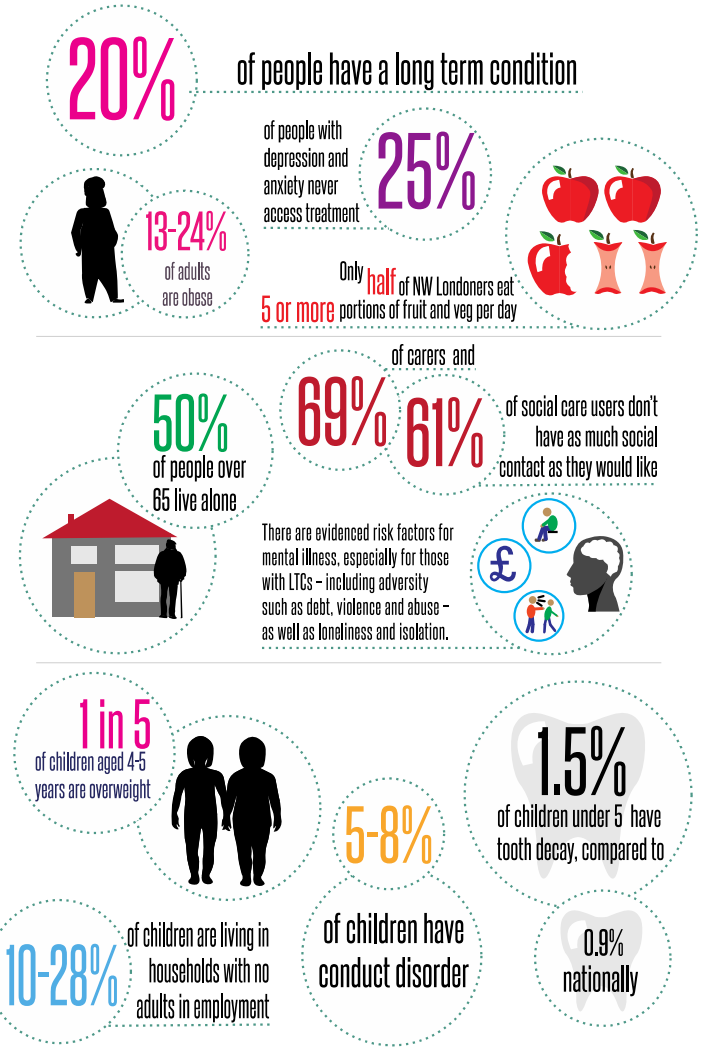
- **Kensington & Chelsea** has a very large working age population and a small proportion of children (the second smallest in London)
- Half the area's population were born abroad
- The principle cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

Sources: HSCIC, Shaping a Healthier Future
Statistics are being updated to reflect most recent data

We will improve the health and wellbeing of people in our area

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…



Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

Our Emerging Priorities

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Reduce social isolation
3. Improve children's mental and physical health and well-being

Our vision for health and wellbeing:

"My life is important, I am part of my community and I have opportunity, choice and control"

"As soon as I am struggling, appropriate and timely help is available"

"The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me"

"My wellbeing and happiness is valued and I am supported to stay well and thrive"

"I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing"

We will improve care and quality

Our as-is…	Our to-be…	Our Emerging Priorities
Over 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy.	4 Ensure people access the right care in the right place at the right time.
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health.	5 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population.
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences.	6 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice.
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year.	7 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves.	8 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease.
1500 people under 75 die each year from cancer, heart diseases and respiratory illness. **If we were to reach the national average of outcomes, we could save 200 people per year.**	People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.	9 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness.

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

Our emerging priorities and areas of focus

The table below summarises the emerging priorities identified in Section 2 and addresses the three gaps in the Five Year Forward View. These priorities map to our core themes for addressing the challenges in NW London. Further work will be done on these before the end of June.

Triple Aim		Emerging priorities	Themes for addressing the priorities
Improving health & wellbeing Improving care & quality Improving productivity & closing the financial gap	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves	**Prevention** People supported to take responsibility for their own wellbeing and health and making healthy choices
	2	Reduce social isolation	
	3	Improve children's mental and physical health and well-being	
	4	Ensure people access the right care in the right place at the right time	**Integration** Local integration of services across all providers at the place where the person needs it (primary, community, MH, some acute) delivered via joint teams
	5	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population	
	6	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	
	7	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed	
	8	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**Technology & Innovation** Fully digital care and support, integrated health and social care information, right information available in the right place at the right time, paperless services
	9	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	

Appendix 1: Partnership organisations with the NW London STP Footprint

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board	25 May 2016

Safeguarding Children & Young People Service Annual Report 2015-2016

Executive summary:

The Trust board is asked to note and approve the Safeguarding Children and Young People Declaration, which is required to be posted on the Imperial College Healthcare NHS Trust website. The declaration has been recommended for approval by the Executive Quality Committee and Quality Committee.

The Board are to receive the annual report; setting out progress in 2015/16 and actions for 2016/17.

Quality impact:

This paper relates to the CQC Safe domain.

Financial impact:

A review will be undertaking to determine workload in 2016-17.

Risk impact:

There is currently a risk on the risk register rated 12 regarding the capacity of the children's safeguarding team. This will continue to be reviewed in light of new posts agreed and further posts that may be required as a result of the safeguarding review. This will be addressed following completion of the Phase 2 trust restructures.

Recommendation(s) to the Committee:

The Board are asked to approve the Safeguarding Children and Young People Service Report for 2015-16.

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

Author	Responsible executive director	Date submitted
Sarah Green, Named Nurse for Safeguarding Children and Young People Lynda Hassell, Deputy Divisional Director of Nursing – Women's and Children Division	Janice Sigsworth, Director of Nursing	18 May 2016

Imperial College Healthcare NHS
NHS Trust

SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE ANNUAL REPORT 2015-2016

1. BACKGROUND

The Children Act 1989 HM Gov. (1989), the Children Act 2004 HM Gov (2004) and the Government's Statutory Guidance contained within Section 11 of the Children Act 2004 specifies that the Trust Board has a legal responsibility to safeguard and promote the welfare of children and young people.

The Healthcare Commission's Child Safeguarding Review in February 2009 highlighted cause for concern in areas of England and Wales resulting in the Secretary of State requesting that the Care Quality Commission (CQC) undertake a review of arrangements across the NHS for safeguarding children and young people CQC (2009).

The Trust Board received David Nicholson's letter of the 16th July 2009 setting out the minimum requirements for Trust Boards to be assured that appropriate arrangements were in place for safeguarding children and young people and directing that a declaration should be placed on the website of each provider and commissioning Trust confirming that requirements were in place for safeguarding children and young people. A declaration was first placed on the Imperial College Healthcare NHS Trust (ICHT) website on 19th October 2009 and an updated declaration is placed on the website annually. The March 2016 declaration is included in Appendix 1.

2. CONTINUING IMPROVEMENTS TO THE SAFEGUARDING CHILDREN AND YOUNG PEOPLE SERVICE FOR 2015- 2016

Thirteen priorities were identified for 2015-2016; progress against these is reported below:

2.1 To develop and launch a Trust wide Safeguarding Children and Young People Operational Strategy

Due to the Trust restructure, Safeguarding Review and the recruitment of a new Adult Safeguarding Lead in March 2016, a joint operational strategy between the Safeguarding Children and Adults Team will now be considered for 2016-17 with the new and expanded team in place.

2.2. *To develop a Trust wide Domestic Violence Policy together with the Safeguarding Vulnerable Adults Team and Standing Together*

A Trust wide Domestic Violence Policy together with the Safeguarding Vulnerable Adults Team and Standing Together has been produced and will be ratified at the May 2016 Safeguarding Children Committee. The Safeguarding Team continue to work closely with the domestic violence charity Standing Together on a project that was funded from the Big Lottery. This enabled Independent Domestic Violence Advisors to be placed in A&E and maternity. This ensures that any women who disclose domestic violence are risk assessed and followed up in a timely manner by one of the specialist advocates who then continue to work with them if required. In addition we have also been supplying additional training to staff to enable them to become Domestic Abuse Links (DALS) This has increased awareness, disclosures and subsequent referrals into the Safeguarding Team. Standing Together have applied to the Big Lottery for further funding to continue this project and a decision is expected to be made by the end of April 2016.

2.3 ***To adapt the Standard Operating Procedure for the admission of 16 to 18 year olds, in order to incorporate placements of all children on adult wards trust wide, taking into consideration that the NSF standards ended in 2014, it will therefore take into consideration the current relevant documents and standards guiding this practice***

This Standard Operating Procedure (SOP) sets out the key criteria for decision making in order to ensure that all adolescents are admitted to the department which best meets their needs. The document was updated to reflect the end of the NSF standards in 2014. The updated version has been circulated through the Safeguarding Children team and Children's directorate senior team in March 2016. The final version will be ratified and launched once the Trust wide 2016 restructure has been completed.

2.4 ***To achieve trust wide agreement from the Divisional Directors to the recommendations from the Review of Safeguarding Children Service; to form part of the 2015-16 Business Planning process***

The review was updated in late 2015 to incorporate the latest activity figures for the Safeguarding Children team in order to inform the business planning process for 2016/17. The review found that there had been a 97.5% increase in referrals relating to paediatric cases. This was thought to be due to a greater awareness generated by safeguarding training and by the additional safeguarding psychosocial meetings that have been put in place within the Western Eye Hospital and Adult A&E departments. A Risk Assessment was undertaken by the Deputy Divisional Director of Nursing for Children and Safeguarding and the named nurse for safeguarding children. As a result the Women and Children's Division have agreed to fund an additional band 7 Clinical Nurse Specialist to support the team.

In addition the paediatric Liaison Health Visitor now attends on a weekly basis to ensure there is a robust process for screening any children or Adults with Safeguarding concerns who have attended the A&E departments. These are then discussed at a weekly psychosocial safeguarding meeting to ensure that all cases have been followed up.

Further actions highlighted following the safeguarding review will be followed up following phase 2 of the organisational restructure.

2.5 ***To develop the Trust's Liaison Health Visitor /Nurse team and service to include the Western Eye Hospital***

The job plan for the liaison Health Visitor for Charing Cross Emergency Department (ED) has been reviewed to ensure that there is a weekly Safeguarding presence for the Western Eye Hospital, Hammersmith Hospital and Urgent Care Centres. The health visitor attends these sites on a weekly basis to liaise with staff, review activity and referrals. A weekly safeguarding support meeting is in place to review and discuss the previous week's referrals. In addition a multi-agency safeguarding meeting is held in the Emergency Department at Charing Cross Hospital at which any cases of adults presenting with safeguarding concerns, who have responsibility for children together with teenagers in the 16-18 age range who also present in this department are discussed.

2.6 ***To review the Safeguarding Children Supervision Policy and Practice***

The Safeguarding Children Supervision Policy has been reviewed with minor amendments made. It has been incorporated into the overarching safeguarding policy.

2.7 ***To develop more integrated working with the Trust's Vulnerable Adults Team***

A greater degree of integrated working has been incorporated between the safeguarding children and vulnerable adults teams. The named midwife attends the safeguarding vulnerable adults committee and the Deputy Director of Patient Experience, who is the Adult Safeguarding Lead, attends the Safeguarding Children Committee.

In addition there has been an increasing amount of integrated working in relation to corporate work including Cerner IT development.

A safeguarding lead nurse for adults has been appointed. Regular meetings will take place between the named safeguarding professionals to ensure this integration of services is developed.

2.8. ***To complete a Trust wide audit of adult areas to establish whether we are asking our patients if they have children at home and assuring ourselves that they are safe and being cared for***

The ability to ask this question has now been built into the Cerner functionality and will enable us to be able to more accurately audit this standard.

2.9 ***To achieve 95% of staff completing the appropriate level of safeguarding children training***

In March 2016 87% of staff completed the appropriate level of safeguarding children training. This is an increase from a figure of 80% in March 2015. The Safeguarding Team utilises a flexible approach to providing training at Level 3 to ensure that that these figures continue on an upward trajectory. In addition regular communication and planning takes place in conjunction with the Trust Core Skills Team. Training compliance figures is an agenda item on both the Divisional Women and Children's Quality and Safety Committee and Safeguarding and Young Peoples Committee.

2.10 ***To develop a Level 3 e- learning module to support the class room level 3 training.***

To further develop learning and accessibility for Level 3 Training, a selection of relevant courses have been identified, including e-learning packages. Accessing particular modules or courses will build on the face to face delivery of Level 3 training, enabling clinicians to enhance their safeguarding knowledge in areas particularly relevant to their specialty. The updated training policy will reflect this and will be ratified in May 2016. Details of the learning modules will then be incorporated into training delivery going forward.

2.11 ***To review the training matrix for staff that require safeguarding children training to clarify which level is required.***

Due to the introduction of the WIRED training reporting system, the allocation of safeguarding levels of training has been reviewed to ensure the allocation remains in line with the Royal College of Paediatrics and Child Health(RCPH) intercollegiate document 201 (see references). Minimal changes have been required and these are currently going through the Core Skills Training Team and Safeguarding and Young People Committee for approval.

2.12 ***To complete action plans that may arise from the Serious Case Reviews and Domestic Homicide Reviews in progress***

Four cases are under review and action plans are awaited.

2.13 ***Continued partnership working with our Inner North West London colleagues.***

The Trust continues to work in partnership with our Inner North West London Colleagues by ensuring continued attendance at Local Safeguarding Children Board meetings, and sub groups. The safeguarding team participate in multi-agency Level 3 training and joint project working. Named professionals have been part of the review team for Serious Case and Domestic Homicide Reviews.

3. GOVERNANCE ARRANGEMENTS FOR SAFEGUARDING CHILDREN AND YOUNG PEOPLE (CYP)

3.1 Executive Leadership

The Intercollegiate Guidance RCPCH (2014) defines roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation. In accordance with this, the Director of Nursing is the Trust Champion and Executive Lead for Safeguarding Children and Young People, and is a member of the ICHT Safeguarding Children and Young People Committee.

3.2 The ICHT Safeguarding Children and Young People Committee

The ICHT Safeguarding Children and Young People Committee was established in November 2009. The terms of reference were reviewed and amended in August 2014 and are due to be reviewed again in August 2017.

The ICHT Safeguarding Children and Young People Committee reports to the Trust Board via the Executive Quality Committee.

3.3 Implementing safe recruitment practices through rigorous disclosure and debarring service checks (formerly Criminal Records Bureau Checks)

The Trust carries out either enhanced or standard DBS checks on new employees in accordance with NHS Employers' guidelines. Compliance with this standard is monitored.

4. DEVELOPING CAPACITY AND CAPABILITY FOR SAFEGUARDING CHILDREN AND YOUNG PEOPLE

4.1 Named Individuals for Safeguarding Children and Young People

The named individuals for Safeguarding Children and Young People meet together with the specialist clinical leads, the Deputy Divisional Director of Nursing, Children and Safeguarding, and the team administrator at a six weekly operational group meetings. This meeting is structured to provide close monitoring of required actions. An action tracker spread sheet is updated each month to assure compliance and evidence against required actions.

4.2 Safeguarding Supervision for Staff Involved with Children and Young People

In order for the standard of Safeguarding of Children and Young People to continue to be of a high standard it is essential that all staff who have direct contact with children have appropriate safeguarding children supervision as set out in the Intercollegiate Document RCPCH (2014) and also recommended by the CQC.

The ICHT Safeguarding Children and Young People Supervision Policy sets out requirements for the relevant staff groups; this policy has been implemented and identified as a key performance indicator. Performance is reported quarterly to the Safeguarding Children and Young People Committee. The named nurse and named midwife receive formal supervision from the designated safeguarding nurse at the CCG.

5. POLICIES AND PROCEDURES IN PLACE TO SAFEGUARD CHILDREN AND YOUNG PEOPLE

Policy review and development continues to be a significant aspect of the Safeguarding Team's role. Safeguarding children policies are regularly reviewed to reflect national and local guidelines. In

February 2016 all four Trust policies relating to safeguarding children and young people were reviewed and amalgamated. The Safeguarding Children and Young People Operational Policy has been structured as five sections as follows;

- Underpinning principles
- Safeguarding considerations in the assessment of all children and young people
- Maternity specific considerations in safeguarding children and young people
- The ICHT Safeguarding Children and Young People Training Policy
- The ICHT Supervision Policy for the Safeguarding of Children and Young People.

This policy change was agreed at the February 2016 Safeguarding Children Committee and is in the process of being updated. The new policy will require ratification at the May 2016 Safeguarding Committee.

5.1 Assurance to our Commissioners

Reporting templates to provide assurance to our commissioners have been agreed at the ICHT Safeguarding Children and Young People Board of which the designated nurses for the Tri Borough are members.

6. Key Priorities for Next Year

A series of priorities for next year have been set to continue to build on good practice – Appendix 2.

7. Future Reporting

The next Safeguarding Children and Young People Annual Report will be presented in May 2017.

8. References

HM Government 1989 *The Children Act*. London: HMSO
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HM Government 2004 *The Children Act:* London: HMSO
http://www.opsi.gov.uk/acts/acts2004/pdf/ukpga_20040031_en.pdf

HM Government 2007 The Children Act 2004 *Section 11: Statutory guidance on making arrangements to safeguard and promote the welfare of children* London: HMSO
http://www.dcsf.gov.uk/everychildmatters/_download/?id=1372

Care Quality Commission July 2009 *Safeguarding children: A review of arrangements in the NHS for safeguarding children*; London CQC
http://www.cqc.org.uk/_db/_documents/Safeguarding_children_review.pdf

Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009 13*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015.https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Full.pdf

HM Government 2013 Working *Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*. London: HMSO

http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010

Royal College of Paediatrics and Child Health April 2014 *Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document.* London: RCPCH

Appendix 1

Imperial College Healthcare NHS Trust

Safeguarding Children and Young People Declaration March 2016

1. Introduction

Imperial College Healthcare NHS Trust (ICHT) is committed to the protection and safeguarding of all patients, including children and young people. ICHT works closely with multi-agency partners to ensure that the outcomes for children are improved by having robust safeguarding children arrangements in place.

Imperial College Healthcare NHS Trust meets statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the Trust undergo a DBS check prior to employment. Checks are enhanced or standard depending on the role. All roles providing patient care are subject to an enhanced check, with checking against the barred lists (adults, children or both) as appropriate

The Imperial College Healthcare NHS Trust Safeguarding Children & Young People policies and systems are up to date and are reviewed on a regular basis.

The Trust has a policy and process in place for following up children who miss outpatient appointments within any speciality to ensure their care and wellbeing is not compromised. In addition, the Trust has a system in place for flagging children who are subject to a child protection plan from the four neighbouring boroughs.

All eligible staff undertake relevant safeguarding children training and this is regularly reviewed to ensure that it is up to date. The Trust has a robust training policy in place with regard to delivering safeguarding children training. Previously the Trust has reported the safeguarding children training delivered per level, per month, on a rolling year basis. The Trust is now reporting the percentage of staff that are compliant with their safeguarding children training at each level.

Between 2015 -16 the Trust target was 95%. In 2016-17 the target has been set by the Trust Core Skills Team at 90% to take into consideration the changes in staffing that take place across the Trust.

	Staff in Post	Staff trained	% compliance
Level 1	2471	2136	**86%**
Level 2	4960	4340	**88%**
Level 3	1115	920	**83%**
Overall	8546	7396	**87%**

2. Named Professionals for Safeguarding Children and Young People

The Safeguarding Children and Young People Team is led by a named doctor, named Nurse and Named Midwife. They are clear about their roles and responsibilities and receive appropriate support and training to undertake their roles. This team is supported by sessions from a clinical nurse specialist, two lead/midwives covering maternity/neonates along with an administrator. In addition recruitment is in process for a second Clinical Nurse Specialist to work across sites.

The team comprises:

Named Nurse	1 wte
Named Midwife	1 wte
Clinical Nurse Specialist	1 wte - (agreement is in place to uplift to 2wte),
Safeguarding Lead/ Midwife	2 wte
Named Doctor	0.4wte
Administrative support	1
Liaison Health Visitor	1wte
Liaison Nurse	1wte
Administrator for Liaison Team (A&E)	1wte

3. Executive Director Lead for Safeguarding Children and Young People

The Director of Nursing is the Trust Executive Lead for Safeguarding Children and Young People and ensures that the Trust Board fulfils its corporate responsibility and continues to provide direction in relation to the Safeguarding of Children and Young People within ICHT.

The Deputy Director of Nursing chairs the ICHT Safeguarding Children and Young People's Committee which reports to the Trust Board on safeguarding children and young people. The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on Safeguarding Children issues. The Safeguarding Children and Young People Annual Report was last received by the Trust Board via the Director of Nursing's Report taken to the Trust Board Meeting on 27th May 2015.The minutes of all public Trust Board meetings where safeguarding children has been discussed can be found at http://www.imperial.nhs.uk/aboutus/ourorganisation/boardmeetings/index.htm

Appendix 2

Key Priorities for Next Year

The following are the key priorities for the Safeguarding Children and Young People Service for 2016 - 17:

- To develop a Trust Wide CERNER Safeguarding Folder in conjunction with a visible Safeguarding Alert so that all notes regarding safeguarding can be recorded and visible across the Trust.
- To develop and launch a Trust wide Safeguarding Children and Young People Operational Strategy.
- To work in conjunction with multi agency colleagues to launch the nationwide initiative - The Child Protection Information System (CP-IS)
- To complete the Team Safeguarding Review and Business Planning Process following the restructuring within the Trust.
- To review processes around timely discharge of high risk safeguarding cases in conjunction with the Multi-Agency Teams.
- To audit pre/post bespoke teaching on the completion of interagency referrals by clinicians by the Clinical Nurse Specialist and Safeguarding Midwife.
- To launch the Trust Wide FGM Policy and recruit a Specialist FGM Lead to support with training for staff around FGM Policy and processes within the Trust and continue to work jointly with Multi-Agency colleagues with women and children where FGM has been identified.
- To continue to work with North West London colleagues to ensure a joined-up response with partner agencies through care and referral pathways for treatment and recovery services for children who have been sexually exploited.
- To complete action plans which may arise from the Serious Case Reviews and Domestic Homicide Reviews currently in progress.
- To launch a Safeguarding Children and Young People's Action Group across sites. This will ensure that the Safeguarding Agenda is discussed on a regular basis on the three main sites.
- To ensure recommendations from the MBRACE-UK Dec. 2015 report (Mothers and Babies: reducing risk through audits and confidential enquiries across the UK) have been incorporated into Safeguarding Practice and ensure joint working with the Safeguarding Adults Team to ensure this is achieved.

Imperial College Healthcare NHS Trust

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

Adult safeguarding annual report 2015 - 2016

Executive summary:

This report describes adult safeguarding systems, processes and activity during 2015/16. These continue to develop and are more robust and effective than they were in 2014/15.

Quality impact:

This report describes adult safeguarding systems, processes and activity during 2015/16. These continue to develop and are more robust and effective than they were in 2014/15.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

Comprehensive safeguarding arrangements minimise the risk of patients' experiencing harm from abuse and exploitation.

Recommendation to the Trust board:

The Trust board is asked to note the report

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young Deputy Director of Patient Experience	Janice Sigsworth Director of Nursing	17 May 2016

Adult Safeguarding Annual Report 2015/16

1 Introduction

Safeguarding adults is an important responsibility of the Trust. The primary objective of adult safeguarding activity is to prevent harm to patients at risk from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices about their care and safety.

In 2015/16 the Trust worked closely with tri-borough partners to ensure consistent, effective and safe systems for protecting vulnerable adults.

The primary aim of the Trust's work in this year has been to further consolidate and strengthen adult safeguarding systems and processes.

2 Background

In 2014, the *No secrets* guidance for the protection of vulnerable adults from abuse and neglect, was replaced by The Care Act (DoH, 2014). This wide ranging piece of legislation outlines the way in which local authorities should provide support for adults in need of care and support. There is specific reference (chapter 14) to safeguarding arrangements and, whilst the guidance is aimed primarily at local authorities, collaborative working with partners such as the NHS, is critical to delivering appropriate safeguarding systems.

The Trust has been working closely with colleagues in the local authority to ensure that the principles of the act are properly applied.

3 Structures, Processes and Roles

The Director of Nursing provides the executive lead for adult safeguarding. The Deputy Director of Patient Experience has managerial responsibility for adult safeguarding and is the designated adult safeguarding manager (DASM).

The Deputy Director of Patient Experience chairs the Trust's Adult Safeguarding Committee and represents ICHT on the Tri-borough Safeguarding Adults Executive Board (SAEB). They also provide quarterly adult safeguarding update reports to the commissioners via the Clinical Quality Group.

There is a named doctor for adult safeguarding and each clinical division has a designated adult safeguarding lead (either the Divisional Director of Nursing or one of their deputies) who can be contacted for advice and support. In March 2016, the Trust also appointed an adult safeguarding nurse specialist, who brings additional knowledge and expertise to further develop adult safeguarding activities.

The Adult Safeguarding Committee consists of all the adult safeguarding leads as identified above as well as representatives from tri-borough social services, Trust's child and maternity safeguarding services and the Trust's security team.

All safeguarding concerns are recorded on the trust incident reporting system (Datix) where they can be categorised and themed in a number of ways. Any incident categorised as adult safeguarding is automatically forwarded to the DASM, nurse specialist and the relevant divisional safeguarding lead.

Information related to adult safeguarding is available on the Source, which provides a number of resources to help staff with adult safeguarding issues - http://source/safeguardingadults

The Trust adult safeguarding policy was updated in November 2015 to reflect revised local authority safeguarding forms and details. The policy will be subject to a further review in 2016/17.

4 Adult Safeguarding Activity

Work undertaken in the year focused on strengthening the process for raising and recording safeguarding concerns. Working with the local authorities, the Trust reviewed local polices and guidance to ensure that safeguarding alerts are raised in a timely and appropriate fashion.

In particular, efforts have been made to improve the quality of information in referral documentation so that the local authority is in a good position to make decisions about required actions.

During the year, 452 safeguarding incidents were recorded on Datix. This is roughly the same as 2014/15. Around 90% of these were related to pressure ulcers acquired in the community. The remaining 10% of incidents were predominantly categorised as neglect, with a small number of incidents categorised as physical or financial abuse.

Approximately 20% of the total volume of incidents led to a safeguarding referral to social services. Around a quarter of these resulted in some kind or action plan or intervention from social services.

There is additional activity related to domestic abuse that is not included in these numbers. Independent domestic violence advisors (IDVAs) are based in maternity and A&E and support women who are subjected to domestic abuse. This activity is not currently captured in the adult safeguarding numbers but this will be worked towards in 2016/17.

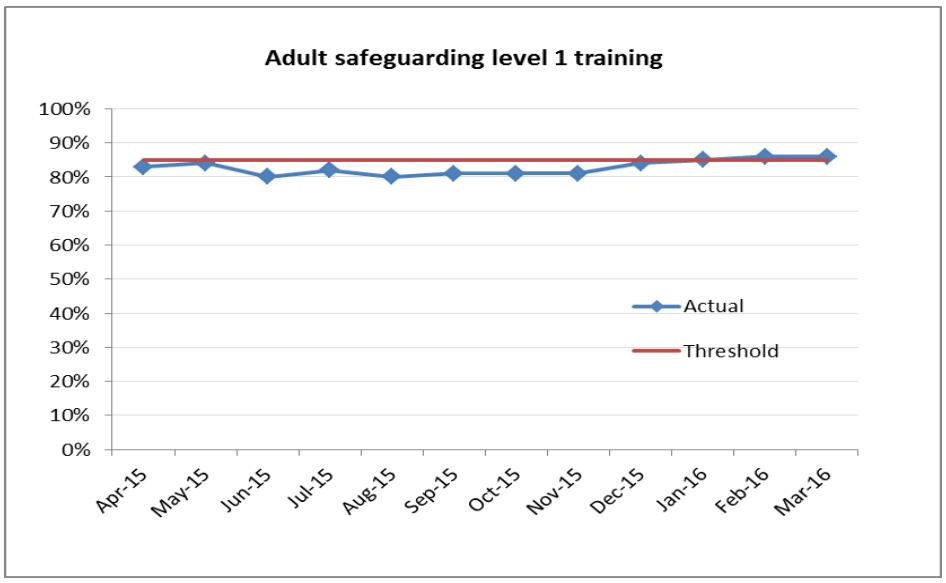
An internal audit of adult safeguarding data quality at the end of the year identified concerns about the data in Datix. This was mostly related to inaccuracies in, for example, the spelling of patients' names, however steps will be taken to improve this. It is also intended in 2016/17 that the data recording will change in order to capture a wider range of adult safeguarding activity, such as domestic abuse as highlighted above.

Another issue identified in the audit was an inconsistent approach to filing safeguarding paperwork, such as referrals, in the patient record. An electronic solution has now been agreed so that these documents can be stored in a folder in the patient's Cerner record. This is a major improvement and is expected to be in use during quarter one of 2016/17.

5 Adult Safeguarding Training

Compliance with level 1 adult safeguarding (figure 1) was significantly better than the previous year, with the level above 80% throughout the whole year.

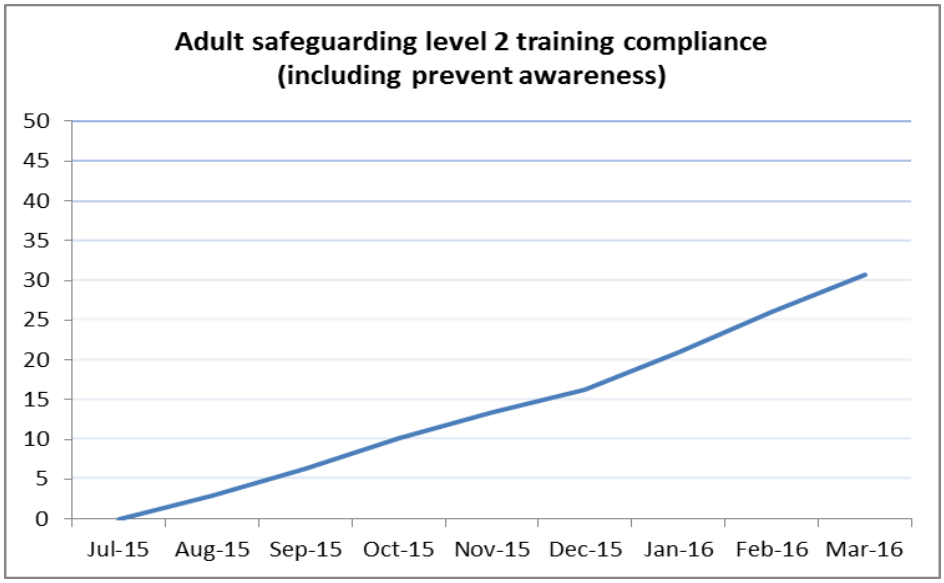
Fig 1



In August 2015, the Trust updated its online adult safeguarding training to a package provided by Skills for Health. This provides improved level one training in line with the Care Act and includes newer categories of abuse such as modern slavery and human trafficking. It also introduced a level 2 programme that includes Prevent awareness training and information about the Mental Capacity Act and DoLS.

Level one training is aimed at all staff who have patient contact. Level 2 is aimed primarily at clinical staff who are likely to be making decisions about safeguarding issues. The compliance with level 2 training up to March is shown in figure 2 and represents 1750 people having undertaken the programme since its introduction. There is no threshold for this level of safeguarding training although the CCG core quality requirements stipulate that that Prevent awareness training compliance will reach 60% in Q3 and 70% in Q4 of 16/17.

Fig 2



6 MCA and DoLS

Mental Capacity Act (MCA) online training is undertaken by all clinical staff in addition to the level 2 safeguarding training described above. The named doctor for safeguarding does face-to-face training for doctors.

A self-assessment of the CQC effectiveness domain carried out by the medical director's office in quarter 4 found that there was good understanding of the MCA and evidence of appropriate support for people who needed to make decisions. However, there were some concerns identified in relation to taking consent and recording of MCA assessments and decisions in the patients' records. This will be addressed over the coming months.

Equally, there was some uncertainty about the correct application of the Deprivation of Liberty Safeguards (DoLS). This is not uncommon and in 2015 the Law Commission undertook a major review of DoLS as the current legislation and guidance is not seen as fit for use in the acute setting. Work is ongoing to improve the understanding and application of DoLS in the Trust. In 2015/16 81 applications were made under the DoLS legislation compared with 28 the year before, which suggests that awareness has increased across the trust.

7 Prevent

Prevent is a component of the government's counter terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Focusing on radicalisation of at risk young people, the strategy sits under the safeguarding umbrella.

There is significant Home Office interest in the application of Prevent strategies in the NHS given recent terrorist attacks in Europe. In 2015, the Trust dealt with a number of incidents under the Prevent agenda and these resulted in a total of 4 cases being referred to *Channel*, the police arm of the Prevent agenda. Two of these were staff members and two were patients/relatives. These came to light because of awareness and diligence of staff in the Trust. An example was a young woman who, during and emergency attendance, disclosed extremist activity being conducted in her home that she wanted to get away from. The Trust was able to protect the patient through the safeguarding agenda, but also reported concerns through Channel which resulted in a wider police anti-terrorist investigation.

During the year, management responsibility for Prevent moved from the Head of Security to the Deputy Director of Patient Experience. The primary requirement for the Trust is to ensure Prevent awareness training is delivered to all relevant staff. As described in section 5 of this report, the basic awareness training it being delivered through the online level 2 safeguarding training. This is going well and is on track to meet contractual requirements.

More challenging is the next level of prevent training which needs to be delivered in a face to face workshop; so called WRAP training. To date uptake has been low, but the Trust has now trained eight WRAP trainers and a schedule of sessions will be implemented in the coming year.

8 Summary and plans for 2016/17

Overall, adult safeguarding systems and processes have been strengthened during the year. The appointment of an adult safeguarding nurse specialist is a real step forward. Work does need to continue and the key priority areas for the coming year are shown below:

- Achieving the required training compliance for Prevent training and delivery of WRAP

sessions

- Strengthening links between adult and child safeguarding, with a view to centralising functions into a corporate safeguarding team
- Improving the application of the MCA across the trust and addressing any actions arising from the Law Commission review of DoLS
- Developing a robust adult safeguarding dataset and implementing the recommendations arising from the internal audit report of data quality.

Imperial College Healthcare NHS Trust

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

Improving Quality of Care - CQC Update Report

Executive summary:

The following report provides an update in relation to; the Trust's CQC registration for quarter four (Q4) of 2015/16, the implementation of the compliance and improvement framework and progress against the CQC action plan.

CQC registration for Q4 (2015/16)

- The Trust made 25 applications under the deprivation of liberties safeguards
- No patients died whilst being detained by the Trust under the Mental Health Act 1983
- No certified treatment was sought or delivered for Trust patients
- Nine IRMER incidents were notified to the CQC
- The CQC received three complaints about the Trust and raised one concern with the Trust

Compliance and improvement framework for 2016/17

A draft *Compliance and improvement* framework for 2016/17 is out for comment

- Key components of the framework include:
- The management of residual actions from 2015/16
- Undertaking self-assessments against the 5 CQC domains
- Undertaking quality reviews
- Re-running the ward accreditation programme
- Preparing for an inspection
- A communications programme

Progress against the CQC action plan

- Two actions have been completed since the last update to the Trust Board
- There are five outstanding actions to be completed
- All actions have revised timescales for completion and progress towards achieving these is monitored by the Executive Quality Committee on a monthly basis.

Quality impact:

The report applies to all five CQC domains.

Financial impact:

This paper has no financial impact.

Risk impact:

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

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

Recommendation to the Trust board:

- To note the paper

Trust strategic objectives supported by this paper:

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

Authors	Responsible executive director	Date submitted
Priya Rathod, Deputy Director of Quality Governance Kara Firth, Regulation Manager	Janice Sigsworth, Director of Nursing	18 May 2016

Improving Quality of Care - CQC Update Report

1. Purpose

The following report provides an update in relation to; the Trust's CQC registration for quarter four (Q4) of 2015/16, the implementation of the compliance and improvement framework and progress against the CQC action plan.

2. CQC registration for Q4 (2015/16)

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

2.1 Intelligent Monitoring

The CQC did not contact the Trust in relation to outcomes of its Intelligent Monitoring during Q4 and no outlier alerts were made to the Trust.

2.2 Notifications made to the CQC by the Trust

2.2.1 Mental health notifications

- In the best interests of patients and to support the safety and quality of care, the following applications were made to "deprive patients of their liberties" (DoLS applications) as part of the safeguarding processes:
    - 11 in January 2016 (all outcomes are pending a decision).
    - 5 in February 2016 (all outcomes are pending a decision).
    - 9 in March 2016 (all outcomes are pending a decision).
- No patient deaths took place whilst being detained under the Mental Health Act.

2.2.2 Ionising Regulation (Medical Exposure) Regulations (IRMER) Incidents

- In Q4 the Trust notified the CQC about nine incidents as required under Regulation 4(5) of the Ionising Regulation (Medical Exposure) Regulations (IRMER) 2000.
- IRMER incidents are managed in line with the Trust's incident management policy.
    - They are discussed at the Medical Director's incident meeting held each Friday.
    - They are included in the incidents section of the monthly Quality Report presented to the committee.
    - Following a focused review of incidents an improvement plan is in place.

2.3 Complaints to the CQC about the Trust

- Three complaints were made to the CQC about the Trust relating to services within the division of medicine and the CQC raised one concern with the Trust relating to the division of surgery.
- The complaints and concern were investigated by the Trust and a response provided to the CQC who have confirmed they are satisfied that the issues have been addressed.
- The divisions have taken forward key actions and lessons learnt from these complaints.
- No whistleblowing alerts were made to the CQC about the Trust in Q4.

2.4 CQC Inspections

- The Trust was not inspected by the CQC in Q4.
- The CQC has published their inspections through to August 2016 and the Trust has not been identified.

2.5 New CQC strategy

- At the time of writing this paper the CQC is yet to publish it's new strategy, due for publication in May 2016.
- Once the strategy is available, key elements will be incorporated into our 2016/17 compliance and improvement framework

3. Compliance and Improvement Framework for 2016/17

- The current *Compliance and improvement framework* was reviewed based on lessons learned during 2015/16, the Trust's divisional restructure, and input from senior divisional colleagues, the Medical Director's Office and members of the Trust's clinical quality group (CQG).
- The corporate nursing team has also spoken with Frimley Park Hospital NHS Foundation Trust (rated 'Outstanding') and NHS Gateshead (rated 'Good') to understand their approach.
- A draft version of the framework is currently out for comment but key points to note are summarised below:

3.1 Unchanged from 2015/16 and will continue:

- Managing outcomes from CQC Intelligent Monitoring: i.e. outlier alerts for a key indicator
- Confirmations of registered services: these will continue to be done quarterly, in particular to keep a handle on community services

3.2 New for 2016/17 approach:

3.2.1 The management of residual actions from 2015/16

- The Executive Committee agreed at its meeting on 5 April 2016 that as the majority of the CQC actions has been completed, management of the outstanding actions will be considered 'business as usual' with the monitoring and reporting undertaken by divisions. Going forward, this will form part of the Trust's new reporting structure through the Safety and Effectiveness Committee, which will report to the Executive Quality Committee from June 2016.
- The corporate nursing team have undertaken an extensive triangulation exercise to compare information from all components of the 2015/16 framework e.g. action plan, ward accreditation, deep dives etc.
- The outcomes of the exercise will be shared with divisions over the coming month in order to inform and support their quality governance activities during 2016/17.

3.2.2 Six-monthly directorate and divisional self-assessments; continuing to 'have quality conversations'

- It is proposed that directorates and divisions undertake six-monthly self-assessments against the 5 CQC domains, underpinned by evidence.
- The outcomes of these assessments will be validated at directorate and divisional quality meetings and approved/signed off by the Divisional Director.
- An improvement and assurance panel will convene twice a year to where the general managers and chiefs of service will present the self-assessment outcomes and any associated action plans to the divisional management teams.
- A six monthly report of the outcomes and action plans from the panel will be reported to the Safety and Effectiveness Committee and the Executive Quality Committee by the Divisional Director.
- As part of the new framework, a self-assessment procedure has been developed which includes a draft timetable for undertaking self-assessments during 2016/17.
- A self-assessment toolkit and accompanying evidence guide will be developed by the nursing directorate to support this process and will be part-based on methodology used in Australia for managing accreditation processes.

3.2.3 Quality reviews

- Ward accreditation will commence again and where appropriate will incorporate the outcomes of self-assessments (being presented to this committee at this meeting) as potential key lines of enquiry when reviewing areas. A ward by ward feedback session will be scheduled for the senior teams.
- Areas can request a quality review if they have a concern or if they want independent confirmation that a programme of work has been successful
- Responsive reviews may take place and can be requested by the divisional directors for their services or by a corporate director for pan-divisional/trust-wide issues as a result of the following:
    - Follow up of findings from an external review of inspection e.g. CQC, HENWEL
    - The outcomes of self-assessments, including:
        - Failure of a directorate or division to properly complete a self-assessment;
        - Significant delays to achieving a related action plan;
        - Trends across directorates, divisions, CQC core services or the Trust which suggests a wider / underlying problem.
- Where major concerns / key risks are identified, an internal Quality Surveillance Meeting held jointly with the medical director's office would take place.

3.2.4 Preparing for a CQC inspection

- In order for the Trust to be prepared for CQC inspection (announced and unannounced), the corporate nursing team is developing an inspection workbook, based on the successful approach of other Trusts.
- The purpose of the workbook is to have a central document that includes all the information and SOPs for managing an inspection.

3.3 Communications to support the new framework

- A communications plan to support the launch of the framework will be developed.

4. Progress against the CQC action plan

- All actions within the plan are largely on track. At the last Board meeting there were 7 outstanding actions.
- Two further actions have been completed since the last update to the Board.
- The remaining five actions relate to; achieving statutory and mandatory training targets in three specific areas (3 actions), introducing a web-chat function as part of the outpatient improvement programme (1 action) and embedding the revised nil by mouth guideline (1 action).
- All actions have revised timescales for completion and progress towards achieving these is monitored by the Executive Quality Committee on a monthly basis.

5. Next steps

- Continue to develop the compliance and improvement framework for 2016/17 in light of any comments received the publication of the new CQC strategy (due May 2016).
- Continue with the programme of self-assessments and ward accreditations.
- Complete implementation of the CQC action plan.

6. Recommendations to the Trust board:

- To note the paper

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board	25 May 2016

Nursing and Midwifery Establishments Review and Safe Staffing Update

Executive summary:

The divisional management teams have undertaken a detailed and comprehensive review of nursing and midwifery establishments using the clean sheet approach. This work has been led by the divisional directors of nursing, and signed off at the Divisional Management boards. The review has been a fundamental part of the divisional business planning and budget setting.

Nationally, work continues to support NHS providers to deliver the right staff, with the right skills, in the right place at the right time with many arm's length bodies working together to determine the optimum approach within a realistic and efficient financial envelope.

This paper will provide the Trust Board with:

- An overview of the establishment review process adopted by the Trust to provide assurance that ward establishments are safe and that the workforce is of a sufficient number and skill mix to provide optimum quality clinical care
- The high level establishment changes by division
- An overview of the work on-going nationally to deliver safe, sustainable and productive staffing and the way in which the Trust has engaged with this work
- A suggested timeframe for refreshing the Trusts Nursing and Midwifery Safe Staffing Policy

Quality impact:

This paper describes the Trusts approach to securing safe, sustainable and productive nursing and midwifery staffing which contributes to the conditions required to deliver the best possible clinical care to patients and their families and carers.

Financial impact:

This has been considered at divisional level and incorporated into business planning.

Risk impact:

This paper presents no quality risk. The Trust has identified a risk regarding safe staffing which is reviewed monthly by the Divisional Directors of Nursing (DDoNs) and for which there are controls and mitigating actions in place, one of which is the annual establishment review cycle.

Recommendations to the Trust board:

The Trust board is asked to:

1. Note that the 2016/17 establishment review of nursing and midwifery staffing has been completed in line with Trust policy and that it has been aligned with business planning for the year ahead
2. Note the establishment changes prompted by the review
3. Note the national and local work to deliver safe, sustainable and productive staffing
4. Expect to receive a refreshed Nursing and Midwifery Safe Staffing Policy in six months based on national guidance and good practice.

Trust strategic objectives supported by this paper:

This report supports the following strategic objectives:

- 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 improvements

Author	Responsible executive director	Date submitted
Marie Batey Project Manager, Quality Governance	Janice Sigsworth Director of Nursing	19 May 2016

Nursing and Midwifery Establishments Review and Safe Staffing Update

1. The Trust's Nursing and Midwifery Establishment Review Process

The 2016/17 nursing and midwifery clean sheet establishment review has followed the process set out in the Trust's Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments. It is the third year that this annual process has been adopted within the Trust and it follows that which is advised in key national guidance issued by the National Institute for Health and Care Excellence (2014) and the National Quality Board (2013).

Staffing data has been extracted from the Trust's Safe Care module in the Healthcare E Rostering system and in addition, the following have been used to provide a rounded view of staffing and skills mix needs:

- Changes in the environment of care (e.g. the ward design or layout)
- Patient characteristics (e.g. changes in the case mix or specialty)
- Professional judgement of the nursing and midwifery leadership team leading the review and those working in the local area (e.g. the Sister or Matron)
- Data from the Trust's Harm Free Care reports and other quality reports

The Trust's Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments lists the following principles and these have been taken account of within the review:

- Staying above a 65:35% ratio (registered nurse : unregistered care staff) unless DDoN approved
- Not going above a 1:8 ratio (registered nurse : patient) during the day
- Optimising the visibility and supervisory status of the Sister/Matron so that s/he can lead the clinical nursing/midwifery team in delivering the best possible care

Whilst the clean sheet establishment review primarily focuses on inpatient areas, this most recent review also included theatres and private patients.

2. The Outcome of the 2016/17 Clean Sheet Establishment Review

The clean sheet establishment reviews were undertaken by the DDoNs between November 2015 and January 2016 in partnership with DD/DDO and has been aligned to the budget setting process and business planning cycle. They were then finalised during February and March 2016 as part of budget setting. A summary of the review findings and a more detailed overview are appended. There have been a number of clinical service, bed base and acuity shifts during the past twelve months across almost all departments and these have been considered by the DDoNs as part of 2016/17 business planning.

Since completing their reviews each of the DDoNs have met individually with the Executive Director of Nursing to discuss their approach, the findings, the assurances that they have taken with regard to clinical quality and patient outcomes and the level of engagement and involvement they have had with their staff during the review. They have also confirmed that that change in the establishment are reflected in the divisional 2016/17 baseline budgets.

To take additional assurance the Executive Director of Nursing talks to front line nurses, midwives and care assistants during her weekly Back to the Floor visits to clinical areas. As part of the establishment review cycle she also meets with a group of matrons and sisters from each division to discuss the staffing and skill mix arrangements in their areas and to determine the level of engagement they have with the establishment review process. This is triangulated during her discussions with each of the DDoNs.

2.1 The Division of Medicine

The DDoN for the Division of Medicine has confirmed that the establishment for both emergency departments delivers safe staffing presently. Two business cases, which will see the footprint of the A&E at Charing Cross Hospital and at St Mary's Hospital increase, will see staffing adjustments within the division, once the business cases have been approved.

Increased acuity or dependency in a number of areas (e.g. AMU at St Mary's Hospital and John Humphrey and Christopher Booth wards at Hammersmith) has prompted a review in year of staffing and skill mix and has seen an increase in their establishments. The entire 9th floor in Charing Cross is being given over to the care and treatment of patients with a stroke and this has prompted an on-going review and the introduction of additional clinical nursing leadership at 8b. In addition to this the division has strengthened nursing support within the TIA (transient ischaemic attack) clinics and also for thrombolysis on 9 North. This has seen the establishment increase as reflected in the table below (9.89 WTE).

As regards occupancy, the bed base in 4 South is funded for 21. As it is regularly opened to 25 beds the Division is discussing a contingency for this. Discussions are also on-going about the level of care and the nature of the establishment on De Wardener ward. Whilst it is not flagging within the Harm Free Care reports, agreement needs to be reached, with other divisions, on where it fits within the critical care strategy.

Establishment Required after Review March 2015	Establishment Required after Review March 2016	Difference:
1117.77	1128.0	Increase of 10.20 WTE

The complexity of changes in medicine will be further validated. The changes have already been approved by the division's management board.

2.2 The Division of Surgery, Cancer and Cardiovascular Services

The DDoN undertook the clean sheet review for her clinical areas based on the agreed methods, including benchmarking theatres against good practice.

The divisional staffing model has seen a modest shift, mainly in Healthcare Assistant posts. Investment at Band 6 reflects a move towards the creation of an advanced nurse practitioner role across a number of specialities to support changes in the medical workforce profile and to enable registered nurses to develop their skills and competencies for patient benefit.
In year the division has seen additional beds opened on Samuel Lane to support the growth of the vascular service and also within the ICU at Charing Cross Hospital to enable the expansion of neurosciences. All of these beds were funded and establishments adjusted.

Establishment Required after Review March 2015	Establishment Required after Review March 2016	Difference:
985.23	987.32	Increase of 2.09 WTE

As a result of the organisational review, managerial responsibility for theatres has transferred to the Division of Surgery, Cancer and Cardiovascular Services and the outcome of the establishment review for theatres is reflected below.

Theatres		
Establishment Required after Review March 2015	**Establishment Required after Review March 2016**	**Difference:**
408.99	411.99	Increase of 3 WTE

2.3 The Division of Women's and Children's Services

As the DDoN is new in post she took the opportunity to review each clinical area in each specialty within the Directorate to align Qlikview with Cost Centres and E roster templates. This included line by line review and reconciliation of Qlikview data with local intelligence and current service requirements and a refresh of the E roster templates to ensure the provision of safe staffing for 100% bed utilisation. This exercise enabled a more detailed review of each and every clinical area to ensure the delivery of safe staffing. The use of staff for enhanced care (specials) was examined as were the roles of Specialist Midwives, Matrons, the community teams and Clinical Educators.

In maternity, the application of Birth Rate Plus indicated that 10 fewer midwives were required across the department and following the Ealing maternity transfer a further 20 WTE midwife posts were found to be surplus for the current service. In anticipation of potential activity changes 15 posts have been retained in order to be able to respond to demand quickly.

The gynae service has seen a modest reduction owing to a modest reduction in activity at weekends. Paediatrics has seen no change except for in two clinical areas where uplift is required for acuity and increased flow.

Establishment Required after Review March 2015	Establishment Required after Review March 2016	Difference:
599.25	555.64	Reduction of 43.61 WTE

2.4 The Division of Investigative Sciences and Clinical Support Services
The Division of Private Patients Services

The clean sheet review for both of these divisions was undertaken by the Head of Nursing for Imperial Private Healthcare. Last year theatres were included, but as explained earlier, this has moved to and been reviewed by another division.

As a result of the process the leadership structure for the outpatients department was reviewed from an operational and clinical management capacity perspective. Site based nursing leadership posts have been added into the establishments and there is now a band 7 sister on each site. An additional lead nurse has been appointed at 8B with clear responsibility for outpatient transformation. The Imaging Department was successful in obtaining funding from HENWL for a year for a practice educator post. This post is fully funded by HENWL but it adds to the complement of senior nursing leadership within the department. The Clinical Research Facility are in the process of restructuring and aim to create Band 5 posts to facilitate junior nurses developing careers in clinical research. In total the change in establishment for ISCS is from 140.04 WTE in 2015 to 144.19 in 2016 – an increase of 4.15 WTE.

Within the private patient clinical areas the working establishments were found to be adequate for the level of activity required. Assurance was taken from the Head of Nursing for Imperial Private Healthcare that this is sufficient to enable a safe level of staffing and that she checks this weekly. Funding that had been made available for possible increased activity within the department is being removed as this activity did not materialise. Within Maternity in this area, the staffing was found to be well established and key posts are being recruited to.

Private Patients Services		
Establishment Required after Review March 2015	**Establishment Required after Review March 2016**	**Difference:**
184.90	183.24	Reduction of 1.66 WTE

The DDoNs have individually confirmed to the Executive Director of Nursing that the establishment requirements are being met for the clinical areas reviewed and that where there is a need for additional posts this has been funded.

3. Safe Sustainable and Productive Nursing and Midwifery Staffing

There is much work taking place nationally to achieve and maintain safe, sustainable and productive nursing and midwifery staffing with all of the arm's length bodies, including the regulators, commissioners, professional bodies and providers working together to optimise alignment of challenging and very complex work streams.

3.1 Further NICE Guidance

The past year has seen work to generate additional NICE publications on nursing and midwifery staffing that were commissioned by NHS England, paused but then issued unfinished. The Trust has used this published material to inform approaches to safe staffing in departments such as the Emergency Department and as one of our senior nurses was on the NICE panel we have been able to use his insights and expertise locally.

3.2 The Workforce Efficiency Network Programme

The Department of Health established a Workforce Efficiency Network, led by Lord Carter to examine how best to get the most out of the existing workforce. In joining this programme we have been able to not only learn from colleagues elsewhere but share our work on key staffing issues, such as the enhanced care of patients with compound care requirements (e.g. mental health needs or at risk of harm from falls). Our progress on 'specialling' (enhanced care) led by the Division of Medicine, has been picked up and used as an exemplar of not only securing efficiencies, but in delivering a better service for patients and also for members of staff. We will continue to network with other member of this forum to share good practices and outcomes.

3.3 Good Practice Guidance (rostering, enhanced care etc.)

The Workforce Efficiency Network has also started to issue draft good practice guides on matters such as rostering and we are responding and advising on content. This advanced notice clearly places the Trust is a good position to be able to adopt the guidance once it is finalised. Our rostering practices and their key performance indicators are monitored at divisional level and, with the recent addition of management reports from Allocate Software sent regularly to the DDoNs, this will be central to optimising the way in which we get the best out of our workforce and secure the equitable and safe patterns of working for staff.

3.4 New Expectations from the National Quality Board

As a follow up to the 'right staff, right skills, right time and right place' guidance issued in 2013, the National Quality Board (NQB) is preparing to issue a refreshed set of expectations. Again, we have had very early sight of this document and, once it is published we will be able to revise and update our Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments and other core governance processes.

3.5 Staffing Metrics (Care Hours per Patient Day)

Alongside the new NQB document, guidance will be made available on adding a further safe staffing metric (Care Hours per Patient Day – CHPPD) to the existing measure (actual versus planned staffing). We have had notice about this already and we will be required to upload this information monthly via UNIFY by the middle of June (for May data). As a Trust we played a key role in testing and refining the CHPPD metric, providing advice and insight to colleagues in the Department of Health as the proposed approach was generated. Work is underway to meet this national reporting requirement and will feed into the review of the Trust's Safe, Sustainable Staffing policy.

3.6 Summary

The pace is not slowing down regarding safe nursing and midwifery staffing with guidance being made available to inform and challenge our approaches to delivering the best possible care. The Trust is very firmly engaged in and supportive of the generation and application of any material that aims to underpin high quality compassionate services that are not only effective but provide value for money.

4. Conclusion

The Trust's nursing and midwifery establishment review has been completed in line with existing national and local policy. It has informed business planning and secured the appropriate resource through budget setting. The Executive Director of Nursing has taken assurance from each DDoN that their nursing and midwifery workforce is of a sufficient number and skill mix to provide optimum care quality. She has also offered them challenge and support regarding the process they have adopted to achieve the review.

Each division has signed off the establishment plans through its own management board.

Appendix 1 - Ward level clean sheet establishment review findings

SUMMARY OF CLEAN SHEET ESTABLISHMENT REVIEW - MARCH 2016

Division	Date of clean sheet review	Tools/standards used	Clean sheet establishment in March 2016 (WTE)*	Clean sheet Establishment in March 2015(WTE)	Gap (+/-) between est review in March 2015 and after review in March 2016	Skill mix (WTE) in March 2015		Skill mix ratio in March 2015		Skill mix (WTE) in March 2016		Skill mix ratio in March 2016	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
Surgery & Cancer	May-15	•AUKUH/SNCT •British Association of Critical Care Nurses standards for nurse staffing in critical care	987.32	985.23	-2.1	826.69	158.54	85.3%	14.7%	837.20	150.12	85.0%	15.2%
Surgery Theatres	May-15	Association for Peri-Operative Pratice	411.99	408.99	-3.0	337.81	71.18	82.0%	17.3%	340.81	71.18	83.3%	17.4%
Medicine	May-15	AUKUH/SNCT	1128.00	1117.77	-10.2	845.96	271.81	75.0%	24.1%	846.70	281.30	75.7%	25.2%
Private patients	May-15	AUKUH/SNCT	183.24	184.90	1.7	147.92	36.98	80.7%	20.2%	148.63	34.61	80.4%	18.7%
Women's and Children's		• AUKUH/SNCT											
Gynaecology		•Paediatric Intensive Care Society	49.30	**52.67**	3.4	38.74	13.93	78.6%	28.3%	35.08	14.22	66.6%	27.0%
Neonates		2010 standards	110.71	**106.51**	-4.2	95.97	10.54	86.7%	9.5%	100.02	10.69	93.9%	10.0%
Maternity		•British Association of Perinatal Medicine staffing standards •Birth-Rate Plus	275.41	**323.28**	47.9	250.47	72.81	90.9%	26.4%	214.52	60.89	66.4%	18.8%
Paediatrics	May-15		120.22	**116.79**	-3.4	111.29	5.5	92.6%	4.6%	113.85	6.37	97.5%	5.5%
TOTAL			**3266.19**	**3296.14**	**29.95**	**2654.85**	**641.29**	**81%**	**19%**	**2636.81**	**629.38**	**81%**	**19%**
			***includes ppts**	***includes ppts**	***includes ppts**	***includes ppts**		***includes ppts**		***includes ppts**		***includes ppts**	

Appendix 1 - Ward level clean sheet establishment review findings

DIVISION OF SURGERY: Mid-year establishment review findings - March 2016									
Division	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Establishment before review (WTE)	Clean sheet establishment required after review in March 2015	Establishment required after review in March 2016	Skill Mix WTE March 2015	
								RN	HCA
	6 South Ward	CXH	25		34.25	**34.25**	**34.25**		
	6 South Ward	CXH	25	7	3			3.00	
				6	7			9.00	
				5	15			13.00	
				3	3				3.00
				2	6.25				6.25
	6 North Ward	CXH	26		28.5	**30.50**	**31.50**		
	6 North Ward	CXH	26	7	1			1.00	
				6	2			4.00	
				5	18			18.00	
				3	2				2.00
				2	5.5				5.50
	Ward 7 North - Gi	CXH	26		33.75	**36.75**	**35.75**		
	Ward 7 North - Gi	CXH	26	8A	1			1.00	
				6	3			4.00	
				5	22			24.00	
				3	2				1.00
				2	5.75				6.75
	Ward Riverside	CXH	26 + 18 trollies		29	**47.50**	**42.80**		
	Ward Riverside	CXH	26	7	1			1.00	
				6	2			5.00	
				5	22			25.50	
				3	2				3.00
				2	2				13.00

Appendix 1 - Ward level clean sheet establishment review findings

Inpatient Ward / Department	Site	Number of beds	Nurse grade	Establishment before review (WTE)	Clean sheet establishment required after review in March 2015	Establishment required after review in March 2016	Skill Mix WTE March 2015	
							RN	HCA
Alex Cross Eye Ward	WEH	4	6	15.83	**15.86**	**16.50**		
Alex Cross Eye Ward	WEH	4	5	11.33			11.36	
			2	4.5				4.50
HH CITU (A6)	HH	16		64.56	**61.56**	**59.47**		
HH CITU (A6)	HH	16	8A	1			1.00	
			7	5			6.00	
			6	21.74			22.74	
			5	35.82			30.82	
			2	1				1.00
Zachary Cope Ward	SMH	22 inc. 5 HDU beds		49.75	**47.60**	**47.20**		
Zachary Cope Ward	SMH	22	8A	1			1.00	
			6	12.75			12.75	
			5	25			24.22	
			3	5				3.63
			2	6				6.00
HH CCL & Day-Ward Nurse Staff	HH	12		38.63	**41.93**	**41.93**		
HH CCL & Day-Ward Nurse Staff	HH	12	8A	0				
			7	1			1.00	
			6	13.6			16.60	
			5	16.23			16.53	
			3	5				4.00
			2	2.8				3.80
Weston Ward	HH	14		23	**22.80**	**22.80**		
Weston Ward	HH	14	7	1			0.80	
			6	7			8.00	
			5	13			12.00	
			3	1				
			2	1				2.00
D7 - Clinical Haem Ward	HH	16		16	**27.00**	**27.00**		
D7 - Clinical Haem Ward	HH	16	7	0			1.00	
			6	5			6.00	
			5	7			17.00	
			3	2				1.00

Appendix 1 - Ward level clean sheet establishment review findings

	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Establishment before review (WTE)	Clean sheet establishment required after review in March 2015	Establishment required after review in March 2016	Skill Mix WTE March 2015	
								RN	HCA
				2	2				2.00
	Dacie Ward	HH	14		24	**24.00**	**24.00**		
	Dacie Ward	HH	14	7	1			1.00	
				6	9			8.00	
				5	12			13.00	
				3	2				2.00
	11 West/ North	CXH	14		85.48	**85.90**	**89.95**		
	11 West/ North	CXH	14	8A	1			1.00	
				7	10.45			9.87	
				6	27.49			27.49	
				5	42.54			42.54	
				3	4				4.00
									1.00
	10 South	CXH	23		30	**31.00**	**31.00**		
	10 South	CXH	23	8A	1			1.00	
				6	6			6.00	
				5	18			18.00	
				3	4				4.00
				2	1				2.00
	Marjorie Warren	CXH	0		20.11				
	Marjorie Warren	CXH	0	7	1				
				6	2				
				5	11.61				
				3	1				
				2	4.5				
	Western Eye A&E/OPD/DSU	WEH	0		10.8	**20.40**	**20.40**		
	Western Eye A&E/OPD/DSU	WEH	0	6	1			2.00	
				5	9.8			11.40	
				3					6.00
				2					1.00
	A7	HH	27		30.77	**35.77**	**35.77**		
	A7	HH	27	8A	1			1.00	
				6	7.67			6.67	
				5	17.1			22.10	
				3	4				4.00

Division of Surgery, Cancer & CV

Appendix 1 - Ward level clean sheet establishment review findings

			2	1				2.00
A8	HH	24		26.43	**31.93**	**31.93**		
A8	HH	20	8A	1			1.00	
			6	3			3.00	
			5	15.93			22.93	
			3	2				2.00
			2	4.5				3.00
A9	HH	20		24.22	**25.00**	**25.00**		
A9	HH	20	7	1			1.00	
			6	4.61			5.00	
			5	13			13.00	
			3	2.61				2.00
			2	3				4.00
Major Trauma	SMH	16		30	**30.00**	**30.00**		
			8A	1			1.00	
			6	7.48			7.48	
			5	15.52			15.52	
			3	3				3.00
			2	3				3.00
Valentine Ellis	SMH	24		26.12	**28.22**	**28.22**		
Valentine Ellis	SMH	24	8A	1			1.00	
			6	5			5.00	
			5	13.51			15.61	
			3	1				1.00
			2	5.61				5.61
Charles Pannett	SMH	25		39.61	**42.11**	**42.11**		
Charles Pannett	SMH	25	8A	1			1.00	
			6	10.61			9.61	
			5	22			22.00	
			3	3				3.00
			2	3				6.50

Appendix 1 - Ward level clean sheet establishment review findings

Paterson	SMH	14		21.5	**24.00**	**24.00**		
Paterson	SMH	14	8A	1			1.00	
			7	1			1.00	
			6	2			3.00	
			5	12.5			13.00	
			3	2				1.00
			2	3				5.00
Albert	SMH	20		15	**31.00**	**35.59**		
Albert	SMH	20	7	1			1.00	
			6	3			4.00	
			5	8			15.00	
			3	1				1.00
			2	2				10.00
AICU	SMH	16		101.94	**98.05**	**98.05**		
AICU	SMH	16	8A	1			1.00	
			7	10			10.21	
			6	33.94			34.84	
			5	53			49.00	
			2	4				3.00
GICU	HH	11		70.15	**80.29**	**80.29**		
GICU	HH	11	8A	1			1.00	
			7	5.86			6.98	
			6	25.29			24.83	
			5	35			44.48	
			3	3				3.00
7 South	CXH	25		31.81	**31.81**	**31.81**		
7 South	CXH	25	8A	1			1.00	
			6	5			5.00	
			5	17.81			17.81	
			2	6				6.00
			3	2				2.00
TOTALS				**921.21**	**985.23**	**987.32**	**826.69**	**158.54**

Appendix 1 - Ward level clean sheet establishment review findings

DIVISION OF SURGERY - THEATRES: Mid-year establishment review findings - March 2016

Division	Code	Inpatient Ward / Department	Site	Number of theatres	Nurse grade	Clean sheet establishment required after review in March 2015	Establishment required after review in March 2016	Skill mix WTE		Skill mix WTE March 2016		Skill mix ratio		Skill mix Ratio March 2016		COMMENTS
								RN	HCA	RN	HCA	RN	HCA	RN	HCA	
	TH110	Theatres Main Cx	CXH							COMPLETE THESE COLUMNS FIRST AND TOTALS (IN COLUMN AD) WILL CALCULATE AUTOMATICALLY				RATIO WILL CALCULATE AUTOMATICALLY		
						144.43	**147.43**									
					Band 8a			1		1						
					Band 7			10		10						
					Band 6			43		46						
					Band 5			65		65						
					Band 3				8		8					
					Band 2				17.43		17.43					
												82%	18%	83%	17%	
	71800	Theatres Main Hh	HH			**91.13**	**91.13**									
					Band 8a			1		1						
					Band 7			8		8						
					Band 6			25.13		25.13						
					Band 5			37.7		37.7						
					Band 3				2		2					
					Band 2				17.3		17.3					
												79%	21%	79%	21%	
	THE01	Main Theatre	SMH			**173.43**	**173.43**									
					Band 8a			1		1						
					Band 7			11		11						
					Band 6			68.62		68.62						
					Band 5			66.36		66.36						
					Band 3				11.45		11.45					
					Band 2				15		15					
												85%	15%	85%	15%	
TOTAL						**408.99**	**411.99**	**337.81**	**71.18**	**340.81**	**71.18**	**83%**	**17%**	**83%**	**17%**	

DIVISION OF WOMEN'S AND CHILDREN'S: Mid-year establishment review findings - MARCH 2016

Division	Code	Speciality	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Clean sheet establishment required after review in March 2015	Establishment required after review in MARCH 2016	Skill mix		Skill mix WTE March 2016		Skill mix ratio		Skill mix ratio MRCH 2016		COMMENTS
									RN	HCA	RN	HCA	RN	HCA	RN	HCA	
								COMPLETE THIS COLUMN FIRST AND TOTALS AND SKILL MIX WILL CALCULATE AUTOMATICALLY									
Division of Womens & Childrens	58900	Gynaecology	Victor Bonney Ward	HH	20	Band7	1	1									
						Band 6	3	2.94									
						Band 5	19.4	16.63									Template 16/17 shows 1.5 wte B5 short, directorate given assurance that this will be absorbed within lowered areas of activity and acuity in the week.
						Band 3	0	1									
						Band 2	7.52	6.37									
	58900	Gynaecology	Victor Bonney Ward	HH	20		**30.92**	**27.94**	23.4	7.52	**20.57**	**7.37**	68%	32%	**67%**	**26%**	Beds reduced to 16 at weekends 16/17
	GYN02	Gynaecology	Lillian Holland Ward	SMH	13	Band 7	1.00	1.00									
						Band 6	3.00	2.94									
						Band 5	11.34	10.57									
						Band 3	0.00	0.98									
						Band 2	6.41	5.87									
	GYN02	Gynaecology	Lillian Holland ward	SMH	13		**21.75**	**21.36**	15.34	6.41	**14.51**	**6.85**	71%	29%	**67%**	**32%**	
	46500	Neonates	QCCH Neonates	QCCH	24	Band 7	5.00	6.00									
						Band 6	49.70	47.01									
						Band 5	2.97	5.58									
						Band 4	4.60	5.49									
	46500	Neonates	QCCH Neonates	QCCH	24		**62.27**	**64.08**	57.67	4.60	**58.59**	**5.49**	93%	7%	**94%**	**9%**	Unchanged, not established to BAPM requirements but will nurse at BAPM requirements as units not expected to be at full capacity throughout the year. SOP in place if unit full or high acuity in order to achieve BAPM compliance if clinical requrements indicate needed.
	NEO09	Neonates	Winnicott Baby Unit	SMH	22	Band 7	8.00	5.00									
						Band 6	22.30	18.06									
						Band 5	8.00	18.37									
						Band 4	5.94	5.2									
	NEO09	Neonates	Winnicott Baby Unit	SMH	22		**44.24**	**46.63**	38.30	5.94	**41.43**	**5.2**	87%	13%	**94%**	**11%**	Support roles included in 15/16
	54700	Maternity	QCCH Maternity Inpatient	QCCH		Band 7	26.07	24									Full establishment review done and cost centres split to allow improved management of workforce therefore cost centres will be different and all areas split by June 16. BRP methodology at 1:30 Inpatients include LS,DS,EDW, BC for 16/17
						Band 6	115.5	92.13									
						Band 5	6										
						Band 3	26.74	21.27									
						Band 2	14.58	12.55									
	54700	Maternity	QCCH Maternity Inpatient	QCCH			**188.89**	**149.95**	147.57	41.32	**116.13**	**33.82**	78%	22%	**61%**	**23%**	
	MAT10	Maternity	SMH Maternity / Inpatient	SMH		Band 7	22.44	14									Full establishment review done and cost centres split to allow improved management of workforce therefore cost centres will be different and all areas split by June 16. BRP methodology at 1:30 Inpatients include AB1, Theatre, MDAU and Triage, BC, AB2 for 16/17
						Band 6	77.46	68.64									
						Band 5	3										
						Band 3	21.49	26.07									
						Band 2	10	1									
	MAT10	Maternity	SMH Maternity / Inpatient	SMH			**134.39**	**109.71**	102.9	31.49	**82.64**	**27.07**	77%	23%	**61%**	**25%**	
	56300	Maternity	Stanley Clayton Ward Priv Pats	QCCH	7	Band 7	1.7	2									
						Band 6	4	3.96									
						Band 3	5.2	3.96									
						Band 2		2									
	56300	Maternity	Stanley Clayton Ward Priv Pats	QCCH	7		**10.9**	**11.92**	5.7	5.2	**5.96**	**5.96**	52%	48%	**55%**	**50%**	
	62200	Paediatrics	Ambulatory Paeds	HH		Band 7	0.5	0.5									
						Band 6	4	4									
						Band 5	1	1									
						Band 3	1	1									
						Band 2											
	62200	Paediatrics	Ambulatory Paeds	HH			**6.5**	**6.5**	5.5	1	**5.5**	**1**	85%	15%	**85%**	**15%**	
	PAE01	Paediatrics	Westway +Haem day unit	SMH		Band 7	1.5	2									GWW and PSSU merged instead of WW and PHDU. PHDU now separate for 16/17
						Band 6	2	2									
						Band 5	5	2.4									
						Band 3	2	1									
	PAE01	Paediatrics	PHDU	SMH			**10.5**	**7.4**	8.5	2	**6.4**	**1**	81%	19%	**61%**	**14%**	Uplift of 1wte B5 as 16/17 business planning
	PAE02	Paediatrics	Grand Union	SMH	14	Band 7	1	1									Support roles included last year 15/16, uplift of 3 wte B5 in 16/17 business planning
						Band 6	6.7	5.85									
						Band 5	21.31	23.88									
	PAE02	Paediatrics	Grand Union	SMH	14		**29.01**	**30.73**	29.01	0	**30.73**	**0**	100%	0%	**106%**	**0%**	
	PAE03	Paediatrics	Great Western/PSSU Staff	SMH	20	Band 8a	1	1									
						Band 7	0.5	1									
						Band 6	8.63	11.24									
						Band 5	20.85	23.84									
						Band 3	5.5	6.37									
	PAE03	Paediatrics	Great Western/PSSU/Westway Staff	SMH	20		**36.48**	**43.45**	30.98	5.5	**37.08**	**6.37**	85%	15%	**102%**	**15%**	Westway now included for 16/17 instead of with PHDU
	PAE07	Paediatrics	Paediatrics ICU	SMH	8	Band 8a	1	1									
						Band 7	10.49	5.38									Previous year, all support roles included at B7
						Band 6	21.49	23.44									
						Band 5	18.32	16.22									
	PAE07	Paediatrics	Paediatrics ICU	SMH	8		**51.3**	**46.04**	51.3	0	**46.04**	**0**	100%	0%	**90%**	**0%**	No changes to staffing numbers, support roles excluded in 16/17 figures
	MAT04	Maternity	SMH Community / Outpatient	SMH		Band 7	7.92	3.2									ANC and clinics included for 16/17
						Band 6	30	30.3									
						Band 2	3	0									
						Band 3	7	13.2									
	MAT04	Maternity	SMH Community / Outpatient	SMH			**47.92**	**46.7**	37.92	10	**33.5**	**13.2**	79%	21%	**70%**	**28%**	
	47100	Maternity	Caseload Midwives	HH		Band 7	12.6	8									
						Band 6		6									
						Band 8a											
	47100	Maternity	Caseload Midwives	HH			**12.6**	**14**	12.6	0	**14**	**0**	100%	0%	**111%**	**0%**	QCCH and SMH Caseloading 16/17
	55500	Maternity	QCCH Community / Outpatient	QCCH		Band 7	12.3	8.66									**ANC, MDAU/Triage, MHL, Clinics, CFC in 16/17 figures**
						Band 6	32.88	47.82									
						Band 3	8	15.3									
						Band 2	2	0									
	55500	Maternity	QCCH Community / Outpatient	QCCH			**55.18**	**71.78**	45.18	10	**56.48**	**15.3**	82%	18%	**102%**	**21%**	
	MAT09	Maternity	Management Cost Centre					**15.75**			**15.75**						These are additional left over parts of posts equating to 15.75 wte to be used as flex and to achieve BRP if activity increases throughout 16/17. Have all been noted as RN's
TOTALs							**742.85**	**713.94**	**611.87**	**130.98**	**585.31**	**128.63**	**82%**	**18%**	**82%**	**18%**	**INCLUDING PPts, amb paeds, westway, o/pt and caseload midwives**
TOTAL							**599.25**	**555.64**	**496.47**	**102.78**	**463.47**	**92.17**	**83%**	**17%**	**93%**	**19%**	**EXCLUDING PPts, amb paeds, westway, o/pt and caseload midwives**

DIVISION OF PRIVATE PATIENTS: Establishment - April 2016									
Division	Inpatient Ward / Department	Site	Nurse Grade	Establishment as at MARCH 2015	ESTABLISHMENT April 2016	Skill mix WTE		Skill mix ratio	
						RN	HCA	RN	HCA
IPH	Lindo General Level 2	SMH	Band 8a	1	1.00	1.00			
			Band 7	1	1.00	1.00			
			Band 6	5.5	6.00	6.00			
			Band 5	10	11.00	11.00			
			Band 3	5	5.00		5.00		
					24.00	**19.00**	**5.00**	79%	21%
	Lindo General Level 3	SMH	Band 6	0					
			Band 5	5.9					
	Lindo Day Unit Level 1	SMH	Band 5	4	4.00	4.00			
					4.00	4.00			
	Lindo OPD	SMH	Band 7	1	**4.00**	**4.00**		100%	0%
			Band 6	1.5					
			Band 5	3	3.72	3.72			
			Band 3	2	2.00		2.00		
				39.9	**5.72**	**3.72**	**2.00**	65%	35%
	Lindo Theatres	SMH	Band 7	1	1.00	1.00			

			Band 6	18.2	12.00	12.00			
			Band 5	4	4.00	4.00			
			Band 3	2	2.00		2.00		
				25.2	**19.00**	**17.00**	**2.00**	89%	11%
	Lindo Maternity Level 3 and 4 and ANC	SMH	Band 8a	1	1.00	1.00			
			Band 7	12.53	12.41	12.41			
			Band 6	14.83	10.29	10.29			
			Band 4	8.91	7.91	7.91			
			Band 3	10.63	12.61		12.61		
				47.9	**44.22**	**31.61**	**12.61**	71%	40%
	15 North	CXH	Band 8a	1	1.00	1.00			
			Band 7	2	3.00	3.00			
			Band 6	5.5	7.50	7.50			
			Band 5	19	21.50	21.50			
			Band 3	6	6.00		6.00		
					39.00	**33.00**	**6.00**	85%	15%
	15 South	CXH	Band 6	2	1.00	1.00			
			Band 5	6	4.50	4.50			
			Band 3	2	2.00		2.00		
					7.50	**5.50**	**2.00**	73%	27%
	Chemo Day Unit	CXH	Band 6	1	2.50	2.50			
					2.50	**2.50**		100%	
	OPD	CXH	Band 5	1.5	1.50	1.50			
				46.0	**1.50**	**1.50**		100%	

	Robert & Lisa Sainsbury Wing Level 4	HH	Band 8a	1	1.00	1.00			
			Band 7	1	2.00	2.00			
			Band 6	5	7.20	7.20			
			Band 5	12.1	14.10	14.10			
			Band 3	4	2.50		2.50		
					26.80	**24.30**	**2.50**	91%	10%
	Robert & Lisa Sainsbury Wing Level 3	HH	Band 6	1	1.00	1.00			
			Band 5	2	4.00	4.00			
			Band 3	1	1.00		1.00		
					6.00	**5.00**	**1.00**	83%	17%
	Robert & Lisa Sainsbury Wing OPD	HH	Band 5	1.5	1.50	1.50	1.50		
				28.6	**3.00**	**1.50**	**1.50**	50%	50%
TOTALS				**187.6**	**183.24**	**148.63**	**34.61**	**81%**	**19%**

Appendix 1 - Ward level clean sheet establishment review findings March 2016

DIVISION OF MEDICINE: Mid-year establishment review findings - MARCH 2016

Division	Inpatient Ward / Department	Site	Number of beds	Nurse Grade	Clean sheet establishment required after review in March 2015	Establishment required after review in NOVEMBER 2015 to MARCH 2016	Skill mix WTE NOV 2015 to MARCH 2016		Skill mix ratio NOV 2015 to MARCH 2016	
							RN	HCA	RN	HCA
						COMPLETE THE SKILL MIX BREAKDOWN FIRST BELOW AND TOTALS WILL CALCULATE AUTOMATICALLY	ENTER THESE MANUALLY		RATIO WILL CALCULATE AUTOMATICALLY	
	CX A&E	CXH	N/A		**65.64**	**63.51**	**55.67**	**7.84**	**88%**	**12%**
				8a	1.00	**1.00**				
				7	9.00	**8.00**				
				6	18.00	**17.63**				
				5	29.64	**29.04**				
				3	6.00	**5.88**				
				2	2.00	**1.96**				
	A&E HH	HH	N/A		Closed					
				7						
				6						
				5						
				2						
	A&E SMH (including paeds)	SMH	N/A		**97.68**	**77.62**	**65.27**	**12.35**	**84%**	**16%**
	A&E adults excluding UCC CAS04			8a	1.00	**1.00**				
				7	11.10	**9.60**				
				6	31.38	**21.74**				
				5	44.20	**32.93**				
				3	10.00	**10.35**				
				2 (HK)		**2.00**				

Appendix 1 - Ward level clean sheet establishment review findings March 2016

		N/A		15.60					
				15.60	**19.50**	**18.50**	**1.00**		
Paeds CAS07		N/A	7.00	1.00	**1.50**				
			6	9.60	**9.00**				
			5	4.00	**8.00**				
			3	1.00	**1.00**				
A&E Ward CX	CXH	10 beds + 8 trollies		**27.00**	**26.13**	**18.29**	**7.84**	**70%**	**30%**
			7	1.00	**1.00**				
			6	3.00	**2.59**				
			5	15.00	**14.70**				
			3	4.00	**0.00**				
			2	4.00	**7.84**				
DAAU moving to 4 separate cost centres	SMH			**27.40**	**26.86**	**26.86**	**0.00**	**100%**	**0%**
HDU	SMH	5 level 2 + 5 isolation	7	1.00	**1.00**				
	SMH	5 -10 level 1 & 2	6	10.56	**8.17**				
			5	15.84	**17.39**				
CDU + A.Care	SMH	12.00		**22.25**	**18.25**	**10.49**	**7.76**	**57%**	**43%**
	SMH	12.00	7	1.00	**1.00**				
CDU only Acare separate establishment			6	3.00	**2.59**				
			5	10.02	**6.90**				
			3						
			2	8.23	**7.76**				
Joseph Toynbee	SMH	16.00		**22.12**	**21.69**	**16.52**	**5.17**	**76%**	**24%**
	SMH	16.00	7	1.00	**1.00**				
			6	5.28	**5.17**				
			5	10.56	**10.35**				
			2	5.28	**5.17**				
AMU	SMH	10 beds + 8 trollies		**26.84**	**26.86**	**21.69**	**5.17**	**81%**	**19%**
	SMH	10 beds + 8 trollies	7	1.00	**1.00**				
			6	5.28	**5.17**				
			5	13.56	**15.52**				
			2	7.00	**5.17**				
5 South Ward Cardiology	CXH	9 level 2		**27.40**	**26.25**	**26.25**		**100%**	**0%**
			7	1.00	**1.00**				
			6	10.56	**8.94**				
			5	15.84	**16.31**				

Appendix 1 - Ward level clean sheet establishment review findings March 2016

8 West Ward	CXH	22		**32.50**	**31.77**	**18.84**	**12.93**	**59%**	**41%**
	CXH	22	7	1.00	**1.00**				
			6	3.00	**2.59**				
			5	16.50	**15.25**				
			2	12.00	**12.93**				
South Green Ward	CXH	15		**15.00**	**14.72**	**10.80**	**3.92**	**73%**	**27%**
			7	1.00	**1.00**				
			6	2.00	**1.96**				
			5	8.00	**7.84**				
			3	4.00	**3.92**				
Ward 5 West - Acute Admissions	CXH	26		**39.85**	**39.80**	**29.45**	**10.35**	**74%**	**26%**
			8a	1.00	**1.00**				
			6	9.00	**5.17**				
			5	20.04	**23.28**				
			3	4.81	**0.00**				
			2	5.00	**10.35**				
4 South	CXH	21		**27.50**	**26.87**	**19.11**	**7.76**	**71%**	**29%**
			7	1.00	**1.00**				
			6	4.00	**5.17**				
			5	14.50	**12.93**				
			2	8.00	**7.76**				
9 North Hasu	CXH	20		**49.00**	**39.06**	**30.24**	**8.82**	**77%**	**23%**
			8a	1.00	**0.00**				
			7		**1.00**				
			6	11.00	**10.78**				
			5	28.00	**19.00**				
			2	9.00	**8.82**				
Ward 8 South	CXH	25		**35.85**	**35.14**	**22.21**	**12.93**		
		25	8a	1.00	**1.00**				
			6	4.00	**2.59**				
			5	17.85	**18.11**				
			3	5.00	**0.00**				
			2	8.00	**12.93**				
9 South Ward Medicine now on 7 West	CXH	26		**32.80**	**28.46**	**18.11**	**10.35**	**64%**	**36%**
			7	1.00	**1.00**				
			6	4.00	**2.59**				
			5	17.20	**18.11**				
			3	7.00	**0.00**				
			2	3.60	**10.35**				
Stroke Unit/ New 9 West	CXH	20		**29.00**	**28.43**	**18.63**	**9.80**	**66%**	**34%**
		20	7	1.00	**1.00**				
			6	5.00	**4.90**				
			5	13.00	**12.74**				
			2	10.00	**9.80**				
Lady Skinner Ward	HH	15		**22.00**	**21.57**	**13.81**	**7.76**	**64%**	**36%**
		15	7	1.00	**1.00**				
			6	2.00	**2.59**				

Appendix 1 - Ward level clean sheet establishment review findings March 2016

			5	12.00	**10.35**				
			2	7.00	**7.76**				
Ward B1 Spam/Smac	HH			**18.82**	**19.87**	**17.32**	**2.55**	**87%**	**13%**
			8a	1.00	**1.00**				
			7	3.00	**3.00**				
			6	5.22	**5.09**				
			5	7.00	**6.86**				
			2	2.60	**2.55**				
Fraser Gamble Ward now on 8N	HH CXH	29 (21 in 2015/16)		**30.00**	**29.46**	**19.11**	**10.35**	**65%**	**35%**
		29	8a	1.00	**1.00**				
			6	4.00	**2.59**				
			5	14.50	**15.52**				
			2	3.00	**10.35**				
				7.50					
John Humphrey Ward	HH	21		**27.26**	**30.40**	**20.80**	**9.60**	**77%**	**32%**
		21	7	1.00	**1.00**				
			6	3.00	**2.80**				
			5	13.26	**17.00**				
			2	10.00	**9.60**				
Christopher Booth Ward	HH	28		**33.00**	**32.33**	**24.57**	**7.76**	**76%**	**24%**
			7	1.00	**1.00**				
			6	5.00	**5.17**				
			5	18.00	**18.11**				
			2	9.00	**7.76**				
Manvers	SMH	26		**33.00**	**32.04**	**21.69**	**10.35**	**68%**	**32%**
		26	8a	1.00	**1.00**				
			6	7.00	**5.17**				
			5	16.00	**15.52**				
			3	3.00	**0.00**				
			2	6.00	**10.35**				
Samuel Lane Ward	SMH	24		**33.00**	**21.70**	**13.94**	**7.76**	**64%**	**36%**
		14	8a	1.00	**1.00**				
			6	4.00	**2.59**				
			5	17.50	**10.35**				
			3	2.00	**0.00**				
			2	8.50	**7.76**				
Thistle	SMH	20		**27.40**	**26.87**	**19.11**	**7.76**	**71%**	**29%**
		20	7	1.00	**1.00**				
			6	2.00	**2.59**				
			5	16.40	**15.52**				
			3	2.00	**0.00**				
			2	6.00	**7.76**				

Division of Medicine

Appendix 1 - Ward level clean sheet establishment review findings March 2016

Grafton (now 9S stroke)	SMH	16		**24.80**	**24.32**	**16.48**	**7.84**	**68%**	**32%**
	CXH	TBC	7	1.00	**1.00**				
			6	4.00	**3.92**				
			5	11.80	**11.56**				
			3	8.00	**7,84**				
Witherow Ward	SMH	12		**24.80**	**24.29**	**13.94**	**10.35**	**57%**	**43%**
			8a	1.00	**1.00**				
			6	3.00	**2.59**				
			5	10.24	**10.35**				
			3	2.00	**0.00**				
			2	8.56	**10.35**				
Lewis Lloyd Ward	SMH	14		**24.80**	**24.29**	**13.94**	**10.35**	**57%**	**43%**
			7	1.00	**1.00**				
			6	3.00	**2.59**				
			5	10.24	**10.35**				
			3		**0.00**				
			2	10.56	**10.35**				
Almroth Wright	SMH	15							
			8a						
			6						
			5						
			3						
			2						
Rodney Porter / Almroth Wright	SMH	8		**35.90**	**33.69**	**24.52**	**9.17**	**73%**	**27%**
		8.00	7	1.00	**1.00**				
			6	5.00	**6.00**				
			5	19.50	**17.52**				
			2	8.40	**9.17**				
				2.00					
C8	HH	15 - 20		**35.33**	**32.10**	**24.46**	**7.64**	**76%**	**24%**
		15.00	7	1.00	**1.00**				
			6	6.00	**5.88**				
			5	20.53	**17.58**				
			2	7.80	**7.64**				
10 North Ward Neurology & PIU	CXH	15 + 7 PIU		**28.00**	**27.45**	**22.55**	**4.90**	**82%**	**18%**
		15 + 7 PIU	8a	1.00	**1.00**				
			6	6.00	**5.88**				
			5	16.00	**15.67**				
			3	4.00	**0.00**				
			2	1.00	**4.90**				
11 South Neurosurgery	CXH	25		**38.83**	**38.85**	**32.68**	**6.17**	**84%**	**16%**
			7	1.00	**1.00**				
			6	6.00	**5.88**				
			5	26.00	**25.80**				
			3	5.00	**0.00**				
			2	0.83	**6.17**				

Appendix 1 - Ward level clean sheet establishment review findings March 2016

Piu (Planned Inv. Unit) Renal	HH	18 day case		**8.20**	**8.06**			**0%**	**0%**
	HH		7	1.00	**1.00**				
			6	3.00	**2.94**				
			5	2.20	**2.16**				
			3	1.00	**0.00**				
			2.00	1.00	**1.96**				
Handfield Jones Ward	HH	21		**27.00**	**26.47**	**18.63**	**7.84**	**70%**	**30%**
		21	8a	1.00	**1.00**				
			6	3.00	**3.92**				
			5	14.00	**13.71**				
			2	8.00	**7.84**				
Peters Ward	HH	24		**27.00**	**26.47**	**19.13**	**7.34**	**72%**	**28%**
		16	8a	1.00	**1.00**				
			6	4.00	**3.92**				
			5	14.00	**13.72**				
			2	8.00	**7.34**				
De Wardener Ward	HH	12		**22.00**	**21.55**	**20.57**	**0.98**	**95%**	**5%**
		12	7	1.00	**1.00**				
		level 1 & 2	6	10.00	**9.80**				
			5	10.00	**9.80**				
			2	1.00	**0.98**				
Kerr Ward	HH	22		**27.00**	**26.47**	**18.63**	**7.84**	**70%**	**30%**
			7	1.00	**1.00**				
			6	4.00	**3.92**				
			5	14.00	**13.71**				
New establishments			2	8.00	**7.84**				
A care SMH					**4.00**	**4.00**			
			7		**1.00**				
			5		**3.00**				
9 South Neuro reb	CXH	16 + 3 -4 community beds			**30.50**	**17.50**	**13.00**		
			7		1.00				
			6		5.50				
			5		11.00				
			2		13.00				
MATERNITY					**22.39**	**22.39**			
TOTALs				**1117.77**	**1128.0**	**846.70**	**281.30**	**75%**	**25%**

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (20 April 2016)**

KEY ITEMS TO NOTE

Draft annual accounts: The latest position on the draft accounts was shared with the Committee, and it was noted that the draft accounts were due for submission on 22 April. It was confirmed that these would include appropriate provisioning in relation to the Trust freehold and leasehold estate. The Committee noted that: capital spend would not breach the control total; aged NHS debt would be subject to careful review; and that the external auditors had confirmed that they were comfortable with the valuations.

Draft performance report for the annual report: The Committee reviewed and commented on the draft performance report noting that the final full annual report would be presented for approval on 1 June.

Draft annual governance statement & directors report: The Committee reviewed and commented on the draft governance statement and director's report, and approved them for submission subject to the comments made by the Committee being reflected in the final version.

Head of internal audit opinion: The Committee noted that the overall level of assurance in the opinion was 'reasonable', based on the work undertaken by the team during the year.

Draft quality account: The Committee noted the latest version of the quality account and recognised that the quality committee had primary responsibility for the document.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Sir Gerald Acher, Chairman, Audit, Risk & Governance Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 6 July 2016 (Audit only meetings– end of year submissions - on 25 May &1 June)

Imperial College Healthcare NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE (Part I only)
Wednesday 16 March 2016
10.00am – 12.30pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sir Gerald Acher (Chair)	Non-executive director
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
In attendance:	
Richard Alexander	Chief financial officer
Dr Tracey Batten	Chief executive
Prof Janice Sigsworth	Director of nursing
Dr Julian Redhead	Medical director
Jan Aps	Trust company secretary
Siobhan Peters	Deputy CFO
Leigh Lloyd-Thomas	Partner / public sector assurance, BDO LLP
Jodie Etherington	Audit Manager, BDO LLP
Kevin Limn	Director, TIAA
Philip Lazenby	Director of audit, TIAA
Arti Patel	Senior counter fraud specialist, TIAA
Kevin Jarrold	Chief information officer
Prof Jamil Mayet	Divisional director Surgery, Cancer & Cardiovascular (items 4.3)
Martin Lerner	Divisional Director of Operations, Surgery, Cancer, Cardiovascular Division (items 4.3)
Chris O'Boyle	Interim Director of Strategy and Development
Claire Braithwaite	Divisional director of operations (items 4.3)
Nicola Bullen	Associate director, health & well-being (item 3.4)

1	**GENERAL BUSINESS**	**Action**
1.1	**Chair's opening remarks and apologies for absence** The Chair welcomed everyone to the meeting. Apologies for absence had been received from Prof Sir Tony Newman Taylor and Steve McManus. In noting that Mr McManus would shortly be leaving the Trust, Sir Gerry extended thanks to him for his great support of the Committee during his tenure.	
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 2 December 2015** The minutes were approved as an accurate record.	
1.4	**Action log, forward plan, & matters arising report** The Committee noted the updates, particularly that: • Six-monthly updates would be provided on outstanding risks associated with outpatient transformation (including those departments not transferring to central out-patients); • The new head of income, joining the Trust in May/June, would bring expertise in addressing outstanding income from overseas patients; • The findings of the medical education internal audit had mainly been positive; • The Committee could take assurance from the detailed review of the highest cost unfunded overseas patients that their care had been appropriately provided.	

PART I AUDIT		
2	**EXTERNAL AUDIT BUSINESS**	
2.1	**Audit Plan 2015/16** Leigh Lloyd-Thomas introduced the audit plan and progress report, initially highlighting that they would be using 1.25% as the materiality point, but noting any error over £250k would be reported to the Committee; fraud of any value would be reported. He outlined the approach as described in the paper. In relation to 'going concern', a TDA letter of support would be sought in relation to any risks; this would not be a qualification issue, rather a matter of note. Mr Lloyd-Thomas confirmed that the NHS residual business act ensured that suppliers would be paid for goods and services supplied. Mr Lloyd-Thomas noted that changes to the annual account mainly related to structure rather than content. BDO LLP would review the robustness of the recovery plans and their view would be reflected in the use of resources score; there was a risk of qualification given that there was no experience that 8-10% savings could be delivered. Noting that this would be a particularly challenging year-end, the Chair asked that he be kept informed of emerging developments and issues. BDO LLP would review how the Trust was approaching the quality of data reporting, but its work would not be detailed enough to give particular assurance. Mr Lloyd-Thomas would contact Prof Janice Sigsworth and Dr Julian Redhead regarding the quality strategy indicators for review as part of the quality account audit. BDO LLP had been on site for three weeks to conduct the interim audit, understanding the systems, processes and financial controls in place; no significant deficiencies had been identified, and recommendations would be contained in the auditors' full report in May. The Chair asked whether there were any further issues that the Committee should know about. The Committee touched on: the alternative valuation, [redacted] and the need for a prudent level of debt provision given the changing environment. The Committee noted the 25% reduction in audit fees and noted that Richard Alexander would be discussing the fee with the external auditors. The Committee noted the report.	**LLT** **LLT**
2.2	**Timetable for annual report and accounts, including annual governance statement** Dr Andreas Raffel commented that he would not be able to attend the meeting on 1 June. The Committee noted the timetable.	
3	**INTERNAL AUDIT BUSINESS**	
3.1	**Internal audit and counter fraud progress report** Philip Lazenby noted the following audits: • VTE (limited assurance) – this had been reviewed at executive committee and assurance given that the issues highlighted were being addressed; Dr Julian Redhead was confident that processes were improving and noted that the system was being changed. • Financial reporting and budgetary control (reasonable assurance) - TIAA acknowledged the chief financial officer's concerns as outlined in the note added to the report, and recognised that, with the benefit of hindsight, the scope should have been revised. The Committee noted that getting the scope right was vital, but also that if internal audit observed that the scope was inappropriate when commencing the audit, this should immediately be raised with the relevant director. Further consideration would be given to the appropriateness of internal audit conducting this audit in future. The Committee noted the internal audit progress report.	

3.2	**Draft internal audit annual and strategic plan** Kevin Limn noted that the plan had been developed through discussion with the executive team and also a review of Trust risk registers. The plan would remain open to in-year prioritisation, and there were a number of audits reviewing different aspects of data quality. Dr Tracey Batten noted that the plan was supported by the executive committee, and that she was now satisfied with the speed of implementation of recommendations. Siobhan commented that the plan would be reviewed to see which reviews would benefit from being conducted as an advisory review rather than assurance audit. The Committee approved the 2016/17 internal audit plan, noting the plan would be reviewed to consider where advisory, rather than audit reporting, would be appropriate.	**SP**
3.3	**Draft counter fraud plan** Arti Patel noted that the plan covered four generic areas, and would remain flexible to risks identified in-year. The plan had been recommended for approval by the executive committee. The Committee approved the 2016/17 counter fraud plan.	
3.4	**Occupational health audit – management response** Nicola Bullen reported that she had identified a number of managerial issues within the occupational health department, and had requested a review by internal audit. The audit had returned a rating of 'no assurance', with key themes including: a lack of SOPs and guidelines; lack of consistency of working practices; and a poor assurance framework. A comprehensive action plan had been developed and was being implemented. After discussion, the Committee suggested that internal audit undertake a follow-up in August / September. Dr Andreas Raffel welcomed that the audit had resulted from management request, but queried the length of time it had taken to identify the issues. Ms Bullen commented that superficially, all had appeared well, patients were being treated and without particular delay and no issues had been reported. Her concerns resulted from completing a performance review of the team individuals, where issues came to light. Ms Bullen commented that the audit has acted as a catalyst for change, and metrics would be introduced to enable measurement of future performance. The Chair congratulated Ms Bullen for identifying and instigating investigation, and Dr Raffel commented that the Trust needed to encourage further internal quality assurance. Philips Lazenby noted that this was an example of internal audit working to support good management action; further consideration would be given to the use of advisory report format for such work in future, rather than a scored internal audit. The Committee noted the report.	**PL**
4	**FINANCIAL & OTHER BUSINESS**	
4.1	**Tender waivers report** Siobhan Peters introduced the report, noting the continued reduction in both the value and number of waivers; responding to a query from the Chair, she confirmed that alternative processes were not being employed to reduce tender waivers. Sarika Patel particularly commented on the improvement and strengthened processes. The Committee noted the report, and welcomed the improved position.	
4.2	**Losses and special payments register** Siobhan Peters, in reporting on the register, noted the large write-off for time-expired theatre stent stock, an inappropriate volume of which had been purchased. Those responsible had left the Trust, and the loss had been mitigated to some extent where possible. In future, small items would be reported in total. The Chair noted that, excluding the stock write off, the position continued to reduce,	**SP**

	and that the overseas visitor write-off position was particularly encouraging. In response to a question from Richard Alexander, the Committee confirmed that they were assured that an appropriate process was now in place in relation to minimising private patient losses. The Committee noted the register, welcoming the underlying improvement in position.	
4.3	**Operational targets: recovery trajectories** Dr Tracey Batten reported that the responsibility for national targets would be transferring to the individual divisions from April: RTT and Cancer to Prof Jamil Mayet; A&E to Prof Tim Orchard; and Diagnostics to Prof TG Teoh. Kathryn Hughes presented the proposed (but not yet agreed) performance trajectories which would form part of the contractual obligations under the sustainability and transformation fund plans (STP); these had been developed in discussion with commissioners. • *A&E: trajectory forecasts a steady improvement in performance but does not show achievement of target in 2016/17.* • *RTT: trajectory forecasts non-achievement in first four months, linked to junior doctor strikes and theatre refurbishment, and recently identified data integrity issue.* • *Cancer: trajectory forecasts delivery of 85% for each quarter.* • *Diagnostics: trajectory forecasts delivery of <1% patients waiting over six weeks for 10 of 12 months due to implementation of a new PIS/PACS.* Key points of discussion included: • Step change to deliver A&E target sustainably (AR): environmental changes to ED departments required for further improvement. • Risk of being an outlier if other trusts forecasting 95% in 2016/17 (SP): focus in on trying to propose a realistic position (noted the comparison on rate of non-elective beds to admissions). Trajectory assumes growth assumptions (but not that seen in most recent weeks). • Data integrity risk (KJ): an investigation was underway to understand the scale of recently discovered anomalies. A number of orthopaedic and plastics patients may be found to have extended waiting times; both clinical and data reporting risks were being addressed. A further report would be provided to the Committee. • Gender reassignment: the Committee noted that the Trust was the only NHS provider of this service, and that this activity which had not previously been reportable, was to be reported as part of RTT from April 2016 (although not attracting financial penalties). Predominantly due to staffing issues, patients experienced long waits for treatment, and recording this as part of the main RTT would mean the Trust could not achieve the 92% for the year. The Chair commented on the quality of the executive summary of this report. The Committee agreed that the proposed trajectories should be submitted for consideration by NHS Improvement (NTDA).	**KJ**

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust board**

Report from: **Quality Committee (13 April and 11 May)**

KEY ITEMS TO NOTE

Preparation for the junior doctors' industrial action: the Committee was briefed on the preparations in place to manage the action, and at the second meeting, it was reported that it had passed relatively smoothly with good co-ordination in place and no serious incidents having been attributed to the action. A 'lessons learned' review would be undertaken and reported to the Committee.

Reflection on patient story at Trust board: After discussion reflecting on the March patient story where a patient had received distinctly inconsistent, and on one ward unkind, care, the divisional directors agreed in future to highlight wards where they had specific concerns as part of their risk register updates.

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

- Urgent care centre transfer to Vocare: Clinicians had been working closely with the incoming management team to minimise transition risks. However, there had been a number of issues which were being both addressed with the contractor, and highlighted to the CCG as commissioner of the service.
- Proximity of, and access to specialist medication support for, high dependency units: Consideration was being given to re-siting the existing HDU beds to enable a more immediate access to appropriate medical support.
- Patients awaiting elective surgery (RTT target): Further validation had been undertaken to ensure that all patients' were being treated appropriately, and this had highlighted a cohort of patients where the 18 week RTT target had not been achieved; this was being addressed.
- Progress was being made in addressing all risks relating to imaging (equipment failure; reporting delays; staffing shortage).

Quality report: The Committee was pleased to note that compliance with safer surgery on-line training had improved significantly; that there had been a 42% reduction in pressure ulcers in the previous year; and the improvement in doctors' appraisal rates. It also noted that there had been a total of seven never events – each of these had been, or was being, investigated thoroughly and lesson learned to minimise the risk of a repeated event. A total of 73 cases of C difficile (against a threshold of 69 cases) had been recorded in 2015/16, of which seven could be attributable to a lapse in care.
The Committee welcomed the progress report on actions completed following the ionising radiation audit.

Perinatal mortality audit update: The Committee noted the good progress which had been achieved since the external review of perinatal mortality in 2013.

Imperial College Healthcare NHS Trust

Biomedical Research Centre (BRC) annual report: The Committee noted the requirements for the report, the methodology for data collection and the progress made, noting that the narrative would be completed later in the year due to the reapplication for BRC status.

Raising concerns (whistle-blowing): in noting the report, the Committee considered that the fact that the number of incidents had reduced may reflect a falling-off in reporting; this was being addressed by a review of the policy and further communication to staff.

The Committee also supported a number of items which would be presented to the Trust board in May:

- Safeguarding reports – adult; children
- CQC report
- Patient stories stocktake
- Responsible officer's report
- Final draft quality report
- Nursing & midwifery establishment sign-off.

RECOMMENDATION:

The Trust board is requested to:

- Note the report

Report from: Prof Sir Anthony Newman Taylor, Chairman, Quality Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 15 June 2016

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (18 May)**

KEY ITEMS TO NOTE

The Committee noted the:

- Final 2015/16 month 12 position –a deficit of £47.9m, £17.7m of which relates to increases to provisions, and £30.1m to operational performance (£29.2m adverse to plan, with £11.6m relating to operational performance)
- Submission of the final business plan 2016/17 (noting the public version would be presented to the Trust board) and most recent commissioning position, which demonstrated a much improved process with local commissioners, and an good result, particularly when viewed against the context of national financial shortages
- Terms & conditions of the cash support from the Department of Health
- Post-implementation reviews for private oncology and increased neuroradiology capacity, and early benefits identified from Cerner clindocs implementation
- Amended entry for the financial sustainability risk for the corporate risk register.

The Committee approved:

- Delegation of the final reference cost submission to the CFO
- Submission of St Mary's emergency department refurbishment business case to the Trust board for final approval.

Financial improvement programme: The committee received a presentation from the PwC financial improvement programme; key messages, thus far were:

- No accounting inaccuracies or treatment errors had been identified
- There are risks in achieving the planned levels of CIP which are unprecedented for the Trust
- The Trust was facing a significant challenge in 2016/17, and would need further rapid development of cost improvement plans to enable delivery of the planned outturn; it was noted that the Trust was working hard to address this risk
- The Trust's additional financial divisional controls should be made consistent
- Improved cash flow forecasting and working capital management could reduce the level of external funding required
- The overall scale of further cost saving opportunities had yet to be arrived at.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 20 July 2016

Imperial College Healthcare NHS Trust

Report to:	**Trust board**
Report from:	**Redevelopment committee report (27 April 2016)**

KEY ITEMS TO NOTE

The Committee noted that progress continued in developing options for developing the St Mary's site, and the further discussions that had been held with both Sellar and the Westminster planning office.

The Trust's legal advisors proposed an approach to be taken in relation to obtaining the required approvals to proceed with site development, to ensure compliance in the most effective manner; the Committee supported the proposal and authorised the chief executive complete a letter to NHS to this effect.

The Committee also noted to on-going discussions with NHS Improvement and NHS England in relation to development of an appropriate business case.

RECOMMENDATION:

The Trust board is requested to:

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

Report from: Sir Richard Sykes
Report author: Jan Aps, Trust Company Secretary
Next meeting: 29 June 2016

Imperial College Healthcare NHS
NHS Trust

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

Responsible Officer's Annual Report – Revalidation & Appraisal

Executive summary:

Revalidation via the General Medical Council (GMC) is a statutory requirement for all doctors registered with a licence to practise.

NHS England monitors compliance with Responsible Officer Regulations via the Framework of Quality Assurance for Responsible Officers (FQA). A requirement of the FQA is that the Responsible Officer (RO) for any Designated Body (DB) must submit an annual report on compliance with these regulations for approval to the Trust Executive Team.

This report was therefore submitted to the executive quality committee and was approved on 3rd May 2016. The report is now submitted to the quality committee to note the executive approval and the statement of compliance which is required to be submitted to NHS England.

The purpose of this report is:

1. To provide the Trust board with the annual report on compliance with FQA standards
2. To provide the Trust board with assurance of the Trust's compliance with the FQA standards and to note the Statement of Compliance (Appendix A) which will be submitted to NHS England;
3. To inform the Trust board of changes to the way in which appraisal compliance is reported in the Trust board scorecard.

Quality impact:

This paper reflects the CQC domain 'well-led', in that it supports a culture of learning and innovation through regular reflection and continued professional development, focuses on engaging formal colleague and patient feedback on individual doctors, and ensures the development of open and transparent culture focusing on continually improving quality.

Financial impact:

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

1) Has no financial impact.

Risk impact:

The risks associated with this paper are referenced in the risk register, and are managed through regular team meetings.

Recommendations to the Trust board:

- Note this report which confirms that the executive team are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" and the statement of compliance which will be submitted to NHS England by 29/05/2016;
- Note the change to appraisal compliance reporting to the Trust Board for 2016/17.

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.

Author	Responsible executive director	Date submitted
Victoria Ward, Professional Development Manager	Dr Julian Redhead, Medical Director	4 May 2016

Responsible Officer's Annual Report – Revalidation & Appraisal

Purpose of the report:
Revalidation via the General Medical Council (GMC) is a statutory requirement for all doctors registered with a licence to practise.

The expectation of regulators[1] is that the boards of designated bodies (or executive teams for some designated bodies) monitor the organisation's progress in implementing the Responsible Officer Regulations. To assist in this, this board report has been provided.

1. Background

Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Medical Revalidation started on 3 December 2012 and comprises a five year cycle; therefore, it is expected that the majority of doctors will be revalidated by December 2017.

This means that holding a license to practice is becoming an indicator that the doctor continues to meet the professional standards set by the GMC and the specialist standards set by the medical Royal Colleges and Faculties.

Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Licensed doctors will have to revalidate every five years, by having an annual appraisal based on the GMC core guidance for doctors, *Good medical practice*.

Most licensed doctors have a prescribed connection with one organisation that provides them with an annual appraisal, and helps them with revalidation. This organisation is referred to as a 'designated body'.

All designated bodies must have an appointed Responsible Officer (RO) who submits revalidation recommendations to the GMC for all doctors with a prescribed connection to the organisation.

Revalidation recommendations for doctors in training are dealt with by the Local Education Training Board (LETB).

2. External Monitoring & Assurance

NHS England monitors compliance with Responsible Officer Regulations via the Framework of Quality Assurance for Responsible Officers (FQA). As part of the FQA, NHS England requires designated bodies to adhere to a set of Core Standards (Appendix B). The Trust is required to submit the following as evidence of performance against these standards:

- the Annual Statement of Compliance (see Appendix A and section 2.1) made by the Trust's Executive Team to NHS England, due by 30 September 2016;
- the Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England, due by 31 May 2016 (see Annex A and section 2.2);

[1] General Medical Council, Care Quality Commission, Monitor and the NHS Trust Development Authority

- an Annual Report to the Trust Board on compliance with these standards (this report);

2.1. Statement of Compliance

The Responsible Officer Regulations set out the obligation on the part of designated bodies to provide support to the responsible officer. In demonstrating this support, the chief executive or chairman (or executive if no board exists) is asked to sign a statement of the organisation's compliance to the Responsible Officer Regulations. This is submitted to the higher level responsible officer, along with the AOA.

STATEMENT 1 - A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Imperial College Healthcare NHS Trust is a recognised designated body. The Trust's RO is Dr Julian Redhead, Medical Director who has received the appropriate RO training. The 'Alternative Responsible Officer' is Dr Justin Vale, Associate Medical Director, who is due to receive RO training in May 2016.

***STATEMENT 2* - An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;**

The Professional Development Team (formally the Revalidation Team) is part of the Office of the Medical Director and reports to the Responsible Officer and the Head of Education and Professional Development. The Professional Development Team maintains and verifies an accurate record of all doctors with a prescribed connection to ICHT using the GMC Connect database.

***STATEMENT 3* - There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;**

All appraisers are required to undertake appraiser training and then receive refresher training every 3 years. This was formally delivered by an external training provider, MIAD, but moving forward will be delivered internally. The internal appraiser training curriculum has been validated with NHS England and complies with their guidance 'Training Specification for Medical Appraisers in England'.

As of 31 March 2016, the Trust's ratio of appraisers to appraisees is 1**:**5.3, which complies with the NHS England recommendations[2]. Departments with a high turnover of staff, fewer appraisers than recommended, or have appraisers whom are not active in the role, have been offered the opportunity to train more appraisers. All Heads of Speciality have been made aware of the need to ensure adequate appraisers are trained within their speciality so that appraisal compliance is not compromised.

[2] Core Standard 2.4.1

***STATEMENT 4* - Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[3] or equivalent);**

- Appraiser forums are run on a monthly basis, rotating across sites, which allow appraisers the opportunity to share best practice, benchmark and develop.
- Internal refresher training will be implemented in June 2016, focusing on quality of appraisals.
- Three appraisal leads have been recruited, and are to be engaged in peer review activities.
- We are currently in discussion with other NHS Trusts of similar size, to implement cross organisational auditing on the quality of completed appraisals.

***STATEMENT 5* - All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;**

As well as being a contractual requirement, annual appraisal for doctors is a requirement for GMC Revalidation. Compliance with annual appraisal for the 2015/16 annual period as required to be reported to NHS England in the FQA is shown in Figure 1.

FQA appraisal compliance for 2015/16 has increased significantly in comparison with 2014/15 (+10.7%), with changes made in the reporting to reflect the requirements set out by the regulatory bodies. This has been supported by the publication of the Appraisal and Revalidation policy, including clear escalation processes for doctors who are non-compliant with annual appraisal, as well as the presentation of appraisal compliance rates at the monthly Divisional Performance Reviews.

FIGURE 1: Annual FQA Appraisal Compliance 2015/2016

IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2016 should be included.	Number of Prescribed Connections	Completed Appraisal	Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal
Consultants	675	588 (87.1%)	16 (2.4%)	71 (10.5%)
Staff grade, associate specialist, specialty doctor	86	74 (86%)	1 (1.2%)	11 (12.8%)
Doctors on Performers Lists	0	0	0	0

[3] http://www.england.nhs.uk/revalidation/ro/app-syst/

Doctors with practising privileges	1	1 (100%)	0	0
Temporary or short-term contract holders	314	236 (75.2%)	35 (11.2%)	43 (13.6%)
Other doctors with a prescribed connection to this designated body	0	0	0	0
TOTAL	1076	899 (83.6%)	52 (4.8%)	125 (11.6%)

An audit of all missed appraisals was introduced in March 2016; the results can be viewed in Appendix B.

STATEMENT 6 **- There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;**

Performance is managed through the clinical divisions' local quality structures. Clinical outcome data, such as directorate specific mortality reports, are provided to Heads of Specialty and Chiefs of Service. Clinical Governance information is provided to doctors and the RO by the Safety and Effectiveness Team in line with DOH, NHS England and NICE guidelines.

STATEMENT 7 **- There is a process established for responding to concerns about any licensed medical practitioners fitness to practise;**

The Trust has published a Raising Concerns policy. There is an established process within the Trust for dealing with any concerns about a doctor's fitness to practise; all concerns and investigations are logged electronically.

STATEMENT 8 **- There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner work;**

There is a procedure in place for obtaining and sharing information about doctors between our RO and those of other designated bodies, and with the GMC. The Trust uses the approved NHS Medical Practice Information Transfer (MPIT) form to share this information. We routinely request

information from other organisations where a doctor clinically practices during their revalidation period.

***STATEMENT 9* - The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;**

The Trust held NHSLA Level 3 which included assurances that it conducted appropriate pre-employment, registration and right to work checks. All appropriate pre and post-employment clearances are carried out by HR and the recruiting managers in line with NHS Employers guidance and Trust policy to ensure that all licensed medical practitioners have qualifications and experience appropriate to the work performed. Agency doctors are booked via agreed framework agencies who comply with NHS Employers guidance.

***STATEMENT 10* - A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance;**

2015/2016 Key Achievements:

- 8.6% reduction in deferral rates for revalidation

- 11% increase in overall appraisal compliance;
  - 32.3% increase in non-consultant appraisal compliance
  - 29% increase in temporary or short-term contract holders' appraisal compliance

- Implementation of regular support for doctors across a variety of mediums
  - Monthly whole day drop-in session rotating across the Trust sites
  - Publication of the Responsible Officer's newsletter
  - One to one support four months prior to a revalidation date
  - Appointment of three appraisal leads to support the medical body

- Quality Assurance of appraisal and revalidation process and procedures
  - Development of a more robust honorary contracts process with medical personnel
  - Improved data validation between GMC and local systems
  - Implementation of a formal process for new starters at the trust
  - Alignment of organisational processes and procedures to match national requirements

- Implementation of a fee paying service for private doctors

- Formation of the 'Professional Development Team'
  - Merging revalidation, appraisal, job planning, clinical teaching and clinical excellence award work streams
  - Reduction in staffing costs

4

Key challenges that have been identified through the year:

- Continued data quality issues in ESR which compromises the appraisal and revalidation of doctors.
- The honorary contracts process still requires further improvement, to assure we are not incorrectly issuing prescribed connections to doctors.
- Deterioration in the service provided by Premier IT, for their appraisal and educational module within PReP.

The following action plan has been established to address the above issues and areas of non-compliance reported in the AOA:

- The Education team are leading a project to improve the quality of data within ESR.
- We are working closely with medical personnel to adapt their current procedures to ensure they reflect the current legislation governing appraisal and revalidation.
- A business case will be put forward to look at the service provided by competitors to PReP, and explore the possibility of changing appraisal system before the contract is renewed on 01/04/2017.

2.2. Annual Organisational Audit

The Responsible Officer has confirmed that the Trust is compliant with all aspects of the AOA End of Year Questionnaire (see Annex A).

2.3 Quality Assurance

Governance Arrangements

Progress is monitored through the Professional Development Team, and disseminated to the Medical Director, Deputy Medical Director, DD, HRPB's and COS through monthly reports of all overdue appraisals. Further to this, appraisal and job planning compliance reporting has formed part of the Divisional performance reviews for the majority of the 2015/2016 round, and is also reported to ExCo.

The Professional Development team also maintains an accurate list of doctors with a prescribed connection to ICHT, by cross referencing this against the organisational systems in addition to verifying information directly with the doctor. Where possible, doctors who are leaving the Trust are given advice at the end of their prescribed connection as to the next steps in their revalidation.

Further to the external audit in 2014 from MIAD, and the Independent Verification Visit in 2015 from the GMC, we are currently in discussion with designated bodies of a similar size, regarding cross–organisational peer review of revalidation processes and quality assurance of appraisals.

The GMC have informed us that we will next be due an Independent Verification Visit in 2020.

Policy and Guidance

The Appraisal Policy is currently under review

Access, security and confidentiality

Information is stored either in a secure area on the Trust network electronic drives, or on the appraisal system PReP. PReP has been approved by the Caldicott Guardian and is due to be reviewed again on the 11/08/2017, in line with local processes. Premier IT, the owners of PReP,

take reasonable steps to protect any information a doctor submits via the System, in accordance with the Data Protection Act 1998. The Data Protection Act governs the collection, retention, and transmission of information held about living individuals and the rights of those individuals to see information concerning them. The Act also requires the use of appropriate security measures for the protection of personal data. Any information management breaches are escalated to the Professional Development team.

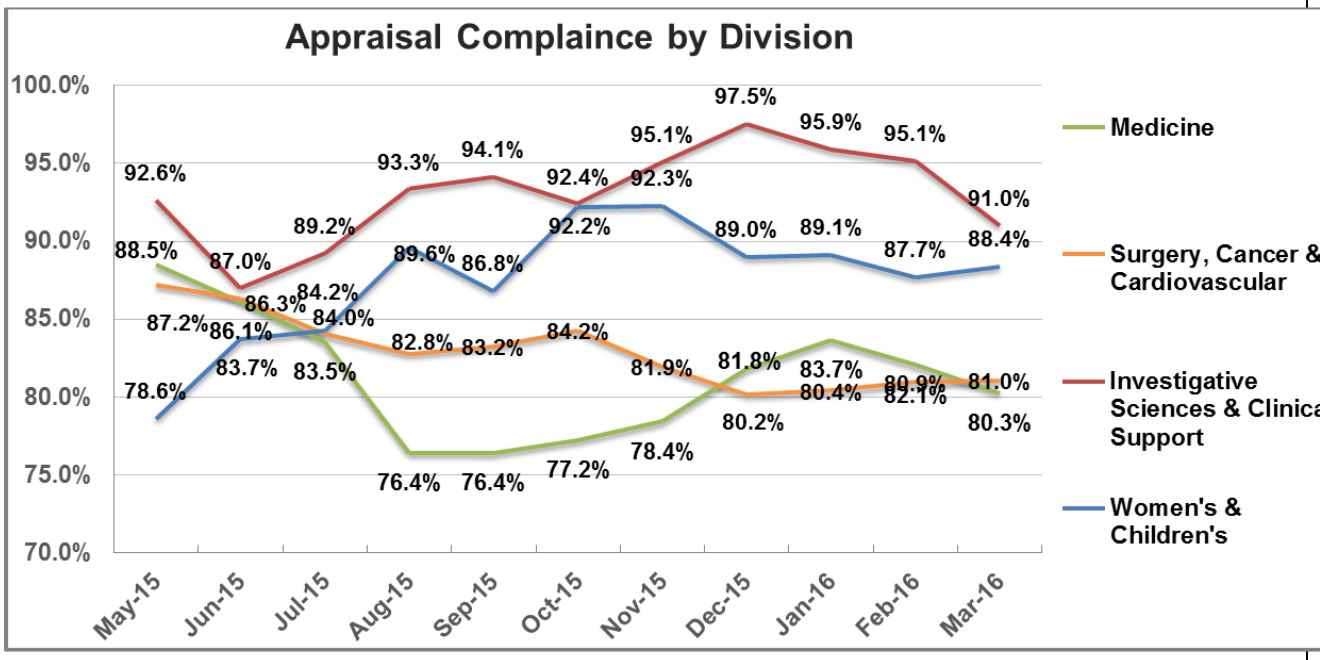
All information is handled in line with the document, 'Information Management for Medical Revalidation in England' produced by the NHS England team.

Clinical Governance

Outline of data for appraisal. Corporate data used for individual doctors to contribute to supporting information. What is provided to individuals for appraisal e.g. clinical incident and complaint database, record keeping audit, activity data?

3. Appraisal and Revalidation Performance Data

Appliance compliance is reported monthly in the Trust Board Scorecard. The appraisal compliance measure reported in the Trust Board Scorecard has previously differed from the definition of compliance required in the FQA submitted to NHS England quarterly. This has been rectified during the change of management in the last year.



- ***2014/2015 Trust Board scorecard:***
  - Includes consultants who have a prescribed connection to the Trust but does not include

career grades;
- A doctor is considered as being compliant if they have completed an appraisal in the previous 12 months at the time of reporting;
- All doctors with a hire date in the previous 12 months at the time of reporting are exempt from the figures.
- A doctor is considered as having completed an appraisal if they have submitted the 'input form' on the ePortfolio system (PReP) which is not the final stage of the appraisal process.

- ***2015/2016 Trust Board scorecard:***
  - **Includes all doctors;**
  - **As appraisal is a national standard, all new starters must provide the date of their last appraisal or ARCP and their compliance is monitored from this date;**
  - **A doctor is only considered as having completed an appraisal if they have signed an 'output form' on the ePortfolio system (PReP) which is the final stage of the appraisal process.**

The changes were instigated in June 2015, and reflected in the expected drop in the compliance. Since then, the appraisal rate has increased and the significant improvement in recording of appraisal compliance has allowed a greater level of support to be given to the doctors.

We will also be providing alternative reports that illustrate the appraisal compliance when measured by the Trust standards for the Professional Development Review.

An audit of all missed or incomplete appraisal was competed on the 31/03/2016 for the previous year. Details of this audit can be found in **Appendix A;** Audit of all missed or incomplete appraisals audit.

Trust Standards

Appraisal compliance can also be measured in accordance with the Trust's Performance and Development Review Policy. By following these standards, the medical body have achieved 96.4% appraisal compliance.

	Number of Prescribed Connections	Compliant with appraisal	Non-compliant with appraisal
Consultants	675	655	20

Staff grade, associate specialist, specialty doctor	86	80	6
Doctors on Performers Lists	0	0	0
Doctors with practising privileges	1	1	0
Temporary or short-term contract holders	314	301	13
Other doctors with a prescribed connection to this designated body	0	0	0
TOTAL	1076	1037 (96.4%)	39 (3.6%)

Appraisers

As of 31st March 2016, the Trusts ratio of appraisers to appraisees is 1**:**5.3, which complies with the NHS England recommendations[5].

New internal appraiser training has been verified with NHS England, and the core content meets the requirements set out in the NHS England documents, 'Training Specification for medical appraisers' and 'Quality Assurance of Medical Appraisers'.

Appraisal refresher training is offered on an annual basis, and there are monthly appraiser forums offering further support.

[5] Core Standard 2.4.1

APPENDIX A

Designated Body Statement of Compliance

The executive management team of Imperial College Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: Yes

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: Yes

5. All licensed medical practitioners[6] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: Yes

[6] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[7] have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[7] Doctors with a prescribed connection to the designated body on the date of reporting.

APPENDIX B – Audit of missed or incomplete appraisals.

The audit of missed appraisals was sent to appraisals overdue by more than 28 days as of 31/03/2016. In total, it was sent to 74 of the 131 overdue, in accordance with the AOA figures.

Doctor factors (total)	**Number**
Maternity leave	0
Sickness absence	0
Prolonged leave	1
Suspension	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	2
Postponed due to incomplete portfolio/insufficient supporting information	1
Lack of time of doctor	11
Lack of engagement of doctor	0
Appraiser factors	**Number**
Difficulty selecting an appraiser	4
Lack of time of appraiser	5
Unplanned absence of appraiser	3
Organisational factors	**Number**
Error with appraisal system (PReP)	2
Delay in signing off the appraisal outputs	7
Other	20
Did not reply	**18**

The audits responses were collated within the Professional Development team. Where the doctor did not provide a clear response but returned a narrative explaining their circumstance, we have included them under ‘Other’.

In summary of the above findings, the most common response was a lack of time to complete appraisal. In order to address this we have updated the job planning guidance, providing more clarification on the SPA allocation within job planning, and the reiteration that all doctors are to be allocated 1PA for professional development activities.

It was also highlighted that a number of doctors were having difficulties with the electronic system, PReP, and in order to address this we will be creating a business case to analyse the impact across the medical body of moving to another appraisal system.

ANNEX A – **Annual Organisational Audit (**AOA)

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2015-16

https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2016/03/annx-c-aoa-15-16.pdf

North West London Collaboration of
Clinical Commissioning Groups

2nd Floor
15 Marylebone Road
London, NW1 5JD
19 May 2016

Dear Colleague

RE: Changes to some children's services at Ealing Hospital from 30 June 2016

To improve children's care across North West (NW) London, there will be changes to some children's services at Ealing Hospital. On 30 June the children's ward at Ealing Hospital will close and, from that date, ambulances will no longer take children to Ealing's accident and emergency department.

It is important to understand that the urgent care centre at Ealing Hospital will still be open 24/7. If a child needs more specialist care than the UCC can provide, they will be looked after by doctors and nurses and transferred to another hospital and appropriate transport will be arranged.

The changes, which have been ratified by Ealing's Clinical Commissioning Group's Governing Body this week, are necessary to provide consistent high quality seven-day children's services across five hospitals in North West London, allowing more specialist senior doctors to be available throughout the day and night to treat children. This will improve the quality of clinical care and patient experience and get children back to health more quickly.

Along with improvements in care, all five children's A&E departments at: West Middlesex, Hillingdon, Northwick Park, Chelsea and Westminster and St Mary's hospitals have seen significant investment, refurbishment and expansion. These changes have also seen the introduction of paediatric assessment units (PAUs) on four sites. The PAUs will provide care in a more appropriate setting than A&E, for those that need assessment and treatment but don't require an admission into hospital.

All other children's services, including day clinics and outpatient appointments, will stay at Ealing Hospital. A full list of these services can be found at: www.lnwh.nhs.uk/children-ealing-hospital

In addition, there are important new services that have been introduced at Ealing Hospital. These include a new rapid access clinic, which provides GPs in the Ealing area with expert advice on children's health and access to specialist appointments. In addition the Children's Community Nursing Team will also be moving to Ealing Hospital, ensuring the care children receive in hospital and in the community is coordinated, giving children access to the specialist team on site when needed.

A public information campaign has now launched to ensure that parents and carers are aware of the changes and I have enclosed a copy of the public information booklet for your information.

The main messages for parents/carers are:

- In a life-threatening emergency call 999.
- If it's not a life-threatening situation, you can go to Ealing Hospital's urgent care centre, visit/call your GP or call NHS 111.

North West London Collaboration of
Clinical Commissioning Groups

If you would like to order more copies of the booklet, translations or an easy read version, please contact us at **healthiernwl@nw.london.nhs.uk** or call **0800 1777 990** stating the formats and quantities you require and the delivery address.

More information about the changes can also be found at www.healthiernorthwestlondon.nhs.uk

Yours faithfully

Dr Mohini Parmar

Chair, NHS Ealing CCG