

TRUST BOARD AGENDA – PUBLIC

6 April 2016

11.30 – 13.00

Clarence Wing boardroom

Agenda Number		Presenter	Timing	Paper
1	Administrative Matters			
1.1	Chairman's opening remarks & apologies	Deputy chairman	11.30	Oral
1.2	Board member's declarations of interests	Deputy chairman		1
1.3	Minutes of the meeting held on 27 January 2016	Deputy chairman		2
1.4	Record of items discussed at Part II board meeting 27 January 2016	Deputy chairman		3
1.5	Action Log	Deputy chairman		4
1.6	Review of Trust board declarations of interest	Trust company secretary		5
2	Operational items			
2.1	Patient story	Director of nursing	11.40	6
2.2	Chief Executive's report	Chief executive		7
2.3	Operational report & scorecard	Director leads for each domain		8
2.4	Finance report – month 11	Chief financial officer		9
3	Items for decision or approval			
3.1	Shaping a Healthier Future paediatric service transition – letter of assurance	Divisional director, women's', children's & clinical support	12.25	10
4	Items for discussion			
4.1	Proposal to consolidate stroke and neuro-rehabilitation bed base at Charing Cross Hospital	Director of medicine & integrated care	12.30	11
4.2	Improving the quality of care – CQC update report	Director of nursing		12
4.3	Quality accounts - update	Medical director		13
5	Board committee reports			
5.1	Audit, Risk & Governance Committee – Part I minutes (2 December) and report (16 March)	Committee chair	12.45	14
5.2	Quality committee report (9 March)	Committee chair		15
5.3	Finance and investment committee report (23 March)	Committee chair		16
5.4	Redevelopment Committee report (24 Feb and 23 March 2016)	Committee chair		17
6	Items for information			
7	Any other business			
8	Questions from the Public relating to agenda items			
			12.55	
9	Date of next meeting			
	25 May 2016, W12, Hammersmith Hospital			

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 27 January 2016
 11.45 – 13.10
 New board room, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
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
Sir Gerry Acher	Non-executive director
Sarika Patel	Non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Prof Chris Harrison	Medical director
Steve McManus	Chief operating officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Jan Aps	Trust company secretary (minutes)
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Chris O'Boyle	Interim director of strategy & redevelopment
Dr Julian Redhead	Deputy medical director
Prof Jonathan Weber	Vice Dean of the Faculty of Medicine (Research), Imperial College (item 3.2)
Guy Young	Deputy director of nursing, patient experience
Margaret Smedley-Stainer	Inclusion and vulnerability officer

1	General business	Action
1.1	Chairman's opening remarks and apologies The chairman welcomed members to the meeting. Apologies for absence had been received from Prof Gavin Sreaton.	
1.2	Board members' declarations of interest and conflicts of interest There were no additional conflicts of interests declared at the meeting.	
1.3	Minutes of the meeting held on 25 November 2015 <i>The minutes were agreed as an accurate record.</i>	
1.4	Record of items discussed at Part II board meeting 25 November 2015 <i>The report was noted.</i>	
1.5	Matters arising and action log Dr Batten noted that all items were either completed or were on future agendas. <i>The Trust board noted the updates to the action log.</i>	
2	Operational items	
2.1	Patient story The chairman welcomed Anne Forde, accompanied by Guy Young and Margaret	

	<p>Smedley-Stainer, to the meeting. Mr Young noted the Trust continued to seek to improve the way in which it provided services for patients with learning disabilities. Mrs Forde explained that her daughter Kelly had been left with severe learning disabilities since a virus as a baby. Mrs Forde was informed by telephone that Kelly had experienced a minor fall at the care home; she was later to discover that it had been more serious, and Kelly was admitted with her injuries. When her plaster was later removed, Kelly's arm remained very tender, but when Mrs Forde sought an appointment, she was told she would have to wait given that Kelly had been discharged; this was very distressing. On being informed by the visiting consultant (to the care home) of the situation, Margaret Smedley-Stainer arranged an appointment within 24 hours. Margaret Smedley-Stainer ensured that the experience was a positive one and Mrs Forde felt supported at all times.</p> <p>Mr Young highlighted that patients with learning disabilities (approximately 1%) could not be treated in the same way as other patients, and required additional support. Margaret Smedley-Stainer responded to Mr Isaacs question by noting that systems were improving whereby the tri- borough social care team would inform the team if similar patients were due to attend, but there were less robust systems for emergency patients. The emergency department teams would now contact patient experience and the site team when patients with learning disabilities attended; attempts were also being made to include such information on Cerner.</p> <p>In response to the Chief Executive's query, Mrs Forde confirmed she now had a telephone contact number for the Trust. Guy Young explained that staff training was being delivered to improve awareness and understanding of patients with learning disabilities across the Divisions. The Chairman thanked Anne Forde for taking the time to share her and her daughter's experiences with the Trust board. Jeremy Isaacs asked that details of actions taken to ensure systematic access to support patients with learning disabilities were reported to the Trust board.</p> <p>The Trust board noted the experience outlined in the patient story.</p>	JS
2.2	<p>Chief executive's report</p> <p>Dr Tracey Batten particularly highlighted the following items:</p> <ul style="list-style-type: none"> • NHS planning guidance for 2016/17 required the development of not only a Trust operational plan, but also the development of a five year sustainability and transformational plan across the health economy. Whereas planning in previous years had been adversarial at times, parties were taking an open book approach to agreeing a balance between what was required to achieve targets and what could be afforded. Plans would be presented at the finance and investment committee and Trust board in March / April 2016. • The implementation of electronic patient records and electronic prescribing on Cerner had been completed at St Mary's and Hammersmith Hospitals, and would be completed at Charing Cross by the end of March 2016. Clinical feedback had been positive, reporting that it supported the clinical team in their jobs and improved patient safety. Pilots on bedside interface units were being undertaken in 26 areas. A software upgrade would be introduced shortly, which would enhance functionality with no additional risk being envisaged; learning had been sought both from other Trusts and internationally. In response to Sir Gerry Acher, Kevin Jarrold commented that increased efficiency savings were being achieved, mainly in staffing requirements in medical record. This would be presented to the finance and investment committee as part of the post-implementation review. • The Trust would shortly see the transitioning of Medical Directors; Prof Chris Harrison was leaving the post to take up a post in Manchester, and Dr Batten extended her thanks to him for the tremendous contribution he had made to the Trust, particularly in embedding comprehensive quality systems. He would be ensuring that Dr Julian Redhead, who would be replacing him, received a comprehensive handover; a warm welcome was extended to Dr Redhead and thanks expressed to Prof Harrison. 	

	The Trust board noted the chief executive's report.	
2.3	<p>Operational report & integrated performance scorecard</p> <p>Steve McManus highlighted that, whilst there was a risk of the Trust breaching the threshold for C difficile, only 3 of the 57 cases had been identified as lapses in clinical care; the overall message was that the Trust had strong and effective infection control arrangements. The 30 day readmission rate had reduced from 7% to 3%, reflecting both an improvement in data capture and the enhanced services in place to care for patients without the need for admission.</p> <p>Mr McManus acknowledged the indicators for responsiveness were less satisfactory. The Trust had not achieved the single referral to treatment target; this was now receiving daily oversight at senior level, and a further detailed report would be provided to the Trust board in March. The six week diagnostic waiting time standard had not been achieved; this was related to an unforeseen operational estates failure. All patients had been rebooked, and it was expected that January's performance would be back within tolerance. Whilst A&E waiting times target had not been achieved, performance had improved on 2014/15, and an agreed recovery plan (additional resources; discharge teams; extended hours of ambulatory teams) was in place. It was expected that Charing Cross Hospital would achieve the 95% four hour wait standard by the end of March 2016, although it was expected that further system wide improvements would be required (currently being addressed) to return St Mary's A&E to a similar position.</p> <p>The Trust's cancer performance remained some of the strongest across London, with seven of the eight targets again being achieved. However, there was a small slip in November on 62 day screening, but the Trust was expected to achieve all eight targets for the quarter. Sir Richard Sykes welcomed the significant improvement.</p> <p>In response to a query from Sarika Patel on the low Friends and Family Test response in A&E, Prof Sigsworth recognised that this had been disappointing, but that there had been problems in getting traction from staff and volunteers to feel it appropriate to approach patients to ask for their feedback, mainly as a result of the pressures and challenges in the department over the previous few months. Prof Sigsworth felt confident that new matrons and a change in head of service would help galvanise the change required; she noted that most patients were positive about their experience, and that evidence suggested that the higher the response rate the more positive the resultant rating would be. It was also noted that the recommendation rate amongst maternity patients was lower than in other areas, although the national maternity survey suggested that the patient experience was moving in the right direction, and there appeared to have been an improvement in the previous three months. This would be kept under close review. Focused attention on statutory and mandatory training had improved compliance slightly, but the national project to create a training 'passport' for junior doctors would significantly help.</p> <p>In response to a query from Dr Rodney Eastwood, Steve McManus confirmed the link between high rates of hospital cancellations and 'did not attend' rates; positive improvement had been experienced in recent months and, with information now available at consultant level being acted upon, further improvement was expected. Steve McManus further explained the enhancements to existing text reminders being developed, to include the cost and impact of not attending clinic appointments. Following clinical review of patient referral letters, patients who did not attend appointments would be referred back to their GP to seek re-referral; this would both ensure better clinical overview of the patient, and was also hoped to improve attendances. A more detailed review of Western Eye DNA for first appointment would be provided to the Trust board.</p> <p>The Trust board noted the operational report.</p>	SM
2.4	<p>Finance report</p> <p>Richard Alexander noted the £25.4m deficit position which was an adverse position of</p>	SM

	<p>£11.7m against the Trust's plans. The Trust was responding at three levels: management approach looking at all areas of cost, looking for savings; talking with commissioners about improving alignment between provider plans and commissioner budgets (this was proving positive); and at national level making it clear that the Trust was underfunded (sustainability funding was being offered, but had yet to be at an appropriate level). The issues, mitigation and resolution were being discussed in detail at executive and board committee level.</p> <p>The Trust board noted the financial report.</p>	
3	Items for decision or approval	
3.1	<p>Imperial College Healthcare Charity</p> <p>Dr Tracey Batten reminded the Trust board that this paper followed that presented in July 2015 proposing independence for the ICH charity. The principles of such independence had been confirmed by the Chairman of the Charity and the proposed form of the Charity was consistent with the guidance from the Charities Commission, included the core legal commitments that the DH requires, and was in line with other NHS trust charities. Dr Batten confirmed that legal advice had been sought, and there remained a couple of minor issues to address. Dr Rodney Eastwood suggested, and the Trust board agreed, that the agreement should only be signed once it was clear that each of the four conditions outlined in the paper (the statement from the Charity's chairman) were fulfilled.</p> <p>The Trust board approved in principle the signing and sealing of the proposed memorandum of understanding, and delegated authority to the Chief Executive to finalise further amendments to ensure alignment with the conditions outlined by the Chairman of the Charity as detailed.</p>	
3.2	<p>Academic Health Sciences Centre – revised joint working agreement</p> <p>Prof Jonathan Weber outlined the strengthening of the working committees and the introduction of an information sharing agreement, all of which were consolidated in the revised joint working agreement.</p> <p>Responding to Jeremy Isaacs, Prof Weber confirmed that the data had commercial value, and were protected in terms of intellectual property by the joint agreement in place, which also covered commercialisation. The potential value of the anonymised data held was acknowledged by the developers.</p> <p>The Trust board approved the signing and sealing of the updated Joint Working Agreement.</p>	
3.3	<p>NHS TDA self-certifications – November / December 2015</p> <p>Jan Aps reported that the self-certifications had been reviewed by individual directors and at executive committee. The Board discussions in relation to financial position and organisational review would be noted.</p> <p>The Trust board ratified the submission of the November return and approved the submission of the December return.</p>	
4	Items for Discussion	
4.1	<p>Improving the quality of care – CQC update report</p> <p>Prof Janice Sigsworth introduced the report which covered the Trust's CQC registration, the implementation of the compliance and improvement framework and progress against the CQC action plan. She also noted continuing progress on the programme of deep dive reviews and core service reviews which continued across the Trust, particularly that undertaken in intensive care, where issues raised were being addressed, although she noted some were more intransigent and would require further time. The earliest the Trust would now be the subject of a planned inspection would be May 2016, but she reminded the Trust board that an unannounced inspection could be carried out at any time.</p> <p>Prof Sigsworth would complete a stocktake of the original CQC action plan, and would present any residual actions (mainly in relation to outpatients; ICU; mandatory training)</p>	

	<p>to the Trust board in March; it was intended that all actions would be completed or on trajectory by the end of March 2016.</p> <p>In response to a query from Jeremy Isaacs, Prof Sigsworth reported that core service reviews acted as a mock inspection, being undertaken by both internal and external representatives, no pre-warning to the area, and using the CQC key lines of enquiry. It may be appropriate to consider a site-based review in 2016/17. Prof Sigsworth assured Sir Gerry Acher that CQC would welcome the proposed capital improvements in the emergency department, but that the Trust would need to ensure that patient experience was carefully considered during the works.</p> <p>The Trust board noted the report.</p>	
4.2	<p>Emergency preparedness</p> <p>Steve McManus introduced the report, reporting that its completion and return was a statutory return under the Civil Contingencies Act. There were a total of 59 indicators, and internal assessment had rated 51 as 'green', and with no 'red' ratings, providing an overall compliance rating of 'substantial' (which was confirmed by external assessment). Benchmarking would be undertaken when the London-wide ratings were made available.</p> <p>The Trust board noted the outcome of the review, and that actions were being completed to address those area where improvement was considered appropriate.</p>	
5	Board Committee items	
5.1	<p>Audit Committee minutes, part I minutes (2 October) and report (2 Dec) report</p> <p>The Trust board noted the minutes and the report.</p>	
5.2	<p>Report from Quality Committee</p> <p>Prof Sir Anthony Newman Taylor noted that many of the issues had been raised and discussed earlier in the meeting. With its focus on infection control, the Committee had been pleased to learn that the CRE outbreak had been declared closed; the team deserved considerable credit for the timely and effective way in which this had been handled. In the transfusion annual report the Committee had noted the very small number of adverse incidents, and recognised the significant work in hand to address blood traceability issues.</p> <p>The Trust board noted the report.</p>	
5.3	<p>Report from Finance & Investment Committee</p> <p>In his first verbal report as Committee chair, Dr Andreas Raffel noted that the key items discussed had also been the subject of discussion at Trust board.</p> <p>The Trust board noted the report, the continued concern expressed by the Committee at the financial position, and the actions being taken by the Trust to bring amount an improvement both short-term and for longer-term sustainability.</p>	
5.4	<p>Redevelopment Committee</p> <p>Sir Richard Sykes noted that: the Shaping a Healthier Future ImBC would be presented to the Trust board in May; that advisors had been appointed in a number of areas; that the second committee meeting had been held on 26 January; and that an outline plan would be provided to commissioners.</p> <p>The Trust board noted the report.</p>	
6	Items for information	
	There were no items for information.	
7	Any other business	
	There was no other business.	
8	<p>Questions from the public relating to Agenda items</p> <p>In response to questions from the public the following points were made:</p> <ul style="list-style-type: none"> • Thanks to a member of the public for the expression of thanks following a recent 	

	<p>attendance at the emergency department;</p> <ul style="list-style-type: none"> • The polls on the emergency department were to start to encourage interaction with the 'blog' area, and in no way sought to trivialise the waiting timing experienced in the department; • The Trust were aware of the submission of the planning application for a 'Paddington Shard', which it felt would help with the regeneration of the area, and would work closely with the developers to ensure that appropriate access to the emergency department and the rest of the hospital was maintained throughout any building works; • KPMG had been appointed as the strategic advisors to the Trust's plans for redevelopment, alongside planning and other advisors; • Redevelopment plans had included revaluation of the land, and would review the benefits of refurbishment versus rebuild across the site; • The Trust had received and read the Mansfield Report; the accountable officer for Shaping a Healthier Future was Clare Parker. 	
9	<p>Date and time of next meeting</p> <p>The next meeting would be held on 6 April 2016 at 11.30.</p>	

Report to:	Date of meeting
Trust Board	6 April 2016

Record of items discussed at the confidential Trust board on 27 January 2016

Executive summary:

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

Issues of note and decisions taken at the Trust board's confidential meetings held on 27 January 2016:

- **Organisational review:** the Trust board approved the recommendations of organisational review, including the amendments to the executive team (restructuring to three clinical divisions and direct reporting line to the chief executive via divisional directors), and the dis-establishment of the post of chief operating officer.
- **Hard facilities management (FM) contract:** the board approved the award of a five year contract with CBRE Managed Services Ltd.
- **Replacement of imaging equipment:** the Trust board approved the lease of two SPECT-CT scanners (to replace two gamma cameras at Hammersmith Hospital), and the lease of two MRI machines (to replace the temporary mobile scanner and one time expired scanner) at Hammersmith Hospital.
- **Emergency department refurbishment:** the Trust board approved the business case for the refurbishment of the emergency department at ST Mary's Hospital, noting that the Charity had, in principle agreed to provide funding.

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

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	First report in CE Report

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible
May 2016	Learning disabilities: to outline details of actions taken to ensure systematic access to support patients with learning disabilities.	27 January 2016	Prof Janice Sigsworth
May 2016	Referral to treatment: details of recovery trajectory to be achieved during 2016/17	27 January 2016	Prof Jamil Mayet

Report to:	Date of meeting
Trust board - public	6 April 2016

Board members' register of interests

Executive summary:

Please find attached the latest board members' register of interests as will be published on the Trust website. All board members have confirmed these are correct.

Quality impact:

Well led domain

Financial impact:

Not relevant

Risk impact:

Ensuring that the board members' register of interests is kept up to date minimises the risk of actual or perceived conflicts of interest.

Recommendation to the Committee:

The Committee is asked to note the report and ensure that any changes are reported in year to the Trust company secretary.

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	Dr Tracey Batten	31 March 2016

Board Members' Register of Interests**Sir Richard Sykes** Chairman

- Director, EDBI Pte Ltd since 2011
- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Non-Executive Chairman of NetScientific plc since 2008
- Chairman of Royal Institution of Great Britain since 2010
- Chancellor Brunel University since 2013
- Chairman PDS Biotechnology Corporation since 2014

Sir Gerald Acher Non-Executive Director

- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Trustee of KPMG Foundation
- President of Young Epilepsy
- Chairman Brooklands Museum Trust
- Chairman Cobham Community Bus CIC

Dr Rodney Eastwood Non-Executive Director

- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy [Secondary school]
- Trustee of the London School of ESCP Europe (a pan-European Business School)
- Member of the Editorial Advisory Board of HE publication
- Member of the Board of Trustees of the RAF Museum
- Chairman, Audit Committee, Royal Society of Biology
- Consultant to Brunel University

Jeremy M Isaacs Non-Executive Director

- JRJ Group Limited – Director
- JRJ Jersey Limited - Director
- JRJ Investments Limited – Director
- JRJ Team General Partner Limited - Director
- Food Freshness Technology Holdings Ltd – Director
- Kytos Limited - Director
- Support Trustee Ltd – Director
- Marex Spectron Group Limited – Director (NED)
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust
- Designated member of JRJ Ventures LLP
- Member of LSBI LLP
- Director of Elljay Limited
- Member of Bridges Ventures Advisory Board
- Nomad Foods Limited – Director (NED)

Professor Sir Anthony Newman-Taylor Non-Executive Director

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

Sarika Patel Non-Executive Director *

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

Dr Andreas Raffel Non-Executive Director

- Senior Adviser at Rothschild
- Deputy Chair of Council of Cranfield University
- Member of the International Advisory Board of Cranfield School of Management
- Non-Executive Director, Olswang LLP
- Trustee and board member Crime Reduction Initiative (CRI)

Dr Tracey Batten Chief Executive

- Trustee of The Point of Care Foundation
- Spouse appointed Non-Executive Director of BUPA Board (12th January 2016)

Richard Alexander Chief Financial Officer

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

Professor Janice Sigsworth Director of Nursing

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

Dr Julian Redhead Medical Director

- Trustee – Royal Society Prevention Accidents
- Director – Stadium Doctors Ltd
- Shareholder – Fortius Clinic
- Medical Director – Fortius Clinic
- Inspector – Care Quality Commission
- Major Incident Doctor – London Ambulance Service
- Doctor – Chelsea Football Club

* Commissioner, Board of the Gambling Commission from 11 April

Report to:	Date of meeting
Trust board - public	6 April 2016

Patient Story

Executive summary:

HB will describe her experience, both positive and negative of her care at Imperial. Whilst she will describe some excellent care she will also highlight some clear areas for improvement.

Quality impact:

Patient stories provide the Board with direct feedback on the experience of their care in the Trust.
This sits within the CQC caring domain

Financial impact:

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

Risk impact:

By learning from such patient experiences will support the Trust in reducing the risk of poor or inconsistent care in future.

Recommendation to the Committee:

The Committee is asked to note the paper

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young, Deputy Director of Patient Experience	Janice Sigsworth, Director of Nursing	31 March 2016

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

HB’s Story

Mrs HB is a 64-year old lady who was previously well and had never been admitted to hospital. She lives with her husband in Maida Vale and is a retired PR consultant. Since retirement she has continued working voluntarily as the chairperson for a Literary Society. Over the past couple of years, Mrs HB has developed rheumatoid arthritis with a sudden onset that has resulted in 2 emergency hospital admissions.

In September 2014, Mrs HB was admitted as an emergency via A&E. At this time she was in great pain and unable to move. Mrs HB’s experience during this admission was varied.

Accident & Emergency Department

- Although the department was very busy she was nursed in a quiet calm bay
- Delays in finding a bed so nursed on trolley for approximately 8 hours before being transferred to a ‘holding ward’

‘Holding ward’

- Lovely, quiet and staff kind
- After a brief period she was transferred to Joseph Toynbee Ward

Joseph Toynbee Ward

- Environment was noisy
- Certain Staff were not kind in how they spoke with and cared for Mrs HB.
 - Drinks were left out of reach. On one occasion a straw was provided but this was then taken away with the empty cup and later she was shouted at for not keeping her straw and told they did not have another one.
 - She was not offered help with food and was shouted at by a sister for not ordering breakfast.
 - A HCA woke Mrs HB at 4:45 hrs for a wash. Another time paper towels were used. They used commodes to wheel patients to the toilet and did not ensure that patients were appropriately positioned to use the toilet.
 - When she needed to use a bed pan staff did not ensure she was positioned comfortably and she was left alone in a precarious undignified position.
 - Mrs HB saw staff talking over patients whilst caring for them.
- Mrs HB was then transferred to Thistlethwaite ward

Thistlethwaite ward

- Staff were kind
 - Was greeted by a student nurse who knew her name and made her feel welcome
 - Nursed near to the nurses' station, felt safe here
 - Was able to clean her own teeth (had not been helped with this on Joseph Toynbee ward)
 - Was supported to have a shower
 - Felt staff were on her side
 - Discharged home from here

Discharge

- Felt the discharge was too soon. Did not get home until 20:00 hrs and her husband had not been informed so bed was not ready at home.
- Did not receive copy of discharge letter

On 20 January 2015, Mrs HB was admitted via an urgent GP referral with what was diagnosed as neutropenic sepsis. Her husband brought her directly to A&E rather than await an ambulance.

Accident & Emergency

- On arrival, parking was very difficult. Her husband went into A&E to try and get some assistance and was initially met with unhelpful staff. A senior nurse overheard the conversation and immediately helped him. The care from this point on in A&E was very good, efficient and staff were all pleasant. Mrs HB had left a notebook in the department and the senior nurse returned this to her on the ward the next day.
- She was admitted to High Dependency isolation for the first night and then moved to Almroth Wright ward.

Almroth Wright

- The staff were generally nice. Mrs HB was nursed in reverse isolation but the room did not have en-suite facilities, therefore staff would bring commodes in. At times, staff would leave the used commode inserts in the room (up to 2-3 left in the room at any one time).
- Medical staff were kind and did speak with Mrs HB each day but at no point did anyone convey how unwell she was. It was only on reading a doctor's letter later that she realised.
- Communication was variable and one day porters came unannounced to take her for a scan.
- Mrs HB experienced a HCA behaving in an unkind way, the HCA refused to take a stool specimen and insisted Mrs HB did this herself.
- The environment immediately outside of her window was poor with a large number of waste items including urinals and wine bottles being disposed of here (have checked this today and it is clear).
- Mrs HB was discharged home from this ward.

Discharge

- The process was long, Mrs HB was ready at 10:00 hrs but not discharged until 18:45 hrs. There was some confusion about her medication as she was not prescribed any and pharmacy believed this to be an error. In the end Mrs HB was given an inhaler a nebuliser that she didn't need and couldn't use.

Main reflections

- Mrs HB remains overwhelmingly grateful to have survived
- Care was variable with some staff demonstrating great kindness and others were 'unkind'
- Care seemed to change depending on who was in charge
- Communications were variable
- Moments of undignified care in contrast with moments of kind, personalised care

Report to:	Date of meeting
Trust Board	6 April 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 Committee:

The Committee 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	31/03/16

Chief Executive's report

Key Strategic Priorities

1. Financial performance 2015/16 and Operating Plan 2016/17

This year is continuing to be extremely challenging financially. At the end of February (Month 11) the Trust was £9.2m behind its financial plan, with a financial deficit of £27.6m. The forecast outturn remains unchanged from last month at £30.1m within which there are both risks and opportunities. Chief Financial Officer to Chief Financial Officer meetings with our lead commissioner have continued with the aim to resolve the huge level of fines and challenges which have contributed to the reduction in the Trust's income position for 2015/16. This leaves the Trust £10.6m behind plan for income to date, whilst expenditure has only been reduced by £0.5m below planned levels.

The financial plan for 2016/17 is presented in a separate paper to the Board for approval.

Discussions with the Trust's commissioners continue and the Trust expects to agree a contract with north west London CCGs before the 25 April 2016. There is agreement on expected levels of patient activity for 2016/17 with north west London commissioners before reflecting changes for commissioner efficiency schemes (QIPP). Commissioners have indicated an affordability gap to this level of activity and agreement of the financial arrangements are to be finalised. The Trust received a formal contract offer from NHS England on 30 March 2016 and is now reviewing prior to progressing contract discussions.

2. Operational Performance

Cancer: In February 2016 performance is reported for Cancer waiting times standards for January 2016. In January, the Trust achieved six of the eight national cancer standards. The Trust underperformed against the two week GP referral to first outpatient standard, delivering 90.1 per cent against a 93 per cent target. The Trust also underperformed against the 62 day urgent GP referral to treatment from screening standard, delivering 86.2 per cent against a 90 per cent target. The deterioration in the two week wait performance was related to capacity issues in Urology clinics and work is on-going to investigate and to improve the position. The screening standard underperformed due to two breaches, both relating to further diagnostics being required before treatment could be commenced. The Trust continues to achieve the 62 day urgent GP referral to treatment for all cancers and expects to recover performance for February and overall for quarter four.

Accident and Emergency: Performance against the four hour access standard for patients attending Accident and Emergency remained challenged at 86.06 per cent in February 2016. The Trust has been working closely with the local health system to develop detailed site based action plans. The Trust needs to finalise performance trajectories for 2016/17 with local commissioners, NHS England and the TDA/NHS Improvement by 11 April 2016.

Referral to treatment (RTT): The Trust performance for February 2016 for RTT was 90.54 per cent which was a slight improvement in performance from January 2016. However, there was an increase of 204 patients waiting over 18 weeks. This mainly related to patients waiting for surgical treatment. There were 14 patients waiting over 52 weeks for treatment at the end February - all patients who wait over 52 weeks for treatment will be reviewed at the medical directors weekly quality review. The Trust is in the process of agreeing performance trajectories for 2016/17 with commissioners. These account for a risk in performance for the first four months of the financial year due to known junior doctor's strike and Theatre refurbishment programme. It is expected that the Trust will achieve the 92 per cent standard at an aggregate level from August 2016 onwards subject to the future reporting requirements for gender reassignment surgery.

Diagnostic waiting times: The Trust met the monthly six week diagnostic waiting time standard in February 2016 with 0.4 per cent of patients waiting over six weeks against the one per cent tolerance.

3. Cerner Implementation

Cerner clinical documentation and electronic prescribing and administration have now been introduced across all of our hospital sites. The Trust-wide rollout began in September 2015 with theatres and surgical wards at St Mary's, and ended six months later with outpatients at Charing Cross in the week before Easter. This is a significant move towards digital patient records and reducing our reliance on paper. The secure availability of patient records anywhere and anytime brings considerable benefit to our clinicians and to patient care. Planning is in progress for the rollout to paediatrics as this service was not included in the implementation.

During the weekend of 16/17 April, our Cerner system will be upgraded from our current 2010 code to the latest 2015 code. Under the terms of the National Programme for IT (NPFIT), the version of Cerner based on 2010 code was purchased for Trusts. Whilst that contract was in force, new versions were released in 2012 and 2015. Now that the NPFIT contract is finished we are able to upgrade to the new code, and this will give us the opportunity to introduce a range of enhancements to the system. Short films, live demonstrations and training materials are being made available to help staff prepare for the change.

4. Stakeholder engagement

In February we were pleased to host a visit to St Mary's Hospital by Ben Gummer MP, Parliamentary Under Secretary of State for Care Quality at the Department of Health, which focused on the development of seven day services across the NHS in north west London. We attended the formal meetings of Hammersmith & Council's Policy and Accountability Committee in both February and March. Regular update discussions have been held with Westminster City Council's Cabinet Member for Health and the recently appointed Chair of the Health overview and scrutiny committee. We also published our range of bi-monthly electronic newsletters for stakeholders, GPs and our shadow foundation trust membership.

5. Patient and public involvement strategy

Following approval of our patient and public involvement (PPI) strategic framework in November 2015, we have made the following progress:

- A strategic lay forum has been established and is meeting bi-monthly. The chair is Michael Morton, an active lay representative on a number of health fora in north west London. We currently have eleven members. The new 'get involved' section of our website is being updated to reflect this development and to share the forum's terms of reference.
- A strategy implementation group has been established and is meeting monthly to take forward and co-ordinate our PPI workplan. The group includes senior staff from communications, QI, patient experience, membership and Imperial College Healthcare Charity as well as the PPI lead for Imperial College and the chair of the lay forum.
- We ran a workshop on 22 March that brought together over 40 patients (including our lay forum members), community representatives and staff to co-design our PPI offer and to identify priorities for action. The outputs from this workshop are being used to create the PPI workplan which will be tested back with the participants in June, before presentation to the board in July.
- To feed in to our workplan, we have begun an audit of current PPI activities, offers and processes across the Trust. We have also improved the co-ordination of current

involvement opportunities as much as possible with our current processes so that we can include more of them in our bi-monthly membership e-newsletter.

6. Management reorganisation

Consultation on phase one of the restructure, which focussed on changes to the executive team and consolidating the number of clinical divisions, ran from 3 February 2016 to 1 March 2016. Feedback from staff was very supportive of the principles of devolving more authority and responsibility to frontline managers, empowering clinical teams with improved information and support, and creating clearer lines of accountability.

In summary, the changes, which took effect on 1 April 2016, are:

- There are now three clinical divisions rather than five, and the directors of the three remaining clinical divisions now report directly to the chief executive and are members of the executive management team.
- The three 'new' clinical divisions are as follows:
 - Division of medicine and integrated care (MIC)
 - Division of surgery, cancer and cardiovascular (SCC)
 - Division of women's, children's and clinical support (WCCS).
- The following roles have been disestablished: chief operating officer, director of operational performance, director of strategy and redevelopment, divisional director (ISCS), divisional director of operations (ISCS) and divisional director of nursing (ISCS)
- The Imperial Private Healthcare (IPH) division has moved into the chief executive's office and the director of IPH reports to the chief executive.
- The chief executive is being supported in the management of cross-divisional issues and liaison with external partners by the new role of assistant chief executive.

There continues to be constructive and valuable oversight of the process from our trade union partners through the partnership working group as we move into the next phase. In parallel with consultation on phase one, we sought staff views on the design of phase two of the restructure and we are now reviewing the clinical directorate structure in preparation for consultation. All of the feedback received is being reviewed by the relevant leadership teams to help inform the proposals. We plan to publish the phase two consultation paper in mid-April 2016.

Changes have been made to membership of and attendance at board committees. These are outlined in appendix one.

7. Executive team

The implementation of phase one of the management structure came into effect on 1 April 2016 and I would therefore like to welcome Professor Jamil Mayet (Divisional Director of Surgery, Cancer and Cardiovascular), Professor Tim Orchard (Divisional Director of Medicine and Integrated Care) and Professor Tg Teoh (Divisional Director of Women's, Children's and Clinical Support) as members of the newly formed executive director team and as attendees of the Trust board. Ellis Pullinger (formally Divisional Director of Operations for Investigative Sciences and Clinical Support) has also joined the Chief Executive's Office as Assistant Chief Executive on 1 April 2016.

8. Junior Doctor industrial action

The BMA has announced that there will now be a full withdrawal of labour including emergency cover for the planned strike action on 26 and 27 April 2016. The all-out stoppages will take place from 08:00 to 17:00 on both days rather than the originally planned 48 hour industrial action of non-emergency care.

The next planned 48 hour industrial action of non-emergency care on 6 – 8 April will also go

ahead as planned.

The Trust continues to have a good partnership arrangement with the BMA and with junior doctors representatives in particular. The teams will ensure that robust operational plans are in place to ensure the safety of our patients is not compromised.

9. Upgrade and Development of Paediatric Intensive Care Unit

The Full Business Case (FBC) for a scheme to develop the Paediatric Intensive Care Unit (PICU) and High Dependency Unit (HDU) was formally approved by the NHS Trust Development Authority (NHS TDA) Director of Finance at the beginning of March 2016. The total capital costs are £9.6 million, to be financed through internal resources (£4.8 million) and charitable funding (£4.8 million).

It is a requirement for public accountability and openness that NHS Trusts publish business cases that are refreshed for all necessary changes occurring as a result of the approval process. The business case will therefore be published on the Trust website.

10. Governance change for Imperial College Healthcare Charity

Following approval from the Department of Health, Imperial College Healthcare Charity completed its process of changing from an 'NHS Charity' to a fully independent one on 1 April 2016. The new Charity will have the same name, but a new Charity number and company number, and legally will have the status of a charitable company limited by guarantee. The new Charity and the Trust have agreed and signed a Memorandum of Understanding which confirms the Trust as the principal beneficiary of the Charity and covers areas of joint working. The Charity's five current independent Trustees will transfer to the Board of the new Charity whilst one further independent Trustee is being recruited through advertising and a search agency. The Trust will initially be represented on the Charity Board by Julian Redhead (Medical Director) and Michelle Dixon (Director of Communications) with a Trust Non-executive Director to join the Charity Board in due course.

Operationally there will be no noticeable change: all current programmes run by the Charity in terms of grants, fund-raising and arts will continue and the Charity's assets – endowment and other funds and property – transfer from the 'old' Charity to the new one on or just after 1 April 2016.

Key Strategic Issues

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

A lot of work has been undertaken since the last update, both within the trust and externally with our CCG colleagues and NHS England and the Trust Development Authority (TDA) at a regional and national level. Given the national constraints on capital availability, north west London will need to make a strong case for capital and how it will contribute to both the sector financial sustainability and the sector clinical transformation when it submits its Sustainability and Transformation plan (STP). The STP will be submitted to the Board for consideration at the July 2016 meeting.

1. 2016 Budget

The Rt Hon George Osborne MP delivered his eighth Budget as Chancellor of the Exchequer on Wednesday 16 March 2016. His speech centred around "putting the next generation first", and confirmed a number of measures aimed at supporting SMEs (small and medium sized enterprises) and eliminating tax avoidance of large multinationals, advancing the devolution revolution, investment in infrastructure, significant reforms to the education

system and additional help-schemes for savers.

The Budget document states that the NHS's "ambitious programme" to find £22bn in efficiencies remains "unchanged". Overall, health and social care do not feature significantly within this Budget, with two main announcements surrounding obesity and children's health.

Despite the Government recently playing down the prospect of a sugar tax, plans were announced to introduce a sugar levy on the sugary soft drinks industry in a bid to tackle growing obesity rates. The projected £530m this tax is expected to raise - which will come into effect in 2018 - will in turn be directed towards funding sports activities in schools.

In addition, recovered funds from the Libor banking scandal last year are to be invested into a number of charitable bodies, including children's hospital services, with £1.1m to be invested in Central Manchester University Hospitals NHS Foundation Trust for a dedicated helicopter landing pad and £700,000 going to Sheffield Children's Hospital Charity to fund a fully digital intraoperative 3T MRI scanner.

Wider implications for providers of NHS services include revisions to public sector pension employer contributions. From 2019/20 the public sector pensions discount rate will be set at 2.8% and employers will pay higher contributions to the schemes as a result. The treasury indicates that this could have a material financial impact on NHS Trusts and FTs unless funded appropriately. NHS Providers are working to understand the detail with NHS Employers and Treasury and will provide an update in due course.

Further detail of the Budget, and all of its accompanying documents, can be read in full [here](https://www.gov.uk/government/publications/budget-2016-documents) (<https://www.gov.uk/government/publications/budget-2016-documents>).

Board Committees

01 04 16

Strategic Partnership Board
NWL STP Board

Trust board (Bi-monthly)

Non-executives:
Sir Richard Sykes*
Sir Gerald Acher**
 Jeremy Isaacs
 Dr Rodney Eastwood
 Prof Sir Anthony Newman-Taylor
 Sarika Patel
 Dr Andreas Raffel
 Vacancy

Executives:
 Dr Tracey Batten (Chief Executive)
 Richard Alexander (Chief Finance Officer)
 Dr Julian Redhead (Medical Director)
 Prof Janice Sigsworth (Director of Nursing)
 Vacancy

Attending
 David Wells (Director of People & OD)
 Kevin Jarrold (Chief Information Officer)
 Michelle Dixon (Director of Communications)
 Prof Tim Orchard (Divisional director, Medicine & IC)
 Prof Jamil Mayet (Divisional Director, surgery, Cancer & CV)
 Prof TG Teoh (Divisional Director, Women's & Children's & IS)
 Prof Gavin Screaton (Dean of Faculty, IC)

Redevelopment committee

Undertake thorough and objective review of the redevelopment programme

Quality committee

All aspects of patient and staff quality, including patient safety & clinical risk

Finance & investment committee

Financial performance; investment; transactions

Audit, risk & governance committee

Controls & assurances; internal & external audit; overall risk management; regulatory arrangements

Remuneration & appointments committee

Senior leadership remuneration, development & succession planning

Executive committee

Operational & day-to-day leadership of the Trust

Non-Executive Director chair

Sir Richard Sykes
 Jeremy Isaacs
 Dr Andreas Raffel
 Dr Tracey Batten
 Richard Alexander

Attending
 Michele Wheeler
 Bill Oldfield
 Siobhan Peters
 Ian Lush
 Valerie Joliffe

Prof Sir Anthony Newman Taylor
 Sir Gerald Acher
 Dr Rodney Eastwood
 Dr Tracey Batten
 Dr Julian Redhead
 Prof Janice Sigsworth

Attending
 David Wells
 Prof Tim Orchard
 Prof Jamil Mayet
 Prof TG Teoh
 Prof Alison Holmes

Dr Andreas Raffel
 Jeremy Isaacs
 Dr Rodney Eastwood
 Dr Tracey Batten
 Richard Alexander

Attending
 Prof Tim Orchard
 Prof Jamil Mayet
 Prof TG Teoh
 Janice Stevens
 Siobhan Peters

NED only (Pt I) / NED chair Pt II)

Sir Gerald Acher
 Prof Sir Anthony Newman Taylor
 Sarika Patel
 Dr Andreas Raffel

Attending part I / members part II
 Dr Tracey Batten
 Richard Alexander
 Dr Julian Redhead
 Prof Janice Sigsworth

Attending
 Siobhan Peters
 External audit
 Internal audit

Non-Executive only

Jeremy Isaacs
 Sir Richard Sykes
 Sarika Patel

Attending
 Dr Tracey Batten
 David Wells

Executive only

Dr Tracey Batten
 Richard Alexander
 Dr Julian Redhead
 Prof Janice Sigsworth
 David Wells
 Kevin Jarrold
 Michelle Dixon
 Prof Tim Orchard
 Prof Jamil Mayet
 Prof TG Teoh
 Ellis Pullinger

Bi-monthly

Monthly

Bi-monthly

Quarterly

Six-monthly

Weekly

*= chairman

**= deputy-chairman and senior independent director

Report to:	Date of meeting
Trust Board - Public	6 April 2016

Operational Performance Report

Executive summary:

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

Where monthly data for February 2016 are not yet available, this is highlighted in the chart title in red.

Recommendation to the Board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author

Kathryn Hughes (Head of Performance)

Responsible executive director

Julian Redhead (Medical Director)
Janice Sigsworth (Director of Nursing)
Tim Orchard (Divisional Director)
Jamil Meyet (Divisional Director)
Tg Teoh (Divisional Director)
David Wells (Director of People and Organisational Development)

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1. Scorecard Summary

Metric	Period	Standard	Performance	Direction of Travel
Safe				
Serious Incidents (S.I.s)	Feb-16	0	14	
Staffing fill rates	Feb-16	tbc	94.7%	
MRSA	Feb-16	0	0	
Clostridium difficile	Feb-16	56	68	
Harm Free Care (Safety Thermometer)	Feb-16	90.0%	97.7%	
Effective				
Hospital Standardised Mortality Ratio (HSMR)	Oct-15	100	64	
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	Qtr 2 15/16	70.0%	97.5%	
30 day readmissions	Jan-16	tbc	3.4%	
Average length of Stay (elective)	Jan-16	3.4	3.24	
Average length of stay (non-elective)	Jan-16	4.5	4.15	
Activity: First Outpatient	Jan-16	27,722	30,543	
Activity: Follow-up Outpatient	Jan-16	46,457	50,205	
Activity: Daycase	Jan-16	6,681	6,843	
Activity: Elective Inpatient	Jan-16	1,781	1,885	
Activity: Non-elective Inpatient	Jan-16	9,864	9,864	
Activity: Adult Critical Care	Jan-16	2,696	2,696	
Activity: Regular Day Attender	Jan-16	279	83	
Caring				
Mixed-Sex Accommodation	Feb-16	0	1	
Friends and Family Test - Inpatients	Feb-16	95.0%	97.0%	
Friends and Family Test - A&E	Feb-16	85.0%	95.0%	
Friends and Family Test - Maternity	Feb-16	tbc	94.0%	
Complaints (total number received)	Feb-16	100	94	
Well Led				
Vacancy rate (%)	Feb-16	12.6%	10.4%	
Voluntary Turnover Rate (%) 12-month rolling position	Feb-16	10.9%	10.7%	
Sickness absence rate (%)	Feb-16	3.0%	3.4%	
StatMand excl. doctors in training / Trust grades (%)	Feb-16	82.4%	86.5%	
StatMand - doctors in training /Trust grades (%)	Feb-16	59.6%	65.7%	
Consultant appraisal rate (%)	Feb-16	85.5%	86.0%	
Band 2-9 & VSM PDR rate	Dec-15	95.0%	n/a	
Health and Safety RIDDOR	Feb-16	0	0	
Education Open Actions	Feb-16	tbc	156	
Bank and Agency Spend (%)	Feb-16	9.0%	12.8%	
Staff engagement score	Qtr 3 15/16	tbc	43	
Responsive				
18 Weeks Incomplete (%)	Jan-16	92.0%	90.5%	
18 weeks Incomplete Breaches (number)	Jan-16	tbc	4,890	
52 Weeks Waits (Number)	Jan-16	0	14	
Diagnostic tests waiting longer than 6 weeks (%)	Jan-16	1.0%	0.4%	
A&E Type 1 Performance (%)	Feb-16	95.0%	69.1%	
A&E All Types Performance (%)	Feb-16	95.0%	86.1%	
Two week GP referral to 1st outpatient - cancer (%)	Jan-16	93.0%	90.1%	
Two week GP referral to 1st outpatient – breast symptoms (%)	Jan-16	93.0%	93.3%	
31 day wait from diagnosis to first treatment (%)	Jan-16	96.0%	96.8%	
31 day second or subsequent treatment (surgery) (%)	Jan-16	94.0%	100.0%	
31 day second or subsequent treatment (drug) (%)	Jan-16	98.0%	100.0%	
31 day second or subsequent treatment (radiotherapy) (%)	Jan-16	94.0%	97.1%	
62 day urgent GP referral to treatment for all cancers (%)	Jan-16	85.0%	85.3%	
62 day urgent GP referral to treatment from screening (%)	Jan-16	90.0%	86.2%	
New Outpatient DNA rate (%)	Feb-16	11.0%	12.1%	
Follow-up Outpatient DNA rate (%)	Feb-16	11.0%	11.5%	
Hospital initiated outpatient cancellation rate (%)	Feb-16	tbc	7.9%	

2. Indicator Overviews

2.1 Safety

2.1.1 Safety: Serious Incidents (SIs)

Fourteen serious incidents were reported in February 2016. The year to date total is 108, in comparison to 130 this time last year. We continue to review each case.

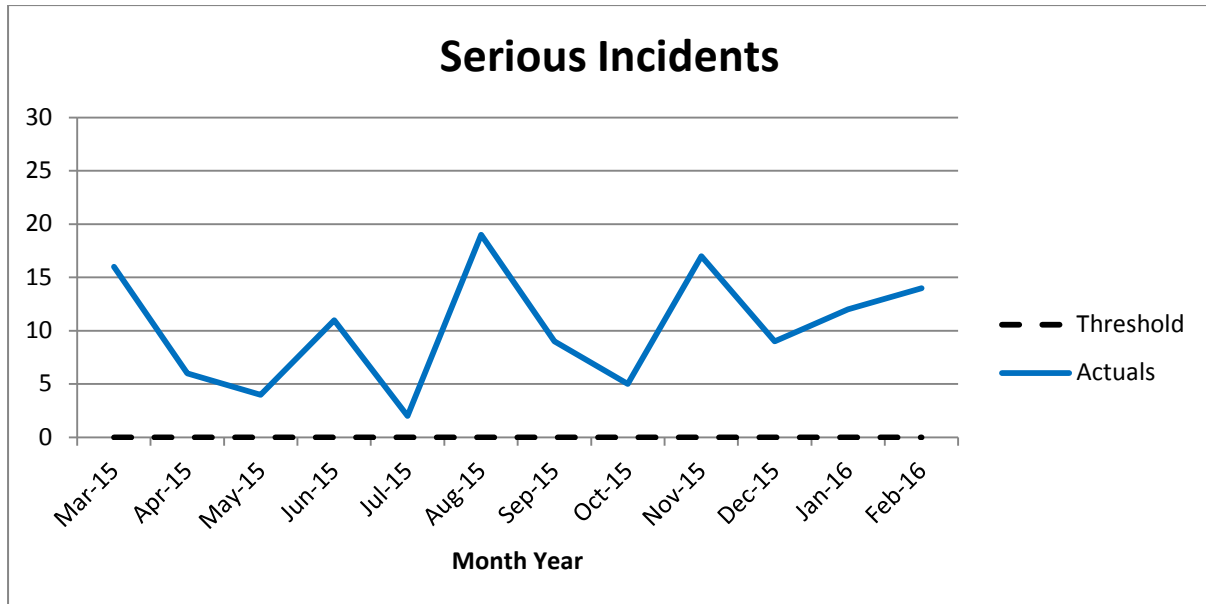


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period March 2015 – February 2016.

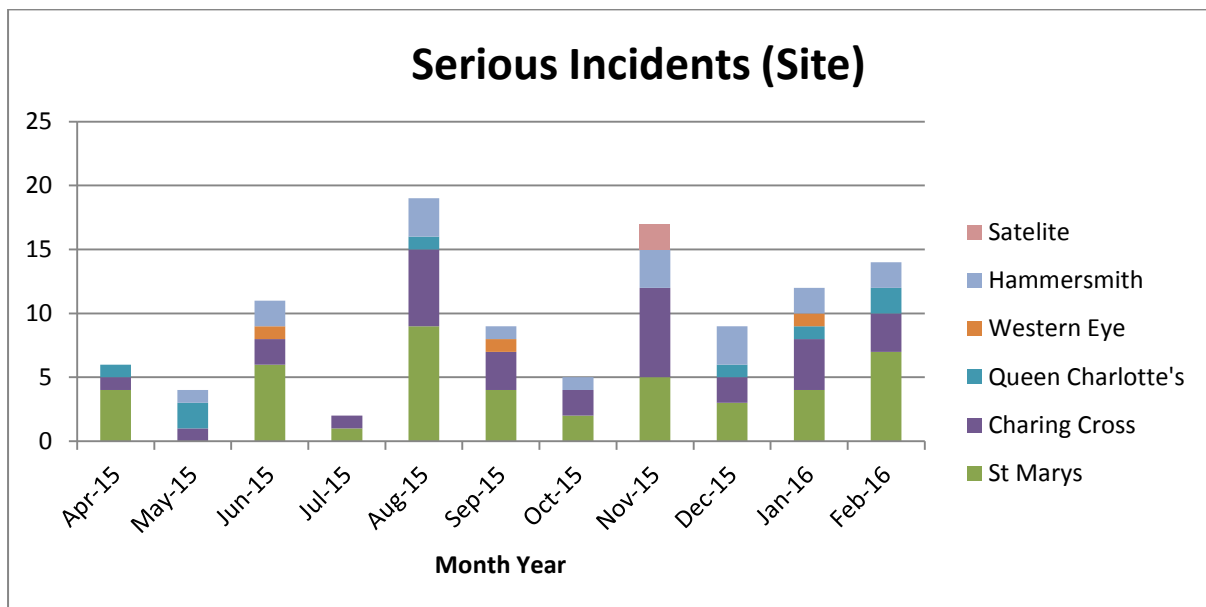


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period April 2015 – February 2016

2.1.2 Safety: Nurse / Midwife staffing levels

In February 2016 the Trust reported the following for the average staffing fill rate overall:

- Above 90 per cent for registered nursing/midwifery staff during the day and night
- Above 85 per cent for care staff during the day
- Above 95 per cent for care staff during the night

The average staffing fill rate for February 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	91.38%	86.79%	95.94%	96.55%
Hammersmith	95.64%	87.66%	97.17%	94.48%
Queen Charlotte's	96.20%	95.16%	95.22%	93.99%
St. Mary's	94.22%	88.90%	96.10%	96.89%

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

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

- 5 West ward: A number of additional care staff shifts were requested for patients who were perceived as having enhanced support needs (specialling). However, some of these were subsequently not required or deemed as appropriate through the daily monitoring process in place. In order to improve the education and training of staff in making decisions about whether patients require enhanced support, work is being undertaken with staff through the re-launch of the Trust's guidance on this and also with the site team.
- A reduced fill rate from the bank service. A meeting will be scheduled with the supplier to discuss how this can be improved going forward.
- Small numbers of unfilled shifts in some areas e.g. St. Mary's birth centre, A6, 10 South, Dacie and Weston which has shown a bigger impact on the overall fill rate for that area.
- Increased operational capacity in some clinical areas and reduced elective activity in others requiring redeployment
- Continued application of tight control on the use of agency staff

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 senior nursing and midwifery leaders to work clinically and take a case load of patients
- 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 February 2016 were safe and appropriate for the clinical case mix.

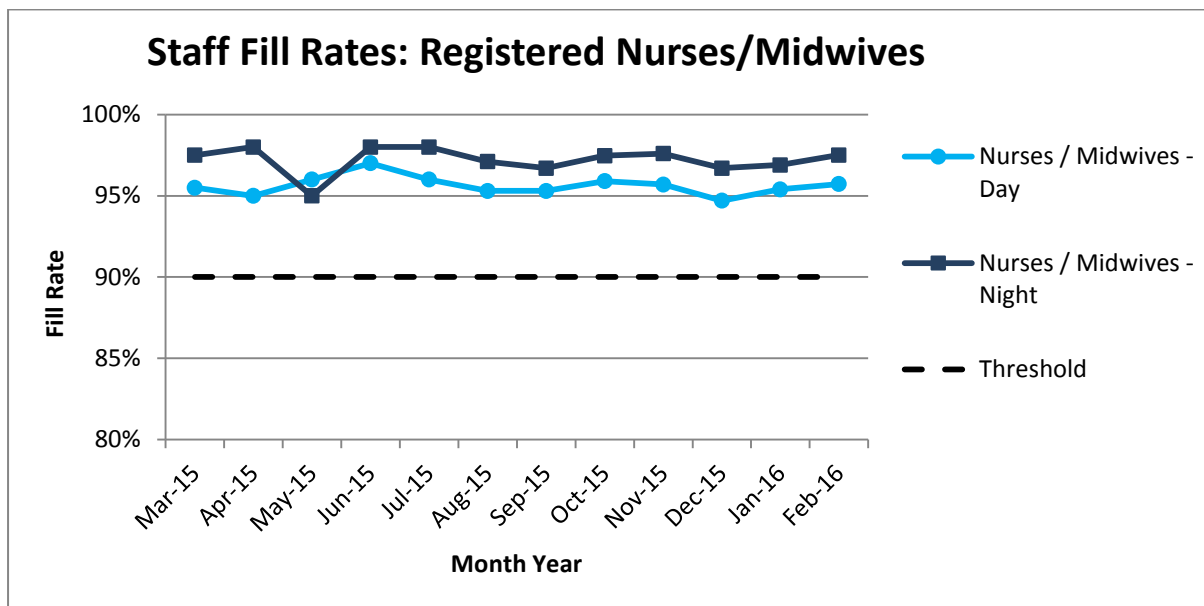


Figure 3 - Monthly fill rates (RNs/RMs) for NHS patients by month (March 2015 – February 2016)

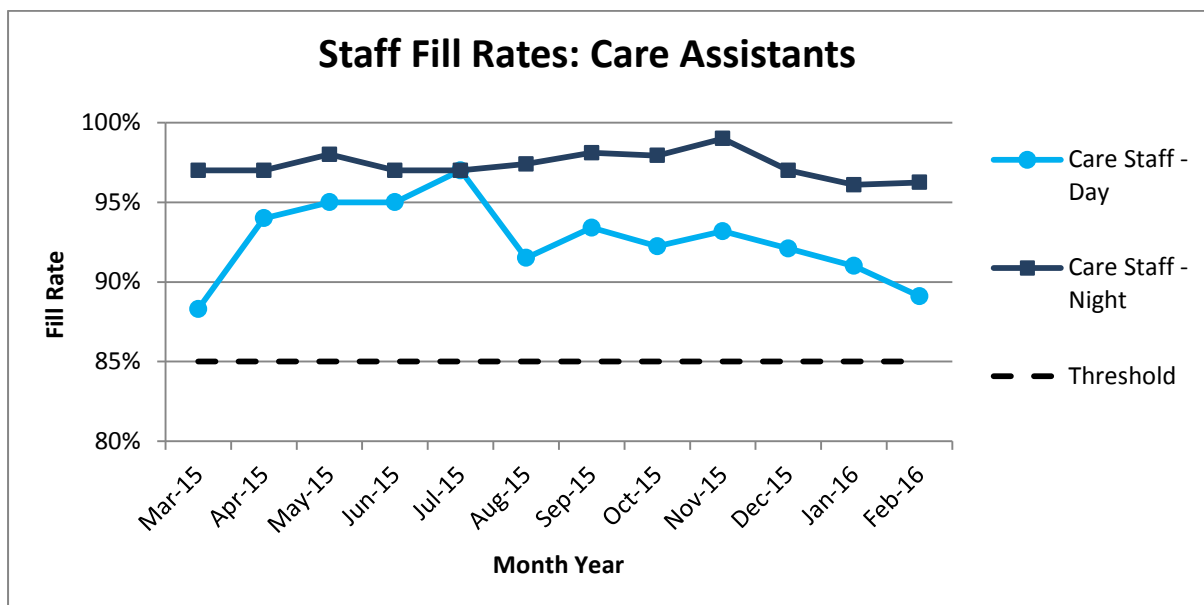


Figure 4 - Monthly fill rates (care assistants) for NHS patients by month (March 2015 – February 2016)

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

There were no cases of MRSA BSI in February 2016. Seven have been allocated to the trust so far this year. One case is awaiting final allocation. The tolerance for MRSA is zero and will continue to be in 2016/17.

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

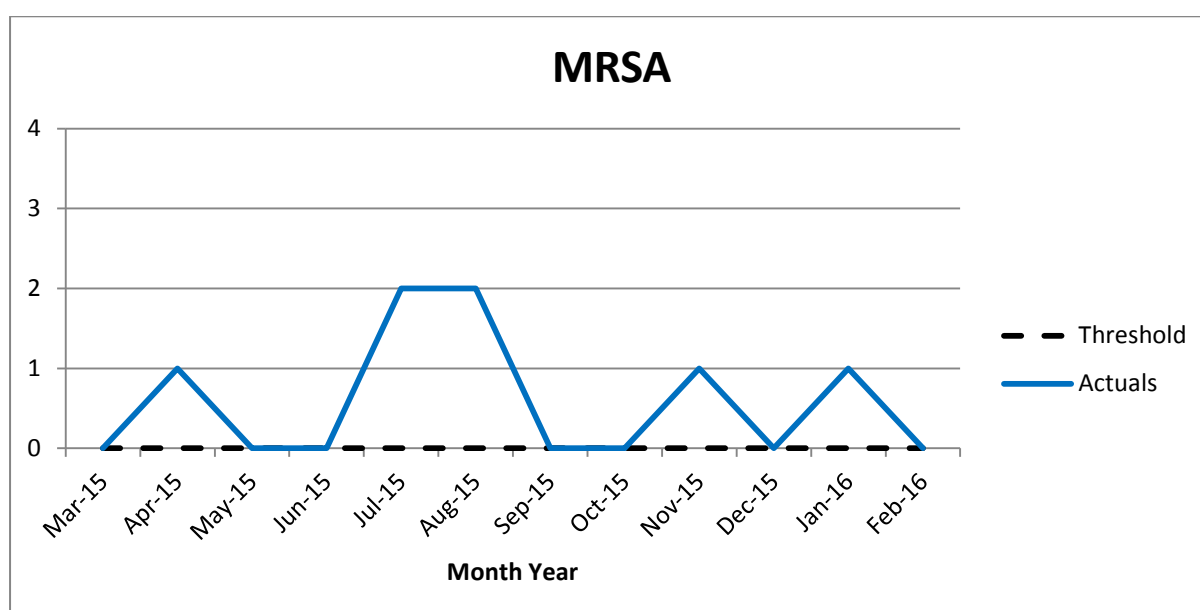


Figure 5 - Number of MRSA (b) infections by month for the period March 2015 –February 2016

2.1.4 Safety: *Clostridium difficile*

Six cases of *Clostridium difficile* were allocated to the Trust for February 2016. One of these cases included a lapse in care related to two patients with *C. difficile* of the same ribotype who spent time on the same ward.

A total of 68 cases have been allocated to the Trust so far this financial year, which is above trajectory to be below the annual ceiling of 69 cases. Five of these are attributable to lapses in care (1 in May-15, Jun-15, Oct-15, Jan-16 and Feb-16). There is one additional potential lapse in case awaiting further laboratory investigations.

Each case is reviewed by a multi-disciplinary team to examine whether any lapses in care occurred. The annual ceiling of 69 will be the same in 2016/17.

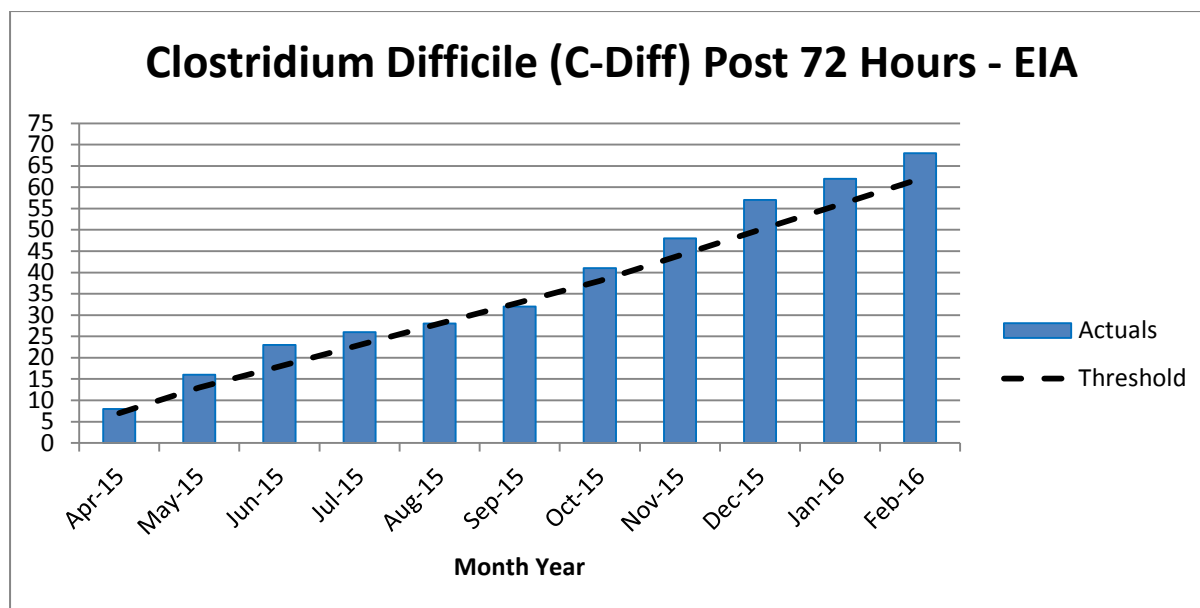


Figure 6 - Number of Clostridium Difficile infections above cumulative plan by month for the period April 2015 – February 2016

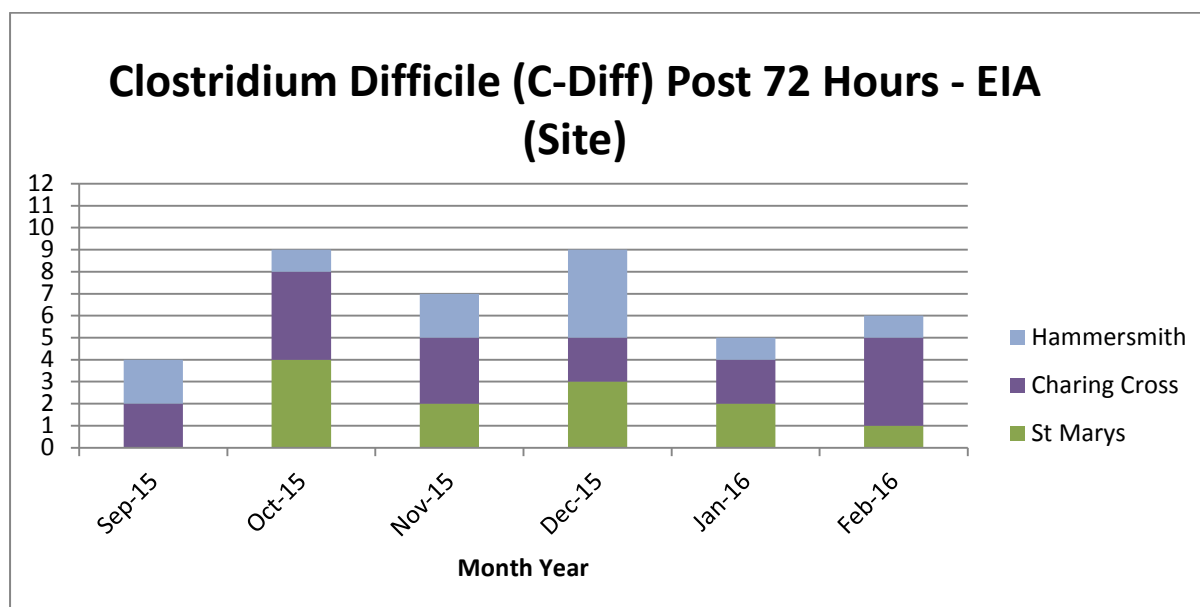


Figure 7 - Number of Clostridium Difficile infections by site and by month for the period September 2015 – February 2016

2.1.5 Safety: National Safety Thermometer – Harm Free Care Score

The Trust's overall score for harm free care as measured by the NHS Safety Thermometer continues to be above the threshold of 90 per cent. The latest averages for London and Shelford are not yet published.

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

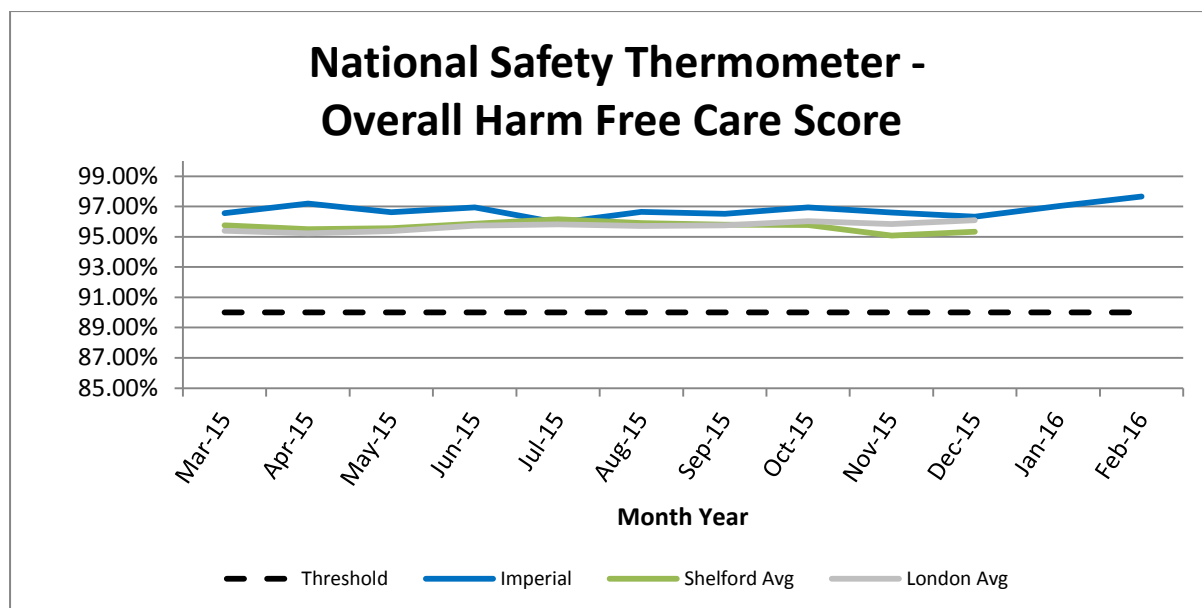


Figure 8 – Harm Free Care (Safety Thermometer) March 2015 – February 2016

2.2 Effectiveness

2.2.1 Effectiveness: Mortality Data

The most recent monthly figure for HSMR is 64 for October 2015. Across the last year of available data (November 2014 – October 2015), the Trust has the lowest HSMR for acute non-specialist trusts nationally and the 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 Q2 2014/15 to Q1 2015/16.

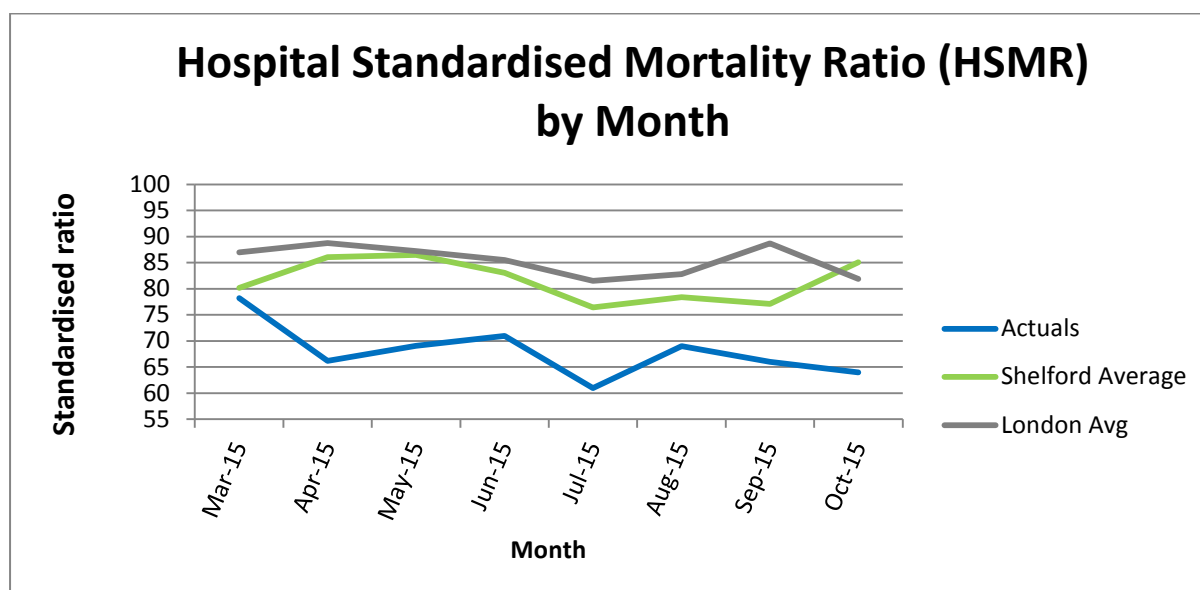


Figure 9 - Hospital Standardised Mortality Ratios for the period March 2015 – October 2015

2.2.2 Effectiveness: Recruitment of patients into interventional studies

The national target for recruiting the first patient into clinical trials within 70 days is 70 per cent. Trust performance for Q2 2015/16 was 97.5 per cent; and for Q3 2015/16 we are forecasting 97.6 per cent.

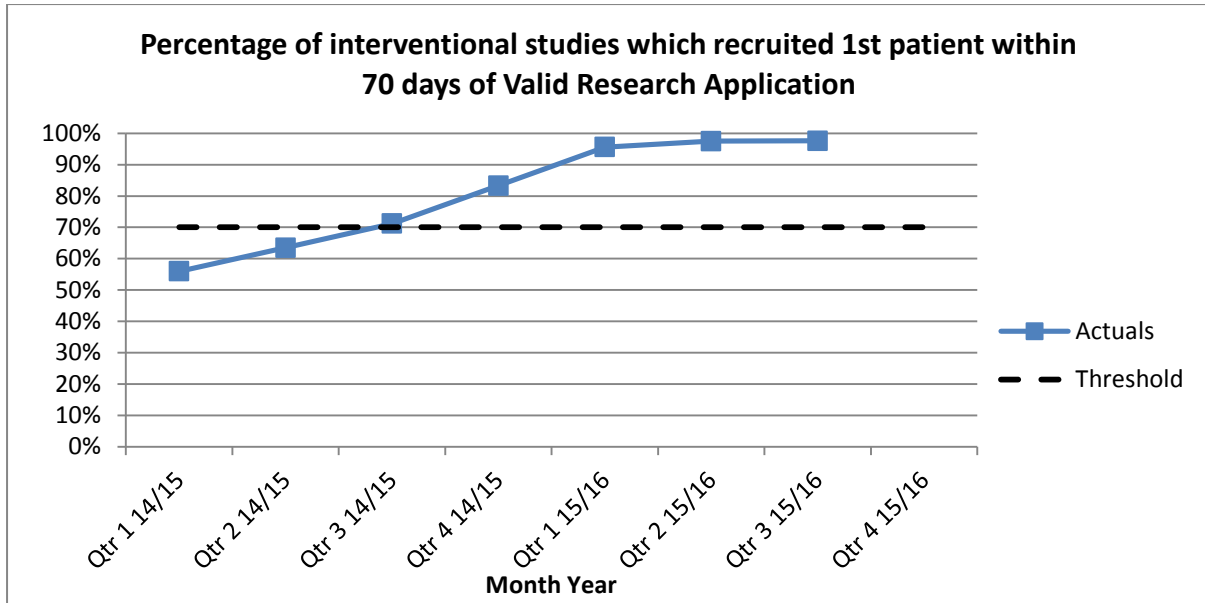


Figure 10 - Interventional studies which recruited First patient within 70 days of Valid Application Q1 2014/15 – Q3 2015/16

2.2.3 Effectiveness: 30 Day Readmissions

The improvement in reported performance for 30 day readmissions may reflect, in part, the increased focus on accurate discharge recording through the admissions and discharge team. Performance has plateaued at around 3.5 per cent.

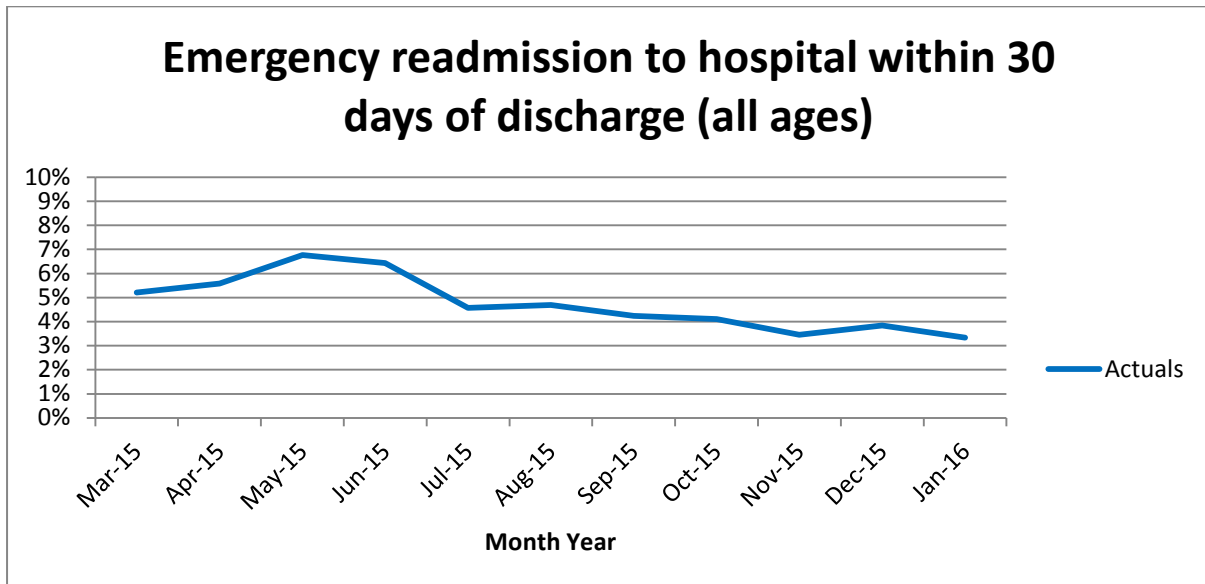


Figure 11 - 30 day readmissions for the period March 2015 - January 2016

2.2.4 Effectiveness: Average Length of Stay

Figures for the Trust length of stay (Elective and Non Elective admissions) are not finalised for February 2016 because of an outstanding data quality query still being investigated. The charts below present length of stay at both Trust and site level.

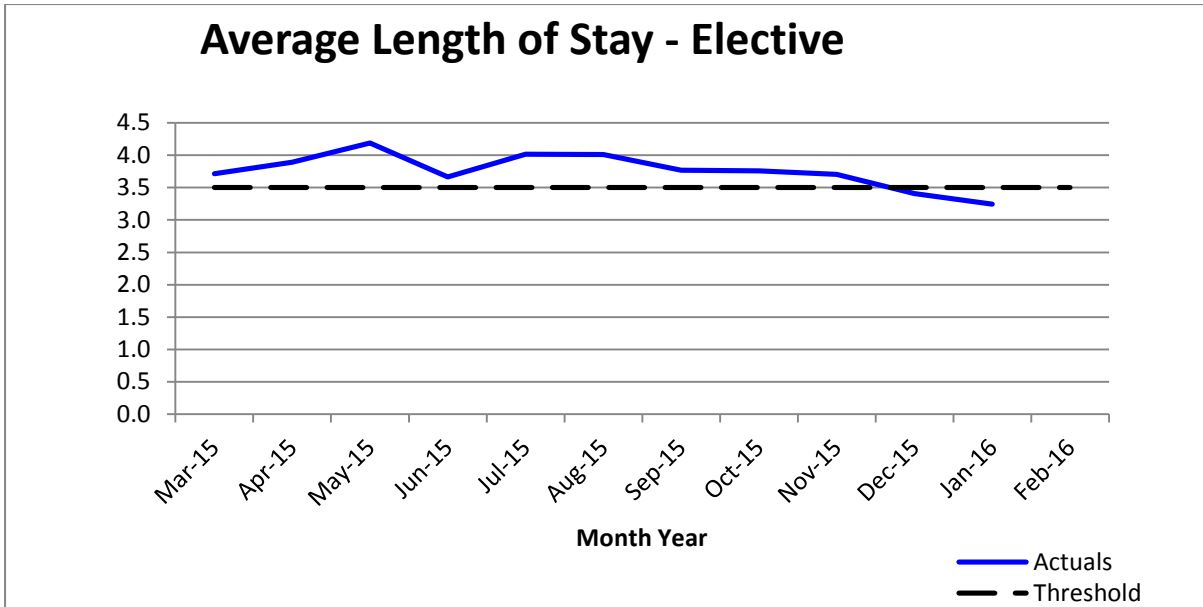


Figure 12 – Average Length of Stay – Elective for the period March 2015 – January 2016

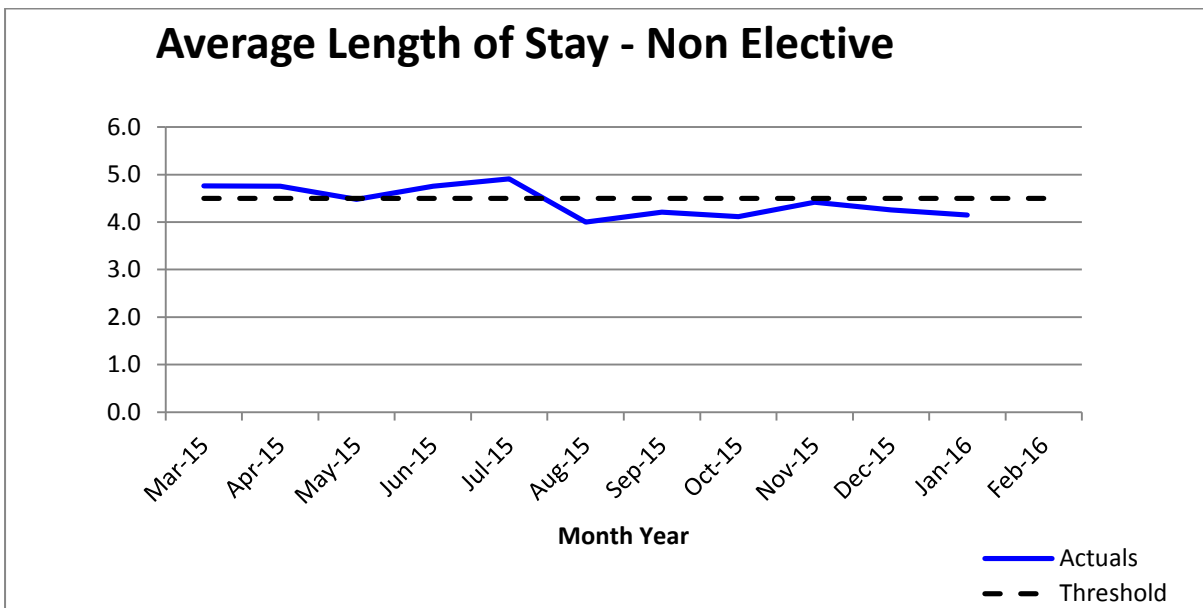


Figure 13 – Average Length of Stay – Non-Elective for the period March 2015 – January 2016

2.2.5 Effectiveness: Activity data

There are regular reviews with the Finance, Operational, and Corporate teams to ensure correct depth of coding. Any outcomes of significant findings will be reported within the operational report.

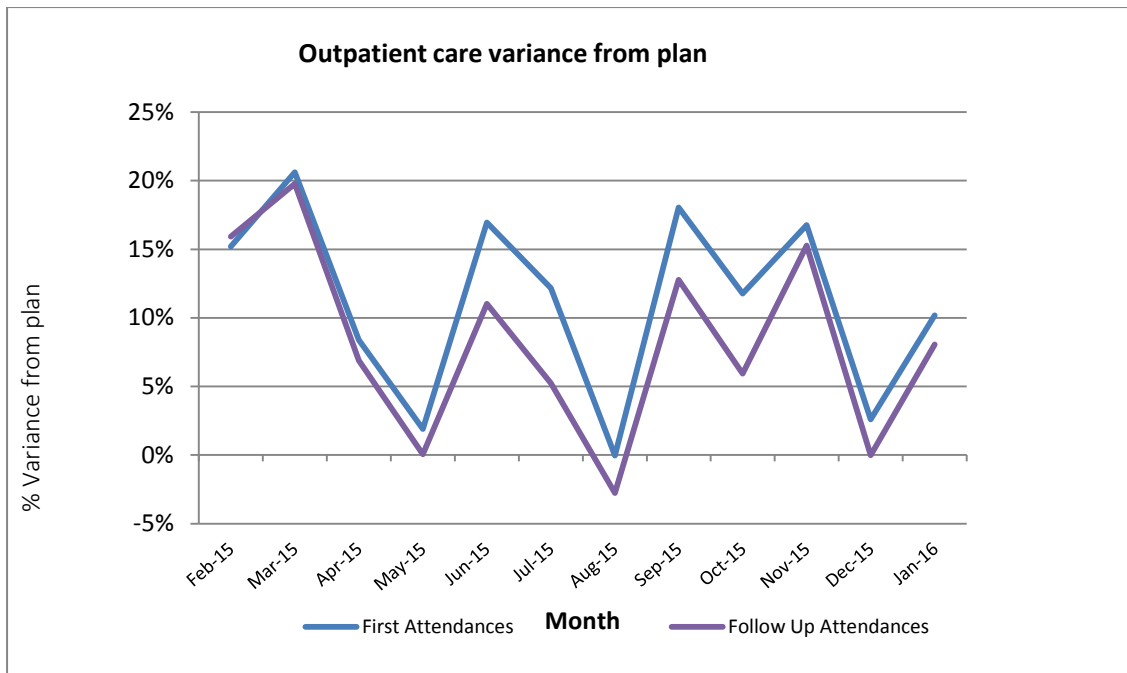


Figure 14 – Outpatient Care Variance from Plan for the period February 2015 – January 2016

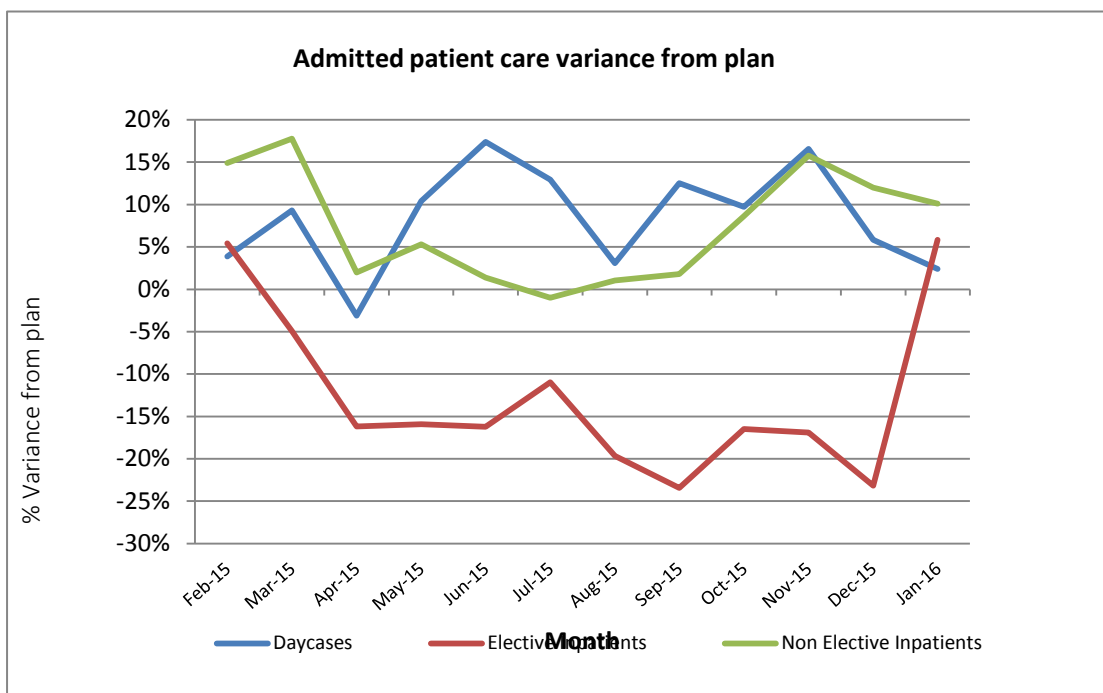


Figure 15 – Admitted Patient Care Variance from Plan for the period February 2015 – January 2016

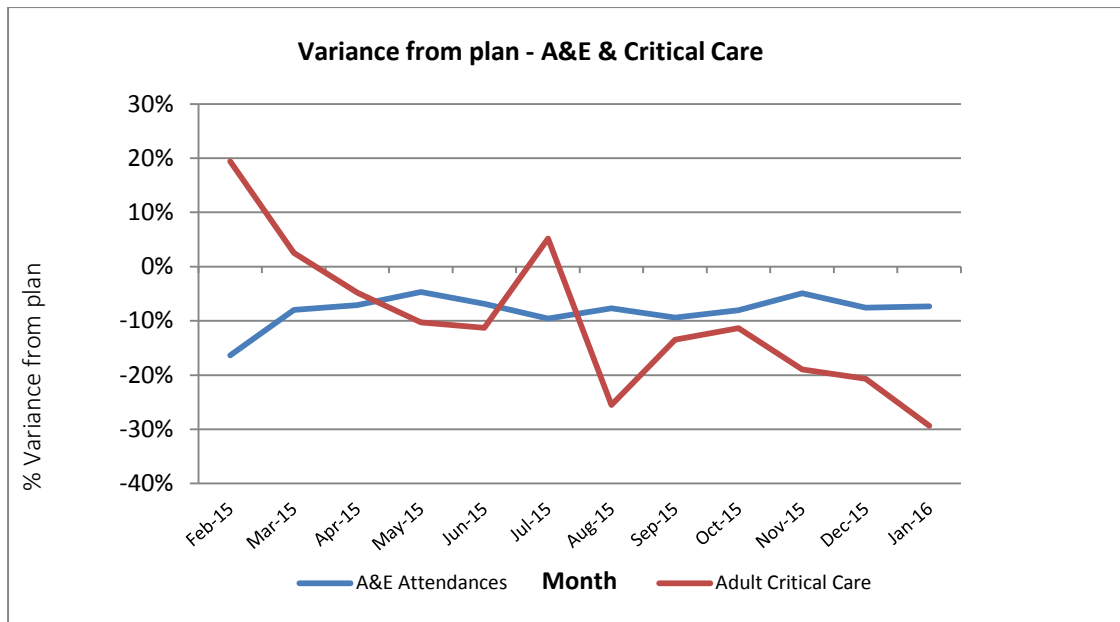


Figure 16 – A&E and Critical Care Variance from Plan for period February 2015 – January 2016

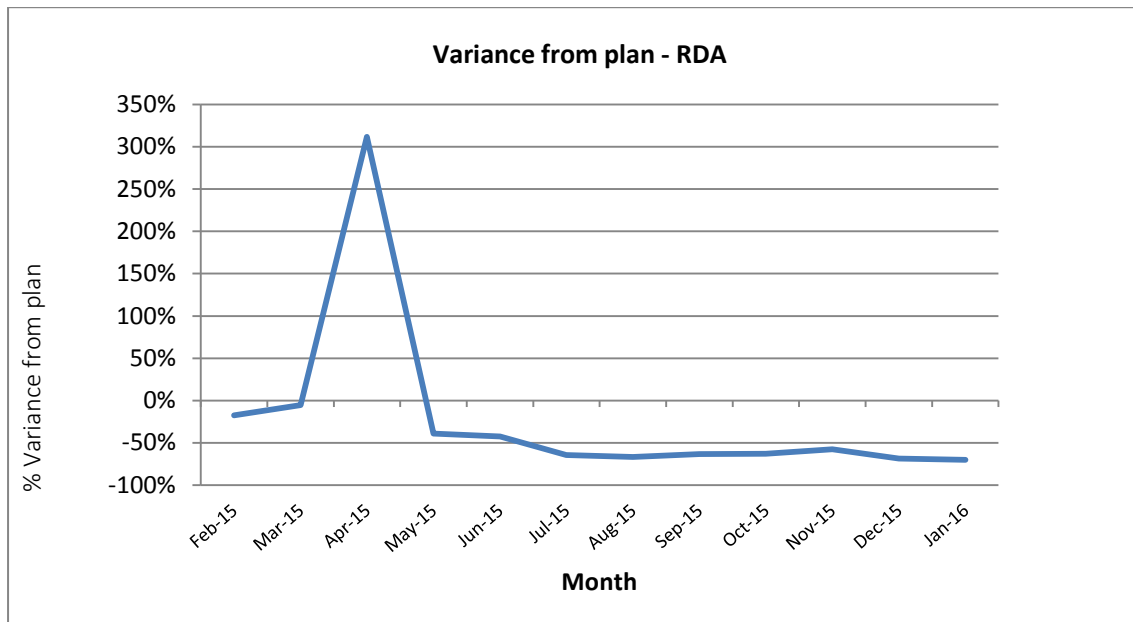


Figure 17 – Regular Day Attender (RDA) Variance from Plan for the period February 2015 – January 2016

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

2.3 Caring

2.3.1 Caring: Eliminating mixed sex accommodation

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

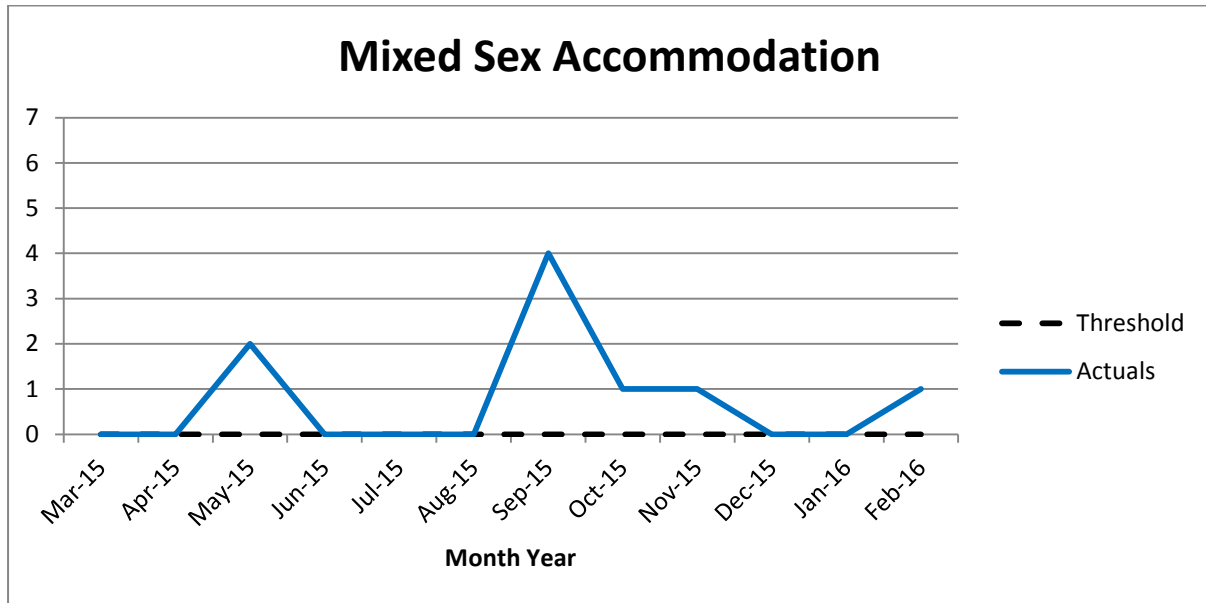


Figure 18 - Mixed Sex Accommodation breaches by month for the period March 2015 – February 2016

2.3.2 Caring: Friends and Family Test

The willingness to recommend remains high across all FFT surveys. The A&E response rate also continues to improve as anticipated following targeted support.

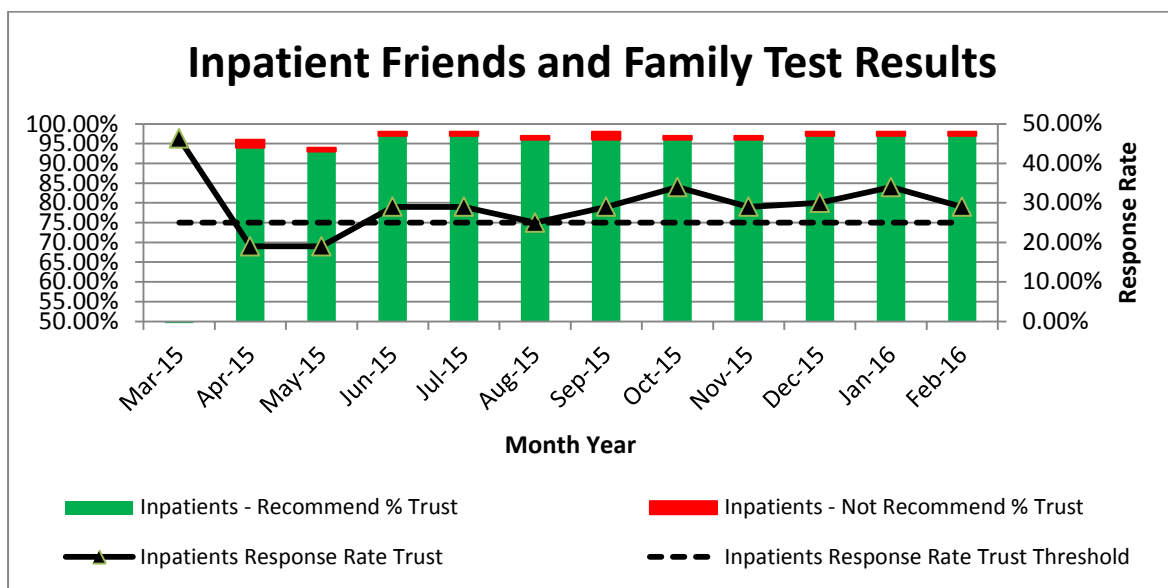


Figure 19 - Friends and Family: Percentage who would recommend ICHT Inpatients for the period April 2015 – February 2016

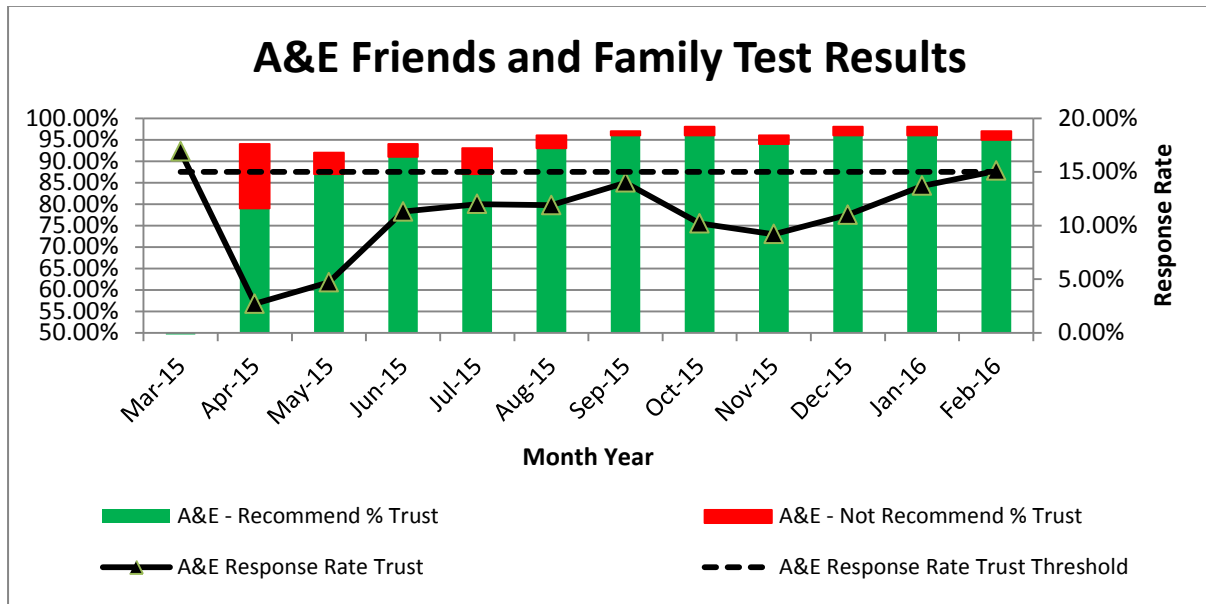


Figure 20 - Friends and Family: Percentage who would recommend ICHT Accident and Emergency for the period April 2015 – February 2016

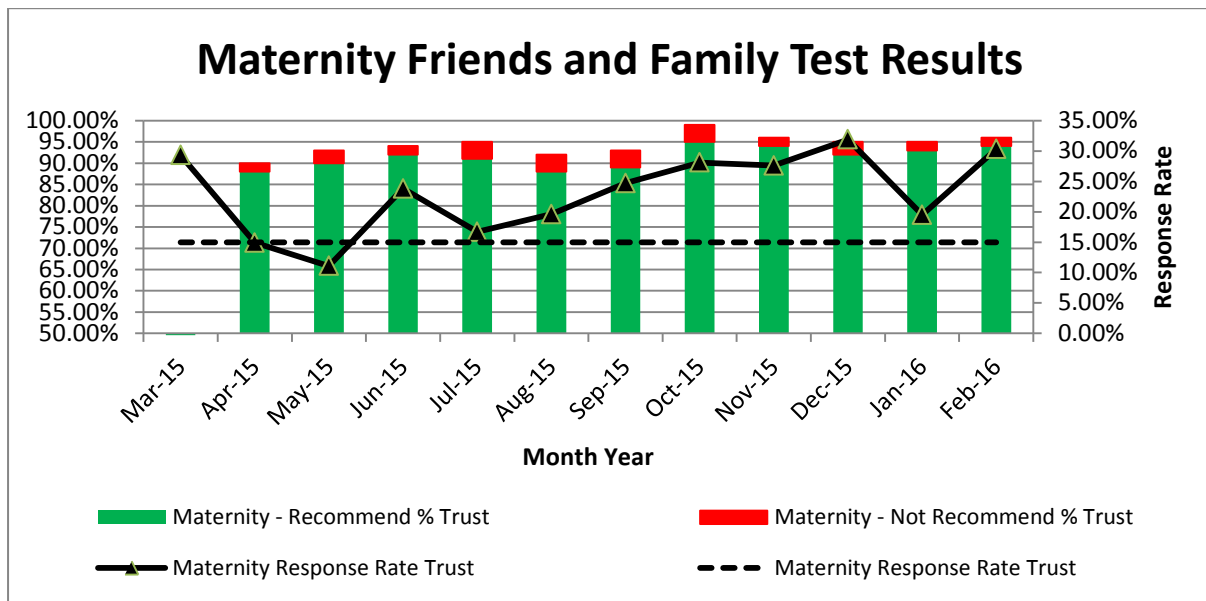


Figure 21 - Friends and Family: Percentage who would recommend Maternity for the period April 2015 – February 2016

2.3.3 Caring: Complaints

The volume of formal complaints increased marginally in February, there is no obvious cause for this although the bulk of the increase is in the division of Surgery, Cancer and Cardiovascular. The response rate remains good.

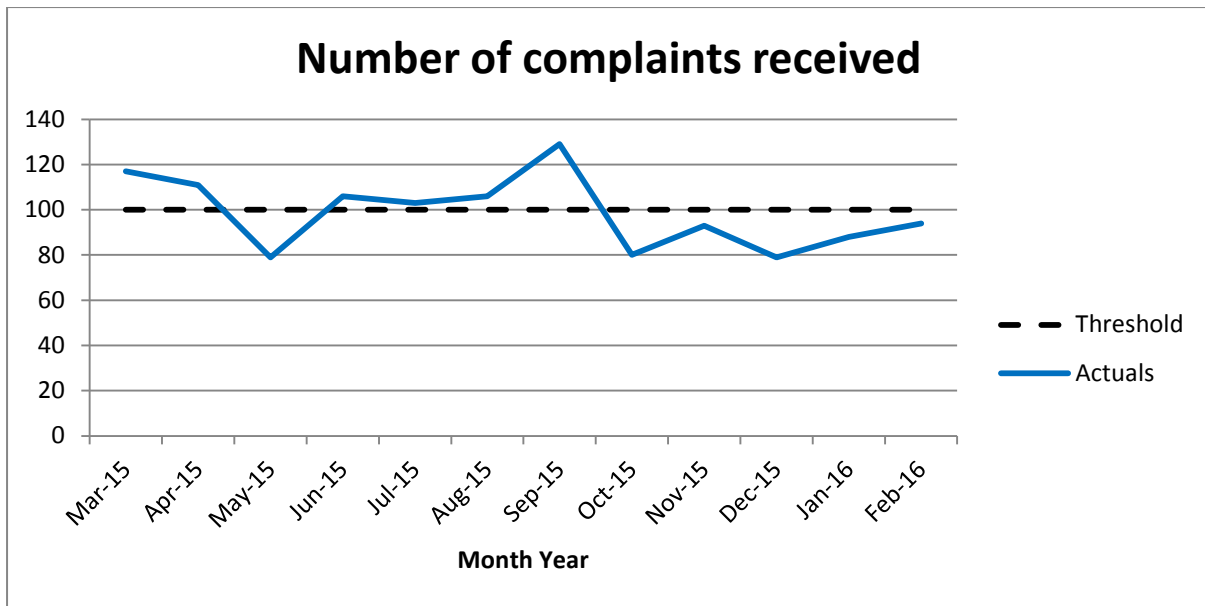


Figure 22 – Number of complaints received for the period March 2015 – February 2016

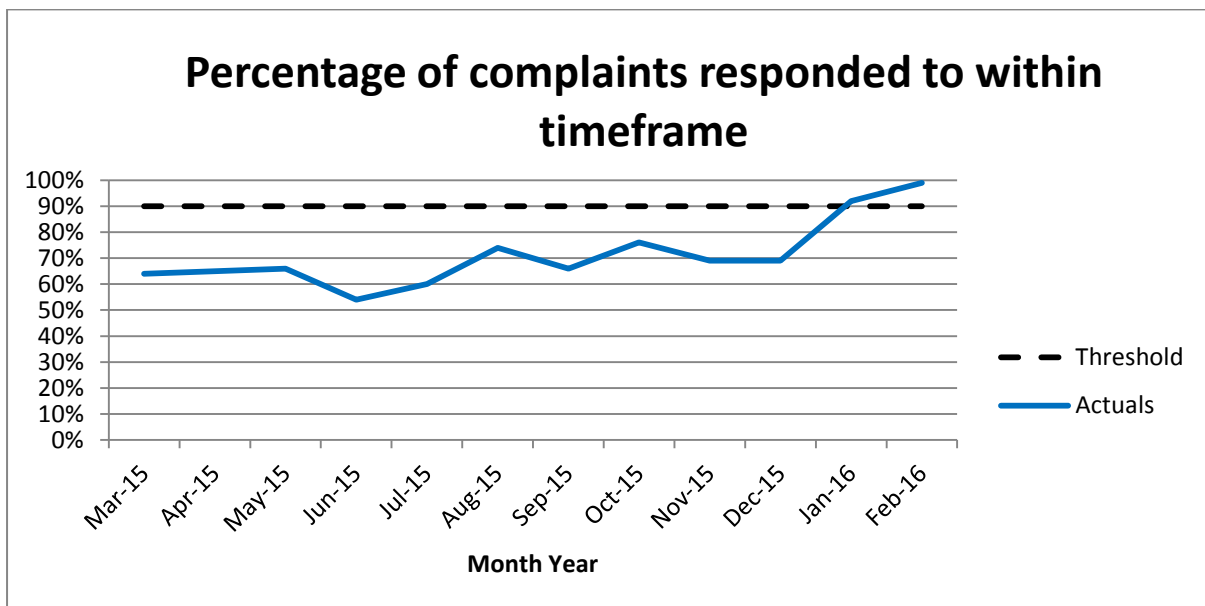


Figure 23 – Percentage of complaints responded to within the period March 2015 – February 2016

2.4 Well-Led

2.4.1 Well-Led: Vacancy Rate

All roles

At the end of February, we directly employed 9,485 WTE (whole time equivalent) members of staff; 32 WTE more than at the end of January and reflective of 198 WTE new joiners and 167 WTE leavers during February. The post establishment has increased by 35 WTE in support of service delivery including new community services and Macmillan cancer support functions. Which, when combined with the increased numbers employed, maintains our contracted vacancy rate at 10.42 per cent; representative of 1,102 WTE vacancies.

Bespoke and generic recruitment campaigns continue to support the reduction of vacancies with 725 WTE pipeline candidates waiting to join us over the coming months (across all occupational groups). The Trust launched its involvement in the Armed Forces Programme on 25th February which was a great success, 30 armed forces personnel attended. The Trusts voluntary turnover rate is currently at 10.70 per cent (rolling 12 month position) which compares favourably against the London NHS turnover rate of 11.63 per cent and all Acute Teaching Trusts (England) of 12.96% (HSCIC). Work has commenced to explore the numbers of leavers we see and to put in place appropriate retention.

Bands 2~6 Nursing & Midwifery on Wards

Within the Trusts wards, the band 2-6 Nursing & Midwifery contractual vacancy rate is 15.68 per cent (391 WTE vacancies); remaining below the London average of 17 per cent for Nursing and Midwifery positions. This is marginally lower than the 15.89 per cent reported at the end of January and reflective of a small establishment increase (2.64 WTE) and 7.32 WTE additional staff in post. There are currently 148 WTE candidates waiting to fill these ward vacancies and we expect them to join over the coming months. The current turnover rate for ward based band 2 – 6 staff is 16.1 per cent; reflective of an average 29 WTE leavers each month. The numbers of leavers seen from our ward based roles has increased steadily over the past 12 months and a project group has been established to focus on the development of a retention strategy and a specific review of leavers alongside the on-going focus on joiners.

Rolling advertisements continue along with a range of focused activity. The Trust attended the RCN fair on 3rd and 4th March and interviewed at the event and made a number of offers were made and a considerable number of expressions of interests were secured. The second Student Nurse Recruitment Event took place on 8th and 9th March and 51 student nurses attended. All Band 5 posts continue to be fast tracked as this is where we have the largest number of vacancies.

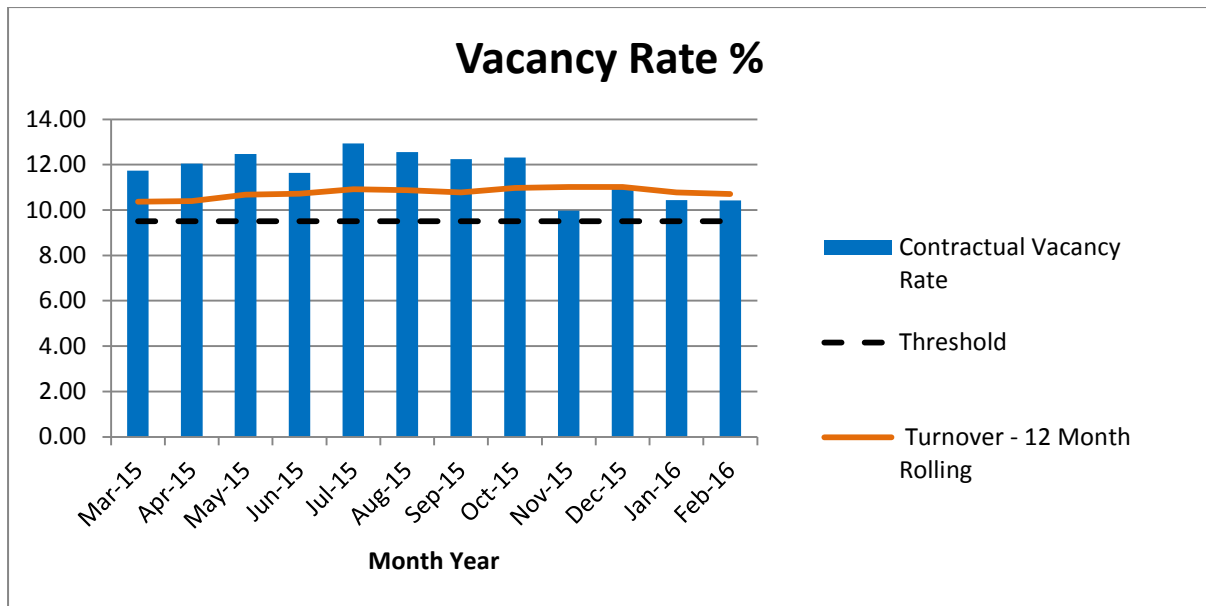


Figure 24 - Vacancy rates for the period March 2015 – February 2016

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence decreased in month from 3.48 per cent to 3.36 per cent and reflects expected seasonal changes. Overall, this maintains the rolling 12-month position to 3.22 per cent which is significantly within the 2015/16 target of 3.40 per cent.

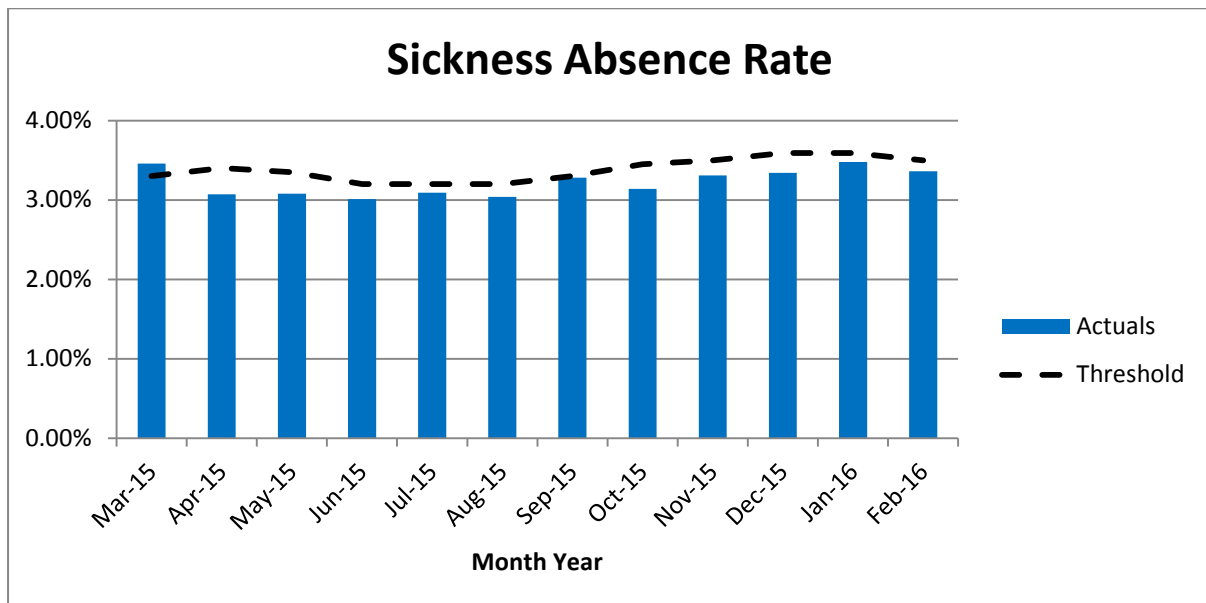


Figure 25 - Sickness absence rates for the period March 2015 – February 2016

2.4.3 Well-Led: Statutory and mandatory training

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

Overall compliance has increased to 86.50 per cent which is the highest compliance to date, from 69 per cent in March 15, and puts Imperial NHS Trust ranked 9th

overall amongst London trusts. A campaign was launched in December specifically for Consultants to improve compliance via e-learning which has resulted in an over 10 per cent improvement already and a huge increase in module completion and now at 76.37 per cent.

Core Skills for doctors in training / trust grade

A new intake of junior doctors arrived in February 2016 and a range of changes have been made in Induction to maximise compliance. It is hoped that the March data will show improve compliance. The current compliance for Doctors in Training is 65.67 per cent March 2016. This is up from 63 per cent in July 15.

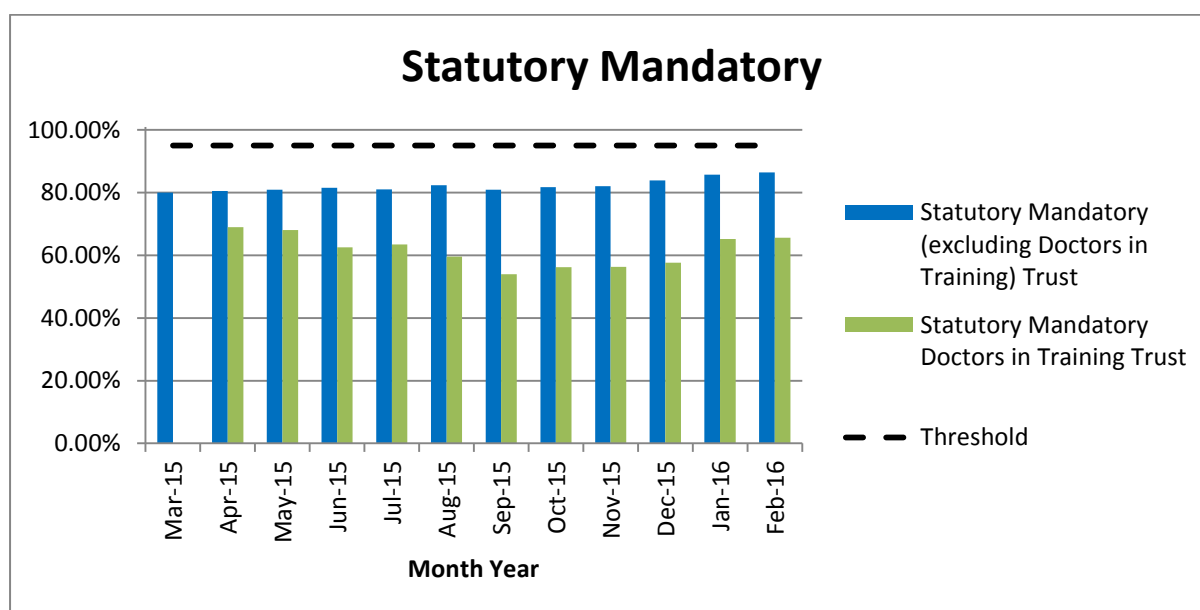


Figure 26 - Statutory and mandatory training for the period March 2015 – February 2016

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

The Trust has made significant improvements in aligning appraisal reporting with the national standards, improving the accuracy of the data. Overall appraisal rates are static, with a slight decrease in the percentage of consultants and a slight increase in the percentage of career grade doctors completing their appraisals. Non-compliance is being escalated to the divisions.

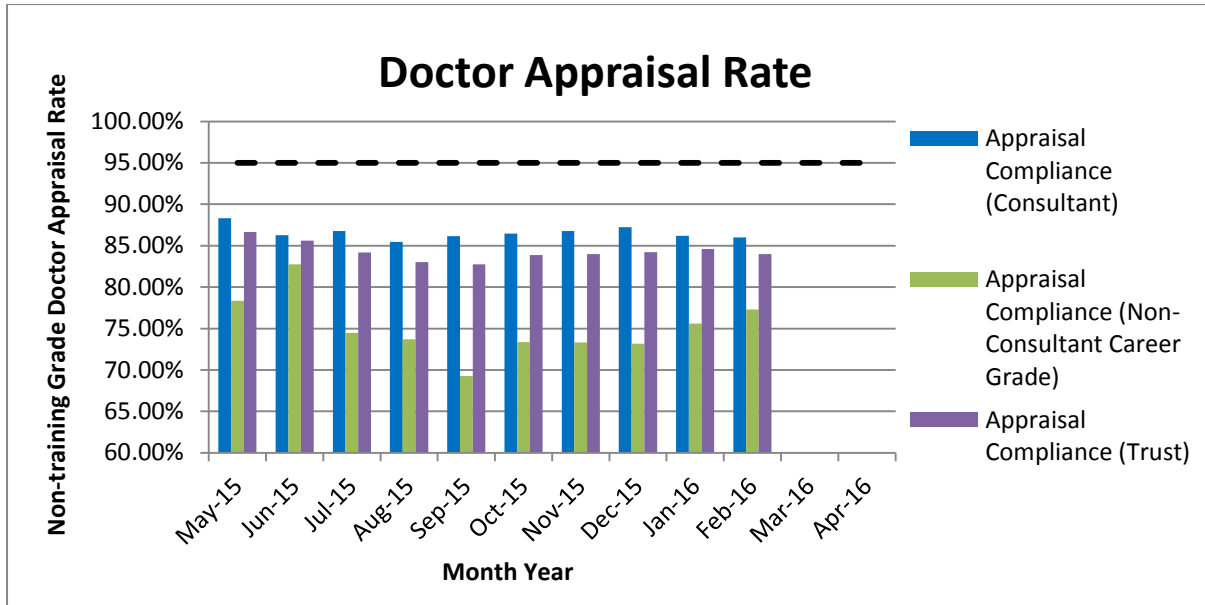


Figure 27 - Grade Doctor Appraisal Rates for the period May 2015 to February 2016

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

This year we have achieved a 92 per cent compliance rate for completed Performance Development Reviews (PDR) for our non-medical staff. The new PDR cycle begins on 1 April 2016 and we expect all of our non-medical staff to have a completed PDR with their line manager by the end of the new PDR cycle.

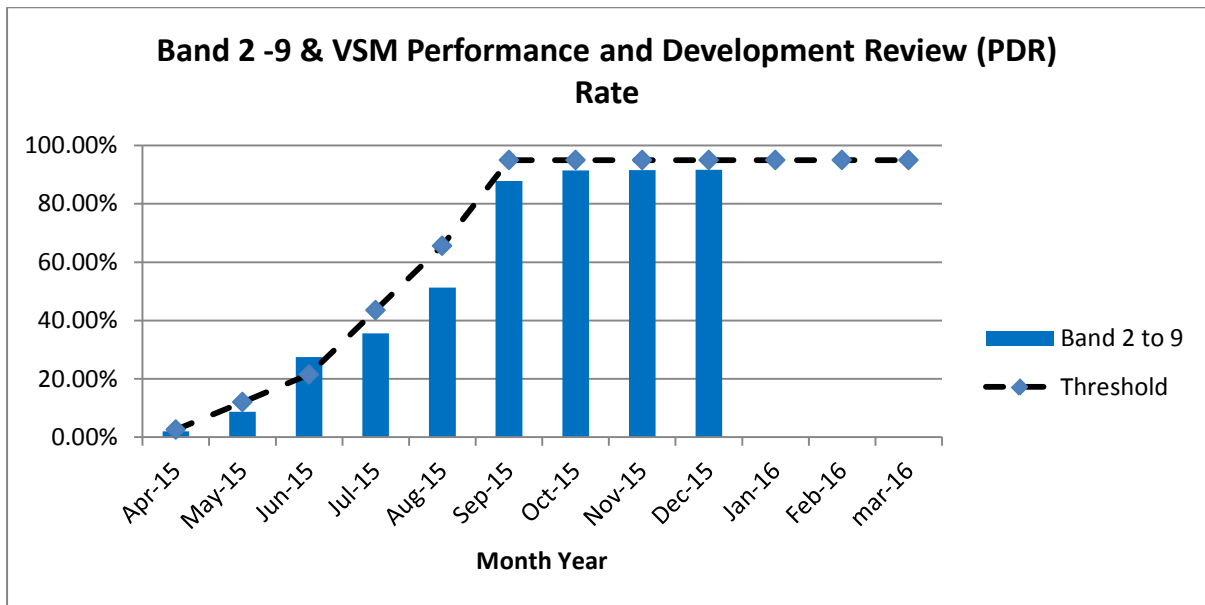


Figure 28 - Band 2 - 9 performance development review rates for the period April 2015 to December 2015

2.4.6 Well-Led: Health and Safety RIDDOR

There were no reportable RIDDOR incidents in February 2016.

In the 12 months to 29 February 2016, there have been 21 RIDDOR reportable incidents of which 11 were slips, trips and falls.

Since April 2015, there have been 19 RIDDOR reportable incidents, 11 of which were 'slips, trips and falls/ collisions'.

Consistently, the majority of all RIDDOR incidents are slips, trips and falls. The Health and Safety service is working with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

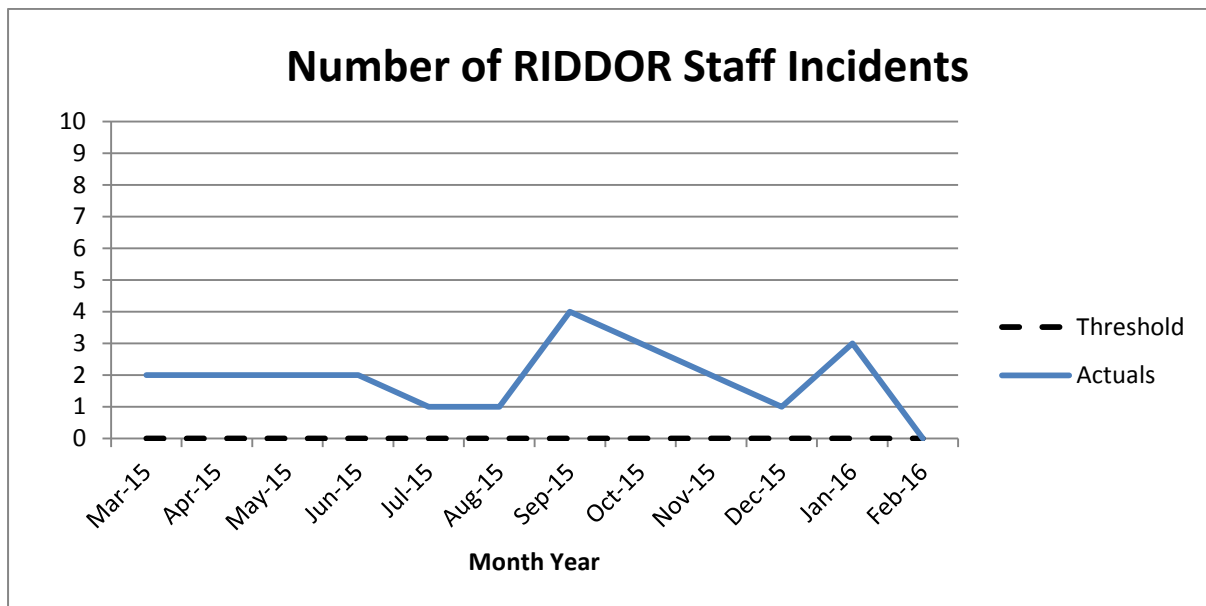


Figure 29 – RIDDOR Staff Incidents for the period March 2015 – February 2016

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

The Trust submitted an interim response to some outstanding actions at HENWL's request in February 2016, although the next full action plan submission date is 29 April 2016. As a result we have 23 actions pending closure for the Quality Visit action plan (out of 133 open actions) and we have 23 actions pending for the NTS red flag action plan. We are expecting a response to our February submission from HENWL the week commencing 14 March 2016, when we will be informed if these actions can be closed.

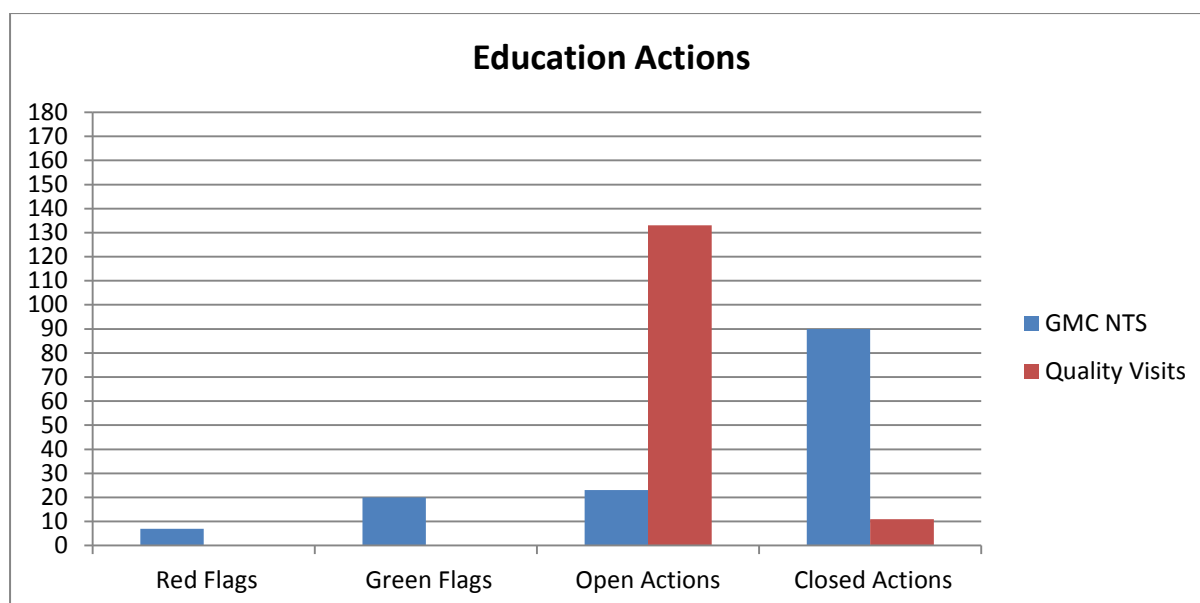


Figure 30 – GMC NTS action tracker, updated at the end of February 2016

2.4.8 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.

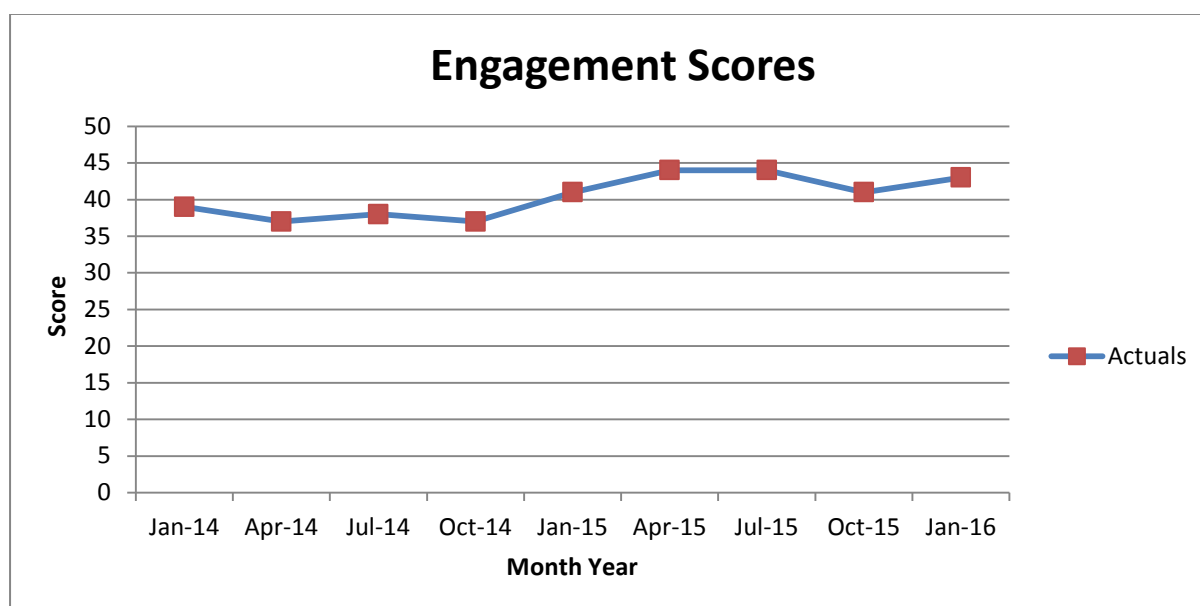


Figure 31 – Engagement scores for the period January 2014 – January 2016

2.5 Responsive

2.5.1 Responsive: Referral to Treatment (RTT)

The NHS Constitution gives patients the right to receive their first treatment within 18 weeks of referral to a consultant-led service. Performance is assessed against two primary performance standards;

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

The primary measure of RTT performance is that 92 per cent of patients should be waiting under 18 weeks at the end of each month.

The Trust performance for February 2016 was 90.54 per cent which was a slight increase in performance from January. However there was an increase of 204 patients waiting over 18 weeks. This mainly related to patients waiting for surgical treatment. The Trust has recently agreed performance trajectories for 2016/17 with Commissioners. These account for a risk in performance for the first four months of the financial year due to known junior doctor's strike and Theatre refurbishment programme. It is expected that the Trust will achieve the 92 per cent standard at an aggregate level from August onwards.

The Trust has been having discussions with NHS England about how to report gender reassignment pathways within the 18 week Referral to Treatment monthly submission. NHS England would like the Trust to include gender reassignment pathways from April 2016 onwards. There are a significant number patients waiting over 18 weeks and 132 patients waiting over 52 weeks.

The inclusion of gender reassignment pathways within the Trust RTT submission for 18 weeks will reduce performance by approximately 0.7 per cent. This is not reflected in the performance trajectories agreed with Commissioners. Commissioners and NHS England have agreed not to take into account financial penalties relating to the inclusion of gender reassignment pathways.

Imperial College Healthcare NHS Trust is the only NHS Trust that provides a gender reassignment surgical service and has requested that the pathways be reported under a separate Treatment Function Code. This will allow visibility of performance for this group of patients. NHS England has not yet found a solution to this challenge and discussions are on-going to ensure this can happen before April.

52 weeks

The Trust had 14 patients in February who were waiting over 52 weeks for treatment. All patients who wait over 52 weeks for treatment will be reviewed at the medical directors' weekly quality review.

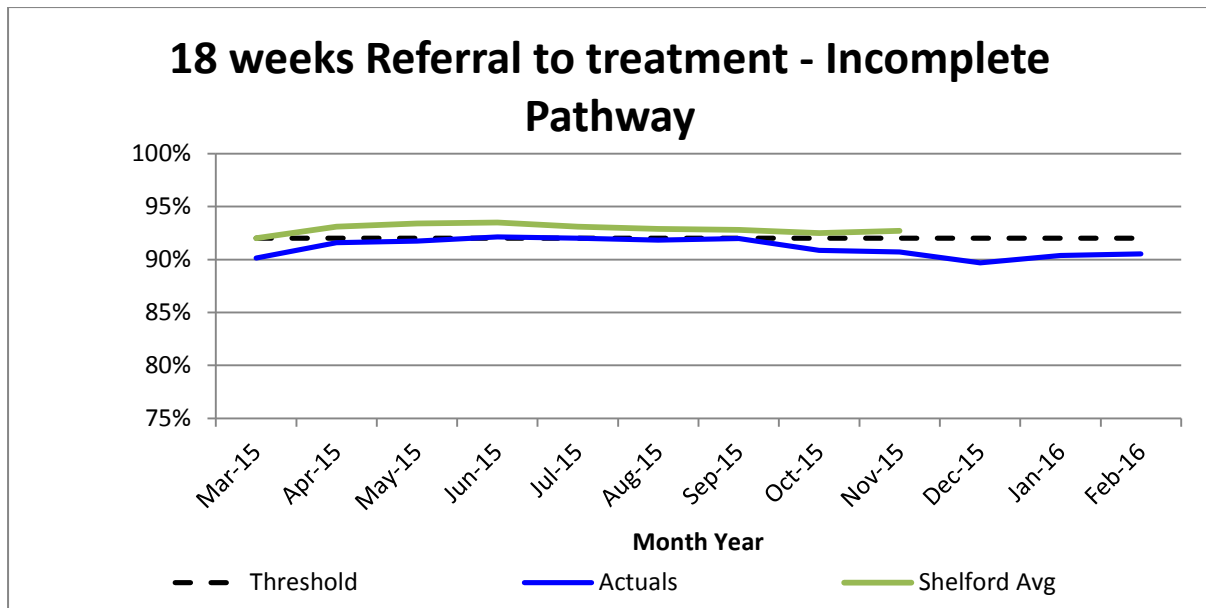


Figure 32 - RTT Incomplete Pathways for the period February 2015 – January 2016

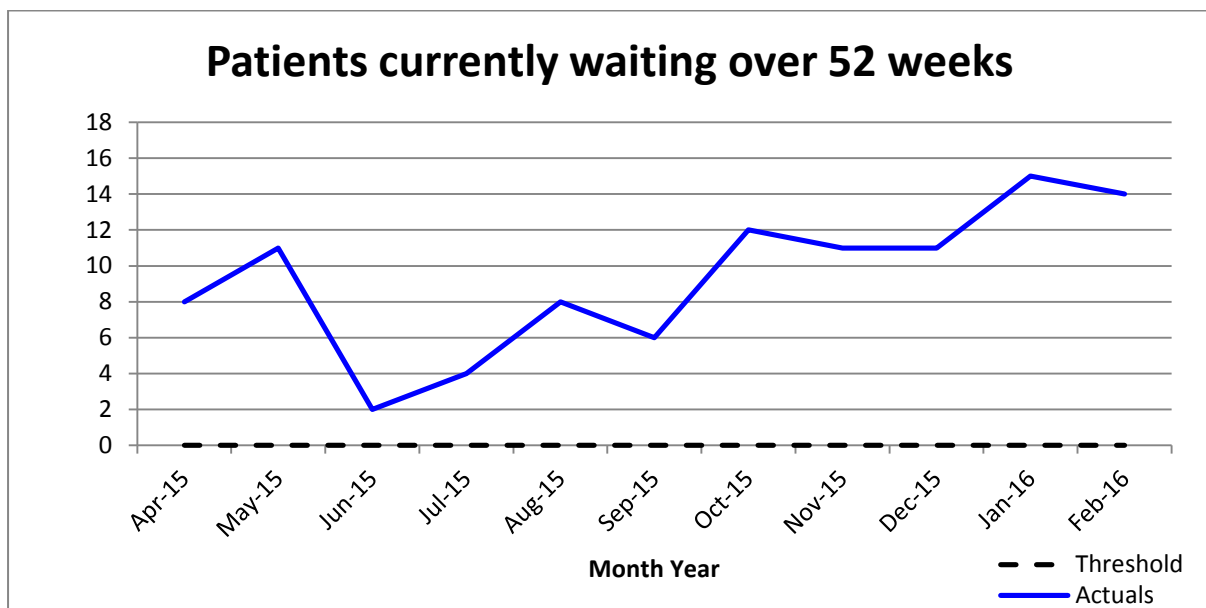


Figure 33 - Number of patients waiting over 52 weeks for the period February 2015 – January 2016

2.5.2 Responsive: Diagnostics

The Trust met the monthly six week diagnostic waiting time standard in February 2016 with 0.4 per cent of patients waiting over six weeks against the one per cent tolerance. It is expected that the Trust will continue to meet the diagnostic standard in 2016/17 except for a 2 month period in May and June when the trust goes live with the Radiology Information System picture archiving and communications system (RIS PACS).

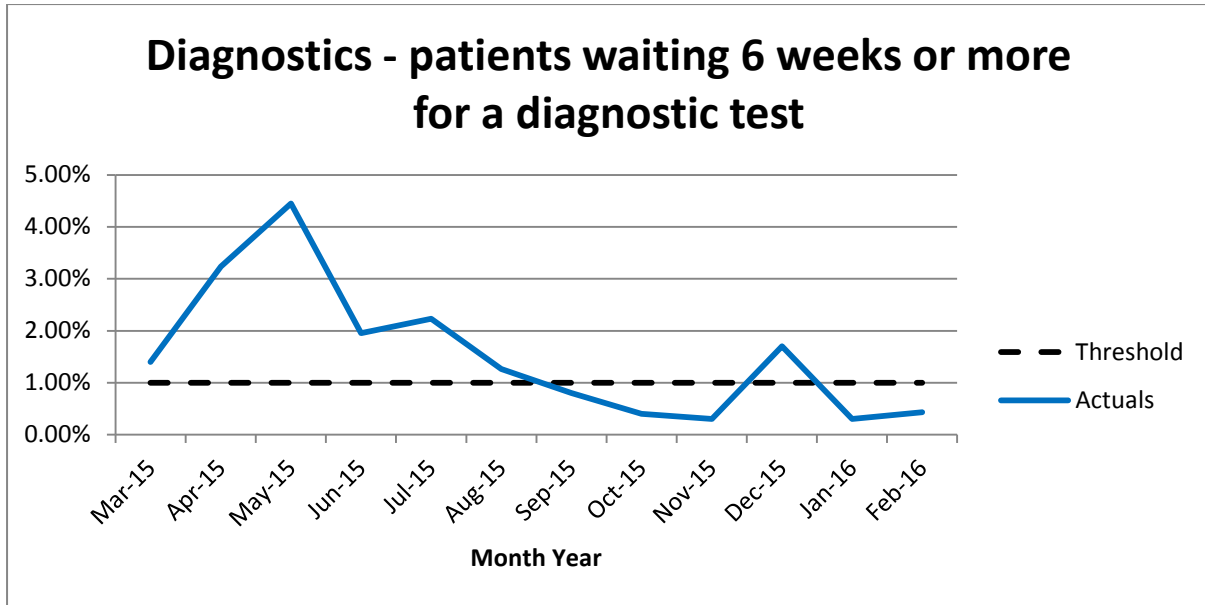


Figure 34 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period January 2015 – February 2016

2.5.3 Responsive: Accident and Emergency

Performance against the four hour access standard for patients attending Accident and Emergency remained challenged at 86.06 per cent in February 2016.

The Trust has been working closely with the local health system to develop detailed site based action plans. The Trust has agreed performance trajectories with local Commissioners. Due to on-going increases in demand and challenges with capacity it is not expected that the Trust will achieve the 4-hour access standard until July 2017.

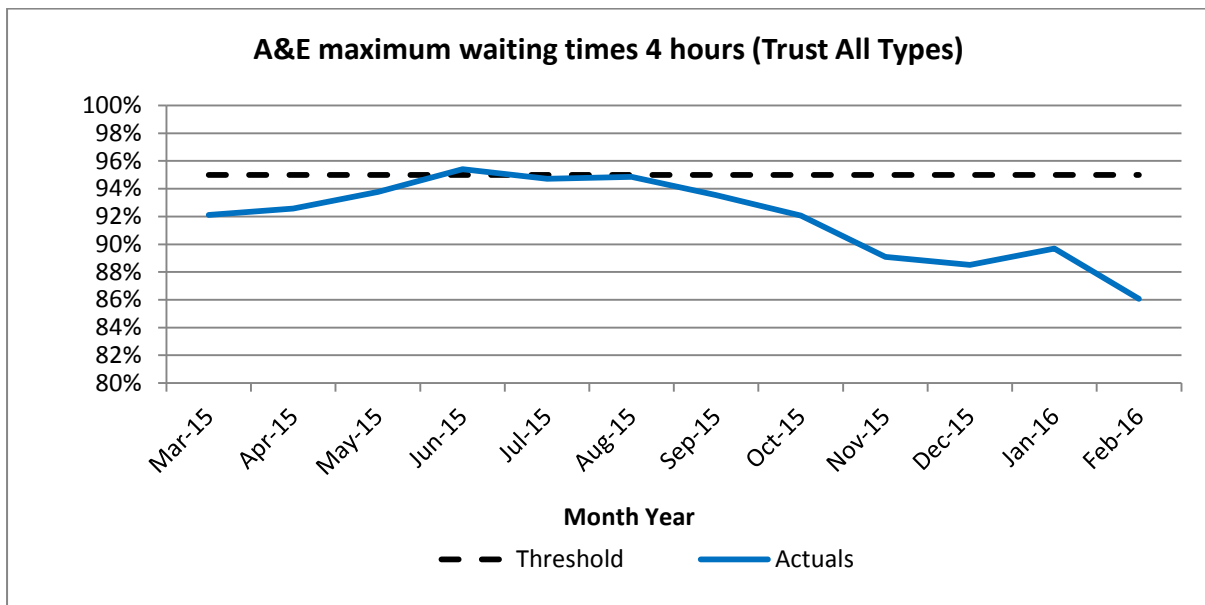


Figure 35 – A&E Maximum waiting times 4 hours (Trust All Types) for the period March 2015 – February 2016

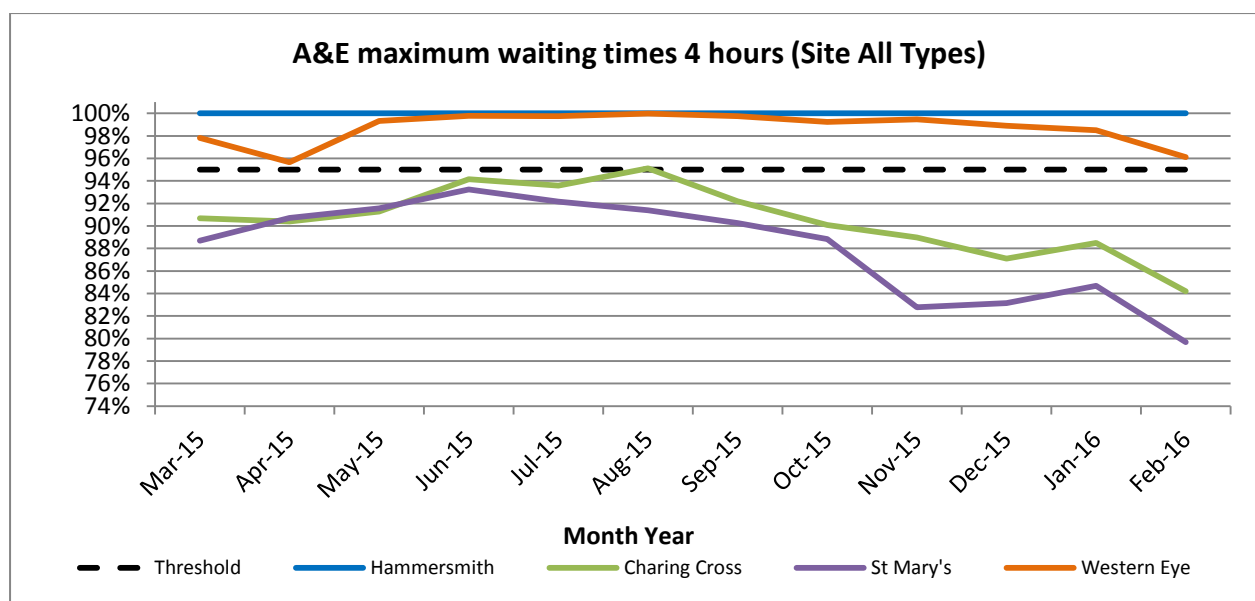


Figure 36 – A&E Maximum waiting times (Site All Types) 4 hours for the period March 2015 – February 2016

2.5.4 Responsive: Cancer

In February 2016 performance is reported for Cancer waiting times standards for January 2016.

In January, the Trust achieved six of the eight national cancer standards. The Trust underperformed against the two week GP referral to 1st outpatient (delivering 90.1 per cent against a 93 per cent target) and for 62 day urgent GP referral to treatment from screening (delivering 86.2 per cent against a 90 per cent target).

- The deterioration in the 2ww performance was related to capacity issues in Urology clinics; work is on-going with the Urology team to investigate the situation and to improve the position.
- The screening standard underperformed due to two breaches, both relating to further diagnostics being required before treatment could be commenced.

The Trust continues to achieve the 62 day urgent GP referral to treatment for all cancers. The Trust expects to recover performance for February and overall for quarter 4.

Indicator	Standard	Q3 15/16	Jan-16
Two week GP referral to 1st outpatient, cancer (%)	93.0%	93.6%	90.1%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.9%	93.3%
31 day wait from diagnosis to first treatment (%)	96.0%	97.2%	96.8%
31 day second or subsequent treatment (surgery) (%)	94.0%	97.6%	100%

Indicator	Standard	Q3 15/16	Jan-16
31 day second or subsequent treatment (drug) (%)	98.0%	100%	100%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	99.7%	97.1%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	86.9%	85.3%
62 day urgent GP referral to treatment from screening (%)	90.0%	90.1%	86.2%

Table 1 - Performance against national cancer standards for January 2016 and Q3 15/16

2.5.5 Responsive: Outpatient DNA rates

The Trust outpatient improvement programme is specifically working to reduce the number of missed hospital outpatient appointments. The two main service interventions are (i) consistent application of the RTT access policy to minimise rebooking of patients who DNA multiple times and (ii) further maximising use of text message reminders by increasing number of mobile numbers on record.

The overall DNA rate for January was 11.7 per cent with a small reduction in DNA rate for first appointments.

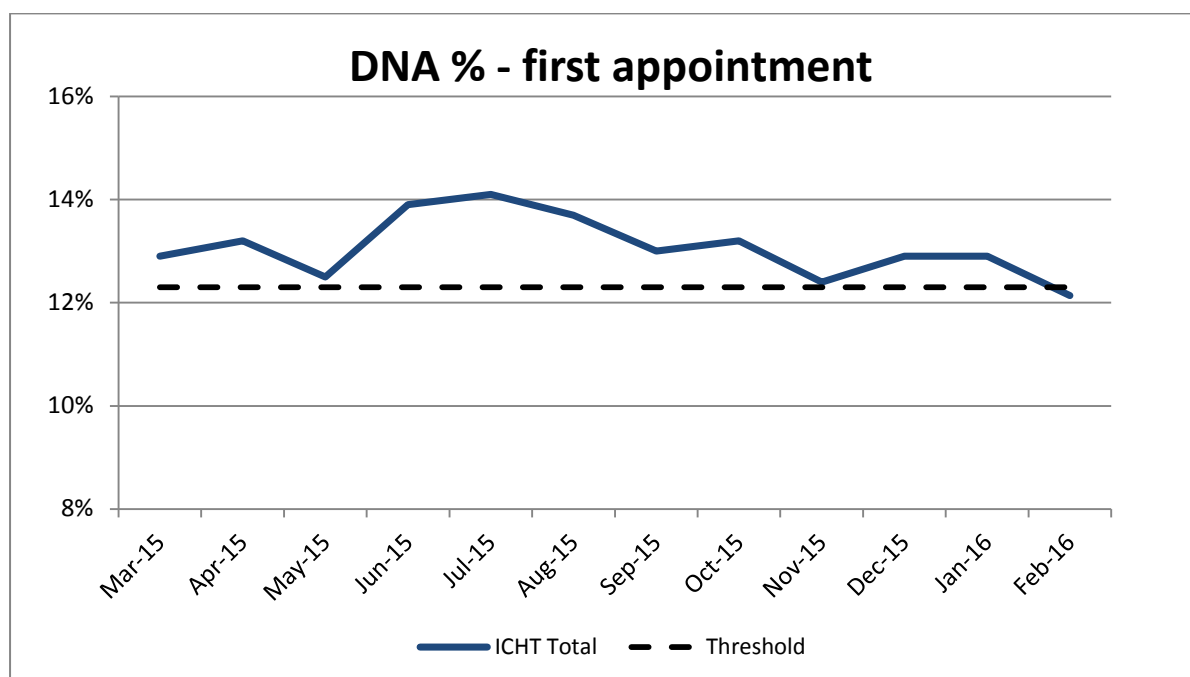


Figure 37 – First outpatient DNA rate (Trust) for the period March 2015 – February 2016

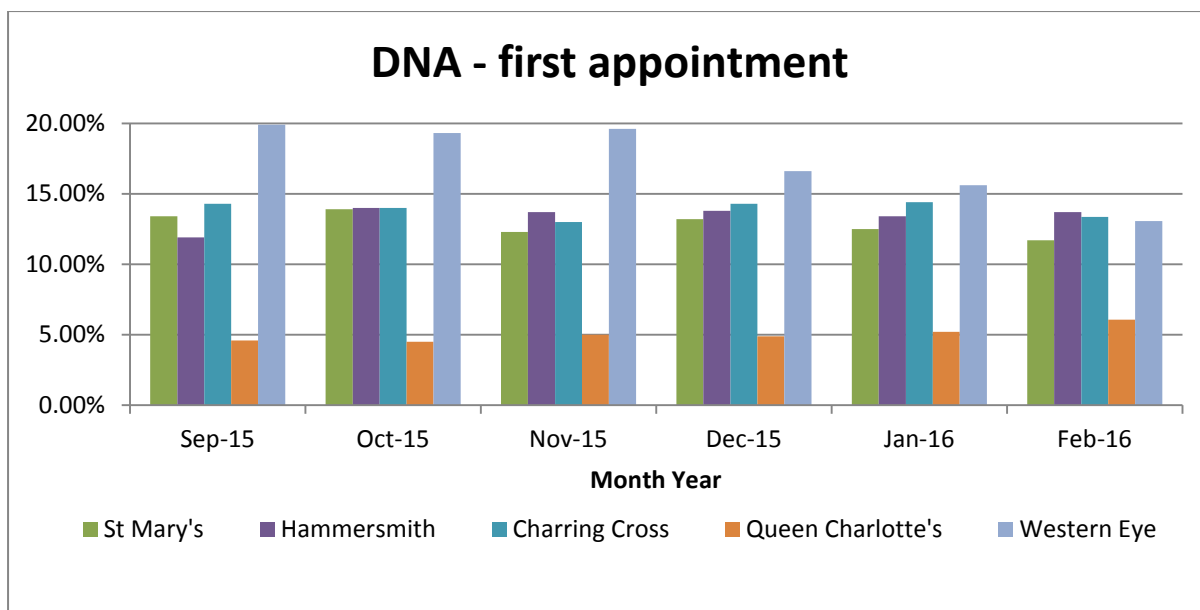


Figure 38 – First outpatient DNA rate (Site) for the period August 2015 – February 2016

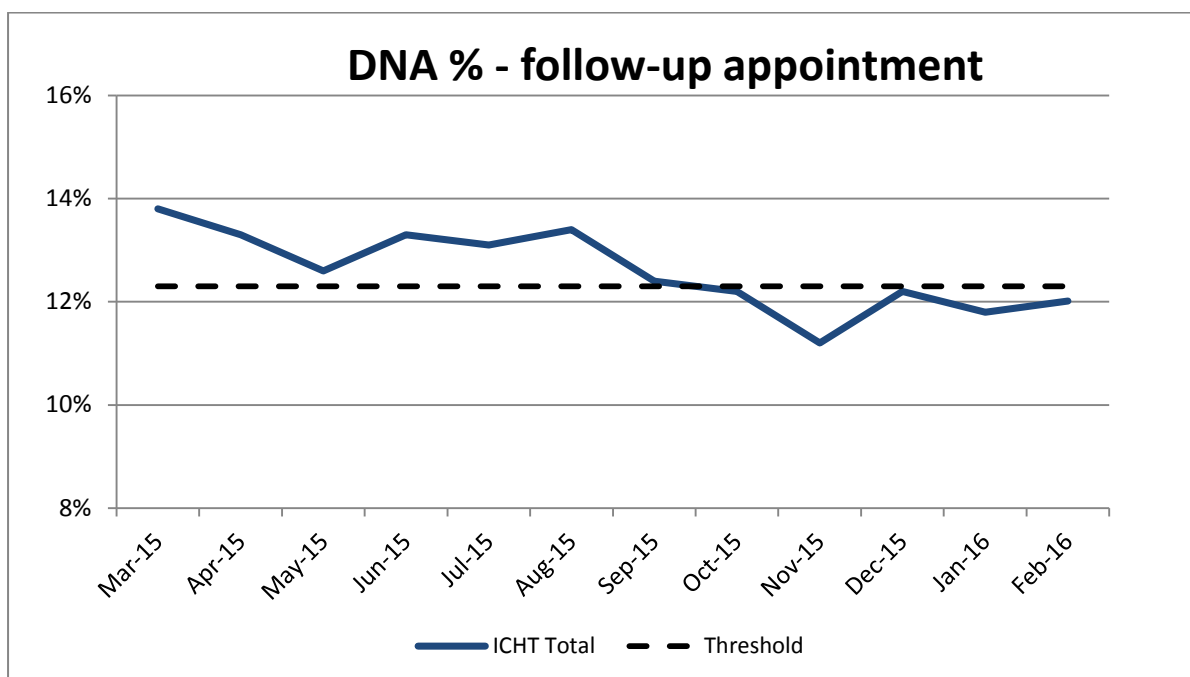


Figure 39 – Follow up outpatient DNA rate (Trust) for the period March 2015 – February 2016

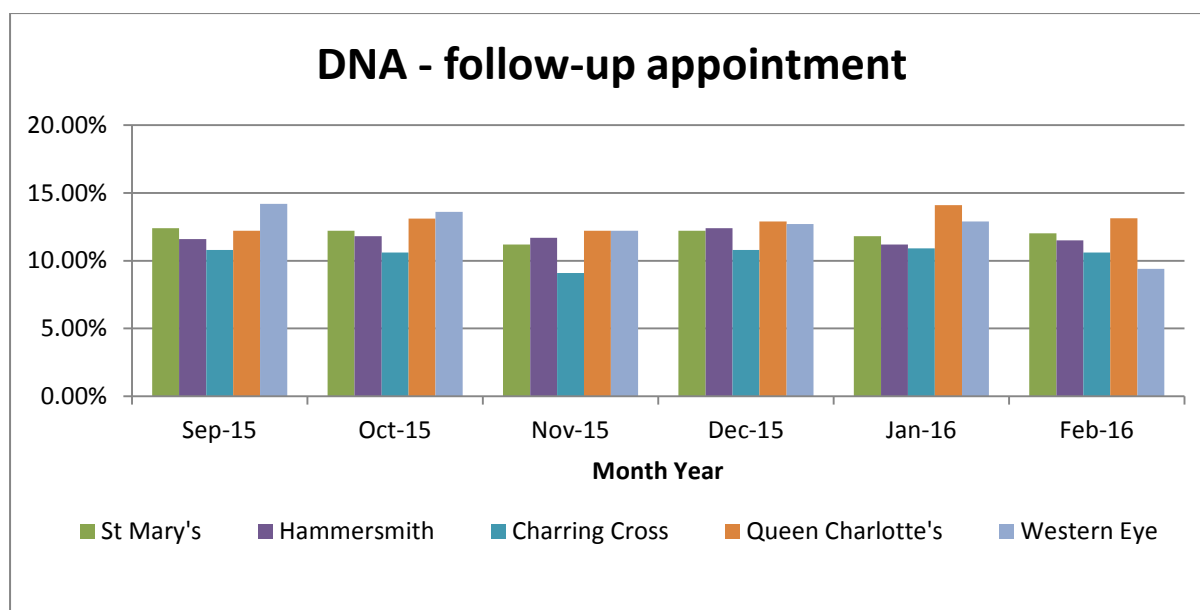


Figure 40 – Follow up outpatient DNA rate (Site) for the period August 2015 – February 2016

2.5.6 Responsive: Hospital Appointment Cancellations (hospital instigated)

Appointments are sometimes cancelled by a service within the hospital. This should only occur in very limited circumstances – such as in an emergency or when a member of staff is ill. Cancelling and rescheduling appointments is hugely inconvenient to our patients and creates additional, unnecessary work for our staff.

The Trust outpatient improvement programme is specifically working to reduce the number of clinic cancellations at less than 6 weeks.

A project was implemented in mid-March to simplify the process of recording cancellations and ensuring the corrected reasons are recorded. The list of reasons has been reduced from around 80 to just 5. This will provide information to identify the root cause, change practices, and reduce the amount of appointments we cancel and rearrange.

An exercise has begun in central outpatients to refresh the process for forward checking on-call rotas and leave (annual and study) to ensure these clinics are cancelled out before any patients are booked.

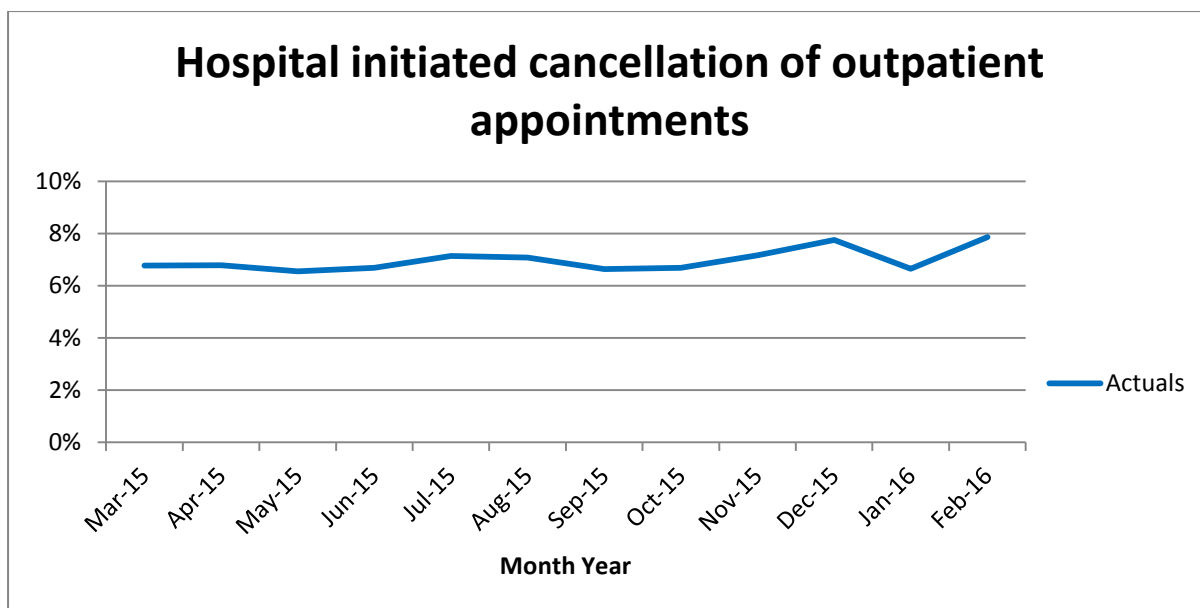


Figure 41 – Outpatient Hospital instigated cancellation rate for the period March 2015 – February 2016

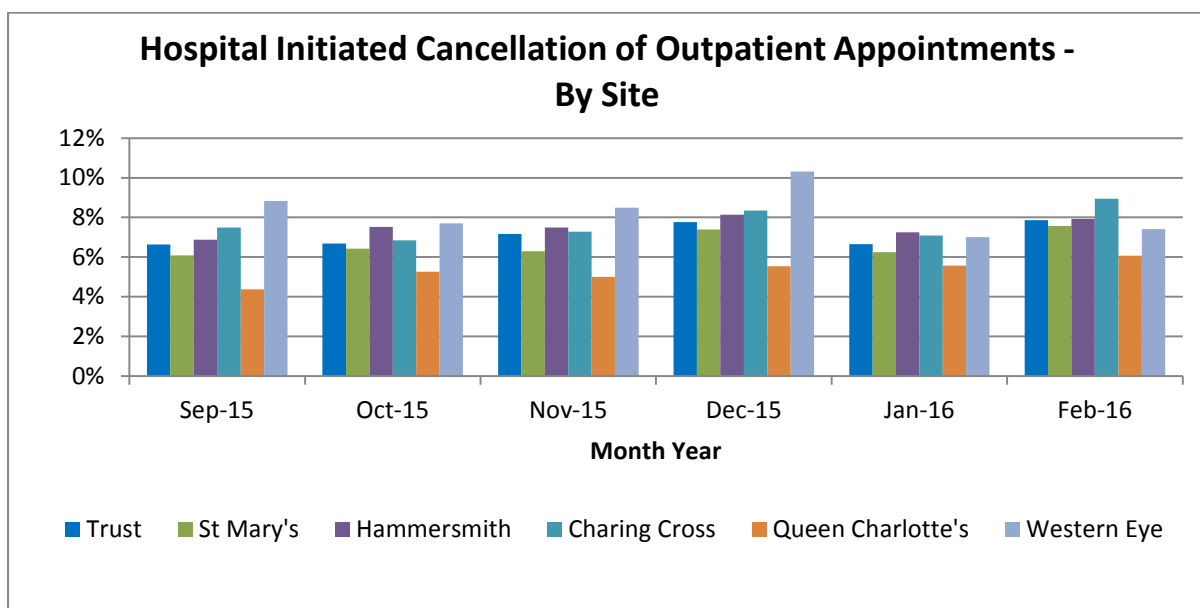


Figure 42 – Outpatient Hospital instigated cancellation rate by site for the period August 2015 – February 2016

3. Finance

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

Report to:	Date of meeting
Trust board - public	6 April 2016

Month 11 finance report

Executive summary:

This report provides a brief summary of the Trust's financial results for the 11 months ended 29 February 2016. The Trust Board is asked to note this paper and the actions proposed to mitigate and recover the position going forward.

After nine months the Trust is reporting a deficit of £27.6m; an adverse variance to plan of £9.2m. This is significant and of concern but is broadly consistent with trends from previous months and the Trust forecast has not worsened. 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	81,738	83,479	1,741	931,674	921,084	(10,590)
Total Expenditure	(81,744)	(83,670)	(1,926)	(907,304)	(906,809)	495
Earning Before Interest, Tax Depreciation and Amortisation	(6)	(191)	(185)	24,370	14,275	(10,095)
SURPLUS / (DEFICIT) including donated asset Treatment	(2,814)	(2,485)	329	(14,933)	(10,507)	4,426
SURPLUS / (DEFICIT)	(3,832)	(3,756)	76	(18,377)	(27,578)	<b style="color: red;">(9,201)

Whilst income is ahead of levels delivered at this point last year, the Trust is not achieving its ambitious growth targets in either NHS or Private income. NHS commissioners are aggressively challenging many elements of our activity and provisions have been made for this. Overall expenditure is below plan. The annual plan is for a deficit of £18.5m; the most recent forecast which takes account of the M11 result, indicates the Trust will be significantly adverse to this. The Executive continue to implement stringent cost minimisation plans, especially in non-patient-facing activities. Further mitigating actions are being discussed with commissioners and the TDA.

The Trust is not meeting its financial and activity plans year to date and is forecasting that it will not meet its full year plan without exceptional, probably non-recurrent, adjustments. This is primarily due to the fact that the Trust is not meeting its ambitious growth targets for treating private patients, is overspending in Medicine Division and under-delivering activity in SC&C Division combined with much more challenge to the level of NHS activity which commissioners are prepared to remunerate. Whilst our NHS income levels are 3% above levels at this point last year, they remain lower than our plans.

The Executive continues to work internally to reduce costs while safeguarding quality and with the commissioners and the TDA to ensure fair remuneration for activity carried out. Very significant work is going on in preparation for 16/17 to ensure better alignment of expectations with our commissioners and to drive down our costs.

Recommendation to the Committee:

The Committee is asked to note the month 11 finance 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	29 March 2016

FINANCE REPORT – 11 MONTHS ENDED 29th February 2016**1. Introduction**

This report provides a brief summary of the Trust's financial results for the 11 months ended 29 February 2016. The Trust Board is asked to note this paper and the actions proposed to mitigate and recover the position going forward.

2. Summary

After nine months the Trust is reporting a deficit of £27.6m; an adverse variance to plan of £9.2m. This is significant and of concern but is broadly consistent with trends from previous months and the Trust forecast has not worsened. The table below provides a summary of the income and expenditure position.

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Total Expenditure	(81,744)	(83,670)	(1,926)	(907,304)	(906,809)	495
Earning Before Interest, Tax Depreciation and Amortisation	(6)	(191)	(185)	24,370	14,275	(10,095)
SURPLUS / (DEFICIT) including donated asset Treatment	(2,814)	(2,485)	329	(14,933)	(10,507)	4,426
SURPLUS / (DEFICIT)	(3,832)	(3,756)	76	(18,377)	(27,578)	(9,201)

Whilst income is ahead of levels delivered at this point last year, the Trust is not achieving its ambitious growth targets in either NHS or Private income. NHS commissioners are aggressively challenging many elements of our activity and provisions have been made for this. Overall expenditure is below plan. The annual plan is for a deficit of £18.5m; the most recent forecast which takes account of the M11 result, indicates the Trust will be significantly adverse to this. The Executive continue to implement stringent cost minimisation plans, especially in non-patient-facing activities. Further mitigating actions are being discussed with commissioners and the TDA.

3. Revenue

The Appendix provides a summary of the position after 11 months.

3.1 NHS Activity and Income

The summary table shows the position by division.

Divisions	Year to Date (Activity)			Year to Date (Income)		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s
A - Medicine	2,660,557	1,846,926	(813,631)	273,871	277,036	3,166
B - Surgery and Cancer	1,276,082	1,364,582	88,500	282,917	283,191	274
C - Investigative Sciences and Clinical Support	1,954,173	2,058,784	104,612	30,553	32,080	1,527
D - Womens and Childrens	278,719	274,009	(4,711)	106,333	102,476	(3,857)
X/Z - Central Divisional Total	110,852	104,819	(6,032)	19,578	6,824	(12,753)
			0			
YTD FEBRUARY's FORECAST ACTIVITY & INCOME	6,280,383	5,649,120	(631,262)	713,252	701,608	(11,644)

[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 (-14%) 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.

3.2 Private Care income

Private care income continues to improve, and is £4.7m behind plan year-to-date at M11, a slight improvement on last month. The run-rate improvement first noted at M7 has been maintained and for the last couple of months over-performance has been £0.3m compared with the £0.7m under-performance in the first six months. The division has agreed a revised forecast for the remainder of the year and is on track to deliver this.

3.3 Clinical Divisions

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

		In Month			Year to Date (Cumulative)		
		Plan	Actual	Variance	Plan	Actual	Variance
		£000s	£000s	£000s	£000s	£000s	£000s
Division of Medicine	Income	1,003	1,819	816	11,148	13,127	1,979
	Pay	(12,061)	(11,757)	304	(130,311)	(133,127)	(2,817)
	Non Pay	(3,675)	(3,445)	230	(40,013)	(42,011)	(1,998)
Division Of Medicine Total		(14,732)	(13,383)	1,349	(159,175)	(162,011)	(2,836)
Division of Women and Children	Income	677	590	(87)	7,047	4,187	(2,860)
	Pay	(6,565)	(6,096)	469	(70,999)	(67,629)	3,370
	Non Pay	(1,260)	(1,127)	134	(13,648)	(12,480)	1,168
Division Of Women And Children Total		(7,148)	(6,632)	516	(77,600)	(75,923)	1,678
Investigative Sciences & C S	Income	2,251	2,379	128	24,754	24,565	(189)
	Pay	(7,610)	(7,520)	90	(83,126)	(82,248)	878
	Non Pay	(2,986)	(3,088)	(102)	(32,995)	(33,627)	(632)
Investigative Sciences & C S Total		(8,346)	(8,229)	117	(91,367)	(91,310)	57
Surg, Canc & Cardiovasc Div	Income	496	873	376	5,461	1,539	(3,923)
	Pay	(14,271)	(14,277)	(6)	(156,525)	(156,830)	(306)
	Non Pay	(4,755)	(4,657)	98	(52,449)	(51,118)	1,332
Surg, Canc & Cardiovasc Div Total		(18,529)	(18,061)	468	(203,513)	(206,409)	(2,897)
Private Patients Directorate	Income	3,439	3,558	119	37,828	31,128	(6,700)
	Pay	(1,128)	(1,080)	48	(12,408)	(11,155)	1,253
	Non Pay	(968)	(907)	61	(10,671)	(10,220)	451
Private Patients Directorate Total		1,343	1,571	229	14,748	9,753	(4,995)
		(47,412)	(44,734)	2,679	(516,907)	(525,899)	(8,992)

The Division of Medicine is £2.8m 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 Surgery Division is £2.9m 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 £5m, £6.7m behind its income plan, partly offset by underspends on pay and non-pay.

4. Efficiency programme

CIP delivery in month 11 is showing an adverse in-month variance of £0.4m, at £3.1m against a plan of £3.5m, due to under achievement against both corporate and divisional schemes. YTD achievement of CIP has remained at 78% leading to a shortfall of £7.0m. The forecast position has worsened to 80% achievement of the £36.1 million target by year-end.

The position has deteriorated for Surgery, Cancer & Cardiovascular (forecast £0.2m worse than last month). The underlying issues have been picked up and included in analysis of the overall performance for the divisions, and mitigating actions are being identified as part of the stretch programme and are actively monitored as part of the regular weekly / fortnightly meetings with the Divisions

5. Cash

The cash balance at the end of the month was £25.4m; £15.9m below plan. Our assessment remains that the cash position remains manageable for the remainder of the financial year.

6. Conclusion

The Trust is not meeting its financial and activity plans year to date and is forecasting that it will not meet its full year plan without exceptional, probably non-recurrent, adjustments. This is primarily due to the fact that the Trust is not meeting its ambitious growth targets for treating private patients, is overspending in Medicine Division and under-delivering activity in SC&C Division combined with much more challenge to the level of NHS activity which commissioners are prepared to remunerate. Whilst our NHS income levels are 3% above levels at this point last year, they remain lower than our plans.

The Executive continues to work internally to reduce costs while safeguarding quality and with the commissioners and the TDA to ensure fair remuneration for activity carried out. Very significant work is going on in preparation for 16/17 to ensure better alignment of expectations with our commissioners and to drive down our costs.

Appendix

Statement of Comprehensive Income – 11 months to 29th February 2016

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	62,973	64,835	1,862	726,026	723,901	(2,125)
Private Patients	4,142	4,465	323	44,798	40,110	(4,688)
Research & Development & Education	8,996	8,884	(112)	98,969	104,063	5,094
Other	5,627	5,295	(332)	61,881	53,010	(8,871)
TOTAL INCOME	81,738	83,479	1,741	931,674	921,084	(10,590)
Expenditure						
Pay - In post	(44,280)	(42,056)	2,224	(479,819)	(456,286)	23,533
Pay - Bank	(1,203)	(2,737)	(1,534)	(17,111)	(29,189)	(12,078)
Pay - Agency	(2,650)	(3,361)	(711)	(30,499)	(47,064)	(16,565)
Drugs & Clinical Supplies	(20,358)	(21,690)	(1,332)	(234,324)	(246,329)	(12,005)
General Supplies	(2,881)	(2,774)	107	(31,698)	(31,686)	12
Other	(10,372)	(11,052)	(680)	(113,853)	(96,255)	17,598
TOTAL EXPENDITURE	(81,744)	(83,670)	(1,926)	(907,304)	(906,809)	495
Earnings Before Interest, Tax, Depreciation & Amortisation	(6)	(191)	(185)	24,370	14,275	(10,095)
Financing Costs	(2,808)	(2,294)	514	(39,303)	(24,782)	14,521
SURPLUS / (DEFICIT) including donated asset treatment	(2,814)	(2,485)	329	(14,933)	(10,507)	4,426
Donated Asset treatment	(1,018)	(1,271)	(253)	(3,444)	(1,538)	1,906
Impairment of Assets	0	0	-	0	(15,533)	(15,533)
SURPLUS / (DEFICIT)	(3,832)	(3,756)	76	(18,377)	(27,578)	(9,201)

Report to:	Date of meeting
Trust board - Public	6 April 2016

Shaping a Healthier Future Paediatric Service Transition – Letter of Assurance

Executive summary:

Paediatric A&E and Inpatient Services at Ealing Hospital will close on 30th June 2016 as part of the Shaping a Healthier Future (SaHF) Programme. As part of this programme, ICHT has agreed to provide a Paediatric Assessment Unit (PAU) to ensure that ICHT can accommodate increases in A&E attendances (1050) and associated inpatient activity (470 admissions) forecast by SaHF.

As part of the transitional assurance process, Ealing CCG Governing Body has requested a letter from each Trust impacted by the close of Paediatric Services at Ealing which provides positive assurance of operational readiness.

A paper (SaHF Paediatric Transition Update) presented at 15th March 2016 Executive Committee provided detailed plans of the implementation of the PAU at ICHT from June 2016 and requested review and approval of the letter of assurance in April's Trust Board.

The governing body has requested updates and assurance against five domains – Paediatric workforce, Estates, New paediatric models of care, Internal staff communication, and Trust project support. The enclosed letter uses the template provided by the SaHF team, and details the work undertaken by ICHT since the last meeting of the Ealing CCG Governing Body in December, alongside confirmation that the ICHT is operationally ready and supportive of the transition.

The key item to action for the Board is:

- 1) Approve letter of assurance for SaHF to confirm ICHT will be ready for Transition at end of June 2016.

Quality impact:

The intended outcomes of developing a PAU include:

- Providing a more efficient clinical service for patients with self-limiting illness who present to urgent care settings and require a period of observation and assessment
- Reducing in-patient admissions
- Reducing pressure on A&E
- Ensuring patients are treated in a setting appropriate to their condition
- Ensuring patients do not stay in hospital any longer than they need to
- Closer integration between hospitals and paediatric community services, resulting in earlier discharge, seamless on-going care and reduced readmissions

Financial impact:		
The financial impact of the assurance letter is nil. The financial impact of the development of the PAU has no financial impact beyond the A&E redevelopment Business Case presented in January 2016 to the Executive Operations Performance Committee and approved by the Charity.		
Risk impact:		
The main risks of the transition plan were detailed in the SaHF Paediatric Transition Update paper presented at the Executive Committee on 15 th March 2016. A review of risks takes place at fortnightly Ealing Paediatrics Transition Steering Group.		
Recommendation(s) to the Committee:		
The Committee is asked to: 1) Approve the letter of assurance for submission to the Ealing CCG Governing Body		
Trust strategic objectives supported by this paper:		
To achieve excellent patients 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
Victoria Kirby,	Prof TG Teoh	30 March 2016

Chief executive: Dr Tracey Batten
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6th April 2016

Via email: mohini.parmar@nhs.net
Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group
Level 3, Perceval House
14/16 Uxbridge Road
Ealing
W5 2HL

Dear Dr Parmar,

Re: Letter to confirm operational readiness and support from Imperial College Healthcare NHS Trust ahead of the forthcoming meeting of the Ealing Clinical Commissioning Group Governing Body

I am writing to inform the Ealing CCG Governing Body that Imperial College Healthcare NHS Trust (ICHT) is operationally ready and fully supports the proposed transition of paediatric in-patient services from Ealing Hospital on behalf of the Trust Board.

At its meeting in December 2015, I note that Ealing CCG Governing Body confirmed that further work needed to be undertaken regards operational readiness, before the agreed transition date of June 30th 2016, for the closure of Ealing paediatric in-patient services could be confirmed. Following this meeting, we have continued to work as a Trust with clinical and operational colleagues across North West London to ensure we are ready for any decision your Governing Body may make.

We have set out below the work undertaken since your last meeting to support your decision making process and confirm our operational readiness for transition.

Domain	Progress made since last meeting
1 – Paediatric workforce	The recruitment of a permanent workforce for PAU is on-going to ensure the required workforce is in place to staff the PAU co-located with A&E at St Mary's Hospital from December 2016. The Trust is on track to have in place the required workforce for our PAU mitigation plan from June to December 2016.

Chairman: Sir Richard Sykes

2 – Estates	<p>ICHT St Marys ED is undergoing a programme of works which includes provision of a 4 bedded PAU situated within A&E, due to be completed in December 2016.</p> <p>From June to December 2016 a mitigation plan has been developed to host the PAU on the Paediatric Inpatient wards at St Marys. This has been shared with and reviewed by SaHF teams.</p>
3 – New paediatric model of care	<p>ICHT provides a full spectrum of unscheduled care services for children, from GP Hotlines through to specialist A&E provision.</p> <p>1) PAU – Established models of care will be further enhanced with the introduction and build of a dedicated PAU, co-located with A&E on the St Mary’s Site.</p> <p>2) The transition and mobilisation of Vocare as a provider for the UCC at the St Mary’s site.</p> <p>3) Paediatric unscheduled care provision at the Hammersmith Hospital site will be brought in line with RAC models of care to improve sign posting for patients and align with NWL pathways.</p>
4 - Internal staff communications	<p>A programme of staff engagement is planned to maintain involvement of staff across Medicine and Children’s services.</p> <p>Staff are being given the opportunity to fully contribute towards transition plans ensuring they are fully sighted and engaged with the transition.</p> <p>Training to ensure awareness of changes to internal pathways within ICHT and new pathways across NWL will be given to ICHT staff.</p>
5 – Trust project support	<p>Robust project governance and support is in place to ensure the timely delivery of operational plans related to the SaHF transition. A dedicated project manager is in post, and a steering group has been established to provide monitoring and oversight.</p>

Based on the progress we have made and as agreed by the Trust Board, I am writing to you in order to confirm that ICHT is ready for the transition of paediatric in-patient activity from Ealing Hospital.

We will continue to work with the *Shaping a Healthier Future* programme and the Paediatric Project Delivery Board to ensure that all preparatory steps are in place for transition to take place as agreed on 30th June 2016

Yours sincerely

Dr Tracey Batten
Chief Executive

ICHT PAU Mitigation Plan for SaHF Ealing Paediatric Transition for SaHF

Phase	Capacity	Detail
Phase 1 Month 1-5 June 1 st -Nov 1 st 2016	4 beds - GWW	4 PAU beds situated on Great Western Ward (GWW) while winter beds are closed <u>Clinical Model</u> <ul style="list-style-type: none"> • Clear identification of PAU patients by admitting A&E doctors as per agreed SOPs. • Beds to be managed by Children’s medical and nursing team due to co-location on GWW to ensure maximum staffing efficiencies • On-call and weekend cover provided by General Paediatric Consultant team • Only 4 beds can be used for PAU at any one time – if PAU is full – the Paediatric admission from A&E policy will be followed. • 14 Consultant PAs to be used to support senior decision making across PAU, Rapid Referral Clinic and training for General Paediatrics and A&E. • Introduction of ‘Fast Track to Home’ criteria for nurse led discharge to facilitate timely discharge of short stay patients on GWW • Discharge coordinator for Paediatrics to help facilitate discharge of long term paediatric patients improving patient flow <u>Workforce</u> <ul style="list-style-type: none"> • 14 Consultant PAs from June 2016 • 1 nurse per shift to manage PAU patients (5.5WTE) • 1 Band 3 per shift (5.5 WTE) <u>Assurance and Monitoring</u> <ul style="list-style-type: none"> • Clear SOPs for Clinical and operational pathways to be updated or produced • Meets SaHF PAU Service Specification Quality Standards • On-going monitoring of improvements to pathways to measure benefits of PAU on impact of A&E standards and inpatient activity to enable feasibility assessment of Phase 2 plans before implementing. • Monitoring of A&E constitutional standards via normal A&E reporting cycle. • ICHT Quality monitoring systems.
Phase 2 Month 6 Nov 1 st –Nov 30 th 2016	6 beds – 7 th Floor	Open 2 beds on Grand Union ward (GUN). 4 inpatient/surge plan beds on GWW open. This 6 extra beds will accommodate the SaHF modelling requirement of 2.5 beds (0.5 PAU, 2 inpatient beds) for Ealing activity <u>Clinical Model</u> <ul style="list-style-type: none"> • Clinical arrangements as in phase 1 • ICHT Children’s inpatient/surge plan

Phase	Capacity	Detail
		<p><u>Workforce</u></p> <ul style="list-style-type: none"> As phase 1 plus ICHT Children's inpatient/surge plan <p><u>Assurance and Monitoring</u></p> <ul style="list-style-type: none"> As per Phase 1
<p>Phase 3 Month 7 Dec 1st – 22nd Dec 2016</p>	6 beds + 2 escalation beds	<p>GUN beds to provide critical care escalation. 4 inpatient/surge plan beds on GWW open. 2 escalation beds collocated in Westway Ward. This 6 +2 extra beds will accommodate the SaHF modelling requirement of 2.5 beds (0.5 PAU, 2 inpatient beds) for Ealing activity</p> <p><u>Clinical Model</u></p> <ul style="list-style-type: none"> Clinical arrangements as in phase 1 ICHT Children's inpatient/surge plan Critical Care escalation open Escalation beds open in collocated ward <p><u>Workforce</u></p> <ul style="list-style-type: none"> As phase 1 plus ICHT Children's inpatient/surge plan <p><u>Assurance and Monitoring</u></p> <ul style="list-style-type: none"> As per phase 1 RTT to be monitored if Black Escalation Trigger required
<p>Final Phase Dec 22nd- onwards</p>	4 Beds - Paediatric A&E	<p>4 beds Co-located in Paediatric A&E</p> <ul style="list-style-type: none"> Responsibility for management and staffing of PAU returns to Medicine Division

Report to:	Date of meeting
Trust board - public	6 April 2016

Proposal for consolidation of the Stroke and Neuro-Rehabilitation bed base at Charing Cross Hospital

Executive summary:

In September 2015 the Trust's stroke services were successfully co-located onto one site at Charing Cross Hospital, following a formal internal staff consultation process and a wider external engagement process.

The co-location involved moving the St Mary's Hospital stroke unit (based on Grafton ward) to the 9th floor of Charing Cross Hospital to create a fully integrated service on one site. This is an interim model for approximately the next five years, until St Mary's Hospital, the Trust's major acute site, is redeveloped. It was agreed as part of the 2009/10 London-wide stroke service re-organisation that ultimately the Trust should run an integrated stroke service out of St Mary's Hospital so that patients can benefit further from co-location with the major trauma centre there.

The co-location enabled the expected improvements which were set out in the original case for change.

Although the original proposal set out that the total number of inpatient stroke beds would remain unchanged, it has now become evident that since co-location the patient flow through the stroke pathway has had a marked improvement in reducing the average length of stay (LOS) and the repatriation of patients into and out of our stroke unit.

There is an opportunity to consolidate and ring-fence beds for stroke and neuro-rehabilitation services together on the same floor, to build an expert nursing workforce and to provide appropriate specialist facilities for all this group of patients.

Proposal:

The current stroke bed base regularly absorbs admissions from acute medical admissions as they are not required for stroke patients. This often dilutes the core specialist teams especially as they are established by nurse to bed ratio (stroke guidelines for accreditation). Currently there are high nursing vacancies across the three wards which form the stroke unit and Hyper-Acute stroke unit (HASU) requiring regular bank agency cover. Furthermore the retention of medical staff has increasingly come under pressure and gaps are emerging across the medical rota. Overall this situation is inefficient and leads to a loss of specialist focus for the nursing staff.

The Trust won the recent specialist neuro-rehabilitation service tender involving the provision of 16 neuro-rehabilitation beds. These beds are often a destination for our stroke patients. We have considered moving the neuro-rehabilitation service from its current home on 9S ward to Marjorie Warren ward, leaving the space on 9S vacant, but there are concerns about some patients, for example those with long-term tracheostomies, being a considerable distance from the main hospital setting.

This is an opportunity to consolidate and ring-fence beds for stroke and neuro-rehabilitation services together, to build an expert nursing workforce and to provide appropriate specialist service facilities for all this group of patients.

Currently our establishment is:

- 20 beds on 9N/HASU (this can flexed up by three)
- 19 beds on 9W stroke unit ward
- 13 beds on 9S ward for stroke and ten for neuro-rehabilitation

This proposal would open the currently flexible beds permanently on the HASU, increasing the size of the HASU from 20 to 23 beds and increase the capacity on 9W ward by one bed to 20 by moving the TIA clinic out of the ward and into an adjacent area. On 9S ward we would adjust the number of stroke beds from 13 to 6 and increase the neuro-rehabilitation beds from 10 to 16.

Proposed plan:

- Neuro-rehabilitation service remains on 9 South ward and opens to 16 beds;
- Ring fence the whole of the 9th floor to neuro-rehabilitation and stroke patients only;
- Further review of the stroke service after a three month period whilst continuing to engage with medical and nursing staff in the stroke service.

Quality impact:

The service will continue to see the same number of stroke patients on the same wards, but the bed base will be ring fenced and we will have the ability to move the patients more easily into a neuro-rehabilitation phase of therapy. This also means that we do not have to open a completely new ward space away from the main acute hospital setting for neuro-rehabilitation patients.

Financial impact:

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

- Has been reviewed by Matthew Crighton, Finance Business Partner, with the delegated authority of the Chief Financial Officer, and can be fully accommodated within the existing departmental budget this year and into the future assuming deliverable levels of efficiency.

Details of the financials outlined above are on page 7.

Risk impact:

Please refer to the risk log on page 7.

Recommendation:

The Board is asked to note the consolidation and ring-fencing of the stroke and neuro-rehabilitation bed base on the 9th floor at Charing Cross Hospital.

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
Heena Asher, General Manager, Stroke & Neurosciences	Tim Orchard, Divisional Director, Medicine	31 March 2016

Proposal for Consolidation of the Stroke and Neuro-rehabilitation bed base at Charing Cross Hospital

Purpose of the report

This proposal is to consolidate and ring-fence beds for the stroke and neuro-rehabilitation service together on the 9th floor of Charing Cross Hospital, to build an expert nursing workforce and to provide appropriate specialist service facilities for all this group of patients.

Background

In September 2015 the Trust's stroke services were successfully co-located onto one site at Charing Cross Hospital, following a formal internal staff consultation process and a wider external engagement process.

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

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

The co-location involved moving the St Mary's Hospital stroke unit (based on Grafton ward) to the 9th floor of Charing Cross Hospital to create a fully integrated service on one site. This is an interim model for approximately the next five years, until St Mary's Hospital, the Trust's major acute site, is redeveloped. It was agreed as part of the 2009/10 London-wide stroke service re-organisation that ultimately the Trust should run an integrated stroke service out of St Mary's Hospital so that patients can benefit further from co-location with the major trauma centre there.

The co-location enabled the expected improvements which were set out in the original case for change:

- Provide the best outcomes and experience for patients, their families and carers;
- Improve access to therapy services;
- Provide 7-day, 24-hour consultant cover for all our patients, in line with best practice guidelines set out by the Royal College of Physicians;
- Co-locate stroke and neurosurgical services;
- Provide 24 hour availability of MRI scanning service;
- Reduce the average length of stay for all stroke patients;
- Have the best trained stroke specialist teams.

Bed occupancy review and patient data

A recent stroke bed occupancy review demonstrates that up to 30 per cent of inpatient stroke beds are being occupied by other medical specialties and whilst the co-location of the stroke services have improved the average lengths of stay (LOS) across the three wards – one for the hyperacute stroke unit (HASU) and the two stroke units - we have also been able to accept all the Westminster borough patient repatriations to our stroke unit without delay as was frequently experienced when they were based at Grafton ward in St Mary's Hospital. This information is shown in Tables 1 to 3.

No transport issues or concerns have been raised by patients or relatives/visitors from Westminster or other neighbouring boroughs and we continue to monitor the situation for any issues.

LOS data and Occupancy data

Based on 12 month rolling data (Feb 15 – Jan 16)

Table 1: All admissions

All Admissions		Agreed Beds 2009		Beds 15/16		Bed Days		No of Patients			Bed Days			LOS		Flex
Ward	Type	Agreed Beds	Flex	Actual Beds	Flex	Total Bed days available	Total Bed days available (flex)	Grafton Feb-Sep 15	CXH	Total	Grafton Feb-Sep 15	CXH	Total Bed Days	Grafton Feb-Sep 15	CXH	Total Occupancy
Grafton/9S	ASU	14	14	13	13	4745	4795	261	179	440	3021	1632	4653	11.6	9.1	97%
9 W	ASU	20	20	19	19	6935	6935		648	648		5769	5769			83%
9 N	HASU	20	23	20	23	7300	8395			2172		2172	6201	6201		74%
Total		54	57	52	55	18980	20125			3260			16623			85%

Average number of beds used: 45

Table 2: Medical admissions only

Medical Pts		Agreed Beds 2009		Beds 15/16		Bed Days		No of Patients			Bed Days			LOS		Flex
Ward	Type	Agreed Beds	Flex	Actual Beds	Flex	Total Bed days available	Total Bed days available (flex)	Grafton Feb-Sep 15	CXH	Total	Grafton Feb-Sep 15	CXH	Total Bed Days	Grafton Feb-Sep 15	CXH	Total Occupancy
Grafton/9S	ASU	14	14	13	13	4745	4795	90	51	141	613	358	971	6.8	7.0	20%
9 W	ASU	20	19	19	19	6935	6935		173	173		999	999			14%
9 N	HASU	20	23	20	23	7300	8395		577	577		1728	1728		3.1	21%
Total		54	56	52	55	18980	20125			891			3698			18%

Average number of beds used: 10

Table 3: Stroke & Neurology admissions

		Agreed Beds 2009		Beds 15/16		Bed Days		No of Patients			Bed Days			LOS		Flex
Ward	Type	Agreed Beds	Flex	Actual Beds	Flex	Total Bed days available	Total Bed days available (flex)	Grafton Feb-Sep 15	CXH	Total	Grafton Feb-Sep 15	CXH	Total Bed Days	Grafton Feb-Sep 15	CXH	Total Occupancy
Grafton/9S	ASU	14	14	13	13	4745	4795	171	128	299	2414	1275	3689	14.1	9.6	77%
9 W	ASU	20	19	19	19	6935	6935		475	475		4770	4770		10	69%
9 N	HASU	20	23	20	23	7300	8395		1615	1615		4474	4474		2.8	53%
Total		54	56	52	55	18980	20125			2389			12933			64%

Average number of beds used: 35

Proposal

The current stroke bed base regularly absorbs admissions from acute medical admissions as they are not required for stroke patients. This often dilutes the core specialist teams especially as they are established by nurse to bed ratio (stroke guidelines for accreditation). Currently there are high nursing vacancies across the three wards which form the stroke unit and HASU requiring regular bank agency cover. Furthermore the retention of medical staff has increasingly come under pressure and gaps are emerging across the medical rota. Overall this situation is inefficient and leads to a loss of specialist focus for the nursing staff.

The Trust won the recent specialist neuro-rehabilitation service tender involving the provision of 16 neuro-rehabilitation beds. These beds are often a destination for our stroke patients. We have considered moving the neuro-rehabilitation service from its current home on 9S ward to Marjorie Warren ward, leaving the space on 9S vacant, but there are concerns about some patients, for example those with long-term tracheostomies, being a considerable distance from the main hospital setting.

Currently our establishment is:

- 20 beds on 9N/HASU (this can flexed up by three);
- 19 beds on 9W stroke unit ward;
- 13 beds on 9S ward for stroke and 10 for neuro-rehabilitation.

This is an opportunity to consolidate and ring-fence beds for stroke and neuro-rehabilitation services together, to build an expert nursing workforce and to provide appropriate specialist service facilities for all this group of patients.

This proposal would open the currently flexible beds permanently on the HASU, increasing the size of the HASU from 20 to 23 beds and increase the capacity on 9W ward by one bed to 20 by moving the TIA clinic out of the ward and into an adjacent area, expected completion of this area is by the end of April. On 9S ward we would adjust the number of stroke beds from 13 to 6 and increase the neuro-rehabilitation beds from 10 to 16.

The service will continue to see the same number of stroke patients on the same wards, but the bed base will be ring fenced and we will have the ability to move the patients more easily into a neuro-rehabilitation phase of therapy. This also means that we do not have to open a completely new ward space away from the main acute hospital setting for neuro-rehabilitation patients.

Proposed plan:

- Neuro-rehabilitation service remains on 9 South ward and opens to 16 beds
- Ring fence the whole of the 9th floor to neuro-rehabilitation and stroke patients only
- Further review of the stroke service after a three month period whilst continuing to engage with medical and nursing staff in the stroke service.

Proposed Bed configuration

Ward	Service	Stroke bed utilisation	Current Bed Configuration (Stroke only)	Proposed Bed Configuration (Stroke only)	Current Bed Configuration (Total)	Proposed Bed Configuration (Total)
9S	Neuro Rehab	N/A	0	0	10	16
9S	Stroke	77%	13	6	13	6
9W	Stroke	69%	19	20	19	20
9N	Stroke	53%	20	23	20	23
Total		64%	52	49	62	65

Implementation plan and review

Milestones	Apr-16	May-16	Jun-16	Jul-16
Ring Fence 9th Floor Bed Base (9S, 9W, HASU)				
Internal Consultations with Nursing and Medical teams				
Increase Neuro - Rehab to 16 Beds on 9 South				
Flex to 23 Beds on HASU				
TIA Service to transfer to 8W Assessment Hub				
Open 9W to 20 Beds				
Review of Services and Outcome				

The implementation programme will be led by the General Manager for Stroke and Neurosciences, who will report to the Directorate Committee to the Divisional Management Committee. Progress will be reviewed on a weekly basis.

Finance

There would be an approximate saving of £250K related to pay cost in 2016/17 and we will have avoided spending the capital allocation for the refurbishment of Marjorie Warren Ward.

Risks

Risk	Likelihood	Mitigation
Anxiety and disengagement amongst staff on 9S about further change in light of the service consolidation in September 2015	High	Programme of staff engagement sessions and 1:1 meetings in place. Team members will be made aware of trust-wide options for redeployment, although all can be accommodated within the stroke service establishment.
Continuing high nursing vacancies and gaps across the medical rota	Medium	This is a current risk which will be mitigated by the consolidation of services. The focus on building a truly specialist service will improve recruitment and retention.
Concerns from external stakeholders about further change in light of the service consolidation in September 2015	Medium	Initial communication has taken place with the National Clinical Director for Stroke. Wider engagement plan in development.
Insufficient capacity to accommodate demand for stroke beds	Low	Daily monitoring of capacity requirements and formal review of occupancy in July 2016.
Insufficient space to accommodate requirements of Neuro-Rehab	Low	Joint working with clinical, directorate and estates teams.

Recommendation

The Trust board is asked to note the consolidation and ring-fencing of the stroke and neuro-rehabilitation bed base on the 9th floor at Charing Cross Hospital.

Report to:	Date of meeting
Trust board - Public	6 April 2016

CQC Update Report

Executive summary:

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

The Board will recall that a trust-wide Compliance and Improvement Framework has been developed to drive improvement in the quality of care delivered. This framework is based on the 5 CQC domains and underpinned by the CQC regulations. As part of the framework, the third set of core services reviews were carried out in January 2016 and the overall findings are summarised below:

- **Maternity and gynaecology (SMH and QCCH)**
 - Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Good' overall.
- **Neonatal (QCCH)**
 - Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Requires improvement'. A new matron and senior nurse are now in post.
- **Services for children and young people (HH)**
 - Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Requires improvement' overall.

With regards to progress against the CQC action plan, there are currently seven actions which are off track but these are all largely anticipated to be completed by the end of April 2016 and progress towards achieving these are monitored by the Executive Quality Committee on a monthly basis.

Next steps include:

- Review the compliance and improvement framework in light of lessons learnt in 2015/16, and the new CQC strategy when it is published (currently scheduled for May 2016) and set out the work programme and approach for 2016/17.
- Complete implementation of the CQC action plan.

Quality impact:

The report applies to all 5 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(s) to the Committee:

- To note the updates in Parts 1 and 2

Trust strategic objectives supported by this paper:

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

Authors	Date submitted
Priya Rathod, Deputy Director of Quality Governance	24 March 2016

CQC update report

1 Purpose

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

2 Update on the Implementation of the Compliance and Improvement Framework

The Board will recall that a trust-wide Compliance and Improvement Framework has been developed to ensure the Trust is compliant with CQC regulations and to drive improvement in the quality of care delivered. As part of this, the third set of core service reviews for areas rated overall as 'Requires improvement' were carried out in January 2016.

2.1 Maternity and gynaecology at St. Mary's Hospital and QCCH

- Although this core service was rated as 'Good' overall by the CQC, a core service review was undertaken because the CQC published revised key lines of enquiry (KLOEs) in July 2015 for this core service which now includes gynaecology-related surgery, which was previously captured in the Surgery core service.
- Key findings are summarised below:
 - All review team members noted that across the service, staff were exceptionally caring, professional and supportive towards patients.
 - An improvement in midwifery staffing levels was observed as a result of on-going recruitment and the transition from Ealing.
 - Although statutory and mandatory training levels were improving, they were not at the required target at the time of the review.
 - The estates in some areas of gynaecology at SMH were deemed old although no concerns about patient safety were observed.
 - Some capacity issues in relation to gynaecology outpatients and the emergency service at SMH were noted although staff were able to talk about plans in place to address this.
 - Performance against key quality indicators such as falls, infection, complaints etc was observed as being good and swab count audit performance was at 100%.
- Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Good' overall

2.2 Neonatal services at QCCH

- Key findings are summarised below:
 - Progress has been made towards improving learning from incidents and risk management.
 - A Lead Risk and Audit Nurse has been in post since June 2015 to support the area.
 - All staff were clear about managing safe staffing levels in relation to the number of cots available and what process to invoke. However, different versions of the SOP articulating the process were found (although the content in each were very similar).
 - The 'Integrated Family Delivered Care' programme is an example of outstanding practice.
 - The appointment of a Matron and secondment of a senior nurse will positively impact leadership and further drive improvements; however, other recruitment challenges were present.
 - The vision / strategy for the service and improvements to culture in the unit were in their early stages at the time of the review, and not yet embedded.
- Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Requires improvement'.

2.3 Services for children and young people at Hammersmith Hospital (the David Harvey Unit)

- Key findings are summarised below:
 - Incident management in the unit is good and the area was clean and well maintained.
 - Some progress has been made towards review of the operations, effectiveness and responsiveness of the unit although it is acknowledged that a more systematic approach to clinical audit could be implemented
 - The unit carries out a reflective learning session each week where the team come together and use case studies from the unit to improve practice and learn lessons. The review team felt this was a good and innovative approach that is locally owned.
 - Review members spoke with parents at the unit who all praised the staff and the service.
 - A review of the capacity and local population's needs should be carried out to make the service more responsive.
 - It was recognised that the longer term strategy and vision for the unit needs to be considered in light of the demand and capacity of the unit.
- Based on the CQC's current ratings principles, this review provides reasonable assurance at this time that the service could potentially continue to be rated as 'Requires improvement' overall.

2.4 Managing actions from the reviews

- High level feedback has been given to each division following the reviews, and reports have been shared with the areas. Each report includes a set of prioritised recommendations ranging from 'urgent' to 'routine' for the division to action.
- Progress against the actions will be monitored through the Executive Quality Committee.

3 Progress against the CQC action plan

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

CQC 'Must-do Compliance' Actions Overview			
Status of actions	Jan	Feb	Trend
Actions completed on time	36	36	↔
Actions on track	2	2	↔
Actions completed late	15	15	↔
Actions off track	0	0	↔
Actions not completed	2	1*	↔
Total	55	54*	

CQC 'Must-do' Actions Overview			
Status of actions	Jan	Feb	Trend
Actions completed on time	24	24	↔
Actions on track	1	1	↔
Actions completed late	8	8	↔
Actions off track	0	0	↔
Actions not completed	4	4	↔
Total	37	37	

*One action has been absorbed into a trust-wide programme of work

CQC 'Should-do' Actions Overview			
Status of actions	Jan	Feb	Trend
Actions completed on time	14	14	↔
Actions on track	0	0	↔
Actions completed late	5	5	↔
Actions off track	0	0	↔
Actions not completed	2	2	↔
Total	21	21	

- There are currently seven actions which are off track but these are all largely anticipated to be completed by the end of April 2016 and progress towards achieving these are monitored by the Executive Quality Committee on a monthly basis.

4 Having quality conversations

The Board will recall from its meeting in November 2015 that a programme of self-assessments against the 5 CQC domains is underway. These assessments are currently being undertaken at Director and Divisional level with the outcomes being presented to the Executive Committee. It is anticipated that this process will roll-out to directorates over the summer.

5 Next steps

- Review the compliance and improvement framework in light of lessons learnt in 2015/16, and the new CQC strategy when it is published (currently scheduled for May 2016) and set out the work programme and approach for 2016/17.
- Continue with the self-assessments and present the findings from the divisional ones to the Executive Committee in May 2016.
- Roll-out the directorate level self-assessment process over the summer.
- Complete implementation of the CQC action plan.

5 Recommendations:

To note the paper

Report to:	Date of meeting
Trust board - public	6 April 2016

Quality account progress update

Executive summary:

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

The trust's quality strategy 2015-18 is being delivered through the achievement of our quality goals which are supported by specific annual targets. These are set out in our strategy under the five quality domains (safe, effective, caring, responsive and well-led). From 2015 to 2018, our annual quality account reports on progress against the three-year strategy and confirms the priority areas and targets for the following year.

The current targets have been reviewed with internal and external stakeholders as part of a consultation process, and have been amended where appropriate. They are presented in this paper for noting following approval at executive quality committee and board quality committee in March. Delivery of these targets, and the quality strategy goals, in 2016/17 will be supported by a number of improvement programmes which have either already been established or are in the process of being set up.

This paper provides an update on progress with the draft quality account and outlines the quality strategy targets for 2016/17.

Quality impact:

The quality strategy has been designed to increase and sustain the quality of our services for our patients, people and stakeholders. It will be delivered in 2016/17 by the targets and programmes outlined in this report, which support the quality goals. Delivery of the quality strategy will ensure the care we provide is safe, effective, caring, responsive and well-led.

Financial impact:

This paper has no financial impact.

Risk impact:

Risks associated with failure to deliver the quality strategy are outlined in the corporate risk register.

Recommendation to the board:

The board is asked to note the quality strategy targets for 2016/17 and the programmes to support their delivery, which have been reviewed and approved at executive quality committee and board quality committee in March 2016.

They are also asked to note progress with the quality account and next steps described.

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
Clementine Brun, Quality Strategy Implementation Manager	Julian Redhead, Medical Director	30 March 2016

Quality account progress update

Purpose of the paper:

This paper outlines the finalised quality strategy targets, which will be published in the quality account, for noting. It also describes progress with producing the quality account.

Introduction:

The trust's quality account reports on performance against the quality strategy goals and annual targets for 2015/16 and defines the targets for 2016/17.

A period of consultation commenced on 5th January 2016 to define the targets for 2016-17. This included consultation with the executive directors, who were asked to review the current quality strategy targets which sit with them, and with our external stakeholders through the quality steering group (QSG). The initial proposals for changes to the targets were discussed at executive quality committee (ExQu) and board quality committee in February and approved at both committees in March 2016.

Delivery of these targets, and the quality strategy goals, in 2016/17 will be supported by a number of improvement programmes which have either already been established or are in the process of being set up. These programmes will be described in the quality account and progress with them monitored throughout the year through ExQu.

The quality account is currently being drafted. The final document will be presented to the trust board on 25th May for sign off.

Quality Strategy Targets 2016/17:

While there was a recognised need to review some of the existing targets, it was also acknowledged both at the QSG and at ExQu, that we should not be adding additional targets for 2016/17, unless necessary. It was agreed that as we are not expected to deliver on some of our targets, our focus for next year should be on implementing the necessary actions and processes to ensure delivery of our current priorities, and on sustaining performance where it has been achieved in year.

It has therefore been agreed that the majority of our targets will be continued through the coming year, with some minor amendments. We set ourselves purposely challenging targets in 2015/16, some of which have not proved possible to meet; where appropriate these have been amended to be more realistic.

The targets are shown below, under each quality domain. The programmes which will support delivery are also included. These programmes encompass the priority areas put forward by internal and external stakeholders as potential new targets for 2016/17.

Safe

Target	Changes made for 2016/17
We will increase our incident reporting numbers and be within the top quartile of trusts	No
We will have zero never events	No
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist	No
We will have a general vacancy rate of 10% or less	No
We will have a band 2-6 ward vacancy rate of 10% or less	Yes – changed from 5% to 10%
We will maintain the percentage of shifts meeting planned	No

safe staffing levels at 90% for registered nurses and 85% for care staff	
We will ensure we have no avoidable MRSA BSIs and cases of c. difficile attributed to lapse in care	No
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	No
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	No
We will stop non-clinical inter-site transfers of patients out-of-hours without clinical agreement and prevent avoidable harm	Yes – wording change
We will assess at least 95% of all patients for risk of VTE and prevent avoidable death as a consequence	No

We have changed one target related to safe staffing levels, which is that we will aim for a band 2-6 vacancy rate of 10% rather than 5%. We believe that this rate is still challenging, but more achievable given the current pan-London recruitment pressures, which mean that the current vacancy rate for this cohort of staff is at around 17% across London.

We have reworded the transfer target to include clinical agreement prior to transfer to reflect the new Transfer policy which is currently being updated.

The programmes which support delivery of these targets are:

- Safety Improvement Programme
- Hand Hygiene Programme
- Falls Prevention Improvement Project
- Sepsis Bundle roll-out
- Critical Care development programme

Effective

Target	Changes made for 2016/17
We will improve our mortality rates as measured by SHMI to remain in the top five lowest-risk acute trusts	Yes – changed to be in the top 5
We will improve our mortality rates as measured by HSMR to remain in the top five lowest-risk acute trusts	Yes – changed to be in the top 5
We will improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third	No
We will ensure that palliative care is accurately coded	Yes – changed from being below national average
We will ensure mortality reviews are carried out in all cases	Yes – wording change
We will increase PROMs participation rates to 80% with reported health gain above the national average	No
We will reduce the number of out of ICU/ED cardiac arrests	TBC – a specific target will be set for this once year end position has been reviewed
We will discharge at least 35% of our patients on relevant pathways before noon	No

We will ensure that 100% of clinical trials recruit their first patient within 70 days.	Yes – changed to 100% from 70%
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We have changed the following targets:

- Mortality rates: we have changed our targets for SHMI and HSMR from being the lowest-risk acute trust, to remaining in the top five. Our focus will be on maintaining our low mortality rates in 2016/17, with the aim of reducing avoidable mortality.
- Palliative Care Coding: In 2015/16 we aimed to be below national average, however we believe a better marker is to ensure that we are accurately coding palliative care coding instead as this will provide assurance that our mortality performance is relevant and accurate.
- Recruitment to clinical trials: We achieved the target of 70% in 2015/16, and therefore propose to change it to 100% - this is challenging, but achievable.

A specific target will be set for reducing the number of out of ICU/ED cardiac arrests in 2016/17 once year end position has been reviewed.

The programmes which support delivery of these targets are:

- Clinical audit programme
- Clinical guidelines programme
- Mortality review programme
- Discharge improvement programme
- Peer review programme

Caring

Target	Changes made for 2016/17
We will achieve and maintain a FFT response rate of 30% in inpatient departments	Yes – changed to 30% from 40% to reflect the revised targets set by the CCG
We will achieve and maintain a FFT response rate of 20% in A&E	No
We will improve our national cancer survey scores year-on-year	No
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	No
We will increase our responsiveness to complaints by responding to 95% within the timeframe agreed by the patient	Yes – changed to 95% from 100% to reflect the revised targets set by the CCG

Two targets (inpatient FFT response rate and responsiveness to complaints) have been changed to reflect the revised quality targets set by the commissioners.

We have removed two caring targets which were included in 2015/16. One of these was to reduce the overall number of complaints received, which we will achieve based on current

performance. We will continue to review the number of complaints; however reducing them will not be a target in 2016/17. It is also important to encourage patients to complain when they have cause. A reduced number of complaints is not necessarily a marker of quality.

An additional target from 2015/16 which has been removed is the development of a dataset that enables monitoring of protected patient characteristics against patient experience measures. This was implemented in 2015/16 and outcomes are reported to ExQu in the quality report. This feedback will continue to be reviewed and improvements made where necessary, but it will not be a target this year.

The programmes which support delivery of these targets are:

- Safeguarding programme
- Volunteer development programme (supported by the Charity)
- Complaints and PALS
- Nursing and midwifery education programme

Responsive

Target	Changes made for 2016/17
We will reduce the unplanned readmission rates for under 15s and be below the national average	No
We will reduce the unplanned readmission rates for over 15s and be below the national average	No
We will have no inpatients waiting over 52 weeks for elective surgery, reduce the number of patients waiting over 40 weeks, and ensure a clinical validation process is in place for each patient who waits over 18 weeks	Yes – included an element to reduce the number of patients waiting 40 weeks
We will reduce the proportion of appointments cancelled by the trust with less than 6 weeks' notice to 5%	Yes – changed from reduce proportion of clinics cancelled
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	Yes – new target
We will reduce the proportion patients who do not attend appointments to 10%	Yes – new target
We will reduce the proportion of patients who wait more than 45 minutes past their allotted appointment time	Yes – new target
We will improve our PLACE scores annually to be in the top 25% nationally where possible	No

All of the outpatient targets have been changed to reflect the priorities of the outpatient improvement programme and ensure we can measure and monitor performance throughout the year. Three targets are therefore new, and relate to improving referral to appointment time, reducing DNAs and reducing waiting times. These replace availability of medical notes prior to clinic, reducing delays due to late arrival of doctors, and improving outpatient letter turnaround time, which we were unable to measure throughout 2015/16. These three areas will continue to be improved as part of the programme although they will not be targets in 2015/16.

We have changed two of the Responsive targets, for the reasons described below.

- Patients waiting for surgery: In 2015/16 we set up a process of on-going review of patients on the waiting list to ensure they were not coming to harm. This process will be further improved in 2016/17. The focus will also continue to be on ensuring a viable operational plan is in place for each patient to reduce further waiting. To ensure this is occurring effectively, an additional step will be added to the target to have no patients waiting over 52 weeks, which is to reduce the number of patients waiting over 40 weeks.
- Cancellation of outpatient appointments: this has been changed to specify the timeframe (within 6 weeks) and a specific target has been defined (5%). 6 weeks is the time limit after which clinics should not be cancelled for reasons such as consultant leave, and when it is likely to cause more inconvenience to patients.

The programmes which support delivery of these targets are:

- Patient transport programme
- Cerner and electronic communications programme
- Clinical Strategy Implementation Programme
- Outpatient Improvement Programme
- RTT review process
- Integrated Care Service
- Patient Services Centre
- 7 day services programme

Well-led

Target	Changes made for 2016/17
We will achieve a voluntary turnover rate of 10%	Yes – changed from 9.50% to 10%
We will reduce our sickness absence rate to 3.10%	Yes – changed from 3.40% to 3.10%
We will have trained departmental safety co-ordinators in 90% of specialties	No
We will achieve a performance development review rate of 95%	No
We will achieve a non-training grade doctor appraisal rate of 95%	No
We will achieve compliance of 90% with core skills training	Yes – changed to 90% from 95% in 2015/16
We will re-run our ward accreditation programme with evidence of documented rapid improvements where issues arise	Yes – programme was launched in 2015/16, target is to re-run the programme
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	No
We will increase the overall number of green flags in the	No

GMC's national trainee survey	
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	No
Target related to patient and public engagement and involvement strategy – TBC	Yes – new target currently being defined

Several of the well-led targets have been changed for 2016/17:

- **Ward accreditation:** This programme was implemented in 2015/16 and is a valuable tool in driving quality improvement and ensuring consistent levels of care across our wards. We will re-run this programme in 2016/17 and report the outcomes in the quality account.
- **Voluntary turnover:** In 2015/16 the target was 9.50%, we have changed this to 10% for 2016/17. This is because voluntary turnover in the trust has been under-reported due to nursing and midwifery leavers remaining on the bank through the same employee number. Current reported turnover is at 11% but nearer to 13% when adjusted for bank retainers. The average across London is 11.63% and 12.96% for acute teaching trusts across England. A revised target of 10% provides challenge and focus for retaining and developing our staff.
- **Sickness absence:** We met our target of 3.40% in 2015/16 so have set ourselves a new aim of 3.10% for 2016/17. We believe this is a challenging, but achievable target. For comparison, the current reported sickness absence rate for London is 3.50%, and it is 3.97% for acute teaching trusts across England.
- **Core skills training:** Our goal in 2015/16 was to achieve 95% compliance, which we did not achieve. For 2016/17, we propose to change the target to 90%. This new target will take into account that approximately 4.5% of all staff are on long-term absence at any one time (for example, maternity leave), and it will also allow a window of 2 months for new starters to complete their core training once they commence employment.

The programmes which support delivery of these targets are:

- Quality Improvement Programme
- People & Organisational Development Strategy
- Patient & Public Engagement and Involvement Strategy
- Ward Accreditation Programme
- Communications Programme
- Education Transformation Programme

Quality account progress

The draft quality account will be reviewed at ExQu on 5th April and board quality committee on 13th April. It is being developed using the Department of Health Quality Account toolkit and complies with the mandatory requirements, in the following structure:

Part 1: statement from the Chief Executive

Part 2: priorities for improvement in 2016/17 and mandatory statements relating to quality

Part 3: review of our quality performance in 2015/16 and statements from stakeholders

It is being drafted using papers, proposals and reports presented throughout the year to

board and committee meetings as well as input from the divisions, the responsible executive directors and their teams.

As part of the process, the Trust is required to seek engagement from internal and external stakeholders; this has already commenced through the Quality Steering Group who have helped define the targets for 2016/17.

In addition, we are required to offer our commissioners, Healthwatch and the local Overview & Scrutiny Committees the opportunity to comment on the draft report. Following presentation at quality committee in April, the draft will be circulated to these external stakeholders and comments collated. Where appropriate, any additions or changes requested as part of this process will be included in the document.

Our external stakeholders are also invited to provide a formal statement ahead of publication. These will be sought in May 2016 and will be inserted in the document prior to publication.

The quality account will be subjected to both internal and external auditing, with the external auditors' statement also included in the published document.

The timetable for completion of the quality account is as follows:

Table A: Quality Account Timetable

Date	Milestone	Action
5th April 2016	Executive Quality Committee	Second draft for review
13 th April 2016	Quality Committee	Second draft for review
19 th April 2016	QSG Meeting	Review of draft with external stakeholders
20 th April 2016	Audit, Risk & Governance Committee	Third draft for review
27th April 2016	CQG Meeting	Draft reviewed at CQG
3rd May 2016	Executive Quality Committee	Presentation of final document for approval (some external stakeholder comments may be outstanding)
11 th May	Quality Committee	Presentation of final document for approval
25th May 2016	Audit, Risk & Governance Committee	Presentation of final document for sign off
25th May 2016	Trust Board	Presentation of final document for sign off
25 th May 2016	Document circulated for stakeholder statements	Final document circulated to stakeholders for their statements to be formulated
26th May 2016	CQG Meeting	Presentation of final document for noting
1 st June 2016	Final internal sign off	CEO and Chairman sign final document on behalf of the board
22 nd June 2016	Stakeholder statements returned	Stakeholder statements incorporated into the

		document
27 th June 2016	Final sign off by external audit	External audit sign off and statement incorporated into the document
30 th June 2016	Publication	Publication of QA on NHS Choices website

Along with the annual report, the quality account will be designed professionally and will include graphics and images to make it more user-friendly.

Recommendation to the Trust board:

The Trust board is asked to note the quality strategy targets for 2016/17 and the programmes to support their delivery, which have been reviewed and approved at executive quality committee and board quality committee in March 2016.

They are also asked to note progress with the quality account and next steps described.

Report to: **Trust board**
Report from: **Audit, Risk & Governance Committee (16 March 2016)**

KEY ITEMS TO NOTE

External audit: An outline of the approach to the audit was provided, and confirmed that the required changes to the accounts related to structure rather than content.

Internal audit: The Committee noted the differing views between internal audit and Trust management as to the appropriate level of assurance provided from the financial reporting and budgetary control audit; learning suggests that audit must be clearly specified.

The 2016/17 internal audit and counter-fraud plans were approved.

A robust management plan was presented which addressed issues identified in an audit of the occupational health services.

Operational targets: The Committee, noting that accountability for operational targets would rest with the individual divisional directors in 2016/17, received a presentation detailing the proposed trajectories for achievement for each of the national targets.

Urgent care centre: Following the commissioner's decision to award the UCC contract to Vocare from April 2016, the Committee noted the progress made in addressing issues raised in relation to the transfer of the management and operational arrangements.

Risk mitigation of deferred capital schemes: The Committee welcomed a report on the way in which the risk of deferring capital schemes was being addressed, noting both the improved capital allocation to address key risks and the strengthened operational arrangements to ensure appropriate mitigation.

Nurse resourcing: The Committee received a report on the continued attention being paid to nurse recruitment, and noted the focus now being paid to improving retention.

Corporate Risk Register

The Committee reviewed the corporate risk register, noting the further changes to be made as a result of recent actions.

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: 20 April 2016

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Wednesday 2 December 2015
10.00am – 12.30pm
Clarence Wing Boardroom
St Mary's Hospital

Present (part I & II):	
Sir Gerald Acher (Chair)	Non-Executive Director
Prof Sir Anthony Newman Taylor	Non-Executive Director
Dr Andreas Raffel	Non-Executive Director (item 1 until part of 3.2)
In attendance (part I) and present (part II):	
Richard Alexander	Chief Financial Officer
Dr Tracey Batten	Chief Executive
Steve McManus	Chief Operating Officer
Prof Janice Sigsworth	Director of Nursing (part of item 4.2 to 7)
In attendance:	
Jan Aps	Trust Company Secretary
Paul Grady	Director, TIAA
Kevin Jarrold	Chief Information officer
Dr Helgi Johannsson	Chief of Service, theatres and anaesthetics (item 5.3 only)
Philip Lazenby	Director of Audit, TIAA
Martin Lerner	Divisional Director of Operations, Surgery, Cancer, Cardiovascular Division (item 5.3 only)
Leigh Lloyd-Thomas	Partner / Public Sector Assurance, BDO LLP
Chris O'Boyle	Interim Director of Strategy and Development
Dr William Oldfield	Deputy Medical Director on behalf of Prof Chris Harrison
Arti Patel	Senior Counter Fraud Specialist
Priya Rathod	Deputy Director of Quality Governance on behalf of Prof Janice Sigsworth
Ian Sharp	Executive Director, TIAA
Dawn Sullivan	Associate Director of HR Operations and Resourcing (item 2.1 – 3.2)
Tracy Walsh	Committee Clerk (minutes)

1	GENERAL BUSINESS	Action
1.1	Chair's opening remarks and apologies for absence The Chair welcomed everyone to the meeting. Apologies for absence had been received from Prof Chris Harrison and Sarika Patel.	
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 7 October 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: <ul style="list-style-type: none"> • Overseas patients – a detailed implementation plan including a timetable would be provided to the Committee meeting in March. • Outpatient improvement programme – The 'caring matters' customer service 	RA

	<p>training was being implemented. Steve McManus reported that by April all outpatients should be receiving texts reminding them of their appointment, a patient's medical history should be available electronically through Cerner and environmental works should have started.</p> <ul style="list-style-type: none"> • RIS/PACS – the full business case had been approved by the TDA. The go-live date with the new provider was on track for late May. The Trust remained in regular contact with GE Healthcare, and there had been a noticeable improvement in performance. • Cerner - Transition from the BT data centre to the Cerner data centre had been successfully completed; the implementation budget had been reduced from £3m to £2m. Clinical documentation had been implemented in approximately half the trust; full implementation would be completed by the end of March 2016. A report on efficiencies would be provided to the Executive Committee, and then the Finance and Investment Committee in May 2016. <p>The Committee noted that arrangements were being progressed to extend the internal audit contract by one year.</p>	KJ
PART I AUDIT		
2	EXTERNAL AUDIT BUSINESS	
2.1	<p>Outline Risk Assessment report</p> <p>Leigh Lloyd-Thomas presented the paper. He reported that whilst there was an underlying presumption that NHS Trusts were 'going concern organisations', where an individual trust would require external support which had yet to receive approval (usually via an agreed recovery plan), this would be referred to in the auditor's report as an 'emphasis of matter'. He also commented that, given the scale of issues in a number of other acute trusts, the TDA may not consider the Trust's recovery plan required formal sign off. Richard Alexander reported that, on the current run rate (which the executive had committee to improve), the Trust had sufficient cash reserves to September 2016. Mr Lloyd-Thomas reported that should external funding be withdrawn from a trust, outstanding supplier debts would be secured by the Department of Health.</p> <p>Mr Lloyd-Thomas noted that the alternative site valuation for land and buildings would need to be reviewed on a regular basis to ensure that the alternative site remained a viable option. He also reported that BDO LLP had received a request from the TDA to review the accounting for North West London Pathology.</p> <p>The Committee noted the areas the external auditors considered risks and requested that BDO review the rating for quality of care 'Management override' and 'Data quality'.</p>	LLT
2.2	<p>External audit progress report</p> <p>Mr Lloyd-Thomas would provide BDO's view on whether the Trust should report full or summarised accounts.</p> <p>The Committee noted progress against the external audit for 2015/16.</p>	LLT
3	INTERNAL AUDIT BUSINESS	
3.1	<p>Internal audit and counter fraud progress report</p> <p>Richard Alexander presented the paper from TIAA noting that two planned audits would be rescheduled, 'Seven day working' and 'Health and Safety arrangements'. In response to a question from Prof Tony Newman Taylor, Philip Lazenby reported that the medical education audit would commence by end of 2015; Prof Tony Newman Taylor requested assurance that this area did not pose the same risk as it had two years previously.</p> <p>The Committee noted the internal audit progress report and the counter fraud report and approved the Counter Fraud policy and Illegal worker protocol.</p>	RA/ PL

3.2	<p>Resourcing function</p> <p>Dawn Sullivan presented the paper noting it was in response to two key issues in the audit of the resourcing function carried out between February and April. Ms Sullivan particularly highlighted:</p> <ul style="list-style-type: none"> • At the end of October the vacancy rate for band 2-6 ward based nursing roles was 14.62% (compared to 12% at Guy's and St Thomas' NHS Foundation Trust) • The reason most cited for people leaving the Trust was lack of development and promotion prospects • The ratio of external to internal appointments was 70:30 (the majority of other trusts had a reverse ratio to this). <p>In response to a question from Sir Gerry Acher, Mr McManus reported that work was being done based on the Trust's values and behaviours to engage line managers in developing junior staff, to improve retention and reduce the need for recruitment. Noting Prof Tony Newman Taylor's query relating to rolling recruitment, Prof Janice Sigsworth reported that this was in place in a number of areas, and was being expanded where appropriate.</p> <p>Ms Sullivan reported that on average it took ten weeks from when the advert was placed to the candidate being in post. The Executive Committee had approved for a minimum of six months additional resources to improve the time it takes to recruit. The ERAF process (how the Trust agreed whether a vacancy can be recruited to), would be reviewed in 2016 to establish whether the current process was impacting on the time to hire.</p> <p>Dr Batten highlighted the hard work of the Resourcing team and the improvement that had been made in a relatively short period of time.</p> <p>The Chairman reported that a private meeting between non-executive directors and both internal and external auditors had been held immediately prior to this meeting. Whilst there was nothing to report to the committee on the auditors agenda, he mentioned that he had raised his concerns regarding quality of data and quality of forecasting and requested both auditors to be particularly vigilant in these areas.</p> <p>The Committee noted the report and requested that a brief summary be provided to the next Committee meeting in March detailing incentives for staff retention and training opportunities.</p>	DW/DS
4	FINANCIAL & OTHER BUSINESS	
4.1	<p>Tender waivers report Q2</p> <p>Richard Alexander presented the paper noting that the refurbishment of 9 South ward had undergone competitive tendering and after a full evaluation had proceeded with the lowest bid.</p> <p>The Committee noted the report.</p>	
4.2	<p>Losses and special payments register Q2</p> <p>Richard Alexander tabled an amended register noting that the main reason for the increase in Q2 to £495k from £316k in Q1 had been an increase in non-payment by overseas visitors and write-offs of pharmacy stock.</p> <p>In relation to overseas visitors, more robust arrangements were required to enable a 'treat and transfer' approach; the Committee acknowledged how difficult this could be to action clinically. Changes in national arrangements should improve payments for these cases. Prof Chris Harrison was asked to review the seven highest write off cases and consider whether there had been an opportunity in the clinical pathways for the patients to be discharged earlier.</p> <p>The Committee noted the register.</p>	CH

Report to: **Trust board**
Report from: **Quality Committee (10 February & 9 March 2016)**

KEY ITEMS TO NOTE

Divisional Director's risk register update

The Committee reviewed the divisional risks:

- Divisional directors reported much improved engagement in surgical checklists, brought about by the enhanced training following the recent 'never events'.
- Risks relating to the transfer of the urgent care contract at St Mary's to Vocare were being robustly addressed.
- A comprehensive action plan had been put in place following identification of risks relating to ionising radiation.
- Risks identified relating to leadership roles across divisions were reducing with recruitment of relevant staff.
- The risk profile in women's and children's and investigative science divisions was reducing following significant commitment to equipment replacement.

Quality report

The Committee noted that analysis of palliative care coding, an area where the Trust was an outlier, had not identified any clinical risk. An electronic tool was being introduced to codify the way in which mortality was reviewed; this would enable compliance with the mortality reporting policy and address concerns raised by the CQC.

Improving the quality of care – CQC update report

The Trust continued to be registered at all sites without any conditions. The committee welcomed to continuing programme of core service and in-depth reviews, noting that directorates were being encouraged to complete these themselves; progress would be provided to the Committee in May. The CQC action plan was now considered to be 87% complete, with outstanding areas being those which required Trust-wide engagement. Each of these were now the subject of Trust-wide groups chaired by a divisional director.

The Committee received an informative presentation from a doctor in training who had worked closely with the CQC during development of the inspection regime; her feedback would be included in future approaches to preparing for inspection.

Nursing staff

The Committee noted that the Trust was compliant with all national guidance relating to safe staffing. However, nurse recruitment remained a concern for the Trust, as it was nationally. The Committee noted that the audit, risk and governance committee were also reviewing the actions being taken to address nurse recruitment and retention.

The Committee also noted that progress was being made in implementing the revalidation plan for nurses and midwives.

Fire and health and safety report

The Committee noted the good progress which had been achieved across fire safety and assurance during the previous year, and towards achieving full compliance with fire safety legislation. Health and safety key risks related to verbal and physical violence, and to slips, trips and falls; actions plans were being developed to address these.

Medical education report

The Committee welcomed the positive feedback received following the medical education quality visit led by Health Education North West London, which noted the considerable progress made against outstanding actions, and confirmed the reintroduction of neurosurgery training from April 2016.

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: 13 April 2016

Report to: **Trust board**
Report from: **Finance & Investment Committee (23 March)**

KEY ITEMS TO NOTE

Business plan 2016/17

The Committee received a comprehensive report in relation to the proposed business plan submission. The position reached in relation to cost improvement plans (CIPs) and cost pressures was acknowledged; and the remaining significant gap was noted. In the following discussion, the Committee concurred with management's view that it would not be possible for the Trust to achieve a financial position that would enable receipt of the sustainability funding.

The final plan would be presented to the private session of the Board prior to submission and at the public Board in May.

The Committee supported the Trust's expression of interest in the NHS Improvement financial improvement programme.

Capital plan 2016/17

The Committee approved the capital plan for 2016/17, noting the significant contribution from the Charity in achieving Trust plans, and the small contingency held for in-year priorities.

Finance Month 11 report

The Committee noted the in-month improvement (£0.08m favourable to plan) and the year to date position, a deficit of £27.58m (£18.4m worse than plan), which was driven particularly by NHS income being behind plan, and higher than expected fines and challenges.

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: 18 May 2016

Report to: **Trust board**
Report from: **Redevelopment committee report (24 February & 23 March 2016)**

KEY ITEMS TO NOTE

The Committee noted that Sellar (the developer of the Post Office site adjacent to the St Mary's site) had withdrawn its planning application, due to concerns (not by the Trust) expressed to the Westminster planning office.

Sellar had been advised to engage with the Trust in discussing further options for development, and are understood to be considering a shorter tower; these discussions continue. The Trust's advisors continue to consider the most effective way in which the St Mary's site could be redeveloped, including the possibility of releasing surplus land for sale to partially offset the cost of the development.

The contract for lead advisors had been extended to allow completion of the current work programme.

The Trust's senior team had met with NHS Improvement and NHS England to discuss a possible option of progressing with early development plans for St Mary's prior to the full approval of the Shaping a Healthier Future (SaFH) business case.

RECOMMENDATION:

The Trust board is requested to:

- Note the report

Report from: Sir Richard Sykes

Report author: Jan Aps, Trust Company Secretary

Next meeting: 27 April 2016