Imperial College Healthcare NHS
NHS Trust

**TRUST BOARD MEETING AGENDA MEETING IN PUBLIC**
**10.00am – 12.00pm**
**Wednesday 27 November 2013**
Clarence Wing Board Room,
St Mary's Hospital.
London, W2 1NY

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| **1** | **General Business** | | | |
| | | **Paper** | **Presenter** | **Time (minutes)** |
| 1.1 | Chairman's Opening Remarks | **Oral** | Chairman | 1 |
| 1.2 | Apologies | **Oral** | Chairman | 1 |
| 1.3 | Board Members' Declarations of Interest and Conflicts of Interest<br>*To note the attached summary of declarations of interest and to declare any conflicts of interests at the meeting.* | **1** | Chairman | 1 |
| 1.4 | Minutes of the meeting held on 25 September 2013 | **2** | Chairman | 2 |
| 1.5 | Matters Arising and Action Log | **3** | Chairman | 2 |
| 1.6 | Chief Executive's Report | **4** | Chief Executive | 15 |
| **2** | **Quality and Safety** | | | |
| 2.1 | Director of Nursing's Report | **5** | Director of Nursing | 10 |
| 2.2 | Medical Director's Report | **6** | Medical Director | 10 |
| 2.3 | Infection Prevention and Control Report | **7** | Director of Infection Prevention & Control | 5 |
| **3** | **Performance** | | | |
| 3.1 | Executive Performance Report Month 7 2013/14 | **8** | Chief Operating Officer | 10 |
| 3.2 | Winter Planning Presentation | **9** | Chief Operating Officer/ Exec Team | 10 |
| 3.3 | Finance Report<br>• A. 2013/14 Month 7 Report | **10** | Chief Financial Officer | 15 |
| 3.4 | Director of People and Organisational Development's Report | **11** | Director of People & Organisational Development | 10 |
| 3.5 | Director of Governance and Assurance's Report<br>• CQC registration application for the regulated activity Management of Blood | **12** | Director of Governance & Assurance | 10 |
| 3.6 | NHS Trust Development Authority Self-Certifications:<br>• August Compliance | **13**<br>**13A** | Chief Financial Officer | 4 |

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| | • August Board Statement<br>• September Compliance<br>• September Board Statement | **13B**<br>**13C**<br>**13D** | | |
| **4** | **Strategy** | | | |
| 4.1 | Director of Research Report | **14** | Director of Research | 10 |
| 4.2 | Non-Executive Directors' Operational Visits | **15** | Director of Governance and Assurance | 10 |
| **5** | **Papers for information** | | | |
| 5.1 | Finance & Investment Committee<br>• Report of meeting on 21 November 2013 and<br>• Committee Terms of Reference for approval. | **Oral**<br>**16** | Sarika Patel | 2 |
| 5.2 | Foundation Trust Programme Board<br>• Report of meetings on 22 October and 19 November 2013<br>• FT Membership Strategy for approval<br>• FTPB Terms of Reference for approval. | **Oral**<br>**17**<br>**18** | Dr Rodney Eastwood | 2 |
| 5.3 | Quality Committee<br>• Report of meetings held on 8 October and 13 November 2013 and<br>• Committee Terms of Reference for approval. | **Oral**<br>**19** | Sir Anthony Newman-Taylor | 2 |
| 5.4 | Audit, Risk and Governance Committee<br>• Committee Terms of Reference for approval | **20** | Sir Gerald Acher | 2 |
| **6** | **Any Other Business** | | | |
| | | **Oral** | Chairman | 2 |
| **7** | **Date of Next Meeting:** | | | |
| **Trust Board Meeting in Public:** Wednesday 29 January 2014, 10am – 12pm, Maple & Ash Suite, W12 Conference Centre, Hammersmith Hospital, London W12 0HS | | | | |
| **8** | **Questions from the Public relating to Agenda Items** | | | |
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| **9** | **Exclusion of the Press and the Public** | | | |
| 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960 | | | | |

Imperial College Healthcare NHS
NHS Trust

**Report Title:** Declarations of Board Members' Interests

**To be presented by:** Stephen Guile, Head of Corporate Services and Trust Secretary

**Executive Summary**: The Department of Health's "Code of Conduct and Accountability" requires that the Chairman and Board members should declare any conflict of interest that arises.

To comply with this requirement a note of all Declarations made by the Board will be taken to each Public Board meeting as a formal record and is attached as Appendix A.

A full register of all Declarations made by all staff, including the Board, will continue to be kept in accordance with the requirements of the Register of Interests Policy.

The relevant extract relating to Declarations of Interests from the Standing Orders is attached as Appendix B.

Action: <u>For noting</u>

**Board Members' Register of interests – September 2013** **Appendix A**

**Sir Richard Sykes** Chairman

- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Member, Bristol Advisory Council since 2006
- President, British Medical and Dental Students' Trust since 2009
- President, Institute for Employment Studies since 2008
- Chairman, Careers Research Advisory Centre since 2008
- Non-Executive Chairman of NetScientific
- Non-Executive Director of ContraFect since 2012
- Chairman of Royal Institution of Great Britain

**Sir Thomas Legg** Senior Independent Director

- Imperial College Healthcare Trust Charity Trustee

**Sir Gerald Acher** Non-Executive Director

- Deputy Chairman of Camelot Group PLC
- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Vice Chairman of RSA Academy

**Dr Rodney Eastwood** Non-Executive Director

- Rector's Envoy, Imperial College
- Governor, Chelsea Academy [Secondary school]
- Consultant, Mazars

**Jeremy M Isaacs** Non-Executive Director

- JRJ Group Limited – Director
- JRJ Jersey Limited - Director
- JRJ Investments Limited – Director
- JRJ Team General Partner Limited - Director
- JRJ Ventures LLP – Partner
- JRJ Partner 1 LP – Partner
- JRJ Partner 2 LP – Limited Partner
- JRJ Carry LP – Partner
- Marex Spectron Group Limited – Director/NED Chairman
- Member, Bridges Ventures Advisory Board (Privately owned Venture Capital Company with a social mission)
- Kytos Limited - Director
- Trustee, Noah's Ark Children's Hospice

**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
- Trustee, CORDA, Preventing Heart Disease and Stroke

- Rector's Envoy for Health, Imperial College
- Head of Research and Development, National Heart and Lung institute (NHLI)

**Sarika Patel** Non-Executive Director
- Board – Centrepoint
- Board – Royal Institution of Great Britain
- Partner – Zeus Capital
- Board – London General Surgery
- Board – 2020 Imaging Ltd

**Dr Andreas Raffel** Designate Non-Executive Director
- Executive Vice Chairman at Rothschild
- Member of council of Canfield University
- Trustee of the charity Beyond Food Foundation

**Professor Nick Cheshire** Chief Executive
- Hansen Medical: Scientific advisory board Member (Endovascular Robotics programme)
- Hansen Medical: Dept level research support.
- McKinsey Company. Member of Medical Directors Advisory Group
- Medtronic Inc: Scientific Advisory Board Member (Branch AAA stent programme), Institution level grant support. .
- Veryan Medical (IC spin out) Shareholder (0.5%)
- NICE: Member of TOPIC Selection Committee
- Cook (UK) Speakers Bureau
- Member, Organising Committee of the Multidisciplinary European Endovascular Therapies Conference (MEET) Rome, Italy
- Member, Scientific Advisory Committee of the Controversies and Updates in Vascular Surgery (CACVS) conference Paris France
- Organiser & speaker, Medtronic University course
- Gore Company - Consulting agreement for advanced endovascular therapies

*Cook, Medtronic and Gore are endovascular equipment suppliers to the Trust*
*Hansen Medical manufactures the only commercially available endovascular robot and supplies hardware and disposable robotic equipment to the trust.*

**Bill Shields** Chief Executive
- Honorary Colonel, 243 (Wessex) TA Field Hospital:
- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Member, Group Board, CIPFA;
- Vice Chairman, Audit Committee, CIPFA
- Board member, NHS Shared Business Services

**Dr Chris Harrison** Medical Director
TBC

**Mr Steve McManus** Chief Operating
- Chair – National Neurosciences Managers Forum
- Chair of Governors – Tackley Primary School

**Professor Janice Sigsworth** Director of Nursing

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

**Marcus Thorman** Director of Finance
Nil

**Extract from Standing Orders** **Appendix B**

**7.1.2 Interests which are relevant and material**

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
d) A position of authority in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services;
f) Research funding/grants that may be received by an individual or their department;
g) Interests in pooled funds that are under separate management.
h) Funding received from a third party, excluding Imperial College London, for a staff member.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

Imperial College Healthcare NHS
NHS Trust

# MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

**Wednesday 25 September 2013**

**Charing Cross Hospital New Boardroom,**
**Fulham Palace Road, London, W6 8RF**

| **Present:** | |
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| Sir Richard Sykes | Chairman |
| Sir Thomas Legg | Senior Independent Director |
| Sir Gerald Acher | Non-Executive Director |
| Dr Rodney Eastwood | Non-Executive Director |
| Jeremy Isaacs | Non-Executive Director |
| Prof Sir Anthony Newman-Taylor | Non-Executive Director |
| Sarika Patel | Non-Executive Director |
| Andreas Raffel | Designate Non-Executive Director |
| Prof Nick Cheshire | Medical Director |
| Steve McManus | Chief Operating Officer |
| Bill Shields | Chief Financial Officer |
| Prof Janice Sigsworth | Director of Nursing |
| **In attendance:** | |
| **John Ahearne** | Trust Committee Clerk (Interim) (Minutes) |
| Stephen Guile | Head of Corporate Services & Trust Secretary |
| Prof Alison Holmes | Director of Infection Prevention and Control *(for item 2.4)* |
| Prof Dermot Kelleher | Principal of the Faculty of Medicine of Imperial College. |
| Cheryl Plumridge | Director of Governance and Assurance |

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| **1** | **General Business** |
| **1.1** | **Chairman's Opening Remarks** |
| | The Chairman welcomed Board members, staff and members of the public to the meeting. The Chairman noted that the Trust's Annual General Meeting was due to be held at 6 pm that day, in the Great Hall, The Shenfield Building, Imperial College, London SW. |
| **1.2** | **Apologies for Absence** |
| | Mark Davies, Chief Executive. Jayne Mee, Director of People and Organisational Development. |
| **1.3** | **Board Members' Declarations of Interest and Conflicts of Interest** |
| | There were no conflicts of interests declared at the meeting. |
| **1.4** | **Minutes of the Meeting held on 24 July 2013** |
| | The minutes of the meeting held on 24 July 2013 were agreed as a true record, subject to recording Dr Andreas Raffel as present. |

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| **1.5** | **Matters Arising and Action Log** |
| **1.5.1** | The Board noted the updates to actions in the log. Updates were discussed where necessary during the meeting. |
| **1.5.2** | *24 July 2013 Minute 1.6.3 action*: Sir Richard Sykes clarified that the Trust Board would need to approve any outside responsibilities a Board member wished to take on. These would be brought to the Board for approval when such an occasion arose. |
| **1.6** | **Chief Executive's Report**<br>The Board noted the Chief Executive's report which was presented by Nick Cheshire and Bill Shields. In particular: |
| **1.6.1** | **Foundation Trust (FT) Application**<br>Good progress was reported, as set out in the Chief Executive's report and in agenda item 6.3. |
| **1.6.2** | **Helix Centre**<br>Imperial College London (ICL) and the Royal College of Arts (RCA) will be launching the joint HELIX centre in the autumn which will bring together designers with NHS staff to develop design solutions to everyday problems on wards and beyond. |
| **1.6.3** | **Liverpool care pathway**<br>A letter was issued by Norman Lamb MP, Minister of State for Care and Support, in July 2013 following an independent review of the Liverpool Care Pathway (LCP). The review report raises serious concerns on potential implications for the current quality of patient care. The letter asked that the boards of all acute NHS Trusts put into effect a number of actions immediately. In response to the letter, the Trust had suspended the use of the LCP from August 2013. |
| **1.6.4** | **CQC Visit**<br>The Trust had been made aware that it would receive a CQC visit in the lead up to FT application. |
| **1.6.4** | **Appointments**<br>A number of appointments had been made:<br><br>1. Dr Chris Harrison had been appointed Director of Public Health as well as Deputy Medical Director for Imperial Healthcare NHS Trust;<br>2. John Underwood had been appointed as Interim Director of Communications;<br>3. Ian Garlington had been appointed as the Director of Strategy and would join the Trust in October |
| **1.6.5** | **Application to host London (NW) Local Clinical Research Network**<br><br>It was reported that the application to host London (NW) Local Clinical Research Network had been successful and would commence from 1 April 2014. The Trust would receive approximately £15m per annum for disbursement among NHS providers in the region, to develop the national research study portfolio, increase the number of patients recruited into studies, improve study set-up times and delivery, and increase commercial investment. The Trust will hold a five year contract with the Department of Health to deliver the LCRN. |
| **1.6.6** | **NIHR Biomedical Research Centre (BRC)**<br>It was reported that an audit would be carried out over the coming months. Professor Dermot Kelleher said there was preparation for the audit was taking place. |
| **2** | **Quality and Safety** |
| **2.1** | **Director of Nursing's Report** |

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| | Janice Sigsworth presented her report, and in particular: |
| **2.1.1** | **Update of Care Quality Commission (CQC) activity at the Trust** |
| | A planned CQC Mental Health Act 1983 monitoring visit took place at the St. Mary's site 4th July. A full report had been received and the Trust had submitted a statement outlining how it would address the recommendations from the report. An oral update was given to the Operations Board on 19 August and the full statement was shared at its meeting on the 2 September.<br><br>A routine unannounced CQC visit took place took place at the St. Mary's site in August. The final report had shown full compliance with no significant issues. |
| **2.1.1.2** | <u>Alerts</u><br><br>A whistleblowing alert was submitted to the CQC on 29 July 2013 in relation to the renal outpatient department at Hammersmith Hospital. The concerns were investigated and a formal response was sent to the CQC who had confirmed they are content with the Trust's response and have therefore closed the enquiry. |
| **2.1.1.3** | <u>Complaints to the CQC</u><br><br>Three complainants have contacted the CQC in relation to:<br><br>• outpatient care<br>• pre and post-operative care<br><br>These are currently being investigated by the relevant areas. |
| **2.1.1.4** | <u>Compliments</u><br><br>Janice Sigsworth was happy to report there had been two compliments delivered to the CQC, one for the outpatient gynaecology service and Victor Bonney Ward at Queen Charlotte's and Chelsea Hospital and the other for the Warren Ward at Charing Cross Hospital. |
| **2.1.2** | **Patient Experience Work plan 2013/2014** |
| **2.1.2.1** | The 2012/14 Patient Experience Strategy was published in October 2012 and focused on the introduction of real time feedback from patients so that the patient voice was at the centre of improving services, highlighting excellence and driving success.<br><br>The strategy would be developed further, to build on the successes made, and to improve on the Trust's engagement with patients and the public to ensure that they have the mechanisms and information to influence, support and scrutinise how services were delivered.<br><br>The refreshed approach for 2013/14 will support the new divisional teams to deliver improvement, identify opportunities, innovate and take responsibility/accountability for improving the patient experience. To demonstrate how this will be achieved a work plan has been produced detailing the key actions which will be delivered. The work plan is aligned to the People and OD Strategy and will provide the foundation upon which to build a comprehensive review of the Patient Experience Strategy and establish a wider patient experience improvement programme which will be launched next spring (2014). |
| **2.1.2.2** | There were three main areas that work concentrate on: |

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| | 1. patient feedback<br>2. people<br>3. operational processes |
| **2.1.2.3** | Janice Sigsworth said that with the new meeting / reporting structures planned; this piece of work may change. |
| **2.1.2.4** | Sir Richard Sykes said in a multicultural / multilingual environment that different cultures would see 'quality' differently to others and it was important that feedback in those languages was properly understood. Janice Sigsworth agreed. |
| **2.1.3** | **Cancer Patient Survey Results** |
| **2.1.3.1** | Janice Sigsworth spoke about the results of the National Cancer Survey which were published on the 30 August 2013. The survey was for the period of September to November 2012. The Trust was bottom of the tables. There had been a lot of work to improve Cancer services since the previous survey but not in time for the most recent one. Work was continually on-going to improve all aspects of patient experience including dialogue with Macmillan and the Christie. |
| **2.1.3.2** | Sir Richard Sykes asked if Janice Sigsworth could see an improvement. She confirmed yes but there was a lot more work to be done. |
| **2.1.3.3** | Nick Cheshire said that the real-time tracker was a powerful tool in improving services. |
| **2.1.4** | **Hearing what patients say** |
| **2.1.4.1** | It was important to hear patients' views on their care, to see care and treatment through the patient's eyes, to understand what is important and when we do not get it right, to learn lessons to make sure it does not happen again. This section contains an (anonymised) patient's story.<br><br>A parent wrote a letter of complaint regarding the issues surrounding the treatment of their child at Charing Cross A&E, following an accident. |
| **2.1.4.2** | Janice Sigsworth said there had clearly been a breakdown in communication. Actions had been taken and an update would be provided to the parents in six months' time. |
| **2.1.4.3** | Sir Gerald Acher wondered if a staff member who had been found to have behaved like this would be placed on restricted duties. Janice Sigsworth said that in this particular case the staff member was junior and training was the appropriate response. |
| **2.1.5** | **Friends and Family Test** |
| | Janice Sisgworth highlighted the Friends and Family Test – April – July 2015 results. It was reported that targets were being reached and that the Trust was doing well compared with other Trusts. |
| **2.2** | **Medical Director's Report** |
| | Nick Cheshire presented the report, and in particular: |
| **2.2.1** | **Serious Incidents**<br>Nick Cheshire said the increase in serious incidents was a directly, result of the new systems in place to monitor such occurrences. |
| **2.2.3** | **Cleavage Sparing Mastectomy** |
| | Nick Cheshire noted there had been some recent press coverage about a surgeon using cleavage sparing techniques during a mastectomy operation. He confirmed that, to his knowledge, this practice had never happened at ICHT. |
| **2.2.4** | **Quality Strategy** |
| **2.2.4.1** | Nick Cheshire presented the Quality Strategy to the Board. The strategy would bring all |

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| | reports and reviews from external agencies and internal work together to improve patients' care. |
| **2.2.4.2** | There were quality goals – six dimensions, which would be monitored through four new Boards:<br>• Safety<br>– Patients should be as safe in healthcare facilities as they are in their own homes<br>• Effectiveness<br>– System must match care to science, avoiding overuse of ineffective care and underuse of effective care<br>• Patient-centeredness<br>– Should honour the individual patient, respecting patient choices, culture, social context and specific needs<br>• Timeliness<br>– Continual reduction in waiting times and delays for patients and those who give care<br>• Efficiency<br>– Never-ending reduction in waste and thereby total-cost of care<br>– Includes supplies, equipment, space, capital, ideas and human spirit<br>• Equity<br>– Seek to close racial and ethnic gaps in health status. |
| **2.2.4.3** | Under the heading of safety, incidents were reviewed weekly by Nick Cheshire with a monthly summary presented to the Committee. |
| **2.2.4.4** | Nick Cheshire said he felt that the proposals for achievement of the six quality dimensions would enable greater clarity for the divisions. |
| **2.2.4.5** | Nick Cheshire explained the reporting structure for new Boards, one for each quality dimension. Divisional Directorates would report into new Boards that covered the six dimensions, they in turn would report to Management Board, and then provide assurance to Quality Committee and thus to the Trust Board. Nick Cheshire said that the new structure would use meetings already in place ready and that it would require minimal reorganisation align those. |
| **2.2.4.6** | Jeremy Isaacs asked if there was cross membership on the new Boards. Nick Cheshire confirmed there was. |
| **2.2.4.7** | Sir Anthony Newman-Taylor stated that historically reports had gone to Board committees when in fact it should have been delivered to an executive committee – the new structure addressed this issue. He reported that the new structure had been to the Quality Committee who had discussed it at length and were supportive of the plans. |
| **2.2.4.8** | Sir Richard Sykes thought it was important that the Quality strategy was communicated |

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| | effectively Trust wide. Nick Cheshire planned a pan-hospital media campaign starting in October 2013. |
| **2.3** | **Infection Prevention and Control Report** |
| **2.3.1** | Alison Holmes presented the report for the months of July and August 2013.<br><br><u>MRSA</u><br><br>• In August one Trust attributed case related to trauma was reported (which will go to arbitration) and one non-Trust case<br>• A prior non-Trust case reported in June was re-allocated to the Trust in August following an arbitration process, which over ruled the opinions expressed<br>• In July there were two non-Trust MRSA BSI cases reported, subsequently re-allocated to the Trust, through the Post Infection Review (PIR) process, as they were contaminants<br>• This brings the total number of 'cases' reported against the Trust to eight for the year to date. |
| **2.3.2** | Alison Holmes flagged that in April a new system was introduced which allocated cases – they could only be attributed to acute care or primary care. The process allowed allocation based on what organisation could have most learning from the experience – this nearly always meant the Acute Trust- and the Board considered that this was unfair. |
| **2.3.3** | Alison Holmes highlighted one case which was going to arbitration as the Trust would not accept the allocation, nor would the CCG. The details were:<br><br>• a case of resuscitation in the community<br>• open heart massage at scene of trauma<br>• patient survived – surgery at Trust later<br>• patient found to have a fever post-surgery cooling<br>• MRSA bacteraemia found to be of a community profile<br>• allocation made to the Trust.<br><br>The issue here was that there were only two allocations – acute care or primary care – there was no option for other complex cases. NHS England would be reviewing the allocation process. |
| **2.3.4** | Sir Richard Sykes thought there should be another allocation i.e. inevitable / unpreventable infection. |
| **2.3.5** | In response to a question on the financial impact of these allocations (and proportionality of time of resources allocated) Bill Shields explained that the penalties attributed to Health Care Acquired Infections (HCAI) had significantly dropped since last year. |
| **2.3.6** | Steve McManus said that it was correct that time and money was invested in investigating HCAI and taking learning form that was essential. However, there was concern at having to resolve attribution. |
| **2.3.7** | <u>*C. difficile*</u><br><br>• In August 17 cases were reported, three cases were Trust attributable<br>• In July 12 cases were reported, three cases were Trust attributable<br>• Year to date 32 cases had been reported<br>• For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of C. difficile infection |
| **2.3.8** | <u>CQC visit</u> |

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| | A routine inspection carried out during an unannounced visit to St Mary's site took place on 30, 31 July and 1 August and found that the site was fully compliant. Patients were protected from the risk of infection because appropriate guidance had been followed and patients were cared for in a clean hygienic environment. |
| 2.3.9 | Antibiotic stewardship<br><br>Alison Holmes flagged that the largest risk to the UK was antibiotic resistant organism yet NHS England were focussing on the few cases of MRSA. |
| 2.3.10 | In response to Sir Richard Sykes' question on whether there were more cases of E Coli at specific sites, Alison Holmes said that there was an issue with E Coli because of renal. E Coli was the most significant organism in the UK at the moment which posed the biggest threat and challenges. Alison would bring a report to the next Trust Board which broke down figures into site and speciality. **Action: Alison Homes** |
| 2.3.11 | The Board noted the report. |
| **3** | **Academic Health Science Centre (AHSC) Report** |
| 3.1 | **AHSC Director's Report** |
| 3.1.1 | Prof Dermot Kelleher presented the report.<br><br>AHSC Application Update<br><br>Work continued to develop the full application for the NIHR AHSC designation process. Final submission deadline was 30 September and interviews with the Designation Panel taking place on 30 October. Up to 6 delegates are to attend the interview; including the AHSC Director and senior representatives from the College and Trust. Confirmation of AHSC designation is expected late November/December (commencing April 2014 for 5 years).<br><br>The current draft application has been reviewed by the Joint Executive Group (JEG) on 3 September and the Strategic Partnership Board (SPB) on 10 September. From the feedback received via these forums, a further version of the application is currently in draft and will be reviewed at the forthcoming JEG meeting on the 17 September. |
| 3.1.2 | Centres For Translational Medicine (CTMs)<br><br>The CTM Executive Forum membership had been finalised. The next meeting of the CTM Executive Forum was planned for October. |
| 3.1.3 | AHSC/Academic Health Science Network (AHSN) Collaborations<br><br>The AHSC had been working closely with the AHSN and the Northwest London Collaboration for Leadership in Applied Health Research & Care (CLAHRC) to develop an internal process to identify readiness and appropriateness of AHSC discoveries for diffusion across the AHSN. Identified discoveries are then put forward for consideration by a higher AHSN committee. |
| 3.1.4 | Sir Richard Sykes said that there were currently five AHSC in the UK today; keeping the number tight would help maintain quality. |
| 3.1.5 | The Board accepted the report. |
| **4** | **Performance** |

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| 4.1 | **Performance Report – 2013/14 Quarter 3 Report** |
| 4.1.1 | Steve McManus presented the report. |
| 4.1.2 | The report for the Trust Board summarised the Trust's Performance against key indicators. Accompanying the report was the Month 5 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.<br><br>In August 2013 the Trust achieved good performance in:<br><br>• Achieving 7 out of the eight cancer access standards (this relates to July data as reported one month in arrears)<br>• Achieving national 18 week referral to treatment waiting time target for admitted, non-admitted patients and patients on incomplete pathways<br>• Achieving the 95% 'all types' 4 hour Accident & Emergency standard<br>• Maintaining zero mixed sex accommodation breaches<br>• Achieving above target for providing national care standards for stroke and maternity patients<br>• Achieving venous thromboembolism assessment rates.<br>• Achieving the national diagnostics waiting time Standard<br>• Sustained good scores for patient feedback<br><br>Areas identified as underperforming were:<br><br>• The year to date number of Trust attributed cases of MRSA is 8 against a tolerance of zero. However the Trust recognised only four of these cases as three of these cases were being activity contested and one was in arbitration. An action plan was in place to further minimise the level of infection<br><br>• The Trust failed to meet the Cancer waiting times for 62 day first standard, with 22 patients having delayed treatment. The focus and scrutiny on cancer performance continues to remain a high priority<br><br>Against the Department of Health 2012-13 Acute Trust Performance Framework The Trust continued to be defined as 'performing' with a score of 2.61. Against the Monitor Compliance Framework for August the Trust is 'Amber - green' (1.0) as not having met the cancer 62 day standard. |
| 4.1.3 | <u>Elective Access - Referral to Treatment</u><br><br>Out of the 57 treatment function codes that form part of the target regime, the Trust was performing against 54. The outlying specialties are General Surgery, Urology and Trauma & Orthopaedics with trajectories and actions in place to improve performance in these areas. The Trust expected to achieve all Treatment Function Codes by October 2013. This was a marked improvement from the 25 out of 57 seen last year. |
| 4,1,4 | <u>Backlog levels</u><br><br>Backlog levels in July and August had increased; this was due to run rate of activities having lowered. Another factor was annual leave. The backlog was expected to be controlled throughout September. |
| 4,1,5 | <u>Cancer Waiting times</u><br><br>In August 2013 the cancer waiting time standards for July were published showing the Trust improved on performance by meeting 7 out of the 8 National Standards as well as the one local standard. The Trust failed to meet the 62 day first standard, hitting 79.7% (an improvement on the previous month) against the 85% target. This meant that 22 patients had their treatment delayed, ten patients above the tolerance level of 12.<br><br>The Audit, Risk and Governance Committee had seen a detailed report on Cancer |

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| | Performance and the recovery plans in place. Steve McManus assured the Board the Trust was on track to deliver all eight measures by October 2013.<br><br>For further assurance here Steve McManus had brought forward the internal audit programme which had been started in September 2013 with results to be reported to the Audit, Risk and Governance Committee.<br><br>Sir Gerry Acher confirmed he was pleased with the way improvements to Cancer Waiting Times were being handled and the measures in place. |
| 4.1.6 | <u>Accident & Emergency - 4 Hour maximum waiting time</u><br><br>ICHT achieved 96.31% overall in August for A&E performance with all sites also above 95%.<br><br>Capacity planning measures were being considered for Q3 and Q4; a full update would be delivered to the next Audit, Risk and Governance Committee in October 2013.<br><br>The Trust Board noted the report. |
| **4.1.2** | **Performance scorecard** |
| 4.1.2.1 | The Board reviewed and welcomed the proposed new Integrated Performance Scorecard> This would be further developed, with additional layers of detail including trends, future forecasts, KPIs and financial performance elements. This was designed to bring the Trust in line with what Monitor expected to be presented to the Board of an FT. |
| 4.1.2.2 | Janice Sigsworth said that the scorecard was an improvement but the Trust must not let it give a false sense of assurance. She recommended deep dives and testing were needed. Rodney Eastwood agreed and said early (lead) indicators were more important than past (lagging) indicators. |
| 4.1.2.3 | Sarika Patel would share with Steve McManus, information gained from reporting in other organisations. **Action: Sarika Patel**<br><br>***Secretary's Note: Sarika Patel suggested after the meeting tha****t the Integrated Performance Scorecard should look at various board reports already and we should truly integrate to avoid duplication. Secondly, once the scorecard is finalised, it should go the ARG committee as it will be an essential governance tool* |
| **4.2** | **Finance Report** |
| 4.2.1 | **2013/14 Month 3 Report** |
| | Bill Shields presented the report. The Trust had achieved a year to date surplus of £4.2m at the end of August (after adjusting for impairments and donated assets), an adverse variance against the plan of £1.0m. This was based on a surplus in month of £1.2m, which was a favourable variance of £0.5m. CIPs were now significantly behind plan by £4.8m. This has partially been offset by over-performance income on CCG contracts and utilisation of the contingency fund. It should not be expected that the over-performance on income will continue and therefore marked improved delivery of the CIPs is required in order to achieve the financial plan for the year.<br><br>If the current trajectory continued then the Trust would not achieve the required plan and that would seriously impact seriously upon the Foundation Trust timeline. It is therefore imperative that all areas ensure CIP plans are back on track and that any discretionary expenditure or new projects are stopped until it is confirmed that the financial position is stabilised. |

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| | The Board noted the 2013/14 Month 5 Financial Report. |
| 4.2.2 | **Cost Improvement Plan** |
| | Bill Shields reported that;<br><br>• The CIP plan for the year was £49.2m. Expected forecast outturn was £40.1m<br>• year to date delivery of CIP was £14.7m (a deficit of £4.8m against plan)<br>• the Transformation Board was closely monitoring the position and plans were in place to ensure delivery of the 2013/14 target. |
| | The Board was asked to note in particular:<br><br>• The surplus of £1,299k for the month of August; the cumulative surplus of £4,230k, a cumulative adverse variance of £986k against the plan<br><br>• Actual achievement of new CIP schemes year to date was £14.7m which is behind plan by £4.8m. Discretionary expenditure and new projects were being limited until it was confirmed the Trust was back on track with delivery of the financial plan<br><br>• Forecast outturn remained at a surplus of £15.1m. However, if the current expenditure position continued the Trust will potentially need to revise this with potential effects upon the timetable for Foundation Trust status. |
| | Sir Gerry Acher said that the Audit, Risk and Governance Committee regarded the delivery of the CIP as significant risk for the Trust, not just as a financial implication but in relation to the Foundation trust application. Short term actions taken may need to be revisited. Sir Gerry thought the CIP was deliverable but it was not going to be an easy process. |
| | Sarika Patel said the Finance and investment Committee had discussed that where the Trust had over performed on activity it should be made clear where there had been increased productivity. The costs associated with increased activity and income should be identified to demonstrate achievement. Bill Shields would reflect on how this was presented. **Action: Bill Shields** |
| 4.2.5 | The Trust Board noted the report. |
| **4.3** | **Director of People and Organisational Development's Report** |
| | The Board noted the report which included:<br>• NHS Staff Survey Action Plans<br>• KPI Report<br>• Leadership Development. |
| **4.4** | **NHS Trust Development Agency Self-Certifications for July 2013** |
| **4.4.1** | The Board approved the Board Statements and Compliance Statements for the NHS Trust Development Agency |
| **5** | **Strategy** |
| 5.1 | **Trust and Charity Engagement** |
| 5.1.1 | Jane Miles, Chief Executive; Josephine Watterson, Director of Fundraising; and David Crundwell, Chairman of the Imperial College healthcare Charity presented their report and gave a PowerPoint presentation. They outlined the scope and scale of the Charity and its future plans and potential to achieve its objectives through working more closely with the Trust. A short video was played as part of the presentation. |
| 5.1.2 | Current work included:<br>• £3m to deliver a healthcare portal for GPs and patients |

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| | • Supporting the improvement in cancer patient experience<br>There was a focus particularly on:<br>• Integrated care<br>• Long term conditions. |
| 5.1.3 | Imperial College Healthcare Charity donations' income in 2011/12 was £1.82m, which compared poorly that of with other prominent London Trusts. The fundraising strategy was therefore being greatly increased and developed to:<br>• Grow income and donor database over 5 years to reach £15m in total<br>• Sustain income of £5m per annum by year 5<br>• A £20m appeal to support Shaping a Healthier Future.<br><br>It was intended to work closely with the Trust and the Board, including :<br>• One-to-one meetings with each Board Member<br>• Attendance at Art events and support of patient activity<br>• All working together to raise more funds for our hospitals<br><br>The fundraising target could only be achieved with good fundraising projects to raise funds for Trust engagement at the most senior level. Stove McManus was a member of the Joint Fundraising Board. A key aspect was finding ways of using the c£70 million in funds given for specific purposes. |
| 5.1.4 | Sir Richard Sykes welcomed the presentation and committed the Trust to working together with the Charity. He invited the Charity to come back to a Board meeting in 12 months' time for a review of progress and plans. **Action Steve McManus/ICHT Charity** |
| **5.2** | **Development on an Outline Business case for the Implementation of 'Shaping a Healthier Future'** |
| 5.1.1 | Bill Shields presented the report which provide an update on the development of the Trust's OBC in response to the Shaping a Healthier Future initiative. The Business Case would be reviewed by the investment Committee and the Finance and Investment Committee. The Trust's Strategy was clinically driven and would include the improvement of facilities at its three main sites: Charing Cross, Hammersmith and St Mary's. Further work was taking place on consultation with patients and other interested parties and on patient flows. |
| 5.1.2 | Prof Dermot Kelleher said that more effort was needed between the Trust and the College to resolve how and where medical training was to be provided. |
| 5.1.3 | The Board noted that a plan was in place for Developing a Healthier future and that a local PID had been approved by the Capital Investment Committee. The OBC would be brought to the board to consider approval in December 2012 or January 2013. |
| **5.3** | **Director of Research Annual Report** |
| | Prof Dermot Kelleher presented the report, which was noted by the Board. |
| **5.4** | **Update on Risk Management Strategy** |
| 5.4.1 | Cheryl Plumridge gave an update. The Risk Management Strategy approved at the July Trust Board meeting was being used and 'embedded' within the Trust. The revised Corporate Risk Register would be presented to the 27 November Trust Board meeting. The new CRR would reflect aggregate risks, including links between infection control and estates' risks. The CRR would help the Board articulate risk and risk 'appetite'. She thanked Sir Gerry Acher for his help in relation to the format of the risk register. The CRR would be reviewed regularly by the Management Board and the Audit, Risk and Governance Committee before review by the Trust Board. Sir Gerry welcomed the update. |

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| **6** | **Papers for Information** |
| **6.1** | **Report of the Audit and Risk Committee meetings on 22 July and 4 September 2013** |
| | Noted. |
| **6.2** | **Report of the Finance & Investment Committee meeting on 19 September 2013:** |
| | Noted. |
| **6.3** | **Report of the FT programme board meeting on 20 June 2013** |
| | Noted. |
| **6.4** | **Report of the Foundation Trust (FT) Board meetings on 29 August and 20 September 2013: Foundation Trust Programme Update** |
| **6.4.1** | Sir Anthony Newman-Taylor drew the Board's attention to the agreement with Imperial College to the arrangement for three AHSC representatives on the Council of Governors (limited to one per partner). His discussions with a Medical Research Council Member indicated that they would be willing to have one nominee on the Council Discussions had taken place with NHS England regarding the opportunity for one nominee too. |
| **6.4.2** | The Board:<br>• Noted the programme update<br>• Noted the risks to the Trust's readiness to undergo HDD1 in October with a favourable outcome<br>• Approved the constitutional arrangements set out in the paper and in particular the make-up of the Council of Members.<br>• Noted the programme risks highlighted. |
| **6.5** | **Report of the Quality Committee meeting held on 11 September 2013.** |
| | Noted. |
| **7** | **Any other business** |
| | None. |
| **8** | **Questions from the Public:** |
| | In response to a question from a member of the public Janice Sigsworth said that she believed that patients generally received excellent care in the Trust but that the Board recognised that more needed to be done to improve patient experience and patient pathways. Work was under way to make connections between feedback from patients and staff and to improve patient experience. She offered to discuss this further outside the meeting. |
| **9** | **Date and time of next meeting:** |
| | **Trust Board Meeting in Public:** Wednesday 27 November 2013, Clarence Wing Board Room, St Mary's Hospital. |
| **10** | **Exclusion of the Press and the Public** |
| | The Board resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960 |

Imperial College Healthcare NHS
NHS Trust

**ACTIONS FROM TRUST BOARD MEETING IN PUBLIC**
**25 September 2013**

| Minute Number | Action | Responsible | Completion Date | November 2013 Update |
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| 2.3.10 | **Infection Prevention and Control**<br>E Coli: A report would be brought to the next Trust Board which broke down figures into site and speciality. | Alison Holmes | 27 Nov 2013 Board | Alison Holmes to provide an oral update |
| 4.1.2.3 | **Performance Scorecard**<br>Information gained from reporting in other organisations to be shared with Steve McManus. | Sarika Patel/ Steve McManus | | ***Secretary's Note:*** *Action completed. Sarika Patel suggested after the meeting that the Integrated Performance Scorecard should be integrated with various other board reports and avoid duplication. Secondly, once the scorecard is finalised, it should go the ARG Committee as it will be an essential governance tool.*<br>Steve McManus to update. |
| 4.2.2 | **Cost Improvement Plan**<br>The costs associated with increased activity and income to be identified which demonstrate achievement to be presented. | Bill Shields/Marcus Thorman | | Updated at FIC 21.11.13.<br>Oral update to be given to the Board on 27.11.13 |
| 5.1.4 | **Trust and Charity Engagement**<br>Invitation to Imperial College Healthcare Charity to return to a Board Meeting in September 2014 for a review of progress and plans. | Steve McManus/ICHT Charity | Sept 2014 | Scheduled for September 2014<br>Steve McManus anything to add please by way of update comment |

## ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
## 24 July 2013

| Minute Number | Action | Responsible | Completion Date | November 2013 Update |
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| 4.1.2 | **Performance Report – 2013/14 Quarter 3 Report**<br>Emergency Departments (A & E) report would be made in September. The report would be to the Quality Committee or to the Audit and Risk Committee; to be determined between the two committee chairmen. | Steve McManus/ Sir Gerald Acher, Sir Anthony Newman-Taylor. | Update to 25 Sept 2013 Board | An oral update was given to the 11.9.13 Quality Committee meeting and a presentation was made to the 8.10.13 Quality Committee meeting.<br>Steve McManus is this action completed and if not please update? |
| 4.1.2 | **Performance Report – 2013/14 Quarter 3 Report**<br>The new integrated performance report – aiming to be delivered to the 27 Nov Board. | Steve McManus | 27 Nov 2013 Board | The revised report will be presented at the 18.12.13 Trust Board Seminar and introduced at the Board Meeting on 29.1.14. |
| 5.5.1 | **Board Committee Structure**<br>The Board approved the Board Committee Structure proposals | Cheryl Plumridge | | The Committees have worked through their terms of reference and these are on the 27.11.13 Trust Board Agenda, for approval. |

Imperial College Healthcare NHS
NHS Trust

**Chief Executive's Report**

**27 November 2013**

## 1 TRUST BUSINESS

### 1.1 Clinical and quality

#### 1.1.1 A 'Call to Action'

NHS England launched 'The *NHS belongs to the people - a 'Call to Action'* in July, which sets out a compelling case for the NHS to survive. A *Call to Action* describes how the NHS is facing a number of significant challenges, including an aging population, increasing prevalence of long term conditions, lifestyle choices that lead to obesity or cancer. This combined with the assumption that the NHS budget will remain flat in real terms, presents an unprecedented challenge to improve clinical quality whilst delivering a financially sustainable health system. The London region of NHS England is planning to build on this work by publishing a London *Case for Change.* It is hoped that this will help stimulate a public debate about the difficult and often unique challenges that all of us working in health and care in London are facing. The London Case for Change will be launched on 14 October 2013 at the London Leadership for health and care commissioners forum alongside a series of CCG data packs. It is hoped that this will help CCGs carry out local patient engagement activity throughout the autumn.

**Lead Director – Professor Janice Sigsworth, Director of Nursing**

### 1.2 People and Organisation Development

#### 1.2.1 Director of strategy

Ian Garlington joined the Trust in October as the director of strategy. Ian has 20 years' experience of driving change and improving quality within NHS trusts and other high profile healthcare organisations, most recently at Buckinghamshire Healthcare NHS Trust, where he played a key role creating the environment for the creation of a hyper acute stroke unit and developing improved services in A&E and endoscopy. This experience will prove valuable to the development of the Trust's strategy as we continue to work to improve the delivery of our clinical services whilst moving towards Foundation Trust status and achieving re-accreditation as an academic health science centre. As agreed at the last Trust Board seminar, Ian will also now become the responsible director for Estates and Facilities at the Trust

#### 1.2.2 Director of Communications

Michelle Dixon has been appointed director of communications and external relations and will join the Trust in the New Year. Michelle will join from the BMA where she is currently director of communications.

#### 1.2.3 Deputy Director of Nursing

Dr Senga Steel has been appointed as deputy director of nursing. Senga joins us from Whittington Health where she is currently assistant director of research, innovation and quality/senior nurse. She is due to start in early January 2014.

#### 1.2.4 Talent development – staff engagement

The launch of the new Local Engagement Survey took place on 21 October. Designed to complement the national NHS Staff Survey, this is a short quarterly on-line survey of 15 questions chosen locally, with 25% of our people receiving the survey each quarter. The survey will deliver much more timely feedback on engagement and will allow us over time to analyse results at a very local (ward) level, which will enable far better action planning than we can do from the national survey.

**1.2.5 Talent development – leadership development**

The Certificate in Medical Leadership, the first of the new Leadership programmes, commenced on 9 October 2013. This programme is a joint venture with Imperial College Business School who are co-designing and delivering the programme with significant input from our Executive Team. This bespoke programme includes all of the Divisional Directors, as well as Divisional Directors of Operations, Chiefs of Service and Divisional Directors of Nursing. The first module focused on the strategic landscape to set the context for the programme and sessions included input from Professor Nick Cheshire and Bill Shields, as well as Professor Dermot Kelliher, and Adrian Bull, Academic Health Sciences Network.

Horizons - Strategic Leadership, a bespoke programme for the Trust's aspiring top leaders and Aspire – the Leadership Way were also launched in October. The programmes include a rich mix of delegates including Chiefs of Service, General Manager, senior nurses and senior leaders from Corporate Directorates. The Horizons programme included a key note speaker Dr Katy Steward, Associate Director of Leadership from the Kings Fund who spoke on the theme of authentic leadership and patient centred leadership.

Foundations – An Introduction to Management was also introduced in October. This is aimed at team leaders, supervisors and junior managers or those who aspire to move into management roles. This will be open to anyone, clinical or non-clinical across the Trust and will be primarily aimed and Bands 2-5. The programme will commence on November 25th.

## 2 PERFORMANCE

### 2.1 Month 7 Performance Summary

The Trust has sustained good performance in Quality Performance Indicators such as, Mortality, Stroke Care and reporting no mixed sex accommodation breaches. The Trust also continued to deliver the Referral to Treatment standards and continues to meet the 95% target for VTE risk assessments. Each month in 2013/14 the Trust has continued to meet the Accident and Emergency 4 hour maximum waiting times standard.

However, there have been five cases of recognised Trust attributed MRSA BSI's year to date against a zero tolerance for 2013/14. An action plan is in place to minimise further infections.

The Trust also failed to meet the Cancer waiting times targets for 62 day first treatment standard with 27 patients having delayed The Trust is now meeting 7 out of the 8 cancer standards and work continues with the Cancer Management team to track patient pathways to ensure that patients receive treatment within the target time.

As we move into the winter period, the Trust is implementing a range of initiatives to build capacity and resilience. Following detailed modelling of the Trust's expected winter capacity and demand, on 4th November an additional 20 beds were opened (across the 3 acute sites) and plans are in place to open to a maximum capacity of an additional 50 beds by mid-December. The opening of the additional beds is supported by a significant change in the medical model of care with plans to provide physician led care for post-surgical elderly patients in a dedicated unit on the St Mary's site from December and to cohort other medical patients together based on specialty and acuity. In addition, a transfer team has been launched in the ED to support moving patients into inpatient beds,

extra weekly trauma lists will be implemented from December, the cancer admissions unit will open seven days per week from January.

The Trust successfully bid for external funding to support the implementation of several schemes and specifically funding was approved for; extended hours for senior clinical decision makers in the Emergency Department and within acute medicine and care of the elderly medicine, increased opening hours for the Urgent Care Centers on both the St Mary's and Hammersmith Hospitals sites to provide 24/7 cover, increased therapy and discharge team staff to ensure 7-day service provision and rapid response services for discharge dependent patients. In addition, the Trust will benefit from successful bids submitted by other providers including extended provision of social worker and psychiatric liaison services over the weekends. The Trust is working in partnership with Central London Community Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust to establish a 20-bed step down facility on the Charing Cross Hospital site.

With effect from 4th November 2013, the Trust opened a 'winter office' which is responsible for implementing an internal daily SITREP process and robust external escalation processes to drive efficiency improvements daily through making essential indicators visible and agreeing specific actions early in the day. The Trust has launched a series of standards aimed at improving inpatient efficiencies and quality of care. For example, maximum waiting times have been agreed for specific diagnostic tests and specialty reviews and the Trust will stop the non-clinical transfer of patients between sites after 10pm. Delivery of these standards will be supported through the winter office.

**Lead Director – Steve McManus, Chief Operating Officer**

## 3 FINANCE

### 3.1 Month 7 Finance Summary

The Trust has achieved a year to date surplus of £10.9m at the end of October (after adjusting for impairments and donated assets), an adverse variance against the plan of £0.5m. This is based on a surplus in month of £4.2m, which was a favourable variance of £0.3m. CIPs are behind plan by £4.0m, an improvement in month. However, this has been offset by over-performance income on CCG contracts and utilisation of the contingency fund. It should not be expected that the over-performance on income will continue and therefore persistent improvement in delivery of the CIPs is required in order to achieve the financial plan target.

The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' anticipated income and expenditure for the year. The forecast includes an estimate for asset impairment of £25m for the devaluation of land & buildings. The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets.

**Lead Director – Marcus Thorman, Director of Finance**

## 4 FOUNDATION TRUST APPLICATION

### 4.1 Foundation Trust (FT) Application Update

In collaboration with the, TDA the Trust is in the process of realigning delivery of key milestones and remains confident that FT authorisation by Monitor during December 2014 is achievable which will mean formally becoming a FT on 1 January 2015. The proposed extension to the programme of one month is a result of a delay in Monitor's confirmation that the Trust will proceed with its application under the old Historical Due Diligence (HDD) format and appointing Independent Reporting Accountants.

Since the last update to the Trust Board in September, the following key areas have been progressed:

- Long Term Financial Model (LTFM) current data updated with Monitor's new Continuity of Services Risk ratings (CoSRRs);
- Progress made on Cost Improvement plans (CIPs) and Project Initiation Documents (PIDs) created;
- Progress of divisional clinical strategies and SaHF as key inputs into the LTFM and Integrated Business Plan (IBP);
- Approval of Membership strategy by the Foundation Trust Programme Board (FTPB);
- Trust strategic objectives approved by the Trust Board;
- Consultation document approved by the Trust Board;
- Public consultation commenced on 11 November 2013;
- Quality Strategy (QG15) approved by the Management Board.

Priorities for the next two months will be to:

- Work with the TDA to agree the detail of the revised programme timescales (pending Trust Board approval of the proposal);
- Agree timing of HDD and CIH reviews;
- Continue refinement of the IBP based on feedback from committee reviews;
- Develop summary of IBP chapters as per Board request;
- Review of LTFM by the Finance & Investment Committee in November;
- Continue to focus on CIP plans and their delivery;
- Commence the Board Development programme;
- Further develop clinical divisional and enabling strategies and delivery plans;
- Continue collation of evidence for Board Governance Assurance Framework (BGAF) and Quality Governance Framework (QGF);
- Appoint external assessors for BGAF and QGF reviews;
- Make further constitutional recommendations to the FTPB.

The Trust's strategic objectives were agreed in principle at the October seminar. It is now requested that the Board formally approves these objectives.

- To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
- To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
- With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
- With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Once the objectives have been approved by the Trust Board, work will take place on the BAF, linking already identified risks (and potential newly identified risks) to the achievement of objectives. This will initially be a paper exercise led by the Director of Governance and Assurance but the December Trust Board seminar will need to be used to consider whether the necessary controls are in place and what assurance there is as to the effectiveness of the controls the Board would wish to see. Thereafter, an action plan will be developed to enable the BAF to be formally approved at the Trust Board meeting on 29 January 2014.

**Lead Director – Marcus Thorman, Director of Finance**

## 5. NWL BUSINESS

### 5.1 "Shaping a Healthier Future"

On Wednesday 30 October the Secretary of State for Health speaking in the Commons, accepted advice from the Independent Review Panel (IRP) on the consultation for changes to NHS services in North West London, including the move to five major hospitals should proceed; "in full".

Implications of this decision for ICHT are in line with the consultation, notably:

**St Mary's;**

- Will remain as a major hospital and will consolidate through a programme of regeneration to create a new state of the art hospital for emergency and inpatient care, and continue its work with Imperial College

**Western Eye Hospital;**

- Ophthalmology will remain a key service delivered by the clinical teams within the WEH, the location will be moved to the redeveloped St Mary's site

A few statements require some additional understanding and we are working with partners to truly understand how to implement these, they are:

**Hammersmith Hospital;**

- In line with the IRP report, changes to A&E at Central Middlesex and Hammersmith hospitals "should be implemented as soon as practicable".

**Charing Cross;**

- Accident and Emergency -The Secretary of State said: Ealing and Charing Cross hospitals will "continue to offer an A&E service, even if it is a different shape or size to that currently offered….In line with the emerging findings of Bruce Keogh's review of A&E, Charing Cross and Ealing hospitals must provide: immediate access to specialist consultant opinion, a wide range of diagnostic services, the ability to admit people for assessment, treatment and rehabilitation...The A&E departments at Ealing and Charing Cross hospitals must be sustained until further work to inform a final decision on the future of these two local hospitals has been completed and the alternative services that will provide a safe, high quality urgent emergency care system for local residents are in place."

- Local Hospital - "The future of the proposed local hospitals at Ealing and Charing Cross....must be the subject of a specific programme of work led by local commissioners and engaging the public, service users, staff and the relevant local authority. This work should address the need for inpatient services for the vulnerable and frail elderly and its outcome will determine whether there is a need for further consultation." The SoS went on to note that "The A&E departments at Ealing and Charing Cross hospitals must be sustained until further work to inform a final decision on the future of these two local hospitals has been completed and the alternative services that will provide a safe, high quality urgent emergency care system for local residents are in place."

  The future form of the local hospital is presently in design with commissioners and their consultants, as part of that ICHT are working in support of those plans and how we can derive greater clinical value from them.

- Maternity and paediatrics -In line with IRP recommendations, maternity and paediatric inpatient services should be "concentrated on the sites identified by Shaping a healthier future" (5 major hospital sites and Queen Charlotte's at Hammersmith).

### 5.2 Integrated Care - Pioneer Bid

In May 2013 Norman Lamb (Minister for Care and Support) announced that the government was looking for 'pioneer sites' to lead the way in providing integrated care. Those areas awarded pioneer

status will be offered long term support and advice to help overcome barriers to care integration from a central Integrated Care and Support Exchange team. The ambition is to make joined up and coordinated health and care the norm by 2018.

Recently ICHT participated as part of NWL bid to become one of 14 Pioneer Sites, the bid was successful and as such the Trust will be working as part of the NWL program team with NHS IQ in the coming weeks to shape the support we require from the central team to take our plans for NWL forward. Initial work will be identifying wave 1 pilots that we can focus on, with changes being implemented from the 1st April 2014, successful schemes will be looking for rapid ability to scale the pathways up to ever greater populations and record the process for exemplar status to other health economies.

**Lead Director – Ian Garlington, Director of Strategy**

## 6. RESEARCH

### 6.1 Clinical Research Network for North West London

After successfully applying to host the new NIHR North West London (NWL) Clinical Research Network (CRN) from 1 April 2014, we have been working with our Local Transition Facilitation Lead on governance, workforce planning, and key appointments. The Trust will receive approximately £15m per annum for disbursement among NHS providers in the region, to grow the national research study portfolio, increase the number of patients recruited into studies, improve study set-up times and delivery, and increase commercial investment. The Trust will hold a 5-year contract with the Department of Health to deliver the CRN. There are opportunities to align the funding with existing research programmes and centres (e.g. BRC) within the Imperial AHSC.

Interviews for the two senior posts of Clinical Director and Chief Operating Officer were held in November. Detailed consideration is now being given to the transition of existing CLRN workforce (delivery and core support staff) to a new structure. This will include 6 Research Delivery Managers, each responsible for growing activity in one or more clinical specialties. There will be a 7th cross-cutting delivery division (RM&G, industry liaison, PPI/E). The new NWL CRN will sit within the Medical Director's office and report through there, with the CEO/Medical Director as Host Organisation Accountable Officer.

A number of engagement events are planned for partner organisations in north-west London during the coming months, and an internal project working group has been established to consider the details around workforce transition and re-location.

**Lead Director(s) – Professor Jonathan Weber, Director of Research and CEO/Medical Director as LCRN Host Organisation Accountable Officer**

### 6.2 NIHR Imperial Biomedical Research Centre (BRC)

As of 1 April 2014, two years of the current NIHR Imperial BRC programme will have passed, with three years remaining until a renewal decision. It is essential to be able to demonstrate sufficient outcomes within this period and, as such, the next two years will be crucial to delivery of BRC plans and to our renewal application.

BRC Themes are therefore currently engaged in planning for 2014/15 and beyond. The first stage of this process will be to agree on the overall priorities and approach to investment of BRC funds in 2014/15 (e.g. new projects, core facilities/platforms, cross-BRC initiatives, training schemes, health economics, sequencing / metabonomics / imaging / biobanking, industrial collaborations). The second stage will involve a more detailed assessment of requirements for 2014/15, per Theme. Theme Leads have been asked to present progress and plans at two meetings in early December.

Following review by the AHSC Research Committee, these discussions will feed into the Trust's planning round for 2014/15.

**Lead Director – Professor Jonathan Weber, Director of Research**

**6.3 NIHR Performance Metrics for Initiating and Delivering Clinical Research**

The Trust continues to make steady improvement in terms of the time taken to approve clinical research studies, to recruit the first patient to studies, and to deliver commercial studies to time and target. To enable this, the DOCUMAS clinical trials database has been fully launched to investigators and study teams in Q2. The system contains all studies, accruals data, alerting functionality, and reporting capabilities. Trust performance is now above the sector average for the first time. For the latest report to NIHR (Q2 2013/14), the Trust's performance is summarised as follows:

a. 120 interventional studies were submitted
b. 36 studies met the 70-day benchmark (30%; sector average ~ 25%)
c. Days between receipt of Valid Research Application (VRA) and First Patient Recruited:
    a. Mean = 101 days (range 5-539)
    b. Median = 78 days
    c. 75th percentile = 139 days; 90th percentile = 216 days
d. Stage 1 (VRA to R&D approval): median = 26.0 days
e. Stage 2 (R&D approval to First Patient Recruited): median = 34.0 days
f. Reported 111 commercial trials, 42 of which met their target (47 trials still open)

**Lead Director – Professor Jonathan Weber, Director of Research**

**6.4 Divisional Research Structures**

The post of Divisional Director of Research (DDoR) has been developed and a role description drafted. The role of the DDoR is to develop the quality and quantity of clinical research within each Division, in line with the over-arching strategic priorities set out by the AHSC Research Committee, and to ensure delivery of research against national and local performance benchmarks. In particular, DDoRs will be responsible for increasing awareness of, and improving performance against, NIHR metrics for initiating and delivering research.

DDoRs will also ensure appropriate feasibility, financial, regulatory, and performance oversight for all clinical research studies within their Division. Working through their respective Divisional Research Committee (DRC), and with the support of a Divisional Research Manager, they will develop an overview of research activities falling within their remit, identify potential areas for growth, and develop efficient and effective local research support infrastructures, focusing resource where it is required.

DDoRs will be full members of the AHSC Research Committee and will chair the DRCs, wherein the budgets for the NIHR Imperial BRC and other NIHR programmes are held. They will be directly accountable to the Divisional Directors but will also have 'dotted line' accountability to the Trust Director of Research.

**Lead Director – Professor Jonathan Weber, Director of Research**

## 7. AHSC - REDESIGNATION UPDATE

**7.1** Imperial College Academic Health Science Centre submitted a full application for redesignation as an AHSC to the Department of Health on the 30th September. Following this submission, preparations took place in the form of mock interviews ahead of the actual application interview with the Designation Panel, which took place on the 30th October. The assessors for the interview consisted of an international panel of medical experts. The Department of Health invited Imperial College AHSC to select up to six delegates to represent Imperial College AHSC, which included senior

representatives from Imperial College and the Trust. The delegates who represented the AHSC at the interview were: Sir Richard Sykes, Professor Dermot Kelleher, Professor Nick Cheshire, Professor Jenny Higham, Professor David Taube and Professor Jonathan Weber. The interview panel confirmed that we could anticipate receiving the outcome of the designation process around late November/early December.

**Lead Director – Professor David Taube, AHSC Director**

## 8. COMMUNICATIONS UPDATE

### 8.1 NHS Medical Director Visit to Hammersmith Campus

Sir Bruce Keogh, NHS England's medical director visited Hammersmith Hospital and campus on Friday 1 November. The visit took in the National Phenome Centre, the Clinical Research Facility at the Imperial College for Translational and Experimental Medicine, and Imanova - a world leading research centre for imaging sciences and an innovative alliance between the UK's Medical Research Council and three world class London Universities – Imperial, King's College and UCL. One of the key topics of discussion during Sir Bruce's visit was the benefits of the academic health centre (AHSC) and the application for the AHSC's re-designation from April next year for a further five years.

### 8.2 Annual General Meeting

More than 130 guests attended the Trust's 2012-13 annual general meeting held on Wednesday 25 September, to hear about the Trust's annual performance, current plans and vision for the future. The AGM was held in South Kensington at the Great Hall of Imperial College London, our partner in the Academic Health Science Centre (AHSC). The meeting formally presented the annual accounts for 2012-13, which showed a significant improvement over the previous year. In addition it was emphasised how the Trust builds all our work and activities on fundamental principles of quality, safety and compassion. Guests were given an overview of the Trust's 2012-13 operational performance, combined with looking forward as he outlined our vision and plans for the future. It was also an opportunity to highlight the Trust's approach to 'putting patients first' and how work is taking place to improve patient experience.

### 8.3 Foundation trust consultation

On Monday 11 November the Trust launched its public consultation to hear from the local community, patients, the public and partner organisations what they think of the Trust's plans to become a foundation trust. The consultation is planned to run for a period of up to 12 weeks closing on Monday 10 February 2014. Details on the proposals for becoming a foundation trust are set out in the consultation document entitled 'Working in Partnership'. The views of patients, people and partners are important and the Trust intends to set its priorities and shape arrangements to ensure that their views and expectations are considered before the final foundation trust application is submitted. Public meetings will be held to give the public and staff the opportunity to ask questions and give their views. The findings of the consultation will be submitted to the Trust board for its consideration.

**Lead Director – John Underwood, Interim Director of Communications**

## 9. PARTNER ENGAGEMENT ACTIVITIES

The Trust's engagement programme has continued as we seek to actively build our external relations with partners. Across the Trust's leadership team we are seeking to work with our partners in an open and constructive way which ultimately benefits the patients we care for. Since the September meeting of the Trust board, the office of the chief executive has been involved in several meetings with councillors, MPs and senior local authority officials representing the residents of Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

**Lead Directors – Professor Nick Cheshire, Chief Executive and Bill Shields, Chief Executive**

## 10. IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

### 10.1 Grants

The charity launched a new grants programme on 4 November 2013. It aims to fund projects that improve healthcare for London's hard to reach communities, including individuals who are homeless, refugees, asylum seekers, victims of domestic abuse, children in care and those who are of black and minority ethnicities (BME). Organisations and local charities that work with such groups in the community are being invited to apply for funding in support of projects that will involve partnering with the trust and cost between £10,000 and £150,000

Following a total of 51 expressions of interest for the latest general grants round, the charity has received 25 full applications. Successful candidates are set to be announced on the week commencing 9 December 2013.

### 10.2 Communications

For the first time, the charity has its own external website which, among other new features, allows site visitors to donate directly to the charity online. It is hoped that the site will be more engaging to visitors and encourage more interaction with the charity in the long term. It links to the trust's website and the charity thanks the trust for its cooperation.

### 10.3 Fundraising

Following the charity's presentation of its five year strategy to the Board in September, the charity is now set to launch to internal stakeholders its £1,000,000 appeal for the major trauma centre at St Mary's on 5 December 2013 at Paddington Hilton. The charity's major trauma appeal video will be unveiled at this event featuring major trauma staff and patients. The public appeal will launch in February 2014.

### 10.4 Art

The launch of Jill Berelowitz's striking six metre high sculpture *Core Femme* in the grounds of Charing Cross Hospital took place on 30 October 2013, attended by the artist and her friends, as well as patients, staff and hospital visitors.

The team behind the installation of internationally acclaimed artist Bridget Riley's new murals on the tenth floor of the QEQM building are making good progress. The new murals will complement the artist's existing work on the eighth and ninth floors of the same building and is due to be finished in early 2014.

Imperial College Healthcare NHS Trust

**Board Meeting in Public**

**For information**

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|---|
| **Report Title:** Director of Nursing's Report |
| **Report History:** Regular report |
| **To be presented by:** Janice Sigsworth, Director of Nursing |
| **Executive Summary**:<br>The attached paper is a consolidated report covering the following areas:<br>• Quality and Safety<br>• Patient Experience<br>• Equality and Diversity<br>• External visits and reports<br>• Other updates for information |
| **Key Issues for discussion:**<br>Please refer to the attached paper which summarises the key issues for discussion. |
| **Legal implications or Review Needed:**<br>a. No |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:**<br>N/a |
| **Recommendations and Actions Required:**<br>To note progress on actions arising from the Mid-Staffordshire NHS Trust Enquiry Report (section 1.2 and Appendix A)<br>To note a Patient's Story (section 2.2 and Appendix B)<br>To note the Trust's Equality and Diversity Strategy 2013/15 (section 3.1 and Appendix C) |

## 1. QUALITY AND SAFETY

### 1.1. Out of hours spot checks

The senior Nursing and Midwifery team are undertaking out of hours spot checks of clinical areas in November (to be known as 'Back to the Night'). This will consist of four six hour night shifts and one six hour weekend shift, and will cover all five hospitals.

### 1.2. Update on progress against the Trust's action plan following the Mid-Staffordshire NHS Foundation Trust inquiry (2013)

The Trust has undertaken several actions in response to the Mid Staffordshire NHS Foundation Trust Inquiry, further to the papers presented at the Board meetings in March and July. The action plan outlines the key recommendations relevant to the Trust and our progress in implementing these. All of the actions have either been completed or are work in progress due to be completed by the target date. This action plan is now part of an overall integrated quality governance action plan aligned to the principles in the Trust's quality strategy 'QG15' and was presented to the Management Board on 18 November.

An annual report summarising progress specifically against the Mid-Staffordshire NHS Foundation Trust inquiry (2013) actions, will be presented to the Trust Board in April 2014.

***Please refer to Appendix A for a copy of the action plan to include progress.***

### 1.3. Update on the Trust's quality impact assessments (QIA) for cost improvement programmes (CIP)

There have been three CIP QIA clinical review meetings between divisions and the Acting Medical Director and Director Nursing since August. A first round of quarterly meetings also took place with corporate areas in early October. Currently, there are no CIP QIAs that have a risk assessment score above 9 on a scale, where the highest (worst) possible score is 25 and where risk has been identified, mitigating actions are in place. Through discussion with divisions/corporate areas, some schemes have been identified which have either been implemented and then withdrawn due to an adverse impact on quality recognised through close monitoring or which have not been implemented at all, due to high risk when carrying out the QIA. The Quality Committee has received examples of such schemes at its meeting on 13 November. The next CIP QIA clinical review meetings will take place in January where the focus will be to discuss schemes for 2014/15.

### 1.4. End of life care

A recommendation from the Francis Inquiry (2013) stated that "it is important that greater attention is paid to the narrative contained … in complaints data as well as to the numbers". The Keogh review (2013) which has informed the recent proposed inspection model for the Care Quality Commission (CQC) also stressed the importance of a detailed analysis of complaints data as part of a wider consideration of patient experience and to facilitate organisational learning. This must also be seen within the context of the recent negative publicity regarding the use of the Liverpool Care Pathway (LCP).

Chaired by Dr. Katie Urch, the End of Life Steering Ggroup has recently been reconvened to examine the delivery of end of life care in the Trust with the aim of improving the quality of care within the national policy framework, which includes the National End of Life Care Strategy (DH, 2008). An evaluation of formal complaints (including a thematic analysis) relating to the end of life care received by the Trust

between July 2012 and October 2013 has been commissioned by the steering group.

The results demonstrate that 5% of the formal complaints received during this period related to end of life care. The principal themes which emerged centered on seven key issues: communication, decisions regarding care and/or treatment, practice issues and/or care delivery, attitude of staff, organisational and environmental factors (including staffing), continuity of care and late/absence of referral to palliative care. Three complaints referred directly to the use of the LCP, citing the negative coverage of the pathway in the media. Whilst the complaints focused on negative aspects of care, it is also important to note, that aspects of good practice were noted in a number of the complaints – especially for a particular service, or Trust hospital or where the complainant expressed that a particular individual member of staff had gone 'that extra mile'.

In terms of the next steps, the Steering Group will discuss the themes identified in the analysis and consider strategies to address the common concerns identified here, either within existing service improvement work streams or to consider new strategies to improve patient experience and the quality of end of life care. It will also agree the governance and frequency for on-going reporting of thematic analyses of complaints relating to end of life care.

**1.5. Savile investigation**

The Trust provided assurance to NHS London in December 2012 and to the Independent Oversight of NHS and Department of Health Investigations team into matters relating to Savile in April 2013. Further assurance has been requested from all Trusts, in particular focusing on employment checks, training for contractors and internet access. The Trust is currently drafting its response.

**1.6. Cavendish Review**

Following the publication of the Cavendish Review 2013, the Trust has set up a Healthcare Assistant Task & Finish Group which has undertaken a gap analysis against the recommendations and produced an action plan. The Group reports to the Nursing and Midwifery Education and Research Group summarising progress against the plan and will formally present an update at the Nursing and Midwifery Professional Practice Committee in December.

## 2. PATIENT EXPERIENCE

**2.1. Revised patient surveys**

The Trust currently collects an array of patient experience data. In order to ensure a more streamlined and coordinated approach, we are revising the way we use our patient experience surveys. Patient experience will continue to be monitored using the iTrack surveys but a shortened inpatient survey based upon key CQC approved questions has been developed. This will offer a simplified survey that will cover the majority of our ward areas and include the friends and family question. Departments outside of this remit will move to using only the Friends and Family test survey. Patients will also be able to provide free text comments to provide more specific information on what we did well or what could be improved. The patient experience team is working towards implementing the change by the end of December 2013.

**2.2. Patient Story**

***Please refer to Appendix B for a patient story***

## 3. EQUALITY AND DIVERSITY

### 3.1. Equality and Diversity Strategy 2013/15

The Trust has recently developed a two year Equality Strategy which sets out our equality and diversity goals and outcomes and how they will be delivered in 2013-15. It also outlines how the strategy is aligned to other initiatives so that equality and diversity is integrated into the everyday business of the Trust; to enable us to deliver services that are personal, fair and diverse and that provide our patients, carers, communities and staff with a great experience. The principles have been discussed with Divisional Management teams and were presented and approved at the Quality Committee on 13 November. Former versions have been shared with the Trust's previous Equality and Diversity Committee in April and July 2013.

***Please refer to Appendix C for the strategy document.***

## 4. EXTERNAL VISITS AND REPORTS

### 4.1. Cabinet Office visit on the implementation of the Friends and Family Test

The Trust hosted a visit from the Cabinet Office's Implementation Unit on 5 November. The unit is a small team who work to monitor and improve the Government's top implementation priorities and is currently undertaking a review of the Friends and Family Test (FFT). The Cabinet Office team identified the Trust as a place they would like to visit so they can focus on some practical examples of how hospitals are putting FFT into practice, and how it is being used to improve services.

### 4.2. Chief Nursing Officer (CNO) visit to the Trust r

The CNO Jane Cummings, Neil Churchill (Director of Patient Experience – Department of Health) and colleagues from Macmillan visited the Trust on 8 October to look at how it is implementing the Macmillan values based standards for cancer patients. The CNO visited the 6th Floor at the Charing Cross site and spoke to various staff. The visit was positively covered in the local media.

### 4.3. Healthwatch 'enter and view' visit report

Following enter and view visits to Samaritan, Thistlewaite, Grafton and Witherow wards in August 2013, the Trust has received a report from Healthwatch Central West London (CWL). Whilst largely positive, the findings identified the potential for improvement in the following areas: staff, patient communication; facilities; the provision of information on treatment and medication; communication on discharge from hospital; the practical implementation of protected mealtimes. Healthwatch has requested a response from the Trust which will be published and circulated together with the report to key stakeholders including the Care Quality Commission. Women and Children's division together with Medicine are currently producing an action plan in response to the report.

## 5. OTHER UPDATES FOR INFORMATION

### 5.1. Implementation of strengths based recruitment (SBR)

ICHT has taken part in this project in conjunction with the Shelford Group (nine other UK teaching hospitals). Strengths based recruitment is about recruiting people based on their natural strengths, values and motivators and not just their competencies. The Trust successfully used SBR in our organisational Nursing restructure and interviewed over 50 nurses in September/ October. As a consequence there is widespread interest in the approach (not just for nursing posts). The Trust is ready to develop profiles for nursing assistants, patient facing administrative staff, staff nurses and new consultants. SBR will be implemented and embedded organisationally at a

pace going forward. To support this NWL Health Education have agreed to fund £100K.

**5.2. Awards**

**5.2.1.** Victoria Harmer has been named Cancer Nurse of the Year in this year's Nursing Times' Awards. Victoria is a team leader and clinical nurse specialist in breast care, leading a team of seven nurse specialists and was nominated for the award by the Breast Cancer Support Group.

**5.2.2.** Julia Gamston one of the Trust's Emergency Nurse Practitioners has won the Patient Safety award at the College of Emergency Medicine Conference for work she did on patient misidentification.

**5.3. Retirement of Professor David Sines CBE**

Professor David Sines CBE, Pro Vice Chancellor and Executive Dean Society and Health Buckinghamshire New University, will be retiring at the end of March 2014.

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For information**

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| **Report Title:** Medical Director's Office Report |
| **Report History:** Regular report |
| **To be presented by:** Professor Chris Harrison, Medical Director |
| **Executive Summary**:<br><br>The attached paper is a consolidated report covering the following areas;<br><br>1. Quality Governance<br>2. Clinical Strategy<br>3. Consultant Appraisal<br>4. Education<br>5. Urgent Care Board<br>6. Public Health & Primary Care |
| **Key Issues for discussion:**<br><br>Please refer to the attached paper which summarises the key issues for discussion |
| **Legal implications or Review Needed:**<br><br>a. No |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br>2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.<br>3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.<br>4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** NA |
| **Recommendations and Actions Required:** NA |

## 1. QUALITY GOVERNANCE

### 1.1 Quality Strategy

The Quality Strategy was presented to the Board in September 2013. The approved document is attached in **appendix A**.

The strategy was launched in November 2013 with a programme of communication and engagement planned across the rest of this financial year. This will fit with the timescales for the Quality Governance Assurance Framework (QGAF) assessment as part of the Trust's FT application process.

The new governance structure for Quality at Imperial College Healthcare Trust (ICHT) has been revised and is outlined in the strategy. The Terms of Reference for the monthly operational quality meetings are in the process of approval with their first meetings scheduled in November. All six improvement principles have an executive lead.

Delivery of the strategy will be monitored through the Management Board (Quality) and Board assurance provided through the Quality Committee.

### 1.2 Care Quality Commission Intelligent Monitoring Report

The report for ICHT is attached in **appendix B**. These new indicators, and this report, will form a key part of our assessment by the Chief Inspector of Hospitals.

The new assessment includes statistical analysis of 87 indicators, nationally compared where possible. The indicators cover the 5 questions Care Quality Commission (CQC) will ask of all trusts; is this hospital safe, is it effective, is it caring, is it responsive and is it well led. The indicators analysed range from Hospital Standardised Mortality Ratios (HSMR) to access targets (e.g. referral to treatment times), to staff and patient surveys, incident numbers and whistleblowing.

Of the 87, ICHT were judged as having no evidence of risk in 79 categories. Three categories were excluded from our assessment. The remaining 5 indicators in which evidence of increased risk was found are;

- 62 day cancer waits (elevated risk Red, score 2)
- The number of whistleblowing episodes to the CQC (elevated risk Red, score 2)
- MRSA bacteraemia numbers (risk Amber, score 1)
- CDiff numbers (risk Amber, score 1)
- National in-patient survey 2012 'worries and fears question' (risk Amber, score 1)

These five areas cover issues that the Trust is already aware of and relevant executives have action plans in place for improvement. A review was undertaken at both the Management Board (Quality) and Quality Committee in November and progress will be monitored going forward.

The Trust is reviewing the methodology which CQC have applied to measure each indicator and plan to report as many of these indicators as part of the Trust scorecard as soon as possible. The Chief Operating Officer is leading the development of the reporting of these indicators.

The CQC have then applied a proportional score for each trust to the above. This has led to ICHT being judged risk band 4, on a scale of 1 to 6 with 6 being the lowest risk. **Appendix C** 'NHS Acute Trust Banding' shows our results compared with other English hospitals. Of note Guys & St Thomas' (score of 3) Bart's (2) and Oxford (3) score higher risk than us. UCLH (6), Kings (5) and Cambridge (6) have lower risk.

### 1.3 Mortality reporting

The Trust's mortality report for month 4 is attached in **appendix D**. The report describes mortality using Dr Foster methodology which includes Hospital standardized mortality ratios (HSMR) and Summary hospital mortality indicator (SHMI). These measure mortality in hospital and post discharge and give an overall summary of how safe our care is.

In summary, mortality rates remain consistently within the top ten best performing when compared nationally.

The Trust monthly HSMR is showing a downward trend with improvement between April to July 2013 with the lowest ratio for the last year of data recorded in July (63).

The current SHMI ratio is 76.49. In both data sets the national benchmark is set at 100 with lower figures indicating better performance.

## 2. Clinical Strategy

The strategy was presented, discussed and accepted at the Trust board seminar on October 31st 2013. The strategy describes an inter-dependent three site vision that fulfils our requirement to meet quality expectations (now and for the future), perform to NHS finance & timeliness standards and capitalise on our relationship with a world class university.

The strategy has been developed using a bottom up approach with over 200 meetings and including significant consultant and senior nurse team involvement. Clinical quality and experience was assessed at the heart of every part of the strategy development and is one of the main drivers.

The strategy includes the unique roles that each of the Trust's three main sites has and incorporates the role of Hospital doctors in community care.

The strategy will ensure that the Trust continues to improve outcomes, drives up quality across the six Berwick dimensions, achieves NHS performance targets and maintains financial viability. It also will increase our national and international profile through AHSC and AHSN, grow services needed to deliver sector unique practices and profile and respond to the need to reduce costs and provide care in new ways, in new settings.

A detailed implementation plan is currently being confirmed and will be presented to the Trust board in the future.

## 3. Consultant Appraisal

Consultant appraisal is a key part of revalidation and the Trust has experienced difficulties in recording and assuring that this is completed. The rate has increased by 20% during this financial year to its current position of 84% in October 2013. Meetings with the Associate Medical Director have commenced with all consultants who have not completed an appraisal in the last year to ensure performance continues to improve.

## 4. Education

An external review of medical education will be complete by December 2013. A detailed report will be submitted and an action plan implemented by the Medical Director. Work has already commenced to improve the experience of our trainees. This includes support from the Educational Team Development Service, part of Health Education England, which is working with the Trust's education team to address concerns about bullying and undermining of junior doctors.

## 5. Urgent Care Board

The Medical Director's Office is represented at the Triborough Urgent Care Board and the Ealing Urgent Care Board by the Associate Medical Director and members of the Operational Team. The Imperial Urgent Care Board has now met twice and is jointly chaired by the Associate Medical Director and the Deputy Chair of Hammersmith and Fulham Clinical Commissioning Group. All these groups are charged with providing oversight of the operational performance of the local and sector health economies, especially during the winter period and ensuring that all provider organisations work effectively and efficiently in a coordinated fashion. The Winter Plan for the three Acute Admitting Sites of the Trust has been agreed and is in the process of a phased implementation over the next six weeks.

## 6. Public Health and Primary Care

Academic Public health and primary care has transferred under the Office of the Medical Director. Operational responsibility for the urgent care centres has moved to the Division of Medicine.

Imperial College Healthcare NHS Trust

**Board Meeting in Public**
**For information**

**Report Title:** Infection Prevention Summary

**Report History:** Regular Trust Board Report

**To be presented by:** Prof. Alison Holmes

**Executive Summary**:
This report includes the Trust's monthly mandatory reports of HCAI for September and October 2013.

## Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

In September there were no trust attributable cases.
In October a trust attributable 'case' was reported from a patient who required urgent abdominal surgery. The source of this bacteraemia was thought to be a contaminant. Actions have included the removal of a bed in a bay to improve access to the sink and to facilitate hand hygiene. Other local actions focussed on mandating the documentation of vascular access devices and blood cultures.

The case in August related to trauma and resuscitation outside hospital was allocated to the Trust following the arbitration process introduced this year. This brings the total number of 'cases' reported against the Trust to **nine** for the year to date.

## *C. difficile*

For 2013/14, the annual ceiling for the Trust is 65 cases of C*. difficile* infection.
In September 11 cases were reported to the PHE, of which 5 cases were Trust attributable.
In October 14 cases were reported, of which 4 cases were Trust attributable.
Year to date 41 Trust attributable cases have been reported to the PHE. There is a marked reduction in the latest quarterly rate.

Of the nine Trust attributable cases in September and October, all but one occurred in patients aged over 65 with six of these patients being over 75 years of age. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in two of the five cases in September and two of the four cases in October All antibiotics were in line with policy or approved by infection clinical team.

## Winter preparedness

The Imperial Health at Work team launched the annual flu vaccination programme on the 14th of October 2013 which includes drop in sessions and Occupational Health staff visiting clinical areas to vaccinate staff. Guidelines for the initial management of patients with suspected influenza have now been updated and communicated to the Trust. In addition, the importance of recognising and managing patients with diarrhoea and/or vomiting during the winter months was highlighted at the Trusts Team Brief sessions

## Antibiotic stewardship

The new adult Treatment of Infection Policy and smart phone antibiotic app will be launched on Monday 18th November to coincide with European Antibiotic Awareness Day (EAAD). Key design features have been introduced to enhance patient safety and prudent antibiotic prescribing. EAAD is supported in England by the Department of Health and Trusts are encouraged to support this initiative. Trust communications are involved to promote the initiative within the organisation. In addition, surveillance of the Trust antibiotic prescribing indicators have been increased to quarterly and work to communicate *C. difficile* risk factors to GP's has been introduced.

## Hand hygiene

**Aseptic Non-Touch Technique (ANTT):** The Trust continues a rolling programme of the ANTT competency assessment programme at Divisional level as part of the infection prevention and control plan. The two-yearly reassessment programme for assessors is due in December 2013 and has now commenced. Completion of assessments has steadily been increasing from 75% in March to 89% (5702 clinical staff) at the end of October 2013. Since the competency assessment programme began in December 2011 a total of 6997staff have been assessed for ANTT competency. Junior doctors are now assessed for ANTT competency on the day of induction in a skills lab setting. These assessments will now be undertaken using medical assessors from the Divisions.
**Hand hygiene compliance**: In October 2013, 89.4 percent of clinical areas submitted a total of 5020 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week). Hand hygiene was 98.4 percent, and compliance with bare below elbows was 98.4 percent.

## Surgical site infection (SSI) Prevention

A cross divisional working group is being developed to encompass all multidisciplinary SSI prevention work programmes, under the leadership of a senior surgeon. This is a key safety and quality outcome and will build upon current work being undertaken at speciality level. This will ensure that Trust wide surveillance is coordinated under one umbrella and will facilitate data being reviewed collectively, along with ensuring evidence based best practice and shared learning.

A detailed monthly Infection Prevention and Control summary is attached as an appendix.

## Key Issues for discussion:

- 'Trust attributed' MRSA BSI cases year to date
- C.*difficile* infections year to date, the reduction in rates and preventive actions taking place.
- Other issues requiring input, investigation or reporting in September and October 2013
- Applied research, Innovation and education

**Legal implications or Review Needed:** N/A

## Link to the Trust's Key Objectives:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

**Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** Management of risks described

**Recommendations and Actions Required:** Continued activity and vigilance, ensuring infection prevention is a core aspect of patient safety and quality of care

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**
**For information**

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| **Report Title:** Executive Performance Report Month 7 2013/14 |
| **Report History:** Regular report presented to the Trust Board |
| **To be presented by:** Steve McManus, Chief Operating Officer |
| **Executive Summary**: Please see report below for month 7 |
| **Key Issues for discussion:** |
| **Legal implications or Review Needed:**<br><br>**No**<br><br>**Details of Legal Review, if needed:** |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br>2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.<br>3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.<br>4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** |
| **Recommendations and Actions Required:** |

## Executive Performance Report

Imperial College Healthcare NHS Trust

### Month 7 : October 2013

**Executive Summary**

This report for the Trust Board summarises the Trust's Performance against key indicators. Accompanying this report is the Month 7 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.

In October 2013 the Trust achieved good performance in:

- Achieving 7 out of the eight cancer access standards (this relates to September data as reported one month in arrears);
- Achieving national 18 week referral to treatment waiting time target for admitted, non-admitted patients and patients on incomplete pathways;
- Achieving the 95% 'all types' 4 hour Accident & Emergency standard;
- Maintaining zero mixed sex accommodation breaches;
- Achieving above target for providing national care standards for stroke and maternity patients;
- Achieving venous thromboembolism assessment rates;
- Achieving the national diagnostics waiting time Standard;
- Sustained good scores for patient feedback.

Areas identified as underperforming are:

- The year to date number of Trust attributed cases of MRSA is 5 against a tolerance of zero. However the Trust only recognises 5 of these cases as 3 of these cases are being activity contested and one is in arbitration. An action plan is in place to further minimise the level of infection;
- The Trust failed to meet the Cancer waiting times for 62 day first standard with 27 patients having delayed treatment. The focus and scrutiny on cancer performance continues to remain a high priority.

Against the Monitor Risk Assessment Framework for October the Trust is 'Amber - green' (2.0) as not having met the cancer 62 day standard and abover the de minimis limit and exceeding the in-year trajectory for cases fof c.difficile.

**Quality**

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| **Mortality**<br>The Trust continues to have one of the lowest mortality rates in England, based upon the Hospital Standardised Mortality Rate and Standardised Hospital Mortality Indicator. | **Scorecard Page 3** |
| **Patient Experience**<br>Overall there has been a slight dip in scores for the trust in the scorecard. This is likely to be attributable to Outpatients no longer collecting iTrack data on Trust core questions, as they now only use the Friends and Family Test (FFT).<br><br>For Friends and family there have been some very positive news. There have been increases in scores for both inpatients (71 from 68 last month) and A&E (significant jump of 69 from 46 last month). Response numbers are good with 35% response rate achieved for inpatients and 19% for A&E.<br>Maternity have also submitted results for the first month in Oct and have scored 65 overall. Monthly performance will now be included in the trust level FFT scores. | **Scorecard Page 4** |
| **Infection & Prevention Control**<br><br>**Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)**<br>In October a trust attributable 'case' was reported from a patient who required urgent | **Scorecard Page 5** |

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| abdominal surgery. The source of this bacteraemia was thought to be a contaminant. Actions have included the removal of a bed in a bay to improve access to the sink and to facilitate hand hygiene. Other local actions focussed on mandating the documentation of vascular access devices and blood cultures.<br><br>The case in August related to trauma and resuscitation outside hospital was allocated to the Trust following the arbitration process introduced this year. This brings the total number of 'cases' reported against the Trust to **nine** for the year to date. However, the Trust only recognises 5 cases year to date as there are three that are being contested and one is in arbitration.<br><br>***C. difficile***<br>For 2013/14, the annual ceiling for the Trust is 65 cases of C*. difficile* infection.<br>In September 11 cases were reported to the PHE, of which 5 cases were Trust attributable.<br>In October 14 cases were reported, of which 4 cases were Trust attributable.<br>Year to date 41 Trust attributable cases have been reported to the PHE. There is a marked reduction in the latest quarterly rate.<br><br>Of the nine Trust attributable cases in September and October, all but one occurred in patients aged over 65 with six of these patients being over 75 years of age. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in two of the five cases in September and two of the four cases in October All antibiotics were in line with policy or approved by infection clinical team. | |
| **Eliminating Mixed Sex Accommodation (EMSA)** In October 2013 the Trust continues its achievement of zero mixed sex accommodation breaches. | **Scorecard Page 6** |
| **Stroke Care**<br>The Trust achieved above both national stroke care targets in October 2013. This performance has been sustained since the beginning of last financial year and the Trust expects this to be maintained. | **Scorecard Page 7** |
| **Research and Development**<br>The Trust continues to report above the 1% increase set by the Trust for proportion of patients enrolled in NIHR Clinical Research network portfolio research studies. Further metrics to assess research and development performance will be included in the Trust Board performance scorecard from January 2014. | **Scorecard Page 9** |
| **Safety Thermometer**<br>The Trust continues to perform extremely well against peers and has one of the best rates of Harm Free care in comparison to the Shelford Group with 95.98% patients being reported as 'harm-free' in October 2013. | **Scorecard Page 10** |
| **Operations** | |
| **Accident & Emergency - 4 Hour maximum waiting time**<br>In October 2013 96.19% of emergency attends at ICHT were seen and discharged within 4 hours.<br>All our three sites were also above the 95% standard. | **Scorecard Page 11** |
| **Accident & Emergency - Clinical Quality Indicators**<br>Our time to initial assessment for ambulance arrivals was below the 15 minute standard at Saint Mary's and Hammersmith but just above at 16 minutes. All our departments have now moved onto the updated version of the Hospital handover system and we are reviewing our ambulance turnaround action plan to reflect the changes related to this.<br><br>Our time to treatment is below the 60 minute standard at Charing Cross and | **Scorecard Page 12** |

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| Hammersmith but just above at 64 minutes at Saint Mary's. we are working on aspects of our winter plans that will assist with this including extra GP support and enhanced consultant presence in our ED's.<br><br>Our rates for left without being seen is within the 5% standard across all sites.<br><br>Our main area of challenge continues to be time in department for admitted patients and as with Time to treatment our winter plans are now advanced and flow from the Emergency Departments and in patient capacity are at the centre of these. | |
| **Cancer Waiting times**<br>Overall for Quarter 2 the Trust met seven of the eight national standards. The failing standard for Q2 was the 62 day first to treatment from GP referral with a performance of 75.3% against a target of 85%.<br><br>In October 2013 the cancer waiting time standards for September were published showing the Trust maintained the same performance as August by meeting 7 out of the 8 National Standards. The Trust failed to meet the 62 day first standard, hitting 76.7% against the 85% target. This was an improvement on the previous month. 27 patients had their treatment delayed. Of the 27 patients delayed, seven patients were referred from local trusts outside the recommended Inter-Trust Referral timeline by day 42 (all were referred > 80 day). The majority of breaches were due to delay in access and reporting of diagnostics, late ITR's and insufficient elective capacity. The tumour site with the largest volume of breaches (13) was within the Urology services as expected as the Trust continues to clear the backlog. Across the 17 Trusts within the London Cancer Alliance, ICHT is one of eight Trusts who are failing the 62 day standard.<br><br>The focus will remain on reducing the backlog position, turnaround time of clinic letters, rigorous PTL management and the re-engineering of cancer pathways focusing on access to diagnostic continues. Agreement has been reached with the diagnostic team regarding prioritisation of all cancer referrals and to give agreed dates to patients within 3-5 days of the referral being made. Two new pathways commenced in September- Head and Neck and Upper Gastro-intestinal (UGI). UGI will undertake a pilot direct to test from 2nd December. The new pathways in Urology (prostate and haematuria) that were launched at the end of October are proving successful in reducing the time to treatment pathway for patients.<br><br>Twice weekly meetings will continue to be held with the Chief Operating Officer and the cancer management team to review and drive improvements in the cancer performance. | **Scorecard Page 13** |
| **Elective Access - Referral to Treatment**<br>M7 continues the performance achievement against all aggregate measures. The admitted performance in September was 93.45% against the 90% target for patients waiting less that 18 weeks on admitted pathways, 96.07% against the 95% target for patients waiting less than 18 weeks on non-admitted pathways and 95.42% against a target of 92% for patients waiting less than 18 weeks on incomplete pathways.<br><br>Out of the 57 treatment function codes that form part of the target regime, the trust is performing against 54. This included achievement of admitted performance for Trauma and Orthopaedics. This was the first time the Trust has delivered this indicator.<br><br>The outlying specialties that had been initially expected to deliver in October 2013, are | **Scorecard Page 14** |

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| non-admitted General Surgery and Urology and revised action plans are in development to improve performance in these areas. In addition, the Trust failed the standard for General Surgery admitted pathways by one patient. The Trust expects to achieve this standard again in November 2013.<br><br>Prospective review of performance for RTT has highlighted the potential for Cardiology and Rheumatology to under-perform against the admitted standard in November due to volume of patients over 18 weeks that have been scheduled for treatment in that month. A capacity review has been undertaken in both specialties to ensure that this is not a re current issue. | |
| **Diagnostic Waiting times** The Trust maintained its year to date performance in October 2013 achieving over 99% performance. | **Scorecard Page 15** |
| **Maternity**<br>The maternity service continued to achieve the 90% target for pregnant women seeing a midwife within 12 weeks and 6 days of pregnancy, at 96.0% in October 2013. | **Scorecard Page 16** |
| **Delayed Transfer of Care**<br>The Trust was below the 3.5% threshold for patients whose transfer of care was delayed in M7. | **Scorecard Page 17** |
| **Quality, Innovation, Productivity and Prevention**<br>The Cost Improvement Programme is driving the delivery of savings as a result of improved efficiencies in key productivity indicators, including staffing, diagnostic demand management, theatre and bed utilisation and outpatient productivity. | **Scorecard Page 18** |
| **Workforce** | |
| Statutory & Mandatory and Cerner training remain the focus of Divisional plans to ensure that compliance of our people, for both of these training elements, are scheduled and completed. Cerner training is due to commence in February and it is imperative that statutory and mandatory training is completed before this to avoid training pressure points for releasing our people for the required training.<br><br>The monthly People KPI Report, which is compiled for each of our Clinical Divisions, is now being rolled out to four of our Corporate Directorates; Private Patients, Estates & Facilities, ICT and Director of Operations. These reports will focus on current performance, issues and areas of concern for all of our key people metrics and will inform the Trust People KPI Report presented to the Operational Board each month. These reports will also be reviewed, discussed and progress monitored at both the Directorate Management and Senior HR Team meetings.<br><br>Recruitment plans to fill current vacancies within the band 2~6 ward nursing establishments and to support the Trusts Winter Wards are being implemented. A successful recruitment open day at QCCH resulted in 19 appointments for Maternity and 3 for Neonatology with the recent recruitment campaign to India resulting in 38 appointments for our ICU and CICU departments. A second recruitment campaign to India is now being planned for March 2014.<br><br>Following a review of vacant posts within the Clinical Divisions, over 150 posts were withdrawn. Combined with the increase in our Nursing and Midwifery numbers this month, this has resulted in the vacancy rate reducing to 10.75% at the end of October. A further audit of vacant posts will now commence within the Corporate Directorates with a view to removing those which are not necessary to deliver the current service requirement. | **Scorecard Page 19** |

Trust Board: 27 November 2013 Agenda Number: 3.2 Paper Number: 9

# Winter Planning 2013/14

## Trust Board

Wednesday 27th November 2013

# Winter Planning 2013/14



- Detailed capacity and demand modelling undertaken to establish the required winter capacity based on 4 key assumptions;
  - 1% growth in emergency activity (based on steady-state impact of QIPP and Office of Statistics data)
  - Reduced elective cancellations
  - 94% occupancy rate to protect quality and improve experience
  - Steady state Length of Stay on emergency pathways
- External engagement and governance
  - Winter plans discussed and agreed with the Commissioning Support Unit, CCG's and the Tri-borough urgent care network
  - Bids to a value of £898,000 funded from the CSU
  - Daily, weekly and monthly monitoring and reporting arrangements in place
- Internal engagement and governance
  - Weekly winter operational delivery group in place to oversee delivery of schemes and performance
  - Winter office and SITREP process launched

# Beds – additional capacity from 4th Nov onwards

Imperial College Healthcare NHS Trust

| Site | Ward | 4th Nov | 11th Nov | 18th Nov | 25th Nov | 2nd Dec | 16th Dec |
|---|---|---|---|---|---|---|---|
| SMH | Lillian Holland | +8 | | | | +16 | |
| | V&A | | | | | +20 | +40 |
| | Witherow | | | | | -14 | |
| CXH | South Green | +7 | | 0 | | | |
| | 4 South | | | +10 | | +20 | |
| HH | C8 | +5 | 0 | | | | |
| | FG | 0 | +9 | | | | |
| **Total** | | **+20** | **+24** | **+27** | **+27** | **+51** | **+71** |

*NB in addition, the Trust is working with Central London Community Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust to open 20 step-down beds on the Charing Cross site from December 2013*

# Other capacity increases



- ED Transfer team
  - Additional team in place between 1-9pm on all 3 sites from 4th November
- Extended senior clinical decision makers
  - ED consultants until 10pm (SMH)
  - Extended middle grade cover in ED until midnight (SMH +CXH)
  - Acute Medicine consultant until 8pm
  - Increased medical discharge capability at weekend (middle grade level)
  - Rapid Assessment & Treatment model CXH and SMH 11am-7pm
- Urgent Care Centre Cover
  - Extended opening hours in place at SMH to 24/7 cover
  - Extended opening hours for HH to be in place from mid-Nov
- Trauma Lists
  - 2 additional weekly trauma lists will be implemented from December 2013
- Cancer Admissions Unit
  - The unit will open 7 days per week from January 2014

# Winter site management

Imperial College Healthcare NHS Trust

- Winter office
  - Manager started in post 4th Nov
  - Support team started in post 11th Nov
- ICHT internal daily SITREP
  - Draft template in place on 11th Nov
  - Go-live with SITREP on 11th
  - External agencies confirmed input to SITREP
- Co-ordinated discharge support
  - 7 days per week
  - Increase allied health professionals/social work availability on all three sites
  - Daily patient level information on delays available to external partners
- External reporting
  - Sector winter reporting commenced 4th Nov (twice weekly)
  - New TDA/NHSE reporting requirements commence daily 5th Nov
- Internal professional standards
  - 5 standards agreed by the Medical Directors office and the Divisional Directors. Implemented November 2013

# Risks



Several risks to the winter plans have been identified and are being managed through the Winter Delivery group;

- Staffing
  - Nursing staff availability for additional beds on the St Mary's Hospital site
- Financial
  - Further £360k agreed from CSU re surgical step-down beds
  - Approximately £600k cost pressure
- CLCH Community beds
  - Availability of nursing staffing arrangements to cover community beds

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For information**

| |
|---|
| **Report Title:** Finance Performance Report |
| **Report History:** Regular Report |
| **To be presented by:** Marcus Thorman, Director of Finance |
| **Executive Summary**:<br>The Trust has achieved a year to date surplus of £10.9m at the end of October (after adjusting for impairments and donated assets), an adverse variance against the plan of £0.5m. This is based on a surplus in month of £4.2m, which was a favourable variance of £0.3m. CIPs are behind plan by £4.0m, an improvement in month. However, this has been offset by over-performance income on CCG contracts and utilisation of the contingency fund. It should not be expected that the over-performance on income will continue and therefore persistent improvement in delivery of the CIPs is required in order to achieve the financial plan target.<br><br>The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' anticipated income and expenditure for the year. The forecast includes an estimate for asset impairment of £25m for the devaluation of land & buildings. The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets. |
| **Key Issues for discussion:**<br>Continued improvement required in future months through improved performance against CIPs. |
| **Legal implications or Review Needed:** No<br><br>**Details of Legal Review, if needed:** N/A |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** |
| **Recommendations and Actions Required:** |

Building world class finance

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# FINANCE REPORT - OCTOBER 2013

## 1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st October 2013.

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

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

2.1 **Statement of Comprehensive Income (I&E Account)** - The Trust's financial position for the month is a **surplus** of £4,183k, with a year to date surplus of £10,874k. This was a **favourable** variance of £339k in month.

2.2 **PCT Service Level Agreement (SLA) Income** – The PCT SLA contract monitoring report for the month was calculated using the month 6 actual data and adjusted for the planned monthly profile within the SLA. Over-performance against plan is £15.2m and is associated mainly with CCGs' QIPP plans to reduce patient flows into hospital not being achieved.

2.3 **Expenditure** - Pay expenditure shows an **adverse** variance of £7,737k year to date as result of under-achievement of CIPs and a failure to reduce agency costs. Non pay expenditure is showing an **adverse** variance year to date of £5,924k which is mainly due to the purchase and sale of drugs for £2.8m to Lloyds Pharmacy as part of them running the outpatient pharmacies.

## 3 Monthly Performance (Page 4)

3.1 Divisional financial performance has been assessed against the Financial Risk Rating. The metrics shown in the tables above reflect the five key themes and summarise performance against 25 detailed metrics. The FRR is supporting improvements in financial management and engagement within Clinical Divisions and plans are on track to expand the FRR to Directorates.

3.2 There needs to be continued focus on CIP delivery thereby reducing unit costs and securing a reduction in the current expenditure run rate which is key to delivering the financial plan targets. Shortfalls against CIP delivery have been mitigated by improved operational financial management and contribution earned from additional income.

3.3 Operational financial management has been strengthened by fortnightly reporting of recruitment, bank & agency, procurement compliance and discretionary spend to Management Board.

3.4 Clinical Divisions and Non-Clinical Directorates have shown an improvement in performance against plan relating to increased CIP delivery.

## 4 Cost Improvement Plan (Page 5)

4.1 The CIP plan for the year is £49.3m. Expected forecast outturn is £46.1m which is an improvement of £4m.

4.2 Year to date delivery of CIP was £24.0m (a deficit of £4.0m against plan)

4.3 The Transformation Board is closely monitoring the position and significant work has taken place to ensure plans are robust in delivery of the 2013/14 target.

## 5 Statement of Financial Position (Balance Sheet - Page 6)

5.1 The overall movement in balances when compared to the previous month is an increase of £4.1m and the significant movements were an increase in Debtors (£14.5m) and increase in Creditors (£15.6m). Increase in debtors was predominantly due to outstanding payments for SLA over-performance, Project Diamond and R+D MFF due from CCGs and NHS England. The increase in creditors was related to the deferral of income received in advance for Education and R&D projects.

## 6 Capital Expenditure (Page 7)

6.1 Expenditure in month was £2.4m (£10m year to date) which is £2.4m behind plan.

6.2 The programme is behind plan due to the Endoscopy project, which was delayed by extended procurement negotiations. The theatre upgrades and backlog maintenance have been re-phased as the detailed works have been now defined and implemented.

## 7 Cash (Page 8)

7.1 The cash profile has been set out as per the TDA plan. Cash is behind plan due to organisational changes in the NHS and delays in agreeing funding for Project Diamond and R&D MFF.

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

8.1 The presentation of the Financial Risk Rating has changed to a tabular format and includes the new Monitor Continuity of Service risk rating. All risk metrics are on track.

## 9 Conclusions & Recommendations

The Board is asked to note:

- The **surplus** of £4,183k for the month of September; the cumulative **surplus** of £10,874k, a cumulative **adverse** variance of £457k against the plan.
- Actual achievement of new CIP schemes year to date was £24.0m which is behind plan by £4.0m. It is therefore recommended that discretionary expenditure and new projects are stopped until it is confirmed the Trust is back on track with delivery of the financial plan.
- Forecast outturn remains at a surplus of £15.1m.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Chief Financial Officer

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For information**

| |
|---|
| **Report Title:** Director of People & Organisation Development Report |
| **Report History:** Regular Report |
| **To be presented by:** Jayne Mee, Director of People & Organisation Report |
| **Executive Summary**: This report updates on the People & Organisation Development strategy developments. |
| **Key Issues for discussion:**<br>For information. |
| **Legal implications or Review Needed:** Yes<br>No<br><br>**Details of Legal Review, if needed:** N/A |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br>2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.<br>3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.<br>4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:**<br>N/A |
| **Recommendations and Actions Required:**<br>For Information. |

# 1. TALENT DEVELOPMENT

## 1.1. Engagement

The National NHS Staff Survey was launched on Monday, 7 October and was sent on-line to a 10% sample of the Trust. This national survey will be open until 2 December 2013 and we will have results in February/March 2014.

We also completed the launch of the new Local Engagement Survey on 21 October. Designed to complement the national NHS Staff Survey, this is a short quarterly on-line survey of 15 questions chosen locally, with 25% of our people receiving the survey each quarter. The survey will deliver much more timely feedback on engagement and will allow us over time to analyse results at a very local (ward) level, which will enable far better action planning than we can do from the national survey.

## 1.2. Leadership Development

The Certificate in Medical Leadership, the first of our new Leadership programmes commenced on 9 October 2013. This programme is a joint venture with Imperial College Business School who are co-designing and delivering the programme with significant input from our Executive Team.

The cohort of sixteen on this bespoke programme includes all our Divisional Directors, as well as Divisional Directors of Operations, Chiefs of Service and Divisional Directors of Nursing. The first module focused on the Strategic Landscape to set the context for the programme and sessions included input from both Prof Nick Cheshire and Bill Shields, as well as Prof Dermot Kelliher, and Adrian Bull, Academic Health Sciences Network.

Also in October we launched two other leadership programmes for our leaders. Horizons - Strategic Leadership, a bespoke programme for our aspiring top leaders and Aspire – the Leadership Way. The opening day included presentations from both of the Executive Sponsors, Jayne Mee, Director of People and OD, and Steve McManus, Chief Operating Officer. The programmes include a rich mix of delegates including Chiefs of Service, General Manager, senior nurses and senior leaders from Corporate Directorates. The Horizons programme included a key note speaker Dr Katy Steward, Associate Director of Leadership from the Kings Fund who spoke on the theme of authentic leadership and Patient Centred leadership.

In addition, we opened up our fourth new programme in October, Foundations – An Introduction to Management. This is aimed at team leaders, supervisors and junior

managers or those who aspire to move into management roles. This will be open to anyone, clinical or non-clinical across the Trust and will be primarily aimed and Bands 2-5. The programme will commence on 25 November.

### 1.3. Communication Skills/Patient Experience

We have been working closely with the Cancer Recovery team on Patient Experience and have been rolling out a bespoke training in clinical communication skills which has been developed by McMillan Cancer entitled “Sage and Thyme”. This is a tailor made training specialising in communicating effectively with patients who are emotionally distressed and has been evaluated very strongly to date. We have trained 740 staff in cancer services to date and continue to roll this out amongst the designated cancer wards and departments. In addition we have just won a bid for additional funding of £130K to continue the roll out of communication training across cancer services and the whole Trust for 2014-5 form the Local Education and Training board.

### 1.4. Performance & Development Review

The department has just concluded a period of consultation and engagement with managers around the redesign of our current appraisal process. The aim of the review has been to develop a PDR (Performance Development and Review process) which allows clear assessment of performance against ratings for all staff. We will aim to re-launch the new process later in the year and support managers with a programme of training and development to bring about the required change in emphasis and culture.

## 2. EMPLOYEE RELATIONS

### 2.1. Employee Relations Service

The Trust’s employee relations advisory service went live on 1 November 2013. Responsibility for advising managers on the application of the disciplinary, sickness absence and other workforce policies will completely transfer from Capsticks (the current provider) to our internally run service by 21 November. The agreements for the transfer have been widely communicated to line managers. Bringing this service in house will enable huge improvements in the quality and speed of our management of sensitive people issues.

### 2.2. Partnership Agreement

The Trust and its trade union partners have agreed a new partnership agreement which reflects the constructive working relationship we have developed with our recognised trade unions. Under this agreement the Partnership Board will become the main forum for discussion between trade union and management representatives. The first meeting of the Partnership Board is on 5 November.

### 2.3. Mediation Service

In October a new cohort of 16 people have been trained to become mediators. The training programme has been funded with the support of the charity. Our mediation service which is provided by CONTACT, the Trust's Counselling and Conflict Resolution Service, enables people in the workplace to resolve disagreements without the need to resort to formal procedures. The service manages about 20 cases per year and is reliant on suitable people giving their time and expertise to act as mediators.

### 2.4. Linking Incremental Pay Progression with Performance

The Trust intends to implement new pay rules which explicitly link performance with pay progression from 1 April 2014. A key stakeholder group comprising management and trade union representatives had been formed to develop a local pay progression policy which will award our people with incremental pay increases in their performance is rated as good (or better) at their annual performance review. This important piece of work is part of a wider redesign of reward arrangements to support the development of a high performance culture at Imperial.

### 2.5. Dignity and Respect

As part of our drive to improve staff engagement levels we are revising what is currently called the Bullying and Harassment Policy. The new Dignity and Respect Policy will focus on the types of positive behaviours we expect from our people. It will also signpost the options and support available to people who experience undermining behaviour from colleagues.

## 3. RESOURCING

### 3.1. Senior Recruitment

- Ian Garlington joined the Trust on 7 October as Director of Strategy.
- Michelle Dixon has been appointed Director of Communications and External Relations and will join in the New Year. She will join from the BMA where she is currently Director of Communications.
- Martin Lerner joined the Trust on 21 October as the Divisional Director of Operations for Surgery & Cancer.
- Dr Senga Steel has been appointed as Deputy Director of Nursing. Senga joins us from Whittington Health where she is currently Assistant Director of Research, Innovation and quality/senior nurse. She is due to start in early January.

- Guy Young, currently at UCLH, has been appointed Deputy Director of Patient Experience; he is due to start in January.

- John Wood, has been appointed as Programme Director- Pathology Modernisation. John joins us from Southampton University Hospital NHS Foundation Trust where he is currently Managing Director; he is due to start on 2 January 2014.

### 3.2. Nursing & Midwifery Recruitment

- The drive to reduce nursing bands 2 – 6 vacancies down to 5% continues. Between April and October of this year 408 nurses, nursing assistants and midwives joined the Trust, of which 51 started in October. During the same period 482 offers were made and accepted.

- 46 student nurses whose final placement was in the Trust have been offered jobs within the Trust.

- The W&C Division Open Day on 19 October was very successful; 16 midwives and 6 nurses have accepted offered.

- An overseas campaign aimed at recruiting 30 ICU nurses from India is taking place from 12-16 November; we continue to explore the possibility of an overseas campaign for neonatal and Imaging nurses.

- Recruitment is also underway in Medicine for an additional 43 Band 5 staff nurses for escalation wards, together with 16 healthcare assistants.

  Although a large number of nurses & midwives have been recruited we are not in a position to stop recruitment and work needs to be maintained in the Divisions on retaining those people who are performing well in the organisation.

## 4. PEOPLE PLANNING & INFORMATION

### 4.1. Workforce Assurance Tool

October will see the first monthly summary report to the Trust Board of our performance as monitored through the National Workforce Assurance Tool. This report has been developed and is produced by the People Planning and Performance Teams and is viewed by the TDA as an exemplar of good practice to other Trusts.

### 4.2. People Planning

Work continues to create a people plan to support the Trusts SaHF, OBC and Clinical Strategy through collaborative working with Clinical, Finance and Performance colleagues. Engagement with the SaHF PMO and NWL LETB started this month.
We hope to establish a forum that will enable discussion and inform direction for the sector in the delivery of an effective workforce plan.

### 4.3. Trust Vacancy Rate

A focused review of all vacant established ESR posts across the Trust has resulted in over 150 posts being removed from the Divisional establishments which were not relevant to current service requirements. The reported vacancy rate for October is now 10.77%; down from 12.10% in September. Further review, within the Corporate Directorate establishments, will take place during November.

## 5. HEALTH & WELLBEING

### 5.1. Occupational Health

The flu vaccination campaign began on 14 October. We are aiming to vaccinate 4000 people. This has been publicised in InBrief and there is information on the SOURCE via Your Working life and Occupational Health. We will focus on the high risk areas initially and we will visit these areas. Thereafter there will be drop in clinics. We have been working with communications on publicising this.

### 5.2. Heath Foundation Shared Purpose Programme

The Shared Purpose Programme, funded by the Health Foundation aims to develop a toolkit based on potential links between workforce predictors and clinical outcome data. The quantitative project is at the data collation and cleaning stage, in preparation for the analysis of three-year retrospective data. Workforce data cleansing for intensive care areas will be complete by the end of November and collation of clinical outcomes data has commenced, with the support of intensive care areas. We now have support of the Professor of Applied Statistics from the University of Cambridge to agree the data analysis process.

The qualitative project to understand staff perceptions of risk and safety is progressing well. Ethics approval is being sought, the pilot is complete and staff interviews are planned for November.

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For decision & For information**

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| **Report Title:** Director of Governance and Assurance report |
| **Report History:** A new, regular report |
| **To be presented by:** Cheryl Plumridge, Director of Governance and Assurance |
| **Executive Summary**: The attached paper is a consolidated report covering the work of the Director of Governance & Assurance area including quality and safety, service quality, legal issues and CQC activity. |
| **Key Issues for discussion:** Please refer to the attached paper which summarises the key issues for discussion and the actions required. |
| **Legal implications or Review Needed:**<br>a. No<br><br>**Details of Legal Review, if needed:** N/A |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br>3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** |
| **Recommendations and Actions Required:** The Board is asked to approve the application and note the changes to the nominated individual. |

Imperial College Healthcare NHS
NHS Trust

**Director of Governance and Assurance Report**

**November 2013**

## 1. Introduction

This is the first report of the Director of Governance and Assurance since taking up post at the beginning of July and asks the Board to note:

- the overview of the work of this Directorate; and
- a brief overview of key areas of work over the last few months.

And asks the Board to approve:

- a CQC Registration.

## Governance

The Board approved an update Risk Management Strategy and Policy in July, and an updated Trust Board Risk Register is now in the final stages of preparation and will go to the Audit & Risk Committee in December before going before the Trust Board in January 14. A dedicated risk manager will be recruited shortly. Other areas of work include Foundation Trust constitution and membership, and reviewing/rewriting Trust guidelines and policies. The latter is a specific area of work that will need considerable resource devoted to it going forward; the resource has now been agreed to enable this to happen.

## 2. Quality & Safety

**The Quality & Safety Team** focuses on **Serious Incidents** (SI). The predominant themes for '13/'14 to date have been pressure ulcers, infection control and maternity service. There were 33 SIs for the first quarter of this year and 41 SIs during the second quarter. A serious incident investigation is undertaken where certain criteria are met, for example, an unexpected death, a grade 3 pressure ulcer or a never event. SI Panels are held following each investigation to ensure root causes, and action and learning points have been correctly articulated and as part of the quality agenda there has been and continues to be an increased emphasis on learning from our mistakes and preventing recurrence. The Medical Director-chaired weekly incident review meeting takes prompt action immediately following incidents. The new Safety & Effectiveness Committee, also chaired by the Medical Director, keeps under review themes and ensures learning is implemented and enduring, and there are further plans to increase Trust-wide awareness and learning through communication e.g. SI bulletins and training events. The Trust Quality Committee will also receive regular appraisals of themes and actions taken.

**Research**: As part of the focus on implementing best practice and evidence-based policy, the Governance and Assurance team will be establishing a research liaison post funded 50/50 by the Trust and the Centre for Patient Safety and Service Quality(CPSSQ). (CPSSQ is a partnership between Imperial College and ICHT and is partly funded by NBIHR as a Patient Safety Translational Research Centre.) The post will enable the Trust to learn of, and translate research findings into patient care, help identify further areas for research (e.g arising out of complaints or serious incidents), and enable the Trust to play a fuller role in facilitating the research work of the Centre and ensuring it is clinically relevant. (NHSLA described this initiative we are taking as innovative and best practice.) Nick Cheshire has

recently been appointed the new clinical lead of the CPSSQ, and both Nick Cheshire and Cheryl Plumridge have been appointed to the CPSSQ Management Board.

## 3. Service Quality

The **Service Quality Team** covers the area of complaints, claims, Inquests and medico-legal enquiries. The work of the team is busy and expanding both in terms of volume and profile.

**Complaints** The number of complaints received in the 6 month period May - Oct '13 was 425 which averages about 70 per month. This shows an increase of 12% on the previous 6 month period but slightly down on the same period last year. All complaints are seen on arrival by the Director of Governance and Assurance and an Associate Medical Director: the more serious complaints are now discussed and investigations into them overseen at the Medical Director's weekly incident review meeting. This new approach of viewing complaints and incidents together enables the Trust to get early warning of potential problems, to triangulate feedback in spotting themes, and to take early action to respond to complaints and take swift remedial action. (A more detailed report on complaint handling in the context of the Ann Clwyd MP report has been commissioned for the Audit, Risk & Governance Committee on 11 December.)

**Claims** The Trust settled 48 claims last year ('12/'13). Some 55 formal claims were made over the last 6 months – virtually the same number as the preceding 6 months. The claims covered a wide range of areas but the more common causes arose from obstetrics and maternity, vascular surgery, emergency department, gynecology, neurosurgery and orthopaedic surgery. Top recurring themes were failure to diagnose, failure to recognize complication in treatment, consent (failure to warn) issues, delays in treatment and surgical foreign body left in situ. More serious claims tend to take several years to reach conclusion: claims recently settled relate to incidents as far back as 1998/9. Many claims will have had investigations carried out: much organizational change will have occurred and improvements put in place. The Medical Director's weekly incident meeting ensures incidents which might give rise to a claim are fully investigated.

NHSLA who underwrite the Trust's claims are making changes to the way they charge Trusts based on a Trust's claims history and in keeping with evidence of a Trust's ability to learn from past claims. We are working closely with NHSLA to ensure changes we are making to put quality at the heart of our agenda are in keeping with best practice. Initial feedback from NHSLA and others is good and we expect to be invited to take part in NHSLA workshops to help develop best practice for communication NHS-wide.

**Inquests**: The number of Inquests involving the Trust rose 62% on the previous 6 months (up to 84) and look sets to be a growing area for the Trust giving changes in coronial law which requires Inquests to be held usually with 6 months of the date of death and facilitates greater involvement from bereaved families. The Francis report also emphasised the importance of Inquests in investigating healthcare related deaths.

The Trust will usually appoint legal representation for Inquests where Trust healthcare professionals are called to give evidence and/or where the next of kin appoint a barrister to represent them. As well as reaching a conclusion on cause of death, a Coroner will also consider whether to make a Rule 43 or Prevent Future Death (PFD) pronouncement which requires the recipient organization to provide a written response and details of which are published. Rule 43s or PFDs are not applicable where the Coroner is provided with evidence of changes or improvements an organization has already taken to avoid similar deaths. Key to this for the Trust is being able to demonstrate in evidential terms that actions have been identified and learning implemented.

**In House Legal Team** A recent development has been approval to a business case to create an in house legal team. Many other Trusts already have in house legal staff and detailed benchmarking was undertaken at King's College Hospital NHS Foundation Trust and Barts NHS Trust. The rationale for establishing an in house capability is to improve both quality and cost effectiveness. The Trust currently outsources all of its legal work, much of which could, in future, be undertaken more efficiently and cost effectively in house. In house roles include legal representation at Inquests, advice on claims, and responding to the high volume of ad hoc medico legal issues. An in house legal capability will not

eradicate the requirement for external legal advice but will reduce considerably current reliance on external advice and enable the Trust to act as an 'intelligent customer' in commissioning external work. An in house legal capability will also enhance our quality agenda by enabling us to be more proactive in running courses, providing teach-ins as part of, for instance, junior doctors' induction programmes, to provide readily accessible advice on issues which arise frequently in a medico-legal context such as consent and mental capacity, and to synthesize and communicate learning from claims, Inquests, complaints and serious incident investigations. The Trust is monitored by CQC, NHSLA and others on its ability to learn from feedback and mistakes, and this will provide us with the capability and capacity to improve significantly our performance in this area.

In addition, we are also looking at establishing an in-house capability to take on the sizeable commercial, real estate and dispute resolution legal work that the Trust currently commissions. The Director of Governance and Assurance is working with the Director of Strategy (including Estates) to do a cost/benefit analysis based on pattern of spend and future requirement in this area before establishing a nascent in-house capability, which can be grown subsequently as required. In quantum terms, we would expect an in-house capability to produce significant cost savings in the medium term.

## 4. Care Quality Commission (CQC)

As part of our ongoing work with CQC, there are three areas to highlight.

**Inspections**

CQC conducted an unannounced routine inspection at Western Eye Hospital site on 3 October 2013. The factual accuracy report has been received and the final report will be published late November 2013. The factual accuracy report highlights some areas that the trust should consider reviewing but found us to be compliant with the five outcomes inspected. The five outcomes were:

Outcome 2: Consent to care and treatment
Outcome 4: Care and welfare of people who use services
Outcome 13: Staffing
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 21: records

Until final, this report is subject to review but the outcome is unlikely to change.

CQC will conduct a short notice Tri-borough safeguarding and looked after children inspection at some point over the next 2 years. Initial meetings have been held to plan for this locally and CWHH CCG Safeguarding Lead will be hosting a Tri-Borough Safeguarding Children Health Network meeting to plan across the sector on November 18th.

**Complaints/ Information of concern/ whistleblowing**

The Trust has not received any whistleblowing alerts since July 2013. In October 2013, the Trust received two complaints from patients who had contacted CQC directly. These were:

Complaint 1: A complaint from a third party re: an alleged incident involving a lady and security at CXH
Complaint 2: A complaint regarding the impact on care of changes to breast services

Both complaints have been investigated. The complainant in complaint 1 has escalated their concerns to Andy Slaughter (MP). A thorough investigation had already been undertaken and the allegations could not be substantiated from statements and CCTV footage. We have responded to the complainant within the constraints of data protection and at present they remain unsatisfied with our response. A response has been sent to Mr Slaughter and the complainant has been advised to contact the Omsbudman.

Complaint 2 has been investigated as far as possible but in order to complete the investigation, the identity of the individual would need to be known. At present the complainant does not want to pursue the complaint further.

Responses have been sent to CQC regarding both complaints and they are satisfied with our actions to date.

**Leadership Walkaround**

Following the recent CQC inspection at WEH a smaller leadership walkaround was conducted at WEH; a walkaround was conducted at Hammersmith Hospital on 25 October, with thirteen areas being visited; and a further walkaround was undertaken at Charing Cross on 15 November.

The key areas with the potential to affect the quality or patient experience included standards of record keeping and the inconsistent use of identifying clean equipment. Action plans have been developed and will be monitored through the divisional governance processes.

Future leadership walkaround arrangements are under review in line with potential changes to the CQC inspection regime and are likely to include more no notice, weekend and evening visits.

**Registration**

CQC have been notified of changes to the nominated individual at the trust arising as a result of the changes to the position of Chief Executive. Professor Nick Cheshire is currently the nominated individual for the Trust. An updated registration certificate reflecting these changes has been received.

An application to register the regulated activity the 'management and supply of blood and blood products,' needs to be approved by the Board. The regulated activity is conducted at Hammersmith Hospital and St. Mary's hospital sites. This activity is ongoing and we have been awaiting confirmation from CQC that our services require registration. We have now received this, hence this submission. An amended statement of purpose will be submitted with the application in accordance with CQC processes.

**ACTION REQUIRED*:* The Board is asked to approve the application and note the changes to the nominated individual**

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For decision**

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| **Report Title**: NHS Trust Development Authority Self-Certifications: for August and September 2013. |
| **Report History:** Regular |
| **To be presented by:** Marcus Thorman, Chief Financial Officer. |
| **Executive Summary**:<br><br>As part of the ongoing oversight by the NHS Trust Development Authority (TDA) and in preparation for the Trust's application for Foundation Status, the Trust is required to submit two self-certified declarations on a monthly basis. These self–certification declarations have replaced the Single Operating Model (SOM), which the Trust completed and submitted to NHS London, up until the end of 2012/13.<br><br>The two returns being submitted monthly are:<br>Oversight: Monthly self-certification requirements – Board Statements;<br>Oversight: Monthly self-certification requirements – Compliance Monitor.<br><br>Under the new oversight model, all performance is reported one month in arrears, with the exception of cancer which is reported two months in arrears.<br>The Board is asked to approve the August and September 2013, submission for ratification.<br><br>The August and September returns were approved by the Chief Financial Officer (CFO) prior to their submissions.<br><br>This process has been agreed with the TDA for approval of retrospective Board sign approval assuming Executive sign off had already been given. |
| **Key Issues for discussion:**<br>• No changes to the compliance monitor returns since July;<br>• Board Statement question 7 updated to reflect approval of the revised Risk Management Strategy by the Board in July;<br>• Board Statement question 10 updated to reflect performance on MRSA and cancer targets for August;<br>• Board Statement question 10 updated to reflect MRSA, C.difficile and cancer targets for the month of September;<br>• Board Statement 12 updated to reflect approval of the revised committee structure by the Board in July. |
| **Review Needed:**<br>a. Yes √<br>b. No |

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| **Details of Legal Review, if needed:** |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br>2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:**<br><br>Continued registration of CQC, without having any conditions or non-compliant inspections recorded against the Trust.<br><br>Monthly reporting of the Trust's performance and action plans being put into place to ensure improvement is measured and monitored by management, where targets are not being achieved. |
| **Recommendations and Actions Required:**<br>a. For review and approval √ |

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For information**

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| **Report Title:** Research Activity Update Report |
| **Report History:** A follow up to the annual research report to the Trust Board meeting on 25.9.13 |
| **To be presented by:** Professor Jonathan Weber, Director of Research |
| **Executive Summary**: Following the annual research report presented to Trust Board in September 2013, attached is an update on recent research activity and initiatives within the Imperial Academic Health Science Centre (AHSC), including the North West London Clinical Research Network. |
| **Key Issues for discussion:** Strategic research agenda across the Imperial AHSC Involvement and engagement of patients and public in our research. |
| **Legal implications or Review Needed:**<br>a. No<br><br>**Details of Legal Review, if needed:** N/A |
| **Link to the Trust's Key Objectives:**<br><br>4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** |
| **Recommendations and Actions Required:**<br>None – for information/noting |

## 1) North West London Clinical Research Network (CRN)

In September, ICHNT was selected to host the NIHR Clinical Research Network (CRN) for North West London (NWL), worth around £15m per annum.

Working with all NHS providers in the region, the CRN will help to increase the opportunities for patients to take part in later phase clinical research, ensure that studies are carried out efficiently, and will support the Government's Strategy for UK Life Sciences by improving the environment for commercial contract research.

The key senior posts of Clinical Director and Chief Operating Officer have been recruited, and a process is underway to enable the transition of existing governance structures and workforce into the new CRN.

## 2) NIHR Imperial Biomedical Research Centre (BRC)

The BRC supports more than 600 active clinical research studies at any one time. Feedback from the NIHR on the first year of operations was very positive. New experimental medicine projects have been implemented across all research Themes in the BRC, and outputs from previous initiatives are also bearing fruit (for example the I-Knife surgical tool, reported previously).

As of 1 April 2014, two years of the current BRC programme will have passed, with three years remaining until a renewal decision. It is essential to be able to demonstrate sufficient outcomes within this period and, as such, the next two years will be crucial to delivery of BRC plans and to our renewal application. BRC Themes are currently engaged in planning for 2014/15 and beyond.

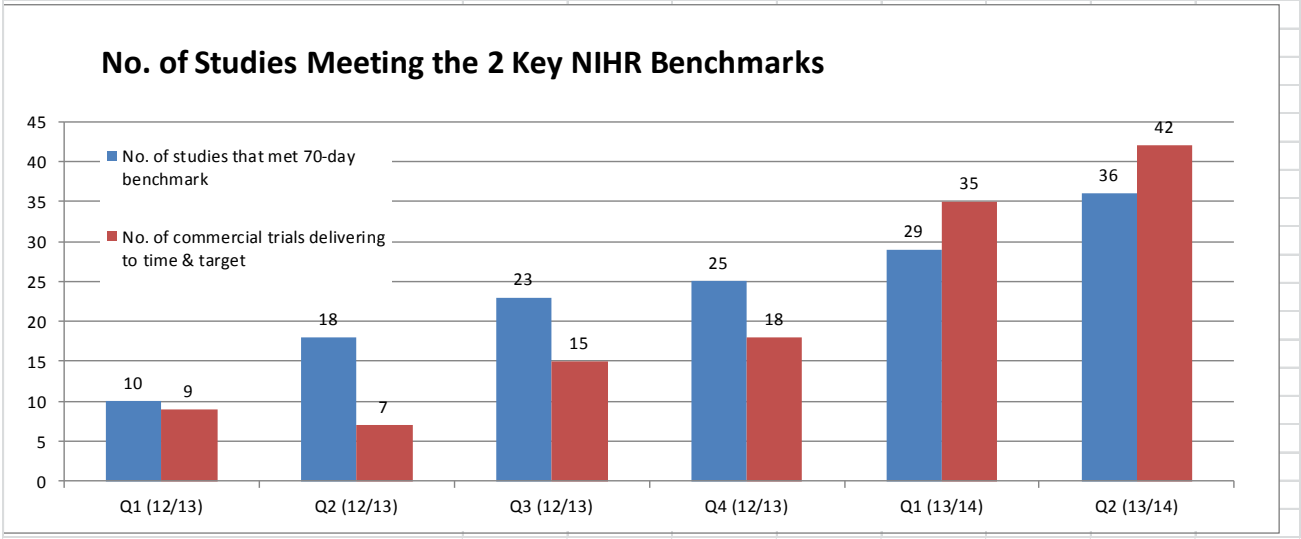
As well the Imperial Clinical Phenome Centre at St Mary's and the MRC-NIHR Phenome Centre at Hammersmith, the BRC is actively involved in supporting the NIHR BioResource – a national resource comprised of UK volunteers who are willing to be approached to participate in research studies and trials on the basis of their genetic make-up. The aim is to include over 100,000 patients and volunteers by 2017. The BioResource is able to provide researchers – including commercial organisations – with groups of volunteers, tailor-made to particular research questions.

The Imperial BRC is also involved in a collaborative initiative to explore the possibility of integrating and sharing electronic patient data, together with genotypic and phenotypic information derived from clinical studies, in order to demonstrate benefits for particular patient populations.

## 3) NIHR Performance Metrics for Initiating and Delivering Clinical Research

The Trust continues to make steady improvement in terms of the time taken to approve clinical research studies, to recruit the first patient into studies, and to deliver commercial studies to time and target. ICHNT performance is now above the sector average for the first time. A median time of 78 days has been achieved for interventional studies to recruit their first patient. Performance per quarter since 2012/13 Q1 is summarised below:

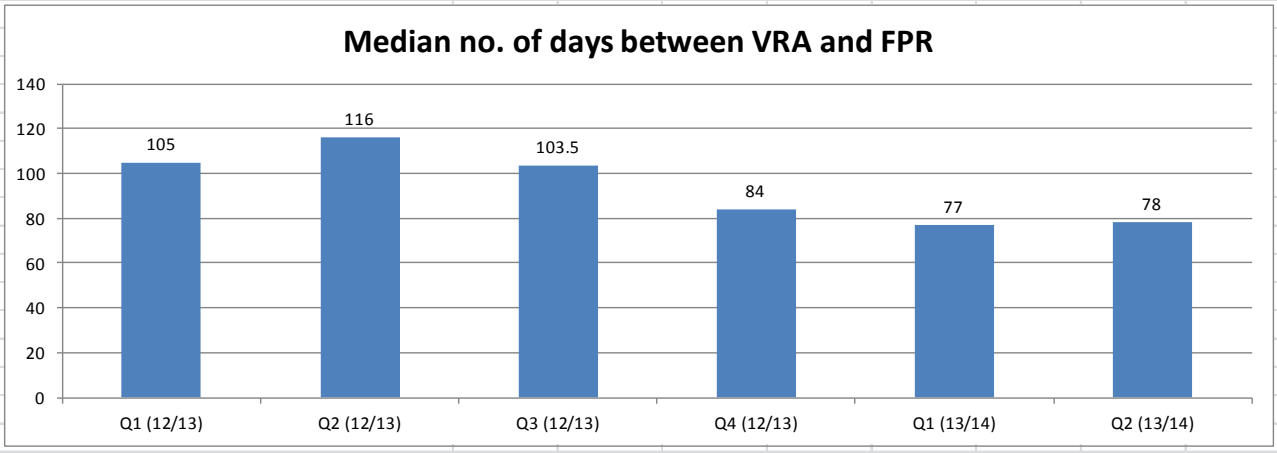
| | 2012/13 | | | | 2013/14 | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 (12/13) | Q2 (12/13) | Q3 (12/13) | Q4 (12/13) | Q1 (13/14) | Q2 (13/14) | Q3 (13/14) | Q4 (13/14) |
| No. of studies that met 70-day benchmark | 10 | 18 | 23 | 25 | 29 | 36 | | |
| No. of commercial trials delivering to time & target | 9 | 7 | 15 | 18 | 35 | 42 | | |




## SUMMARY OF PERFORMANCE ON NIHR METRICS

*VRA = Valid Research Application*
*FPR = First Patient Recruited*

| | 2012/13 | | | | 2013/14 | | | |
|---|---|---|---|---|---|---|---|---|
| **INITIATION** | Q1 (12/13) | Q2 (12/13) | Q3 (12/13) | Q4 (12/13) | Q1 (13/14) | Q2 (13/14) | Q3 (13/14) | Q4 (13/14) |
| Median no. of days between VRA and FPR | 105 | 116 | 103.5 | 84 | 77 | 78 | | |




## 4) Divisional Infrastructure for Research

As part of the Trust's reorganisation into four Divisions, a number of initiatives have progressed to support and enable more high quality clinical research.

*Divisional Directors of Research*

The post of Divisional Director of Research (DDoR) has been developed, whose role is to develop the quality and quantity of clinical research within each Division, in line with the over-arching strategic priorities set out by the AHSC Research Committee, and to ensure delivery of research against national and local performance benchmarks. Working through a Divisional Research Committee, DDoRs will also ensure appropriate feasibility, financial, regulatory, and performance oversight for all clinical research studies within their Division.

*Divisional Research Managers*

A consultation has recently taken place with respect to Divisional Research Managers. A standard role description has been developed to reflect requirements for managing and reporting on clinical research activity within each Division. Reporting and accountability lines have been proposed which will enable flexibility in terms of working across Divisions, and will also ensure that performance against external metrics is managed. Four Divisional Research Manager posts will report to their respective DDoRs, and will provide support for the Divisional Research Committees. One of these will be a Senior Divisional Research Manager, who will have additional responsibility for ensuring that sufficient support is provided to all Divisions, and that consistent approaches are applied to the management of research activity and performance, via close working with the BRC Office. The Senior post would also be responsible for the new feasibility support posts (see below), which will also work across all Divisions as required.

*Research Feasibility*

Two new 'research feasibility support' posts have been created. Working across Divisions, these posts will be responsible for developing and supporting systems at clinical specialty level to ensure robust feasibility assessment of proposed research protocols, as well as driving studies through the early stages of approval. This will be crucial to achieve faster study initiation times and delivery of studies to time and target.

*DOCUMAS Clinical R&D Management System*

A new clinical studies database has been launched to capture activity, speed up governance and approvals processes, and drive performance management in line with national benchmarks and targets. The system is web-based and accessible to investigators and study teams across the AHSC.

## 5) Recruitment to Clinical Research Studies

In 2012/13, ICHNT recruited more patients to NIHR Portfolio research studies than any other NHS Trust in the country - more than 46,500 individuals (including the COSMOS cohort study). In the current financial year, ICHNT is again on course to exceed its recruitment target set by the NWL Comprehensive Local Research Network.

Participation in clinical research demonstrates ICHNT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Imperial College Healthcare NHS
NHS Trust

**Board Meeting in Public**

**For decision**

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| **Report Title:** Visits by Non Executives to Clinical Services |
| **Report History:** A new proposal |
| **To be presented by:** Cheryl Plumridge, Director of Governance & Assurance |
| **Executive Summary**: *Proposal for a programme of visits by non-executive directors to operational services within the Trust.* |
| **Key Issues for discussion:**<br>How to organise visits to achieve maximum benefit and meet pre-determined objectives whilst bearing in mind staff resource implications. |
| **Legal implications or Review Needed:**<br>a. No<br><br>**Details of Legal Review, if needed:** N/A |
| **Link to the Trust's Key Objectives:**<br>1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.<br><br>3. With our partners, ensure high quality learning environment and training experience 3for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves. |
| **Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:** |
| **Recommendations and Actions Required:**<br>It is recommended that Proposal B is adopted. |

Imperial College Healthcare NHS
NHS Trust

**Proposals for Non Executive Visits to Clinical Service Areas**

## 1. Background

As part of the ongoing Board Development work and following a recent meeting of the Audit, Risk & Governance Committee, I took an action to facilitate non executive visits to Clinical Service areas. Some non executives, including the Chairman and Professor Tony Newman-Taylor, already undertake visits to Clinical Service areas and Andreas Raffel undertook a significant number of visits as part of his induction programme in July. Both induction visits and ad hoc visits will continue but there is scope to facilitate ongoing visits for the benefit of all non executives. Such visits will have the benefit of enabling non executives to gain a broader insight into the work of the Trust whilst benefitting staff and patients from enabling access to Board members. Depending on arrangements for organising such visits, there is also scope to use them to enable the Board to come together as a true unitary Board in line with the Intelligent Board principles.

## 2. Timing

To be considered at the next Trust Board on 27 November.

## 3. Issues

Benefits associated with facilitating visits in a more systematic way than at present include: greater understanding of the work of the Trust, the ability to target visits, for example, to support strategy or financial proposals, and to increase interaction with staff and patients. This will be of particular benefit in the run up to the FT application and the work being undertaken on the Board Governance Assurance Framework. But organizing visits will have resource implications, hence the need for the aims and objectives to be clear. In consulting on various options, some key objectives emerged. These were that visits should:

- be systematic;
- be consistent and regular;
- be transparent;
- be based on information and fact (ie anecdote free and manipulation proof);
- have an emphasis on learning and listening;
- facilitate team learning and analysis;
- minimise use of resource in organising; and
- be spread equitably across the Trust (ie not focusing solely on high profile/high visibility areas).

## 4. Proposals for Organising

Two potential ways of organising visits are proposed.

### 4.1. Proposal A – Ad Hoc

Under this proposal, the initiative for making a visit would rest with individual non executives. Non executives would be invited to approach a point of contact (e.g. the executive with whom they are paired) with ideas about both timing and areas that they wished to visit. Proposals would then be discussed and calibrated with a view to offering a visit that took account of the need to ensure an equitable spread of visits across the Trust, and timings that fitted with the Clinical Service area to

be visited. A member of the Executive Team (the 'paired' executive or the Medical or Nursing Director) would accompany the non-executive and help facilitate the visit, make introductions, assist in providing context, respond to follow up questions as required, and provide feedback to Divisional and executive team colleagues. The benefits of this proposal include bespoke arranged visits more likely to suit individual preferences: downsides include potentially significant staff resource per visit, no team learning or analysis, a lack of consistency and regularity in the way visits are organised, and an absence of pre-determined dates which will inevitably impact upon key staff availability.

### 4.2 Proposal B – Organised Board Visits

This proposal is based on the way visits are managed at University Hospitals Southampton. On a specific occasion each month (potentially linked to a Trust Board) the Board as a whole will meet with one of the Divisional Directorates on a rolling basis and receive a short (15 min) presentation from the Divisional Director on the key issues in their domain. The presentation would be kept at a high level and linked to the broader strategic plan. Preceding the presentation there could be an opportunity for the Board to liaise with key members of Divisional staff over a sandwich lunch or refreshments. Following the presentation, the executives and non- executives would form into 3-4 mixed groups to visit areas selected by the Division or the Board. After approximately 1 hour, members would re-gather to de-brief on the visit and discuss any issues arising (for approximately 30 minuites). Benefits of this model are the focus on team learning and analysis, facilitating greater systematic coverage of clinical areas (although limitations would be posed by the practical constraint of visiting one Trust site per occasion), and a more in depth look at specific areas with the ability to link strategy with operational delivery, and to meet and hear from key Divisional staff. Visit impact could be maximised by the provision of briefing packs in advance of the visit relating to the Division and the topics to be covered. Downsides include staff resource, particularly at Divisional level. In terms of the FT application, this proposal would have the benefit of:

- bringing issues to life for non- executives with real examples that could subsequently be provided as evidence of their understanding of the controls in place around quality and governance;
- allowing Board members to link operational issues with strategic discussion at the Board;
- allowing non executives to challenge and gain assurance directly with the leadership team of the clinical divisions;
- giving the Trust Board a face further into the organization (Ward to Board); and
- helping build team spirit, cohesion and assist working together amongst Board members.

In addition the visits would be structured around Don Berwick's 6 principles of quality namely:

- Safety
- Effectiveness
- Patient centredness
- Timeliness
- Efficiency
- Equity

which will enable a well-structured, clear programme to be developed linking back to the work being undertaken within the Trust around Quality.

## 5. Recommendation

It is recommended that Proposal B is adopted.

# FINANCE AND INVESTMENT COMMITTEE (FIC)
## Terms of Reference

### Role
The role of the Finance and Investment Committee (FIC) is to undertake on behalf of the Trust Board thorough and objective reviews of financial policy and financial performance issues reviewing the risks to the financial position. In addition the FIC will advise the Trust Board on finance issues and investment strategy, including those relating to the Trust's estate.

The Committee will review the Trust's financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board.

### Definitions
"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Finance and Investment Committee
"the Directors" means the Trust's Board of Directors.

### 1 Membership
1.1 Members of the committee shall be appointed by the Trust Board. The committee shall be made up of six members. These are three non-executive members / Designate NED, the Chief Executive, Chief Financial Officer and the Chief Operating Officer.

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

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

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

- Director of Operational Finance
- Director of Estates and Facilities
- Deputy Director of Finance (rotational basis)

### 2 Secretary
2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

### 3 Quorum
3.1 The quorum necessary for the transaction of business shall be three members, two of which are non-executive directors'/ Designate NED'. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

### 4 Frequency of meetings and attendance requirements
4.1 The committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of tow thirds of meetings. The Secretary of the

committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

**5 Notice of meetings**

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

**6 Minutes of meetings**

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

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

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

**7 Annual General meeting**

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

**8 Duties**

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

8.1 **Financial policy, management and reporting**

The Committee shall make recommendations to the Trust Board on financial policies, provide oversight of financial management and reporting with consideration to the overall financial performance of the Trust.

Specifically the committee shall:

- advise the Trust Board on financial policies;
- recommend to the Trust Board the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust Board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust Board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review at the request of the Trust Board specific aspects of financial performance where the Board requires additional scrutiny and assurance;

- review the Trust's projected and actual cash and working capital;
- approve and keep under review, on behalf of the Trust Board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control);
- review the financial risks.

8.2 **Investment policy management and reporting**

The Committee shall review and recommend to the Trust Board:

- the Trust's Investment Strategy and maintain oversight of the Trust's investments, including:
  - establish the overall methodology, processes and controls which govern the Trust's investments;
  - evaluate, scrutinise and monitor investments;
  - review the capital programme;
  - prepare post project evaluations for capital projects and for revenue projects which have a whole life contract value of £5 million and above. All projects will have a two stage review that will be presented to the FIC; immediately to assess project or contract completion and approximately 12 months later to review whether anticipated outcomes/savngs had been achieved.

- review and recommend to Trust Board the Trust's treasury management, working capital and estates strategies.
- within limits set out in the Standing Orders, Standing Financial Instructions and matters reserved to the Trust Board, the Committee shall approve, evaluate and scrutinise the financial and commercial validity of individual investment decisions, including the review of Outline and Final Business Cases. Business cases will usually be referred to the FIC following initial review by the Investment Management Committee, with input from the others as appropriate. The current delegated limit for the Trust is £5million.

**9 Reporting responsibilities**

9.1 The committee will report to the Trust Board on its proceedings after each meeting.

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

9.3 The committee will produce an annual report to the Trust Board.

**10 Other matters**

The committee will:

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

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

10.3 give due consideration to laws and regulations;

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

**11 Authority**

11.1 The committee is a non-executive committee of the Trust Board and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

11.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties;

11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

**12 Monitoring and Review:**

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

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

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

12.4 Terms of reference approved: FIC 19 September 2013.

12.5 To be reviewed September 2014.

Imperial College Healthcare NHS
NHS Trust

Version 1.2

# Membership Strategy

# Membership Strategy

## 1. Introduction

Imperial College Healthcare NHS Trust ('the Trust') was created on 1 October 2007, by merging Hammersmith Hospitals NHS Trust and St Mary's NHS Trust.

The Trust comprises Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye hospitals. With more than one million patient contacts each year, it is one of the largest acute Trusts in the country and, in partnership with Imperial College London, was the UK's first Academic Health Science Centre (AHSC). It has an annual turnover of around £970 million.

The Trust delivers services to a local population of some 2 million people in North West London. The Trust also provides specialist care for patients from over eighty commissioners across the capital and nationwide.

The Trust is in the process of applying to become a Foundation Trust (FT) with the aim of obtaining authorisation by the end of 2014. The underlying principle of becoming a FT is to be more accountable and responsive to the community that it will serve. To ensure that the voice of the community is heard the FT has representatives from the community, based on eligibility criteria which reflects the diversity of th local community. Patients, public and staff can become members who elect a Council of Governors, which has various powers including appointing and approving the Chairman and Non-Executive Directors and approving the appointment of the Chief Executive. Being a FT allows a Trust to have more control over its future, the services it provides and its financial affairs.

This Membership Strategy is a revision of the membership strategy introduced in 2009 and sets out the principles of membership, including how the Trust will communicate and engage with its members and what steps it will take to ensure a sustainable and representative membership.



## 2. What is Membership?

Being a member of a FT provides the general public, patients and staff with the opportunity to participate in and get involved with their local hospitals.

Membership engagement and involvement will be at the centre of our organisation. An effective, engaged membership will enable us to ensure that we represent our patients, staff and local communities, providing a real opportunity for people to input and influence the work of the Trust and the local healthcare landscape.

The Trust recognises that our members will have different levels of interest and commitment which may change from time to time. Not all members will want to receive all information and communications nor will they want to be involved in all meetings, projects and focus groups. However, others will want to become more actively involved and help to develop key strategies and have an active say in how the Trust shapes its plans for the future. To ensure that the Trust can best engage with all our members, we will be asking whether different levels of membership would be appropriate to achieve this. Notwithstanding the different levels of commitment, all members will be treated equally and have the same rights as each other and be entitled to stand for election as a Governor. This is about the level of engagement that our members want to have with us at a particular point in time.

We will engage with our members by providing updates on our strategic developments, newsletters, invitations to meetings, focus groups, members' fora on relevant health topics and ways to get involved in service improvement projects. As mentioned above, members will be able to stand as a Governor and vote in Governor Elections. They will also have access to Health Service discounts.

Eligibility for Membership
Membership is free and open to all those over the age of 16 provided that they meet the membership criteria.

### 3. Defining the membership community

The Trust treats patients at every stage of life, from conception, to care of the elderly, with over 50 specialist services for both adults and children and it is essential that our membership is representative not only of these patient groups but also of the wider public that it serves including 'harder to reach' and 'seldom heard' groups to enable all to have a voice in healthcare.

It is recognised that the Trust has both a local presence in North West London, with its population of nearly 2 million people, but also a regional and national reputation particularly through our partnership with Imperial College London through the AHSC. In order to draw on this resource it is proposed that the Trust will include a patient constituency to enable all those who use our services, irrespective of where they live, to have an opportunity to influence the care we provide to give a voice to those with actual experience of the services that we offer.

We are aiming to recruit a total of at least 10,000 public and patient members, which together with our staff, who will automatically become members on authorisation, with an option to opt out of membership, will result in the Trust having approximately 19-20,000 members.

Membership Constituencies
There will be four membership constituencies with a total of 31 Governor seats allocated as below:

- Public Constituency

Anyone residing in the Greater London area will be eligible to become a member of the public constituency. Trust volunteers will also be able to join the public constituency provided that they reside in the area. There will be eight Governor Seats in this constituency.

- Patient Constituency

Anyone who has been a patient of the Trust, including private patients, within the last five years, is eligible to become a member. There will be eight Governor Seats in this constituency.

- Staff Constituency

Every member of staff with a permanent, temporary or fixed-term contract for at least 12 months will automatically become a member and with a choice to opt-out. There will be a total of five Governor Seats in this constituency, split into two classes; clinical and non-clinical with four Governor Seats for clinical and one for non-clinical staff.

- Nominated Partners

There will be a total of ten Seats for appointed Governors as below:

| Nominated partners | Number of seats |
|---|---|
| Commissioners<br>(Clinical Commissioning Groups one seat and NHS England one seat) | 2 |
| Local Authorities | 2 |
| University – Imperial College | 1 |
| AHSC Partners<br>(no more than one seat per partner) | 3 |
| The Medical Research Council | 1 |
| Designated voluntary organisations/charities | 1 |

## 4. Resourcing the membership development

The Trust recognises that the process of building a representative membership and securing active engagement with its communities will require a commitment of time and resources. The development of the Trust's membership strategy and recruitment is the responsibility of the Director of Governance and Assurance, supported by the Head of Corporate Services and Trust Secretary and the Membership Manager, who will also provide support to the Council of Governors once established.

A budget has been identified for membership recruitment and engagement such as publications, membership events, meetings, training and development, Governor elections, expenses and an outsourced membership database management.

The Membership Manager will ensure that the membership database is accurate and up-to-date.

## 5. Building the membership base

The Trust is committed to developing a motivated, representative, informed and engaged membership. The Trust (as at the end of September 2013) has a total of 13,545 Shadow Members, 2,952 of whom are public Members and 10,593 staff.

We will build on our current membership and recognise that we need to re-engage with them. We will target potential members in line with our population profile and overall patient profile, to enable a representative membership to be developed and maintained. We will work closely with the local community and voluntary groups, the Charitable Trusts, local colleges and the University to grow our membership. The Governors, once in place, will also be encouraged to assist with membership recruitment. Growth will be monitored through the analysis of data from the membership database and diversity will be a key performance indicator in the regular membership reports.

We will promote membership to college and University students, through student induction days and college freshers' weeks to help raise awareness and interest amongst those students in the social care field, thus assisting the Trust in attracting and retaining a highly skilled workforce.

## 6. Managing the active membership

Members will be invited to events and join the Trust's service improvement projects in their areas of interest, in accordance with the level of engagement that they have indicated.

Governors will be the key link between the community and the Trust, enabling the Trust to be rooted in its community and able to respond to community needs. Having a broad and representative membership community and a Council of Governors elected from and by our members, is key to working together to better meet the needs of our communities. The Membership Manager will assist Governors with the formulation of action plans for targeted recruitment and engagement within their constituencies.

As the membership drive builds, we will arrange meetings to inform members about the role of the Council of Governors and the work of the Trust. We will provide training sessions for:

- members who might wish to stand as Governors
- Governors to help with achievement of their roles and responsibilities

We will use the national Foundation Trust Network to provide basic Governor training.

The Management Team and the Board of Directors will promote a partnership approach between Governors and management to encourage positive working relationships and dialogue and strive for our membership and Council of Governors to be diverse in their composition.

## 7. Communicating with members

The Trust will continue its programme of raising awareness, engagement and promoting the benefits of membership through a variety of communication channels, including its website, press releases, newsletters and hosting and attending local events. Once the Council of Governors is in place, there will be further channels of communication between the Trust and its members via the Governors, who may require some support with their communications.

Other approaches will include:

- communicating and liaising with local community and voluntary organisations, education authorities and key stakeholders including the local Healthwatch;
- organising community outreach events;
- members' meetings and web chats for specific constituent groups and educational events built around local health issues;
- Support for Governors to engage directly with members and service users, such as 'surgeries' where patients can meet with Governors and comment on services and issues.

Membership Reporting Regime
The management team and Council of Governors will receive regular reports on total numbers and the composition of membership with the Board of Directors receiving six monthly reports. Progress on recruitment will be measured against the targets and trajectories set. There will be regular analyses of the membership's composition to inform recruitment. Views will be sought during consultation on how membership constituencies should be sub-divided to offer effective representation on the Council of Governors.

## 8. Working with other membership organisations

We will work with other Trusts in part through the Foundation Trust Network, to learn from them to consider how we can:

- develop a motivated and engaged membership
- bring further benefits to our members
- share best practice and consider joint membership recruitment opportunities where appropriate

The Management Team and the Board of Directors will engage with our Governors to help us strengthen existing links with local organisations and create new ones.

## 9. Evaluating success

It is important that the membership strategy evolves over time to continue to reflect the community.

Although this strategy has been brought together by the Trust, once the Council of Governors is in place, we aim to support them in developing it so that it is 'owned' by them and the membership. It will continue to be informed by member surveys, feedback from events, and by the members' and Governors' own experiences. The effectiveness of membership will be evaluated regularly based on:

- diversity of membership for representative membership;
- turnover of members (retention/recruitment);
- event attendance;
- members engagement activities;
- results of member satisfaction surveys;
- election turn out.

A virtual membership working group, led by the Membership Manager, will monitor the membership strategy plan. We will ask the Council of Governors, when in place, to lead on the evaluation process.

This process will inform our annual planning and on-going development of the membership strategy.

## 10. Membership recruitment to date

The Trust currently has a total of 13,545 Shadow Members, 2952 of which are public members and 10,593 staff. The Trust held a Foundation Trust Consultation during 2009 and a membership recruitment drive through website, patient letters, Trust and community events.

## 11. Plans for future membership recruitment

A Membership recruitment and engagement action plan to deliver the key aims of this strategy will be produced to recruit a sustainable, representative and engaged membership leading to the creation of the Council of Governors which will be monitored by the Membership working group, and by the Council of Governors when in place.

We will make a focussed effort to reach out to the seldom heard and under-represented communities by organising and attending outreach events and working with voluntary organisations and local Healthwatchs.

The members' engagement programme to best support their needs, will include members' events, annual public meetings, surveys, consultations, focus groups, open days and members newsletters. There will be opportunities for those interested to get involved in service improvement projects and workstreams. Membership information will also be available on the Membership section on the Trust website.

Database and Administration
We will maintain an accurate and informative database of members. It is currently outsourced to a database management services. This allows data to be held securely and progress to be monitored towards meeting recruitment targets.

Membership Office and Governors' Support
We will communicate effectively through the Membership Office with our members, support potential Governors in preparation for the first elections and with communications between Governors and members, following the initiation of the Council of Governors.

As the membership drive builds up, we will set up training sessions for members who might wish to stand as Governors. These will include meetings to inform them about the role of the Council of Governors, work of the trust, and about the workings of the NHS.

We will use the Foundation Trust Network to provide basic Governor training to new Governors, with additional local training on how the Council of Governors will operate. We will continue to maintain training arrangements for governors, and respond to specific needs as they arise.

Staff will be encouraged to FT sessions and to volunteer to become more actively involved in membership recruitment.

The Membership and engagement plan will be reviewed regularly to ensure that the Trust is taking all necessary steps to enable the membership to be representative of the local community and the constituencies set out in this strategy.

Imperial College Healthcare NHS
NHS Trust

**FOUNDATION TRUST PROGRAMME BOARD (FTPB)**

**Terms of Reference**

**Role**

The role of the Foundation Trust Programme Board is established as a time-limited sub-group of the Trust Board. It will exist until the date that the Trust is authorised as a Foundation Trust. At that time, a decision will be made as to whether the FTPB should continue for a limited period beyond the date of authorisation.

The role of the FTPB is to lead and monitor all aspects of the programme. The FTPB will provide leadership and direction to the programme, and assurance to the Trust Board in ensuring its success.

**Definitions:**

In these terms of reference:-

"the Trust" means Imperial College Healthcare NHS Trust;
'the Trust Board" means the Board of Directors of the Trust;
"the FTPB" means the Foundation Trust Programme Board;
"the Directors" means the Trust's Board of Directors;
"the programme" means Imperial's application and programme to achieve Foundation Trust status.

**1 Membership:**

1.1 The members of the FTPB shall be appointed by the Trust Board. The FTPB shall be made up of around 13 members, excluding commissioning representatives and external advisors. Members may appoint deputies to represent them at meetings on a one-off basis if approved by the chair

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

1.3 The chair of the FTPB shall be an independent Non-Executive Director. In the absence of the chair and/or his appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 The initial composition of the FTPB shall be:-

- Four Non-Executive Directors, (one of whom shall be Chair);
- Chief Executive Officer (Deputy Chair);
- Chief Financial Officer (Lead Director);
- Medical Director;
- Director of Nursing;
- Chief Operating Officer;

- Director of Strategy;
- Director of Governance & Assurance;
- Director of People & Organisational Development;
- Director of Communications;
- Trust Development Authority representative;
- Commissioning representative – TBA;
- Senior external advisors – TBA;

1.5 In addition to the Members the following are required to attend meetings of the FTPB:-
Head of Planning & Business Development;
Foundation Trust Programme Manager.
Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of two thirds of meetings.

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**2 Secretary:**

2.1 The Foundation Trust Programme Manager shall act as the secretary of the FTPB.

**3 Quorum:**

The FTPB's quorum shall be not less than one third of members present, including not less than two Non-Executive Directors and two Executive Directors. A duly convened meeting of the FTPB at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the full FTPB.

**4 Frequency of meetings and attendance requirements:**

4.1 The FTPB will meet on a monthly basis throughout the life of the application programme and dissolved once FT authorisation is achieved.

Extraordinary meetings can be convened by the chair if required to deal with particular items of business.

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

**5 Notice of meetings:**

5.1 Meetings of the FTPB may be convened by the secretary at the request of any of its members or otherwise where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to all members, to any other person required to attend, and to all other Non-Executive Directors, no later than five working days, before the date of the meeting.

Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

**6 Minutes of meetings:**

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

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

6.3 Minutes of FTPB meetings should be circulated promptly to all members and, once agreed, to all members of the Trust Board, except any such members who are debarred by a conflict of interest.

**7 Annual General meeting:**

7.1 The chair of the FTPB will normally attend the Trust's Annual General Meeting in order to respond to any questions on the FTPB's activities.

**8 Duties:**

8.1 The FTPB has the following key duties:-

- To provide leadership and direction to the FT Programme;
- To oversee the programme and ensure that appropriate plans are put in place to mitigate any potential deviations from it;
- To provide assurance to the Trust Board that the programme is progressing according to plan and to hold Directors to account for their contributing areas of responsibility;
- To provide effective scrutiny and approval of all programme deliverables prior to review and sign-off by the Trust Board;
- To issue the necessary directions, receive reports and seek positive assurances from directors and managers on the overall arrangements for the poroigramme and its supporting portfolio of change;
- To provide assurance and recommendations to Trust Board for sign-off of submission documents;
- To monitor programme progress and direct action where necessary;
- To ensure required resources are committed to the programme;
- To manage or resolve any conflicts or issues within the programme that have been escalated to it;
- To resolve strategic and directional issues that affect the programme, and which may need the input and agreement of senior stakeholders to ensure the progress of the programme;
- To define the acceptable levels of risk for the programme;
- To review and approve programme documentation and deliverables;
- To agree the key messages to stakeholders.

8.2 Under the guidance of the FTPB, a Foundation Trust Programme Team will lead the day-to-day execution of activities required for the application process. The team will escalate any matters arising to the FTPB for decision or action as required

## 9 Reporting responsibilities:

9.1 The FTPB will report bi-monthly to the Trust Board to update it on the progress of the programme, to provide assurance concerning the mitigation of any issues arising, and to request the Board's action as required by way of inclusion in the Chief Executives report.

9.2 The Chief Financial Officer will provide a monthly update on the programme to the Trust Management Board and weekly during peaks of activity within the programme (e.g. during external assessment phases). Additionally, FTPB members will work with the Trust Board as and when required for example during Board Development sessions.

9.3 The FTPB will receive a monthly update report from the chair of the Programme team updating him on progress against the programme plan and any significant issues for discussion or decision.

9.4 The FTPB shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

## 10 Other matters:

The FTPB will:

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

## 11 Authority:

11.1 The FTPB is authorised by the Trust Board:-

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

The FTPB has no powers other than those specifically delegated in these terms of reference. The FTPB and Trust Board may identify from time to time, delegated authorities which would facilitate the FTPB to discharge its responsibilities. Any approved delegated authorities will be recorded in Trust Board minutes.

## 12 Monitoring and Review:

12.1 The Trust Board will monitor the effectiveness of the FTPB through receipt of its minutes and such written or oral reports as the chair of the Trust Board may require.

12.2 The FTPB's secretary will assess agenda items to ensure they comply with the needs of the programme and the Board's responsibilities.

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

12.4 Terms of reference approved: 20 September 2013 (FTPB)

12.5 To be reviewed:March 2014

Imperial College Healthcare NHS
NHS Trust

# QUALITY COMMITTEE

## Terms of Reference

### Role

The role of the Quality Committee is to obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and continuous improvement evidenced.

Quality encompasses the six principles for improvement set out by Donald Berwick: "care that is safe, effective, patient-centered, timely, efficient, and equitable", which in turn are the key elements of the quality strategy.

The committee will ensure that robust Clinical Governance structures, systems and processes including those for Clinical Risk Management and service user safety, are in place across all services and are line with national, regional and commissioning expectations.

The committee will refer appropriate issues to relevant committees including the operational and management boards.

Approval of required annual reports related to quality will be undertaken through this committee for example Quality Accounts, for recommendation for Trust Board approval where required.

**Definitions**
"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Quality Committee
"the Directors" means the Trust's Board of Directors.

**1 Membership**

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of at least four members. Members may not appoint a deputy to represent them at a committee meeting. The Committee will comprise four Non-Executive Directors, the Medical Director, the Director of Nursing and Midwifery, the Chief Operating Officer, the Divisional Directors, the Director of Governance and Assurance and the Director of infection Prevention and Control.

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

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

1.4 In addition to the Members there may be, from time to time, other persons who are required to attend meetings of the Quality committee: Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of two thirds of scheduled meetings.

**2 Secretary**

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

**3 Quorum**

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

**4 Frequency of meetings and attendance requirements**

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of 75% meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

**5 Notice of meetings**

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

**6 Minutes of meetings**

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

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

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

**7 Annual General meeting**

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

**8 Duties**

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

**8.1 Quality Governance**

8.1.1 Obtain assurance that robust Quality Governance structures, systems, and processes, including those for Clinical Risk Management and service user safety, are in place across all services, and developed in line with national, regional and commissioning expectations;

8.1.2 Approve and assure delivery of the integrated quality governance plan which includes actions related to; Mid Staffordshire NHS Foundation Trust Inquiry (2013), Clinical governance review (2012), Quality Governance Assurance Framework (2013) and QG15;
8.1.3 Obtain assurance that the Divisional Clinical Governance groups are effectively coordinating Clinical Governance activity within the Trust.

### 8.2 Patient Centeredness

8.2.1 Approve and assure delivery of the Trust's user involvement and patient experience annual plans/ strategy;
8.2.2 Obtain assurance that this is a key element of the work of Clinical Governance across the Trust.

### 8.3 Effectiveness (Monitoring and improving clinical performance)

8.3.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;
8.3.2 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented;
8.3.3 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;
8.3.4 Obtain assurance that systems are robust for undertaking nationally mandated audits receiving summary results and monitoring the implementation of recommendations;
8.3.5 Oversee the Trust's work on Care Quality Commission's Improvement Reviews.
8.3.6 Report to the Audit, Risk and Governance Committee any ongoing concerns or risks being overseen by the Committee and to refer other matters to other committees as appropriate

### 8.4 Safety (Managing service user safety and clinical and other risks)

8.4.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;
8.4.2 Receive and review reports on individual serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;
8.4.3 Obtain assurance that effective channels are in operation for communicating and managing issues of Clinical Governance to relevant managers, staff and external stakeholders;
8.4.4 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;
8.4.5 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

### 8.5 Equity (Equality & Diversity)

8.5.1 Approve and monitor delivery of the Trust's equality delivery system so that essential principles of equality are embedded into the culture, behaviour and decision making process of the organisation;

8.5.2 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

### 8.6 Efficiency and Timeliness

8.6.1 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the CIP process;
8.6.2 Obtain assurance that patient access targets are being delivered.

### 8.7 NHSLA

8.7.1 To oversee the Trust's approach to the NHS Litigation Authority (NHSLA) Risk Management Standards assessment.

## 9 Reporting responsibilities

9.1 The committee will report to the Board of Directors on its proceedings after each meeting.
9.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
9.3 The committee will produce an annual report to the Board of Directors.

## 10 Other matters

The committee should:
10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
10.3 give due consideration to laws and regulations;
10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

## 11 Authority

11.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The c committee is authorised:
- 11.1.1 to seek any information it requires from any employee of the trust in order to perform its duties
- 11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary
- 11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

## 12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.
12.2 The secretary will assess agenda items to ensure they comply with the committee’s responsibilities.

12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.
12.4 Terms of reference approved by the Committee 11/9/2013
12.5 To be reviewed in March 2014.

Imperial College Healthcare NHS
NHS Trust

# Audit, Risk & Governance Committee
# Terms of Reference

## Role

The role of the Audit, Risk & Governance Committee is to provide the Trust Board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively.

## Definitions

"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Audit, Risk & Governance Committee
"the Directors" means the Trust's Board of Directors.

## 1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of a minimum of three members. Only non-executive Directors shall be members of the Committee. Members may not appoint a deputy to represent them at a committee meeting. The Chairman of the Trust is not a member of the Committee.

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

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

1.4 In addition to the Members the following are required to attend meetings of the committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of 75% scheduled meetings.

1.4.1 Internal and External Audit representatives will always attend meetings. The committee shall meet privately with the Internal and External Auditors at least once a year;

1.4.2 The Chief Executive will be invited to attend any meeting and should attend at least annually to discuss with the committee the process for assurance that supports the Annual Governance Statement.

1.4.3 The Chief Operating Officer, Chief Financial Officer, Director of Nursing and Medical Director will attend all meetings as requested in the capacity of being in attendance.

## 2 Secretary

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

## 3 Quorum

3.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

## 4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of 75% meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

**5 Notice of meetings**

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

**6 Minutes of meetings**

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

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

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

**7 Annual General meeting**

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

**8 Duties**

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

**8.1 Governance, Risk Management and Internal Control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

8.2 In relation to the management of risk, the Committee will:

- 8.2.1 Review the process under which the trust sets its risk appetite;
- 8.2.2 Oversee and advise the Board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- 8.2.3 Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- 8.2.4 Refer to the quality committee any clinical risks that require further scrutiny by its membership;
- 8.2.5 Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- 8.2.6 Review the statements to be included in the Annual Report concerning risk Management;
- 8.2.7 Review the process and effectiveness of learning from incidents trustwide.

8.3 The Committee will monitor due diligence on any integration or partnership arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

8.4 The Committee will seek assurance on behalf of the Board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

8.5 In particular, the Committee will review the adequacy and effectiveness of:

8.5.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

8.5.2 an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

8.5.3 the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

8.5.4 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

8.5.5 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect

8.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.7 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

## 9 Internal Audit

9.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:

9.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

9.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3 consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

9.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

9.1.5 annual review of the effectiveness of Internal Audit.

## 10 External Audit

10.1 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

10.1.1 appointment of the External Auditor, as far as the relevant rules and regulations permit;

10.1.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

10.1.3 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Organisation and associated impact on the audit fee;

10.1.4 review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

**11 Whistleblowing and counter fraud**

11.1 The Audit Committee will review the adequacy of the trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety and bullying.

11.2 In particular the committee will:

11.2.1 review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;

11.2.2 approve and monitor progress against the operational counter fraud plan;

11.2.3 receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;

11.2.4 monitor progress on the implementation of recommendations in support of counter fraud;

11.2.5 receive the annual report of the local counter fraud specialist.

**12 Other Assurance Functions**

12.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

12.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

12.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

**13 Management**

13.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

13.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

**14 Financial Reporting**

14.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

14.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Board of Directors.

14.3 The Committee shall review the Annual Report and Financial Statements before recommending them to the Board of Directors, focusing particularly on:

•the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

•changes in, and compliance with, accounting policies and practices;

•unadjusted mis-statements in the financial statements;

•major judgmental areas; and
•significant adjustments resulting from the audit.

**15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct**

15.1 The committee will review on behalf of the Board proposed changes to the Standing Orders and Standing Financial Instructions;

15.2 The committee will examine the circumstances of any departure from the requirements of Standing Orders, Standing Financial Instructions;

15.3 The committee will monitor the policy on standards of business conduct for members of staff with reference to the codes of conduct and accountability thereby providing assurance to the Board of probity in the conduct of business;

15.4 The committee will review proposed changes to the Scheme of Delegation before recommending to the Trust Board for approval;

15.5 The committee will review schedules of losses and compensations annually.

**16 Reporting responsibilities**

16.1 The committee will report to the Board of Directors on its proceedings after each meeting;

16.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed;

16.3 The committee will produce an annual report to the Board of Directors.

**17 Other matters**

The committee will:

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

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

17.3 give due consideration to laws and regulations;

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

**18 Authority**

18.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

18.1.1 to seek any information it requires from any employee of the trust in order to perform its duties;

18.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

18.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

**19 Monitoring and Review:**

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

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

19.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.
19.4 Terms of reference approved dd/mm/yyyy
19.5 To be reviewed dd/mm/yyyy

Imperial College Healthcare NHS
NHS Trust

# Public Trust Board Meeting on 27 November 2013

## Supporting Documents

| Agenda item no. | Title | Tab number |
|---|---|---|
| 2.1 | Nursing Director's Report. Appendix A: Update on progress against the Trust's action plan following the Mid-Staffordshire NHS Foundation Trust inquiry | 1 |
| | Nursing Director's Report. Appendix B: Patient Story | 2 |
| | Nursing Director's Report. Appendix C: Equality and Diversity Strategy 2013/15 | 3 |
| 2.2 | Medical Director's Report. Appendix A: Quality Strategy | 4 |
| | Medical Director's Report. Appendix B: Intelligent Monitoring Report | 5 |
| | Medical Director's Report. Appendix C: NHS Acute Trust Banding | 6 |
| | Medical Director's Report. Appendix D: Mortality Report | 7 |
| 2.3 | Infection, Prevention and Control Report: Appendix A: Monthly Report | 8 |
| 3.3 | Finance Report. Appendix A: Month 7 Report | 9 |
| 3.6 | NHS Trust Development Authority Self Certifications: Appendix A: August Compliance | 10 |
| | Appendix B: August Board Statement | 11 |
| | Appendix C: September Compliance | 12 |
| | Appendix D: September Board Statement | 13 |

**APPENDIX A**

**Director of Nursing's Report: Update on progress against the Trust's action plan following the Mid-Staffordshire NHS Foundation Trust inquiry (2013)**

| Berwick Principle | No. | Rec. No. | Action/Milestone | Date of Delivery | Exec. Lead | Service Lead | Progress as at 6th November 2013 | RAG |
|---|---|---|---|---|---|---|---|---|
| SAFETY | 1 | Fr12 | Review Trust incident reporting system (DATIX) and processes to ensure learning takes place across the organisation. | Aug-13 | CP | SB | A DATIX project manager is now in post to review the system and associated processes. A full business case has been drafted and anticipated roll-out for the updated system (to include incident management) is planned for January 2014. Benefits which will include, trust-wide learning and an increase in the number of incidents reported, will be realised within 3 months of implementation. | |
| | 2 | Fr89 | Report all SIs involving death of or serious injury to patients or employees with the Health and Safety Executive. | Awaiting national guidance | CP | SB | Awaiting national guidance. Currently report these types of SIs to the commissioning support unit. | Future date |
| | 3 | Fr105 | Consider whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio | Ongoing | NC | SM/SB | The Trust has established a mortality reporting working group to look at the use of this within the Trust. Mortality information will be triangulated with incident reports and other patient safety information as part of our quality metrics going forward. | |
| | 4 | Fr114 | Ensure there is a process in place that when comments/complaints describe events amounting to an adverse or serious untoward incident, it should trigger an investigation. | 30/06/2013 | CP | SM/KI | A process is in place to manage this. A new training module on complaints amounting to an adverse incident/SI is currently being implemented and will strengthen the process and knowledge of staff further. | |
| | | Fr15 | Review Trust governance structure to ensure all the required elements of governance are brought together into one comprehensive standard. | End of July | CP | SGu | Revised governance structure approved at the Trust Board meeting on 24/07 and the new committee structure has been in place since September. | |
| | | Fr262<br>Fr268 | Undertake a review of Quality & Safety information to standardise reporting and automate processes where possible. | Oct-13 | NC | SM | This has been undertaken as part of establishing the new boards aligned to the principles of QG15. Qlikview will also enable processes to be automated. | |
| | 7 | Fr240 | All staff and visitors to be reminded to comply with hygiene requirements. | N/a | All | All | All medical staff has been trained in A-sceptic non-touch technique. Q2 Hand hygiene audits show compliance rates of 90-100% across areas. | |
| | 8 | Fr242 | A frequent check of medicines needs to be done to ensure that all patients have received what they have been prescribed and what they need. | Ongoing | JS | GM | Monthly medication safety monitoring audits are carried out, on a rolling basis, assessing two wards each month. The assessment includes whether patients are administered all the medication that are prescribed for them. Last month during the monitoring audit, 2 wards were visited and 3 drug charts on each ward assessed. On the charts assessed, there were no omitted or delayed doses for non-clinical reasons. Annually an audit is undertaken assessing the prevalence of omitted and delayed doses (also for anti-infectives).The results are discussed at the Trusts Medication Safety Monitoring audit. | |
| | 9 | Fr243 | The recording of routine observations on the ward should, where possible, be done automatically, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded. | 30/09/2013 | SMc | LP | In progress. This is being addressed as part of the Failure to Rescue project to include the roll out of SBAR. The implementation of the National Early Warning Score system (currently in progress) within this project will ensure that routine observations are recorded reliably. Full roll-out will commence by December | |
| | 10 | Fr279 | Review our current policy to ensure that it states; the Consultant or another senior fully qualified clinician in charge of a patient's case/treatment is responsible for certifying the cause of death. | Aug-13 | NC | SM | Further discussion required | |

| Berwick Principle | No | Rec. No. | Action/Milestone | Date of Delivery | Exec. Lead | Service Lead | Progress as at 6th November 2013 | RAG |
|---|---|---|---|---|---|---|---|---|
| PATIENT CENTEREDNESS | 1 | Fr 2 | Ensure revised Trust objectives align with our values. | 30/06/2013 | CEO | n/a | New strategic objectives have been set and are in line with our values. | |
| | 2 | Fr 198 | Roll-out an engagement survey across the Trust to measure cultural health of organisation. | 30/10/2013 | JM | SG | A new quarterly engagement survey has been launched in October which will ask approximately 2,000 randomly selected colleagues for their views about working life at the Trust. The first results from Quarter 1 will be available in early December and will be shared with Divisions and Directorates. | |
| | 3 | Fr4 | Continue to embed the core values from the NHS constitution into all areas of the Trust. | N/a | JM | SG | The Trust will continue to do this through existing forums e.g. induction, appraisals, objectives. | |
| | | Fr4 | Implement actions from the staff survey | Ongoing for 2013 | JM | SG | Each Divisions and Corporate Directorate has a local Engagement Plan which responds to their Staff Survey feedback. There are planned progress review dates at Management Board in August, November and in February 2014. | |
| | 4 | Fr5 | Ensure that the expectations of the NHS Constitution and local Values & Behaviours are clearly evident in documentation e.g. for recruitment (JDs, contracts etc.) | 30/06/2013 | JM | SG | The NHS Constitution and Values have been inserted into all Job Descriptions and new Contracts for staff including those from Agencies managed by HR (Reed, Brook Street) issued from 1st July onwards. Review of contracts from other services e.g. ISS is currently underway. | |
| | 5 | Fr7 | Enter a commitment to abide by the NHS values and the Constitution into our contracts with staff | 30/06/2013 | JM | SG | | |
| | 6 | Fr8 | Review contracts for outsourced services to ensure they include the NHS Constitution/values into their employment/service contracts | 30/06/2013 | JM | SG | | |
| | 7 | Fr11 | Define a process for the Medical Director and Director of Nursing to manage professional disagreements | 30/06/2013 | JS/NC | SG | There are existing forums and processes in place to manage professional disagreements e.g. MDT meetings, the clinical ethics forum and nurse establishment reviews. | |
| | 8 | Fr178 | Review contracts of employment to ensure they include and are consistent with the inquiry recommendations | 30/06/2013 | JM | SG | Complete | |
| | 9 | Fr199 | Allocate a named key nurse (for each shift) to each patient who is responsible for coordinating the provision of care. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient. Consider this as part of the existing handover project. | 31/01/2014 | JS | CN | Currently in place through the 'shift coordinator' role. In order to strengthen the process and gain assurance of this, it will be taken forward as part of the 'handover project' which is overseen by the Nursing and Midwifery improving practice group. The CERNER handover module has been accelerated and is anticiptaed to be piloted in Januray 2014. | |
| | 10 | Fr204 | Have at least one executive director who is a registered nurse. | N/a | CEO | n/a | Director of Nursing is an Executive Director. | |
| | | | Consider recruiting nurses as non-executive directors as part of NED. | N/a | JM/CP | SG/SGu | All NED posts have been recruited to and the Trust also has 2 Associate NEDs of which one is a Nurse. This action will be considered for future NED appointments | |
| | 11 | Fr236 | To review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care. | Dec-13 | NC | SM | Implementation of white boards above patients' beds and integration into Consultant of the week, will look to address this action. | |
| | 12 | Fr237 | There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued. | Ongoing | All | All | Effective team work is in place through multi-disciplinary working at a clinical level. Ward staff have strong relationships with cleaning and other contracted services staff. | |
| | 13 | Fr238 | Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward round. | Monthly (minimum) | JS | SH | Currently undertaken through monthly leadership walk around and weekly 'back to the floor' Friday. Further work to be taken forward as part of patient experience improvement plan, working in partnership with communications. | |

| Berwick Principle | No | Rec. No. | Action/Milestone | Date of Delivery | Exec. Lead | Service Lead | Progress as at 6th November 2013 | RAG |
|---|---|---|---|---|---|---|---|---|
| PATIENT CENTEREDNESS | 14 | Fr241 | Review the arrangements and best practice for providing food and drink to the elderly. | Ongoing | JS | SH | We currently audit patient satisfaction regarding food and drink on a monthly basis at divisional level, to include the elderly. The audit results for September show that 85-100% of patients across divisions answered 'yes' against a range of questions, showing high satisfaction with food and drink arrangements. A 'patient catering service' action plan is in place and is overseen by the PLACE steering group. | |
| | 15 | Fr239 | Review our discharge planning processes to ensure that a patient in need of care will receive it on arrival at the planned destination. | Aug-13 | SMc | RC | A review has been undertaken and the discharge policy is to be finalised for Director review by mid-November and will include the Francis recommendations | |
| | | Fr256 | Review our post-discharge processes to consider a proactive system for following up patients shortly after discharge to improve patient experience. | TBC | JS | SF | This currently takes place locally within certain specialities; for example the pulmonary hyper-tension service where patients are brought together post-discharge to discuss their experiences to inform service improvement. The Trust is also currently piloting a 48 hour post discharge telephone follow up with cancer patients. | |
| | 16 | Fr112 | Review how we manage feedback that is not deemed to be a formal complaint. | 30/06/2013 | CP | KI | The Trust has a robust PALS and complaints service in place to address these actions. | |
| | 17 | Fr255 | Ensure that results and analysis of patient feedback including qualitative information are made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made. | 30/06/2013 | JS | SF | Itrack results are currently available to all stakeholders within 24hrs via Qlikview and friends and family test information is currently shared with areas 2-3 times a week and will be integrated into Qlikview over the coming month. Qualitative information such as postings on NHS Choices, Care Connect and other digital platforms are shared wtih divisions as soon as possible by the PALS team. As part of the newly refreshed patient experience strategy and work plan, the reporting of patient feedback has been reviewed a new scorecard/dashboard and process been agreed. This will be implemented in November as part of the new trust board scorecard and also through the first meeting of the patient centeredness board. | |
| | 18 | Fr40 | Ensure that complaints reports include both qualitative (narrative) and quantitative data | N/a | CP | KI | All reports currently include both types of data | |
| | 19 | Fr109 | Review our current methods and points of access for registering a complaint/comment to ensure they are readily accessible and easily understood. | 03/06/2013 | CP | KI | This has been reviewed and the Trust has multiple gateways via; PALS, in person, email to complaints and PALS email address, and letter. The new Care Connect system is anther platform to register a complaint/comment | |
| | 20 | Fr110 | Review complaints policy to ensure intended litigation is not a barrier to the processing or investigation of a complaint at any level. | Awaiting DH guidance | CP | KI | The current policy has been reviewed and a paragraph is included within it which outlines that the potential for litigation does not affect the complaints process or investigation. This occurs in practice whereby the complaints process is followed even if litigation is anticipated. | |
| | | Fr111 | Review 'How to make a comment or complaint' leaflet and 'PALS' leaflet and revise if necessary | 01/01/2014 | CP | KI | The leaflet has been reviewed and revised and will shortly be reviewed by the communications team prior to publication. It is anticipated the new leaflets will be available by January 2014. | |
| | 22 | Fr111 QGF3c | Consider if the existing complaints and PALS joint report can feed into patient experience data. | 30/06/2013 | CP | KI | The new Patient Safety Managers will be the single point of contact to collate and triangulate all sources of feedback to include; complaints, PALS and incidents. Work is in progress to review patient experience reporting and metrics which includes complaints and PALS data. This will be part of the new trust board scorecard. | |
| | | Fr115 | Ensure the 4 triggers (SI, expert clinical opinion required, professional misconduct, nature of services commissioned) are included in our complaints policy | Awaiting DH guidance | CP | KI | To be reviewed in light of DH guidance currently being awaited. | Future date |
| | 23 | Fr116 | Include a flowchart in our Concerns and Complaints Policy to ensure it reflects current guidance regarding the recording of meetings | 30/06/2013 | CP | KI | A flowchart has been completed and is being followed. This will be incorporated into the new policy which will be revised once the DH guidance (currently being awaited) has been published. | |

| Berwick Principle | No | Rec. No. | Action/Milestone | Date of Delivery | Exec. Lead | Service Lead | Progress as at 6th November 2013 | RAG |
|---|---|---|---|---|---|---|---|---|
| PATIENT CENTEREDNESS | 24 | Fr117 | Ensure we have a facility available to independent complaint advocacy services and their clients for accessing expert advice in complicated cases. | Awaiting DH guidance | CP | KI | This is available and how to access the service is described in the letter sent to complainants. | |
| | 25 | Fr111<br>Fr118<br>Fr280 | Review feedback and learning from complaints to include Trust Board and consider how we can work closely with a NED who periodically reviews complaints/ concerns and our responses to ensure effective learning. | 30/06/2013 | CP | KI | A regular report on learning from complaints goes to the Trust Board . The Director of Governance and Assurance meets with the medical director's office on a weekly basis to review complaints and our responses to ensure effective learning. Discussions are currently underway about how a NED can review a sample of complaints periodically. | |
| | 26 | Fr79 | Ensure that all Directors are and remain fit and proper persons for the role. | Awaiting national guidance | JM | SG | This is partly addressed during appraisal and through succession planning. However, a 'consultation on proposals for a new fit and proper person test for directors of health and social care providers', closed in September and the outcome is yet to be published. | Future date |
| WORKFORCE | 1 | Fr174<br>Fr175<br>Fr180 | Review the supporting staff and being open policies to ensure they are in line with the NPSA's 'Being open' guidance and are fit for purpose | April-13 | CP | SB | The Being open policy has been informally reviewed and is in line with the NPSA and NHSLA guidance. It will be formally reviewed on 01/11 as part of the Trust's routine policy management process a but no changes are anticipated to the policy. | |
| | 2 | Fr176 | Ensure that any statement made to a regulator or a commissioner in the course of our statutory duties is completely truthful and not misleading by omission. | N/a | All | All | The Trust provides truthful statements to regulators and commissioners. This is embedded within the NHS Constitution and professional codes of conducts in terms of honesty and integrity. | |
| | 3 | Fr177 | Ensure that any public statement made by the Trust about its performance must be truthful and not misleading by omission. | N/a | All | All | | |
| | 4 | Fr179 | Carry out a review of contracts to ensure 'gagging' clauses are not in place. | 31/05/2013 | JM | SG | Completed and no clauses in place. Wording in relation to this area has been reviewed for future contracts. | |
| | 5 | Fr191 | When recruiting nursing staff, whether qualified or unqualified, the recruiting manager should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs. | Ongoing | JS | DDNs | ICHT has taken part in the 'strengths based recruitment' project in conjunction with the Shelford Group (nine other UK teaching hospitals). Strengths based recruitment (SBR) is about recruiting people based on their natural strengths, values and motivators and not just their competencies. The Trust successfully used SBR in our organisational Nursing restructure and interviewed over 50 nurses in September/ October. The Trust is ready to develop profiles for nursing assistants, patient facing administrative staff, staff nurses and new consultants. SBR will be implemented and embedded organisationally at a pace going forward. | |
| | 6 | Fr195 | Ensure that ward nurse managers operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. | 30/09/2013 | JS | DDNs | A paper outlining the approaches being taken to assure safe staffing levels (to include this recommendation) within the Trust will be presented at a Trust Board meeting in November which will also take into account the recommendations of the Keogh review. | |
| | 7 | Fr197 | Include leadership training at every level from student to director as part of continuing professional development for nurses. | 31/05/2013 | KJ | KJ/SG | This remains a key objective in the Nursing and Midwifery Strategy and progress against the strategy to include leadership, was reviewed at the August and October NMPPC meetings. Divisions have been tasked with developing local delivery plans which will be brought back to the Jan 2014 NMPPC meeting. Two further cohorts of Band 6 and Band 7 leadership programmes are currently underway and an evaluation was presented to NMPPC in August as part of a regular update. The evaluation showed that the programmes are of value to staff and will therefore be continued. The Trust has also launched a set of mult-professional leadership programmes of which nursing staff will be a part of the cohorts. The annual N&M conference in November will include a focus on leadership for all bands. | |

| Berwick Principle | No | Rec. No. | Action/Milestone | Date of Delivery | Exec. Lead | Service Lead | Progress as at 6th November 2013 | RAG |
|---|---|---|---|---|---|---|---|---|
| WORKFORCE | 13 | Fr159 | Modify the Trust's internal survey of trainees to include further questions on standards of care, family test etc. | Dec-13 | JL | RA | In progress. To be updated in December. | Future date |
| | 14 | Fr160 | DCS and DMEs to ask students/trainees about patient care in their feedback sessions and present results to HEB bi-annually. | | | | | |
| | 15 | Fr161 | Continue current process for reporting of training visits and wide distribution of results and actions arising. Collate information from visits, survey and medical students to get an overview of education quality and include in bi-annual report. | | | | | |
| TIMELINESS | 1 | Fr142 | Review our current performance management/information flows and processes to ensure that unambiguous lines of information flows exist. | 01/08/2013 | KJa | RH | The Trust is rationalising existing performance reporting systems into a single portal/framework in QlikView. The Trust Performance Team is currently undertaking a review of the scorecards at Trust Board, Management Board and Divisional (Directorate) levels. Draft Integrated Performance scorecard presented to TB and subcommittees and will be will be in use from November. The implementation of QlikView and the review of scorecards will strengthen the performance management/information processes and minimise the risk of unambiguous lines of information flows. | |
| | 2 | Fr143 | Review, approve and implement a revised scorecard taking into consideration QG15 goals and the metrics currently featured on the National Quality Dashboard. Ensure that the revised scorecard is streamlined, easy to understand and sets out information clearly. | Sep-13 | NC/SM | SM/KH | The Trust Performance Team is currently undertaking a review of the scorecards at Trust Board, Management Board and Divisional (Directorate) levels. The review of the content of the scorecards will ensure that all relevant measures are included in accordance with the national and local guidelines. Draft Integrated Performance scorecard presented to TB and subcommittees. Further development in line with 6 quality domains. Scorecard to TB for approval in October. In use from November | |
| | 3 | Fr244 | Assess the Cerner Millenium function against the requirements set out in this recommendation to ensure they are addressed (where possible) | 01/08/2013 | KJa | RC | Where functionality exists to implement the requirements, the Cerner@Imperial Programme Roadmap will be developed to incorporate these recommendations and agreed by Cerner@Imperial Programme Board. Cerner@Imperial Programme Business Case for post 2015 to be developed. | |
| | 4 | Fr245 | Ensure the Board has a designated member with responsibility for information. | N/A | CEO | KJa | Chief Information Officer is the senior responsible officer with responsibility for information, as detailed in the Trust's Information Governance Framework, and attends the Trust Board meetings and meetings of its standing committees as required. | |
| EFFECTIVENESS | 1 | Fr264 | In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review. | N/a | NC | SM | The Trust has established a mortality reporting working group to look at the use of mortality reporting/statistics within the Trust at specialty level. Mortality rates are currently published. Divisional quality and safety scorecards also include information on the efficacy of treatment. | |
| | 2 | Fr269 | Obtain assurance of the robustness of the quality information we currently produce from sources such as audits or other relevant evidence. Collate evidence that data quality has been improved and Is robust across all areas to give assurance given historic issues. | Ongoing | SMc | RH | Operational data quality and clinical coding accuracy is audited annually via a rolling programme of internal audit/ Level three (the highest attainment) was reached for clinical coding quality under the national information governance assessment report in 2012/13. The 2013/14 clinical coding quality audit will be undertaken in February 2014 to gain further assurance. Cancer and Referral to Treatment Waiting Times Data Quality was reviewed by Internal Audit in October 2013. An audit opinion of Limited Assurance was provided for RTT waiting times data quality. The audit opinion of cancer waiting times data quality has not yet been received. Recommendations are reported to and tracked by the Trust's Operational Data Standards Committee, as part of the Trust's Information Governance framework. | |

Appendix B: Director of Nursing's Report

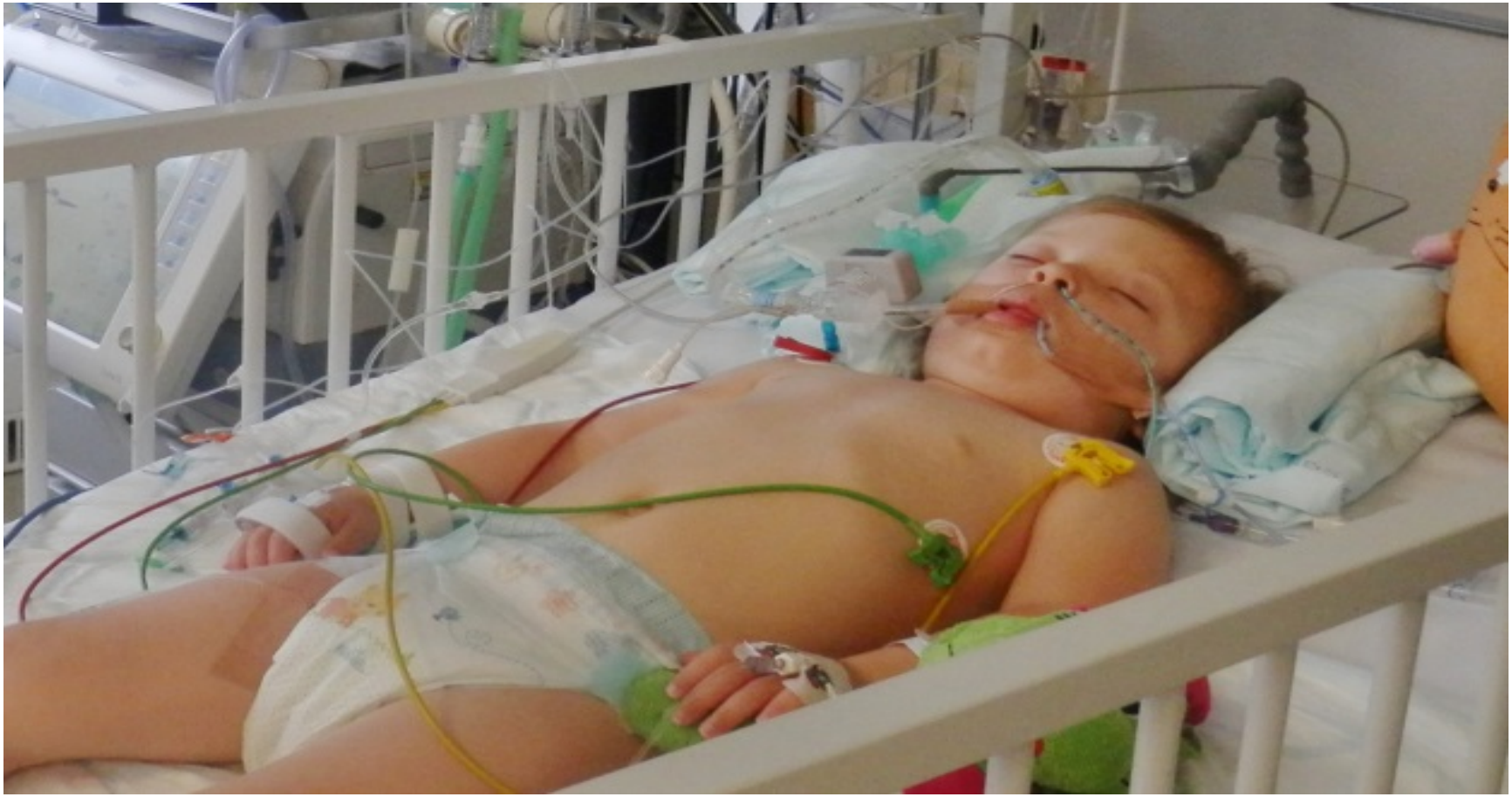
# Patient Story

Trust Board Meeting
27th November 2013

- I’m writing this letter as I’d like to thank all the nurses and doctors for the amazing, exceptional life saving care and treatment you gave to our daughter when she was admitted to the PICU in July from another Trust.

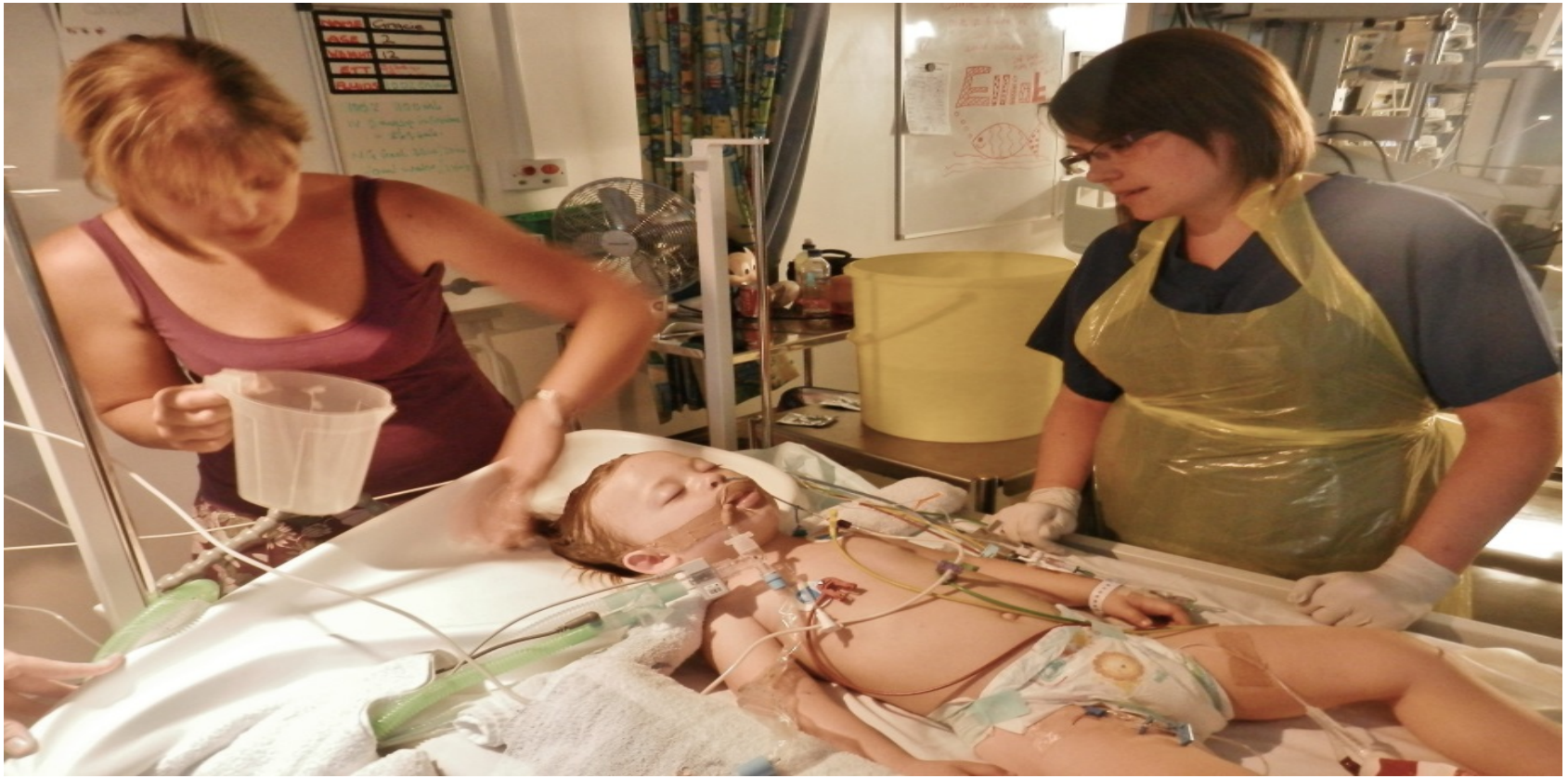
- I can’t tell you how terrified we were not knowing what was wrong with our daughter and why.

- Thank you so much for explaining what was happening and how she was doing every step of the way, and for the care you gave us and her sister during an exhausting and emotional time.



- Dr Cooper….. I will never ever forget you. You're an amazing doctor…….my eye's are welling up as I write this! When you gave us the results from our daughter's tests I remember hugging you, which I don't think you were expecting but you had an answer for us and that was the best news we could have hoped for because her being so ill just didn't make any sense to us.

- Not being able to hold and cuddle our daughter was so hard and we were so pleased when you asked if we'd like to help bath and wash her hair.
- It was the first time we'd been able to do something we'd normally carry out when she's at home. I remember telling you how she loves water and if she was awake she'd be playing with it.
- After bathing and washing her hair, her blood pressure and observations improved and we were all amazed. Myself and her dad walked back to the hotel that night so happy because we felt we'd helped her and although she was still on the life support machine we knew she'd enjoyed it and felt it had made a difference. Thank you girls.



- Thank you for all the care and physio you gave to her whilst in the PICU and for the extra support you gave her on the Grand union ward. We know you didn't have to do this and your support helped in her recovery to start walking again. Thank you for the pushchair you found us so we could take her out of the hospital. She was so excited.

- When she was in hospital I told her how the angels were looking after her… and that's what every single one of you are (Here I go again, welling up) you're angels looking after and caring for critically ill children and words really can't explain how thankful we are to you all for the care you gave. Also for popping into the Grand Union ward to check on her progress and on me as I think you knew I was quite shocked and upset when we moved there.

- Our daughter is fine now and doing well. The only difference being that she's stopped sucking her thumb. I'll miss that but I suppose it may be a blessing in disguise as I haven't got that battle on my hands now.

- Since coming out of hospital she has been stringing words together and counting numbers upwards and downwards. It's almost like she needed a few days rest and sleep which I know sounds strange but she seems to be talking so much more.

- She's back to her normal self, giving the best cuddles and kisses, running around and making a mess (joy), trying to eat sand and drinking the paddling pool water Yuk!

- It took us a few weeks after returning home to get back to normal. Sleeping was very hard for me but I guess that's normal after going through what we did.

- We took both our daughters to Great Yarmouth for a few days in August as I think we all needed a break and they had great fun.

- Our daughter says she misses her nurse friends…haha…… thank you for keeping her entertained especially with her bad leg!.... which wasn't bad at all haha.

- I promised you a cake….. and I remember some of you asking me to send in some photos of our daughter when she was better so I thought why not put them on the cake. They show her story from when she was first ill to what she's been doing since we came home.

- I hope you all enjoy it and manage to get a slice with a cuppa if you're not to busy and once again, thank you……. Thank you from the bottom of my heart, words really can't explain how thankful I am.

Imperial College Healthcare NHS
NHS Trust

**APPENDIX C**

**Director of Nursing Report: Equality and Diversity Strategy 2013/15**

Imperial College Healthcare NHS
NHS Trust

# Integrating equality and diversity into everyday business of Imperial College Healthcare NHS Trust

# 2013-2015

# Contents

Imperial College Healthcare NHS
NHS Trust

# Integrating equality and diversity into everyday business of Imperial College Healthcare NHS Trust 2013-2015

## 1. Introduction

The Trust is committed to integrating equality and diversity (E&D) into everyday business to ensure we deliver services that are personal, fair and diverse and to provide our patients, carers, communities and staff with a great experience.

Promoting equality, diversity and human rights is closely related to the pursuit of quality and actions to address and reduce gaps in health inequalities. A quality service is one that recognizes the needs and circumstances of each patient, carer, community and staff member, and ensures that services are accessible, appropriate and effective for all, and that workplaces are free from discrimination where staff can thrive and deliver.

As a public authority we have legal requirements under the Equality Act 2010 to promote equality in the areas of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Our strategy sets out our equality and diversity goals and outcomes and how we will deliver these.

## 2. Background

A previous version of this strategy was presented at the former Equality and Diversity Committee in April and July 2013 since then, there have been several national and local drivers which have prompted us to review and build on our existing strategy. These have included:

- A new organisational structure within the Trust
- The publication of reports such as; the Keogh review (2013) and the Mid-Staffordshire Inquiry (2013)
- The development of the Quality Governance Strategy (QG15)
- The Trusts' Foundation Trust (FT) assurance process which references equality in the Board Governance Assurance Framework (BGAF) document.

We want to develop our strategy further, to build on the successes we have made. The refreshed approach will support the new divisional teams to deliver improvement, identify opportunities, innovate and take responsibility/accountability for integrating E&D into everyday business. The new People and Organisational Development Strategy will work alongside this Strategy.

## 3. National Equality Delivery System as a framework

The Trust has adopted the National Equality Delivery System (EDS) and the goals and outcomes set out within it, as a framework to integrate E&D into everyday business. The EDS is a national NHS framework developed to promote equality and diversity across all parts of the NHS and is a tool for the Trust in partnership with patients, the public, staff and staff-side organisations, to use to review our equality performance and to identify future priorities and actions.

### 3.1 EDS Goals and Trust outcomes

The Trust's goals and related outcomes (aligned to the EDS) are outlined below. The outcomes have been selected from the EDS in conjunction with internal and external stakeholders.

| Goal | Outcome 2013/14 |
|---|---|
| **1. Better health outcomes for all** | **1.2** The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all |
| **2. Improved patient access and experience** | **2.3** Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised |
| | **2.4** Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently |
| **3. Empowered, engaged and included staff** | **3.1** Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades; |
| | **3.4** Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all |
| | **3.6** The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population |

### 3.2 Alignment with other initiatives

- **QG15:** This strategy is aligned to the Trust Quality Strategy 'QG15' built on Don Berwick's six principles to include Equity - "We will seek to ensure that everyone we care for has the same high quality outcome, regardless of status". Our goal within the context of quality governance is to seek to close gaps in health status (outcomes/inequalities) and to have service related data which is segmented by protected groups and used to improve equality of outcomes to all service users in line with the Equality Act 2010 and the Equality Duty 2011.

- **Staff Survey**: The national annual staff survey includes questions that are relevant to the equality agenda. Areas include equality of opportunity, fair access to career progression, feeling valued by colleagues and the experience of bullying & harassment. The findings of the survey are cut across the demographic groups that consist of the protected characteristic groups.

- **Patient Experience:** Improving the patient experience is a national priority identified in the NHS Operating Plan (2013-14). The Trust works hard to ensure that all patients find it easier to obtain treatment of a high quality and have a good experience whilst being cared for. This is encapsulated in our promise to patients through our Patient Experience Work plan 2013-14. As staff, we will ensure:

  - ✓ **Objective 1 (Patients):** To provide all our patients with excellent experience when they come into contact with our service that we communicate well**.**
  - ✓ **Objective 2 (People):** Provide staff with the support, skills and best practice to provide high quality patient centred care
  - ✓ **Objective 3 (Process):** Develop processes that are reliable, efficient and standardised to improve overall experience.
  - ✓ **Objective 4 (Communicating the message):** Listen to our patients and people to make changes to improve and feedback when we have done so

## 4. Reviewing equality and diversity performance

The measurements we will use to track performance will include:

- Analysis of inpatient, outpatient and A&E data by protected characteristics. This will include analysing the following data by age, ethnicity and gender in the first instance:
  - o Harm free care indicators (falls and pressure ulcers)
  - o Complaints
  - o Patient Experience to include specific analysis of cancer patients

- Establish year on year targets for improvement in service level health outcomes/inequalities

- Yearly reporting on delivery of Equality Delivery System (EDS) grades. At the heart of the EDS are a set of 18 outcomes (see appendix 1) and it is against these that the Trust will analyse its performance, grade itself and determine action going forward. This will take place annually and the outcome published.

To support the above, the following will be undertaken:

- Each division will integrate the EDS goals and outcomes into their business plan
- Each division will have a nominated E&D lead that will be responsible for developing an EDS action plan.
- Each division will be requested to collate evidence to demonstrate progress towards the successful implementation of the EDS and to the achievement of the outcomes.
- Produce an annual Public Sector Equality Duty Report (PSED as required by the Equality Act 2010)
- Develop and agree a set of corporate equality indicators aligned to the selected EDS outcomes

The delivery of the strategy will be overseen by the Patient Centeredness Board and assurance provided to the Quality Committee on a quarterly basis.

## 5. Communications Plan

The intention is to develop a Communications Plan to support the implementation of this Strategy. This will include the following:

i) Identification ok key stakeholder groups.
ii) Stakeholder events to include representation from all protected characteristic groups
iii) Identification of the key messages and method for communication of the information. A plan and timescales for dissemination of the information.
iv) Regular E&D messages throughout the year

## Appendix 1 - Equality Delivery System – Goals, outcomes and grading scale

| Goal | Narrative | Outcome |
|---|---|---|
| 1. Better health outcomes for all | The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results | 1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities |
| | | 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways |
| | | 1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly |
| | | 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all |
| | | 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups |
| 2. Improved patient access and experience | The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience | 2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds |
| | | 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment |
| | | 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised |

| Goal | Narrative | Outcome |
|---|---|---|
| | | 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently |
| 3. Empowered, engaged and well-supported staff | The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs | 3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades |
| | | 3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay |
| | | 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately |
| | | 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all |
| | | 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) |
| | | 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population |
| 4. Inclusive leadership at all levels | NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions | 4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond |
| | | 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination |

**EDS Grading Scale**

| | |
|---|---|
| **Excelling** | **Purple** |
| **Achieving** | **Green** |
| **Developing** | **Amber** |
| **Undeveloped** | **Red** |

Imperial College Healthcare NHS
NHS Trust


# Quality Strategy

**Financial years 2013-15**

# Summary

This paper outlines the quality strategy for the Trust incorporating six improvement principles with associated goals together with the governance arrangements to ensure delivery and sustainability.

The strategy is ambitious, demonstrating the commitment by the Trust to put quality at the forefront of its business whilst recognising the value our people have in enabling this to be achieved.

During the period of implementation the Trust will be constantly refining the approaches required to deliver this strategy together with the development of the succession to the strategy prior to the end of 2015.

# Contents

# Foreword

*Delivering our Quality Strategy is a shared responsibility in which every member of the Imperial team has a vital role to play.*

No-one would deny that quality is important and should underpin what healthcare organisations strive to achieve. Articulating the theory is one thing, putting it into practice is something else. The Trust's Quality Strategy not only explains our approach to quality, it provides the route map of exactly how we are going to achieve it, each and every working day.

We say *we* because whether we work in the front line or support those who do, we all have an impact on our patients' care and experience. It's about careful attention to detail and getting the basics right, so from the moment a patient arrives at one of our hospitals to the moment they leave, their experience is the best it can be – even when they call for advice. After all, they expect and deserve nothing less.

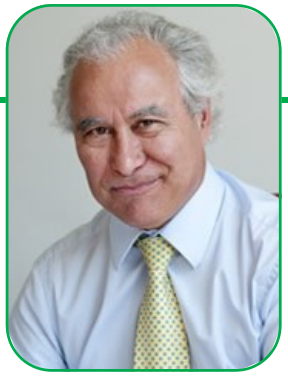
But we cannot just will quality to happen. We have to empower colleagues and give them the knowledge and skills required to do their jobs effectively and efficiently. That's why we are putting in place a wide ranging communications programme to explain what we mean by quality, what it means for colleagues and patients, and the responsibilities that we all share, individually and collectively.

Quality is not an end in itself. It is the means to an end – outstanding clinical outcomes and excellent patient experience. It is also a continual, on-going journey that constantly needs revisiting and refreshing, not a one off programme or activity. It's a process of learning and continuous performance improvement. And it is as much about the way we work, as the outcome of our work.

Please read this strategy document and consider how you can make a contribution to its ultimate realisation. Please also tell us what you think, and how you feel we can make things better – for colleagues and for patients. And please continue to play your part in making Imperial a place where patients get the very best care and treatment available.

We look forward to working with you all as our plans to drive quality and improve what we do gather momentum.

**Professor Janice Sigsworth**
Director of nursing



**Professor Sir Tony Newman Taylor**
Non executive director for quality

**Professor Nick Cheshire**
Medical Director

## What is the Quality Strategy?

The Quality Strategy is the Trust's plan by which we focus on the quality of clinical care at Imperial College Healthcare NHS Trust and ensure that we continuously improve our services. It sets out – under 6 headings - what we mean by quality, as well as giving objectives for each.

It gives vision and direction to how we ensure quality is our number one priority and is central to all that we do.

This three-year strategy will be delivered between the financial years 2013 – 2015. The Quality Goals developed over this period will be called QG15 (Quality Goals for 2015).

## Key messages

- Our approach will be based on Berwick's six goals for improvement; Safety, Effectiveness, Patient Centredness, Equity, Timeliness and Efficiency, along with the recommendations from his recent review of patient safety in England.
- Safe, high quality, patient centred services are central to the vision and objectives of Imperial.
- Imperial is one of the safest trusts in the UK; evidenced by our excellent Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results.
- A modern, comprehensive approach to Quality will continue to improve our clinical care - and in doing so will fulfil the Trust's objectives.
- The Trust's quality goals are called QG15 (quality goals for 2015 – the lifetime of this strategy).
- QG15 will be applicable from ward to board.
- People at every level are key to delivering the strategy. Their roles must be clearly defined and they must be trained to improve care continuously.
- Key indicators of quality will be published at service and ward level. Results will be transparent and monitored constantly to identify variation and the need for improvement quickly.
- The Quality Committee will provide the necessary assurance to the Trust Board that the strategy is delivering continuous improvement.
- The Divisional Directors are responsible for local delivery of the strategy through their quality structures.

## What is covered by the Quality Strategy?

This document – the Quality Strategy for the Trust – outlines the following:

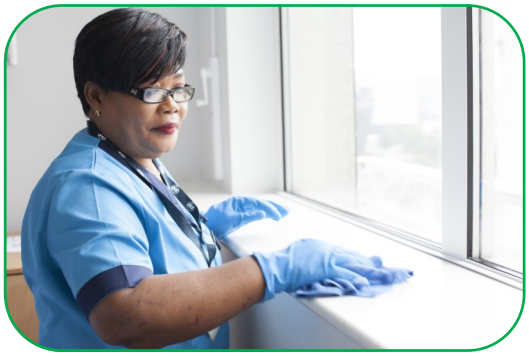
- QG15 - the Trust's six quality goals, which we will deliver by 2015.
- A summary of the processes of governance which oversee the Quality Goals and how performance is reported from ward to board.
- Key actions we will take to achieve our goals including:
  - Measuring our outcomes and comparing with others
  - Ensuring zero tolerance for substandard performance
  - Using only evidence-based practice
  - Minimising risk to patients, their families, and our people
  - Ensuring a culture of learning and training is in place for our people
  - Listening to and acting on what our patients and carers tell us

It also describes how evidence and information about quality flows into and out of the four Clinical Divisions, the Office of the Medical Director, the Quality Committee and to the Trust Board as part of a whole-system approach to improving standards and protecting the public from unacceptable standards of care.

The strategy has been informed by the reports and recommendations from Francis, Keogh and Berwick. It is robust and provides a modern approach to continuous improvement. It also represents our commitment to place quality at the heart of everything we do.

We recognise that for the strategy to be delivered, we must ensure that basic systems and processes are working properly and that our people are clear about their individual accountability and responsibility. We have not previously had a unified quality strategy at Imperial College Healthcare; all existing Trust strategies and action plans are brought together under the QG15 headings and the Quality Governance process.
These include:

- Quality Account
- Francis Action Plan
- Clinical Governance Action Plan
- Patient Experience Strategy
- People and Organisation Development Strategy
- Equality Delivery and Diversity System
- Nursing and Midwifery Strategy
- Infection prevention and control improvement plan



The Quality Account is a statutory requirement and will be used to report annually on the progress of the quality strategy. QG15 implementation will involve a range of actions by designated people through which we will expect to see measurable improvements in the key indicators of quality. It is particularly important to ensure that our people at every level understand the principles and headings by which we measure and improve quality at Imperial. A communication project will commence alongside the launch of the strategy which will promote clinical quality as the Trust's number one aim. The project will be wide ranging capturing our internal and external stakeholders.

We will use the implementation of QG15 to strengthen confidence and pride in the services we provide. We want patients to be confident that Imperial is amongst the best in the world – safe, effective, efficient and responsive to their needs. We want people working in and with Imperial to be confident that they are providing the best service they can, are valued and are important. We want a shared pride in Imperial and a recognition that it is the very best it can be. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so. We must ensure we achieve a balance between publicising what we achieve but appreciating that the information that may drive most improvement is that which shows what has not gone well and the risks the Trust has.

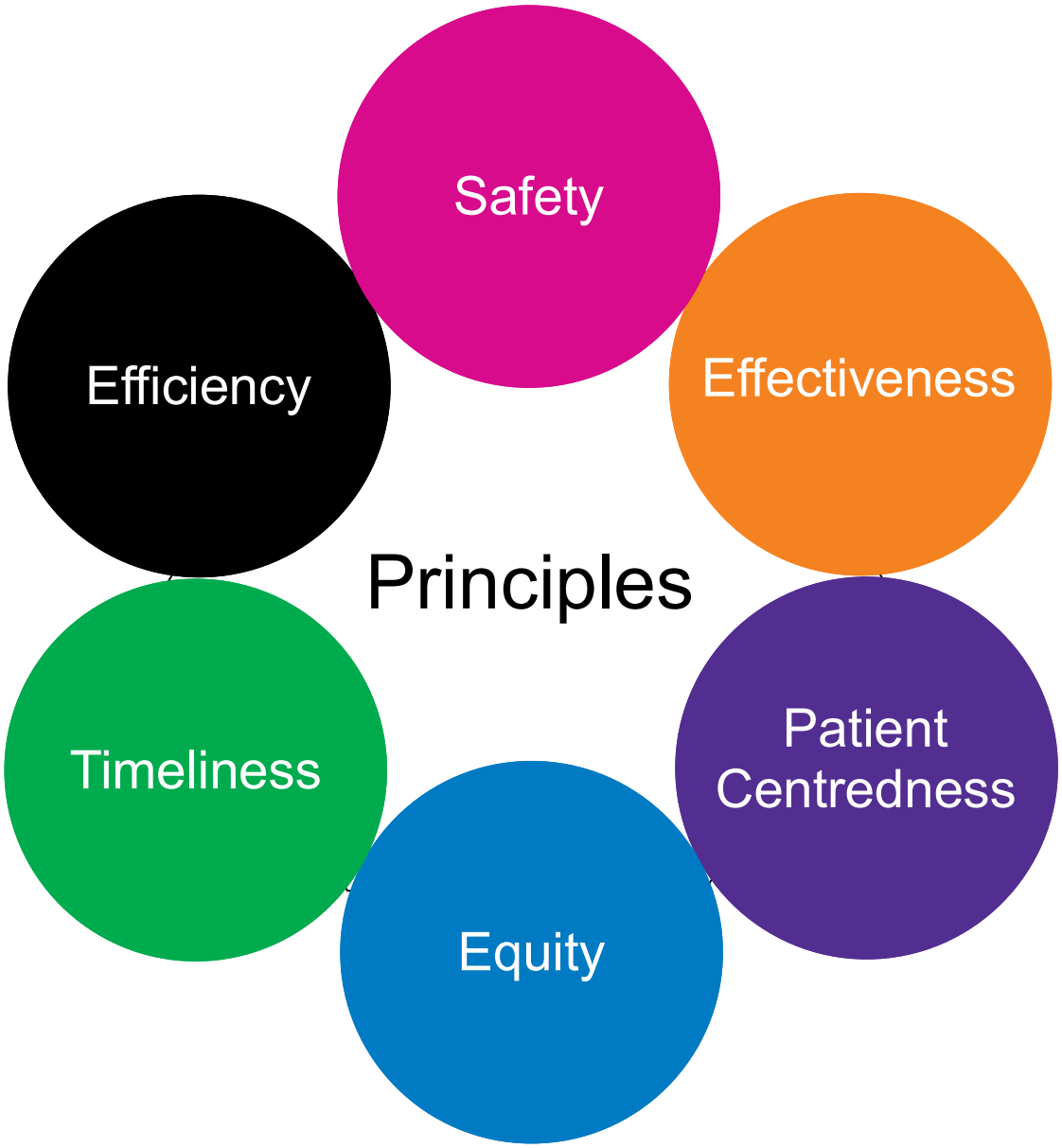
We believe that this strategy is aligned with the recommendations from the Berwick review (2013) in particular the following:

- Placing the quality of patient care, especially patient safety, above all other aims
- Engaging, empowering and hearing patients and carers throughout the entire system and at all times
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust and the growth of knowledge
- Ensuring everybody from ward to board is aware of and held to their responsibilities and accountabilities.

## The Core Principles of the Strategy

We have based our definition of Imperial Quality on the work of Professor Donald Berwick and the Institute of Medicine. Professor Berwick was recently commissioned to review the changes needed in the NHS in the wake of the Mid-Staffordshire Inquiry so it is timely to translate his US work to our strategy.

Quality at Imperial will encompass the six improvement principles advocated by Berwick. These are:




The combination of these principles determines the overall quality of the healthcare we provide. We can only improve services by focusing on each of the principles; however we see safety as the most important.

These improvement principles have been set as the six quality goals for the Trust. The goals can be described as follows:

**Safety** – Our patients will be as safe in our hospitals as they are in their own homes

**Effectiveness** – Our people will minimise the use of ineffective care and maximise the use of evidence based care

**Patient Centredness** – Our people will respect the individual patient and his/her choices, culture and specific needs

**Equity** – We will seek to ensure that everyone we care for has the same high quality outcome, regardless of status

**Timeliness** – We will strive to continually reduce waiting times and delays for patients and our people

**Efficiency** – We will strive to continually reduce waste and thereby cost of care; (this includes supplies, equipment, space, capital, ideas and human spirit)

The strategy details how these goals will be achieved at Imperial. The strategy is ambitious and will require transformation across all areas and professions, however we believe that this will improve quality in a sustained way. We recognise that we can't just "try harder" but we must follow a scientific plan, replacing unreliable human memory and handwritten systems, with technology based, automated ones wherever possible. The clinical strategy for the Trust is being developed based on the quality goals – therefore QG15 will drive the Trust's future.

## What do we want to achieve?

Imperial's vision statement places the improvement of the experience of our patients as the ultimate goal as follows:

*To improve the health and wellbeing of all the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical services in order to transform the experience of patients*

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

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
2. To develop recognised programmes where the specialist services the Trust provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves
4. With our partners in the Academic Health Science Centre and leveraging the wider catchment population afforded by the Academic Health Science Network innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population

These objectives were agreed at the Trust Board in September 2013 and have quality embedded in each one. This shows the commitment and reality that quality drives all that we do.

The quality goals (QG15) will drive improvement in the care that we deliver and in doing so will contribute to all of the objectives and ultimately will ensure our vision is realised.

Each quality goal is outlined, has an objective set and specific actions described which will be taken during the three years covered by the strategy.

## How are we going to achieve it?

We will undertake the following during 2013:

- To show early warning signs of variation and to ensure transparency and clarity, the Trust and divisional scorecards will be reviewed and will include key performance indicators down to ward level. The scorecards will be used as the "smoke detectors" which Berwick highlights as being important

- Data analysis capacity will be reviewed to ensure the systems and people within the Quality and Safety teams are able to analyse, monitor and implement learning

- The Trust's clinical strategy will be finalised and will be based on the use of modernised models of care to improve outcomes in the most efficient way

- The new Trust Quality Committee, launched in September, will provide assurance to the board that Quality is continuously improving

- Implementation of a new meeting structure to enable delivery of goals. This will ensure quality is monitored and variance acted upon from ward to board

- Introduce values based recruitment to ensure we recruit people with the desired values and behaviours to support the culture we are striving to achieve

- A review of the leadership walkaround programme to ensure it fulfils the proactive assessment of delivery of the quality goals in practice incorporating the latest Care Quality Commission (CQC) inspection processes

- A review of how the patient, carer and staff voice is heard, triangulated and acted upon

- Work with commissioners to ensure the CQUIN programme for 2014 and beyond is aligned with the quality strategy

- Patient involvement across the Trust will be reviewed and actions taken to maximise all opportunities

- The disciplinary policies will be reviewed to ensure they are in alignment with the liability criteria outlined by Berwick


- Introduce local engagement surveys to ensure that we listen to staff feedback. These surveys will be quarterly surveys to all our people over a year and will provide results at ward and department level

- Introduce a suite of leadership programmes for leaders at all levels to support the development of the leadership behaviours which will help us achieve a culture of quality.

**The following will be undertaken in 2014 and 2015:**

- A safety and quality improvement network will be set up across the Trust and its learning priorities set to drive the quality goals

- The use of global comparator networks will be introduced in all appropriate areas

- Updated incident and effectiveness systems will be fully rolled out across the Trust

- Targets for improvement in QG15 will be set to directorate level and variation tracked from ward to board

- The meeting structures for Quality will be embedded and their effectiveness reviewed on an annual basis.

# Quality Improvement Goals

The six quality goals will be reviewed and improvements set annually. The goals will be monitored by the Quality Committee which reports to the Trust Board.

## Safety

The Executive Lead for Safety is the Medical Director

Safety in clinical practice is our most significant goal; all patients will be as safe in our hospitals as they are in their own homes and outcomes will be as good as anywhere else in the world.

The key outcomes for this goal include the following:

- For the Trust to maintain or improve our national position within the top five rankings for HSMR and SHMI
- To continuously improve HSMR and SHMI ratios and reduce variation across the week days
- To ensure mortality in low risk diagnostic groups does not exceed the expected range
- To achieve year on year reductions in infection prevention and control targets
- To increase incident reporting rates and reduce their reported harm to meet NRLS peer target

The measurements we will use to monitor quality performance will be undertaken at ward or unit level and utilise the suite of indicators suggested by Donald Berwick in his NHS report 2013 (appendix A). This data is already collected and reported on within the Trust however we will compile a unified reporting system which will be in place by January 2014.

### To support the safety goal the following will be undertaken during 2013/14:

- Weekly quality review meetings for all clinical areas will be held with the Medical Director. This will ensure that issues are highlighted and action taken in real time
- Upgrade of the datix incident system in place at Imperial
- Reporting culture will be encouraged through the communication programme and reinforced through the implementation of real learning and evidence of change
- Serious incident reporting policy and process will be reviewed to ensure it supports our people and is being used
- HSMR and SHMI will be used as the mortality rate indicators and a variance review process will be implemented
- Review of the use of Doctor Foster data and development of a comparator improvement plan
- Review of the appropriate trust policies
- Integrated governance work plan will be agreed with targets devolved to Division, Directorate and ward level
- Staff safety engagement programme will be introduced
- Patient safety alert process will be reviewed to ensure it is robust
- Ensure maximum delivery of the CQUIN targets.

### The following will be undertaken during the financial years of 2014 and 2015:

- Dataset used for the Keogh review will be reviewed and published for the Trust then reported regularly with key improvement projects identified
- Safety credentialing programme will be launched for each specialty including an annual safety review
- Review of the education and training opportunities for our people will be commenced
- Safety champion programme will be implemented
- Internal peer review programme will be introduced
- Peer review partner will be considered
- Patient and carers programme of safety assessments will be planned

This goal will be delivered through the Safety and Effectiveness Board.

## Effectiveness

The Executive Lead for Effectiveness is the Medical Director

Our objective is that systems must match care to science, avoiding overuse of ineffective care and underuse of effective care.

The target for this goal is for the Trust to evidence increasing use of effective care. This is an evolving science and so specific target measures cannot be assigned at this stage but will be developed.

The measurements we will use to track performance will include:

- NICE guidance distribution and monitoring of compliance reports
- New NICE guidance implementation plans
- Appropriate Quality Account metrics
- National/regional audit reports
- Annual clinical audit plan reports by specialty and division
- Progress with the systematic review of individual services.

### To support this goal the following will be undertaken during 2013:

- Review of the Trust wide audit plan to include a systematic approach to audit of effectiveness and the use of evidence based practice
- Review the process of quality assurance at unit Morbidity and Mortality (M&M) level
- Review of the M&M processes across the Trust
- Agreement on criteria for the Divisional credentialing process
- Introduction of practice variation audit tools and measurement of performance
- Review of the corporate and divisional effectiveness structures to deliver QG15
- The introduction of a systematic review process for all individual services delivered at Imperial led by the Medical Director's Office.

### The following will be undertaken during 2014 and 2015:

- Introduction of practice variation audit tools and measurement of performance
- Trust audit plan will be re-launched to deliver QG15
- Introduction of an "audit of audits" process to quality assure audit plan and unit level Morbidity and Mortality (M&M) practice
- Standardisation of the M&M processes across the Trust
- Divisional credentialing process to be introduced
- Peer review partner to be considered.

This goal will be delivered through the Safety and Effectiveness Board.

## Patient Centredness

The Executive Lead for Patient Centredness is the Director of Nursing

Our goal is that our people will respect the individual patient and his/her choices, culture, and specific needs. For Imperial, a key component of this goal is to improve the reported experience of our patients when compared nationally. We have agreed the five indicators that we will use to track our performance which are as follows:

| Indicator | Target |
|---|---|
| Friends and Family Test | 20% or higher response rate<br>Score of 80 or higher |
| iTrack (in house real-time patient experience) | Score of 85 or higher on all Trust core questions |
| National Inpatients Survey | To improve on 2012 overall position, and reduce the number of questions scored 'below average' |
| National Cancer Patient Experience Survey | Mid table within 2 years and top quartile within 3 years (year on year improvement in performance |
| Staff survey | Remain above average of 60% of staff who would recommend the trust to friends/family needing care |

### To support this goal the following will be undertaken in 2013/14:

- A detailed action plan will be implemented to drive improvement of the key measures above
- We will reinforce the importance of the "3P's" to drive improvement (patients, people and processes)
- A communication programme will be implemented to ensure our people, patients and the public understand the key messages relating to patient centredness
- A cultural change programme will be commenced as part of the People and Organisation Strategy delivery
- Develop and use a systematic patient feedback tool to capture patient views which will inform service improvement and demonstrate learning
- Introduction of strength based recruitment, induction and appraisal
- Undertake intentional rounding (regular checks on patients), to give patients the opportunity to discuss any concerns and feel reassured, cared for and safe
- Collate patient experience intelligence to develop a single insight dashboard that we will use to drive improvement in our services
- Listen to our people by introducing a quarterly engagement survey to listen to their views and action accordingly
- Staff training will be reviewed to ensure we provide the correct training and tools to provide high quality patient experience
- Information will be provided to patients to include what to expect, who to contact and what will happen next, for all key points in the patient journey
- Agree a programme of unannounced visits with organisations such as Healthwatch and act on their findings
- Twice yearly benchmarking of nurse staffing
- Restructure of the senior nursing roles to strengthen patient facing leadership
- Business case for remuneration programme will be considered
- Identify innovative models of care delivery in the UK and US and introduce these at Imperial
- Hold the Timeliness Board to account over reduction in access delays and monitor the effect on patient experience as a consequence.

### The following will be undertaken during 2014 and 2015:

- Innovation programme will be launched
- Annual improvement plans will be set and actions monitored.

This goal will be delivered through the Patient Centredness, Equality and Diversity Board.

## Equity

The Executive Lead for Equity is the Director of Nursing

Our goal is to seek to close gaps in health status (outcomes/inequalities). The goal for Imperial is to have service related data which is segmented by protected groups and used to improve equality of outcomes to all service users in line with the Equality Act 2010 and the Equality Duty 2011.

The measurements we will use to track performance will include:

- Analysis of inpatient, outpatient and A&E data by protected characteristics.
- Ensure that all services provided are accessible to all people including those from protected groups
- Establish year on year targets for improvement in service level health outcomes/inequalities
- Yearly reporting on delivery of Equality Delivery System (EDS) grades.

### To support this goal, the following will be undertaken:

- Produce an annual Public Sector Equality Duty Report (PSED as required by the Equality Act 2011)
- Develop and agree a set of corporate equality indicators
- Report quarterly to the Quality Committee using the quality indicators above

This goal will be delivered through the Patient Centredness, Equality and Diversity Board.

## Timeliness

The Executive Lead for Timeliness is the Chief Operating Officer

Our goal is that there should be a continual reduction in waiting times and delays for patients and those who give care.

The target for this goal is for the Trust to improve and then maintain delivery of all key metrics related to timeliness. We recognise that our performance has not always met these standards consistently but we will strive to deliver these as a matter of routine with continued improvement our goal.

The measurements we will use to track performance will include:

- Mandatory access targets
- Theatre productivity measures
- GP access measures
- All operational metrics included in the Trust scorecard
- Length of stay comparison.

### To support this goal the following will be undertaken in 2013/14:

- An operational excellence strategy will be developed
- The process for root cause analysis of all patient cancellations will be developed and improvement plans implemented
- A review of administrative pathways will be completed and a modernised approach proposed
- A review of the choose and book access processes
- Community pharmacy key performance indicators will be embedded.

### The following will be undertaken during 2014 and 2015:

- The operational excellence strategy will be implemented.

This goal will be delivered though the Timeliness Board

## Efficiency

The Executive Lead for Efficiency is the Chief Finance Officer

Our objective is that we will deliver a never-ending reduction in waste and thereby total cost of care (this includes supplies, equipment, space, capital, ideas and human spirit). The goal for this objective is that the Trust will make improvements in all key measures to be in the top 10% of all UK Trusts for all efficiency metrics.

This goal is particularly important given the resource pressures that the NHS will continue to face. We must ensure that we reduce cost through the implementation of modernised systems, processes and ways of working as this will give sustainable change. This approach will drive quality when introduced in conjunction with a trust-wide programme of transformation.

The measurements we will use to track performance will include:

- Dr Foster efficiency measures
- Reference costs
- Nurse and Doctor numbers per bed
- The twenty five financial risk rating metrics as required for Foundation Trusts
- Quality impact assessments for all cost improvement programmes.

It is important to note that efficiency should be seen as a measure of careful and considerate management. To support our improvement agenda we must become efficient.

**To support this goal the following will be undertaken in 2013:**

- Divisional clinical strategy development work will be undertaken in all areas
- A five year plan for each area will be developed to underpin QG15
- A Trust Transformation work-plan will be developed
- A CIP Quality Impact Assessment process will be introduced including authorisation at Medical and Nurse Director level
- A Trust-wide clinical effectiveness group will be embedded to standardise and rationalise supplies
- A review of the Trust's approach to prospective planning of elective activity will be commenced.

**The following will be undertaken during 2014 and 2015:**

- Implementation of the clinical strategy and transformation programme
- Adherence to the financial risk ratings will be a key performance indicator.

This goal will be delivered through the Efficiency Board.

## How will QG15 be implemented and monitored?

The Quality strategy (QG15) has been approved by the Non-Executive Lead for Quality ratified Quality Committee, agreed at Trust Board and will be launched across the Trust.

The launch will be multi-modal in its approach to ensure that the strategy is widely shared internally and externally to the Trust. The launch will signal the start of a Quality Engagement process at Imperial which will aim to raise the profile of the importance the Trust affords to all aspects of Quality. This will be enhanced by a review of the Trust website which will make quality central to everything we do.

The terms of reference of the new Quality Committee have been structured to cover all of the QG15 principles. This monthly committee is a Trust Board sub-committee and will be key in the assurance that Quality is being delivered across the Trust from ward to board. The Committee will receive reports and analysis from the Executive Leads responsible for the six quality improvement goals. The Trust scorecard will include the relevant data to track progress and performance. The Divisional Directors will be in attendance at this committee and will be held to account for all aspects of the plan. Progress with QG15 will be reported to Trust Board by the NED for Quality and the Medical Director.

The terms of reference of the Divisional Quality meetings will be structured to complement the Quality Committee.

Each QG15 objective will have a dedicated group to lead its delivery. These groups will be formed from the previous sub-committees of the Quality and Safety Committee which will be disbanded as appropriate.

Where gaps in assurance are identified actions will be planned and added to the Quality work plan. The work plan will be updated at least quarterly but will be reported on monthly at the Quality Committee. Risks are added to the Trust's risk registers as identified.

## Committee structure (see Appendix B)

The Directorates within the Divisions will be accountable to and report to their monthly Divisional Quality Meeting. The Divisions will be accountable to and report to the monthly quality boards which align with the six quality improvement goals. Trust wide groups/committees will report to the appropriate quality board.

The four quality boards will report operational business to the Management Board and will provide assurance and exception reporting to the Quality Committee which will report to the Trust Board.


Delivering good quality is about getting the basics right. Every patient who comes in to our hospitals expect and deserve a good standard of care. But we don't always get this right.

What does quality mean to you? And how can we improve it?

**Send your ideas and thoughts to the quality team, email quality@imperial.nhs.uk**

Appendix A

**Box 5**

**Illustrating some of the suite of indicators that should be used by NHS organisations to assess safety improvement and variation. This data must be considered at ward/unit or other appropriate sub-organisational level in order to reveal the variation within an organisation.**

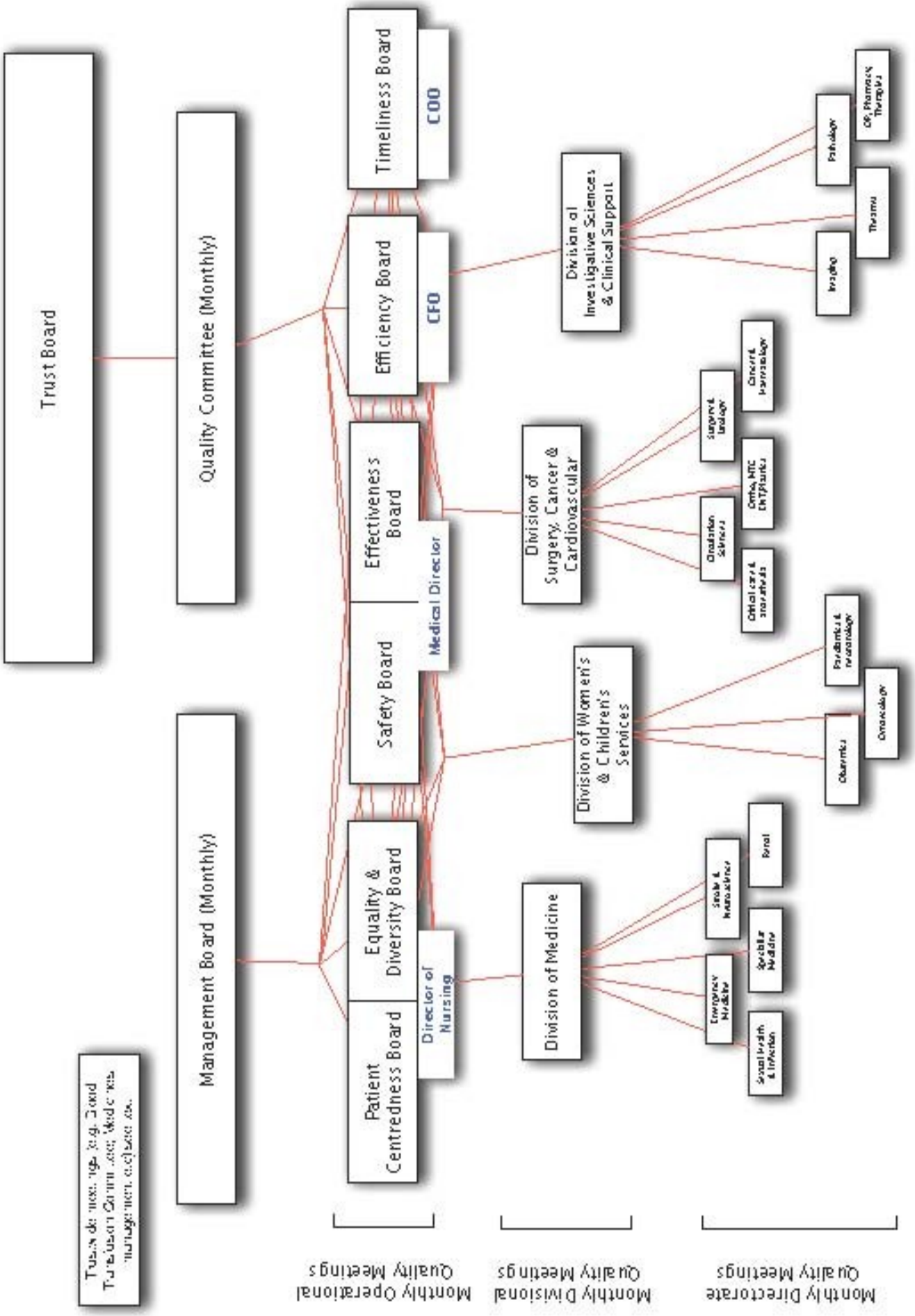
**At sub-organisational level**

| | | |
|---|---|---|
| The perspective of patients and their families | Measures of harm | Measures of the reliability of critical safety processes |
| Information on practices that encourage the monitoring of safety | Information on the capacity to anticipate safety problems | Information on the capacity to respond to and learn from safety information |
| Data on staff attitudes, awareness and feedback | Mortality rate indicators | Staffing levels |
| Data on fundamental standards | Incident reports | Incident reporting levels |

**At sub-organisational level**

**At sub-organisational level**

Appendix B


Trust Board
Quality Committee (Monthly)
Management Board (Monthly)
Timeliness Board
COO
Efficiency Board
CFO
Effectiveness Board
Safety Board
Medical Director
Equality & Diversity Board
Patient Centredness Board
Director of Nursing
Division of Investigative Sciences & Clinical Support
Division of Surgery, Cancer & Cardiovascular
Division of Women's & Children's Services
Division of Medicine
Monthly Operational Quality Meetings
Monthly Divisional Quality Meetings
Monthly Directorate Quality Meetings

# Intelligent Monitoring Report

Report on

**Imperial College Healthcare NHS Trust**

21 October 2013

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

**What does this report contain?**

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Imperial College Healthcare NHS Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z scoring techniques. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

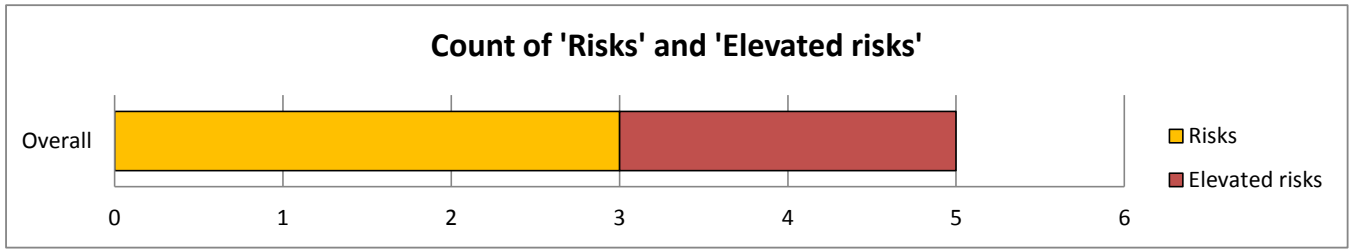
Further details of the analysis applied are explained in the accompanying guidance document.

**What guidance is available?**

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

## Imperial College Healthcare NHS Trust

### Trust Summary




| | |
|---|---|
| Band | 4 |
| Number of 'Risks' | 3 |
| Number of 'Elevated risks' | 2 |
| Overall Risk Score | 7 |
| Number of Applicable Indicators | 87 |
| Proportional Score | 0.04 |
| Maximum Possible Risk Score | 174 |

| | |
|---|---|
| Elevated risk | All cancers: 62 day wait for first treatment from urgent GP referral |
| Elevated risk | Whistleblowing alerts |
| Risk | Incidence of Clostridium difficile (C.difficile) |
| Risk | Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) |
| Risk | Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" |

## Imperial College Healthcare NHS Trust

### Tier One Indicators

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Never Events | STEISNE | Never Event incidence | - | - | No evidence of risk |
| Avoidable infections | CDIFF | Incidence of Clostridium difficile (C.difficile) | 83 | 48.71 | Risk |
| | MRSA | Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) | 12 | 3.47 | Risk |
| Deaths in low risk conditions | MORTLOWR | Dr. Foster: Deaths in low risk diagnosis groups | - | - | No evidence of risk |
| Patient safety incidents | NRLSL03 | Proportion of reported patient safety incidents that are harmful | 0.1 | 0.28 | No evidence of risk |
| | NRLSL04 | Potential under-reporting of patient safety incidents resulting in death or severe harm | 0.85 | 1.49 | No evidence of risk |
| | NRLSL05 | Potential under-reporting of patient safety incidents | 261.24 | 235.27 | No evidence of risk |
| Venous Thromboembolism | VTERA03 | Proportion of patients risk assessed for Venous Thromboembolism (VTE) | 0.95 | 0.95 | No evidence of risk |
| Mortality: Trust Level | SHMI01 | Summary Hospital-level Mortality Indicator | Trust's mortality rate is 'Lower than expected' | - | No evidence of risk |
| | HSMR | Dr. Foster: Hospital Standardised Mortality Ratio | - | - | No evidence of risk |
| | HSMRWKDAY | Dr. Foster: Hospital Standardised Mortality Ratio (Weekday) | - | - | No evidence of risk |
| | HSMRWKEND | Dr. Foster: Hospital Standardised Mortality Ratio (Weekend) | - | - | No evidence of risk |
| Mortality | COM_CARDI | Composite indicator: In-hospital mortality - Cardiological conditions and procedures | - | - | No evidence of risk |
| | COM_CEREB | Composite indicator: In-hospital mortality - Cerebrovascular conditions | - | - | No evidence of risk |
| | COM_DERMA | Composite indicator: In-hospital mortality - Dermatological conditions | - | - | No evidence of risk |
| | COM_ENDOC | Composite indicator: In-hospital mortality - Endocrinological conditions | - | - | No evidence of risk |
| | COM_GASTR | Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures | - | - | No evidence of risk |
| | COM_GENIT | Composite indicator: In-hospital mortality - Genito-urinary conditions | - | - | No evidence of risk |
| | COM_HAEMA | Composite indicator: In-hospital mortality - Haematological conditions | - | - | No evidence of risk |
| | COM_INFEC | Composite indicator: In-hospital mortality - Infectious diseases | - | - | No evidence of risk |
| | COM_MENTA | Composite indicator: In-hospital mortality - Conditions associated with Mental health | - | - | No evidence of risk |
| | COM_MUSCU | Composite indicator: In-hospital mortality - Musculoskeletal conditions | - | - | No evidence of risk |
| | COM_NEPHR | Composite indicator: In-hospital mortality - Nephrological conditions | - | - | No evidence of risk |
| | COM_NEURO | Composite indicator: In-hospital mortality - Neurological conditions | - | - | No evidence of risk |
| | COM_PAEDI | Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality | - | - | No evidence of risk |
| | COM_RESPI | Composite indicator: In-hospital mortality - Respiratory conditions and procedures | - | - | No evidence of risk |
| | COM_TRAUM | Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures | - | - | No evidence of risk |
| | COM_VASCU | Composite indicator: In-hospital mortality - Vascular conditions and procedures | - | - | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Maternity and women's health | MATELECCS | Maternity outlier alert: Elective Caesarean section | - | - | No evidence of risk |
| | MATEMERCS | Maternity outlier alert: Emergency Caesarean section | - | - | No evidence of risk |
| | MATSEPSIS | Maternity outlier alert: Puerperal sepsis and other puerperal infections | - | - | No evidence of risk |
| Re-admissions | MATMATRE | Maternity outlier alert: Maternal readmissions | - | - | No evidence of risk |
| | MATNEORE | Maternity outlier alert: Neonatal readmissions | - | - | No evidence of risk |
| | HESELRE | Emergency readmissions following an elective admission | 1878 | 1784.58 | No evidence of risk |
| | HESEMRE | Emergency readmissions following an emergency admission | 6028 | 5574.09 | No evidence of risk |
| PROMs | PROMS19 | PROMs EQ-5D score: Groin Hernia Surgery | 0.82 | 1 | No evidence of risk |
| | PROMS20 | PROMs EQ-5D score: Hip Replacement | 1.04 | 1 | No evidence of risk |
| | PROMS22 | PROMs EQ-5D score: Knee Replacement | 0.95 | 1 | No evidence of risk |
| | PROMS24 | PROMs EQ-5D score: Varicose Vein Surgery | 0.79 | 1 | No evidence of risk |
| Audit | NHFD01 | The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. | 0.59 | 0.6 | No evidence of risk |
| | SINAP14 | Key Indicator 1: Number of patients scanned within 1 hour of arrival at hospital | 0.41 | 0.28 | No evidence of risk |
| | SINAP15 | Key Indicator 8: Number of potentially eligible patients thrombolysed | 0.04 | 0.05 | No evidence of risk |
| Surgical revisions outlier | SURGHIPREV | Surgical revisions outlier alert: Hip revisions | Not included | Not included | Not included |
| | SURGKNEREV | Surgical revisions outlier alert: Knee revisions | Not included | Not included | Not included |
| Compassionate care | IPSurTalkWor | Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" | 4.90 | - | Risk |
| | IPSurSupEmot | Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" | 6.72 | - | No evidence of risk |
| Meeting physical needs | IPSurHelpEat | Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" | 6.50 | - | No evidence of risk |
| | IPSurInvDeci | Inpatient Survey 2012 Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" | 7.01 | - | No evidence of risk |
| | IPSurCntPain | Inpatient Survey 2012 Q39 "Do you think the hospital staff did everything they could to help control your pain?" | 7.74 | - | No evidence of risk |
| Overall experience | IPSurOverall | Inpatient Survey 2012 Q68 "Overall..." (I had a very poor/good experience) | 7.86 | - | No evidence of risk |
| | FFTNHSEscore | NHS England inpatients score from Friends and Family Test | - | - | No evidence of risk |
| Treatment with dignity and respect | IPSurRspDign | Inpatient Survey 2012 Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" | 8.75 | - | No evidence of risk |
| Trusting relationships | IPSurConfDoc | Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?" | 8.90 | - | No evidence of risk |
| | IPSurConfNur | Inpatient Survey 2012 Q28 "Did you have confidence and trust in the nurses treating you?" | 8.41 | - | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Access measures | AD_A&E12 | A&E waiting times more than 4 hours | 0.04 | 0.05 | No evidence of risk |
| | RTT_01 | Referral to treatment times under 18 weeks: admitted pathway | 0.93 | 0.9 | No evidence of risk |
| | RTT_02 | Referral to treatment times under 18 weeks: non-admitted pathway | 0.97 | 0.95 | No evidence of risk |
| | DIAG6WK01 | Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test | 0 | 0.01 | No evidence of risk |
| | WT_CAN26 | All cancers: 62 day wait for first treatment from urgent GP referral | 0.73 | 0.85 | Elevated risk |
| | WT_CAN27 | All cancers: 62 day wait for first treatment from NHS cancer screening referral | 0.92 | 0.9 | No evidence of risk |
| | WT_CAN22 | All cancers: 31 day wait from diagnosis | 0.94 | 0.96 | No evidence of risk |
| | CND_OPS02 | The proportion of patients whose operation was cancelled | 0.01 | 0.01 | No evidence of risk |
| | CND_OPS01 | The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason | 0.08 | 0.07 | No evidence of risk |
| | AMBTURN06 | Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes | 0.02 | 0.02 | No evidence of risk |
| Discharge and Integration | DTC40 | Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds | 0.01 | 0.02 | No evidence of risk |
| Reporting culture | NRLS14 | Consistency of reporting to the National Reporting and Learning System (NRLS) | 6 months of reporting | - | No evidence of risk |
| | SUSDQ | Data quality of trust returns to the HSCIC | - | - | No evidence of risk |
| | FFTRESP02 | Inpatients response rate from NHS England Friends and Family Test | 0.26 | 0.26 | No evidence of risk |
| Partners | MONITOR01 | Monitor - Governance risk rating | Not included | Not included | Not included |
| | TDA01 | TDA - Escalation score | 3 Concern requiring investigation | - | No evidence of risk |
| | NTS12 | GMC National Training Survey – Trainee's overall satisfaction | Within Q2/IQR | - | No evidence of risk |
| Staff survey | STASURBG01 | NHS Staff Survey - Percentage of staff who would recommend the trust as a place to work or receive treatment | 0.67 | 0.64 | No evidence of risk |
| | NHSSTAFF04 | NHS Staff Survey - KF7. % staff appraised in last 12 months | 0.84 | 0.82 | No evidence of risk |
| | NHSSTAFF06 | NHS Staff Survey - KF9. Support from immediate managers | 0.64 | 0.65 | No evidence of risk |
| | NHSSTAFF07 | NHS Staff Survey - KF10. % staff receiving health and safety training in last 12 months | 0.6 | 0.74 | No evidence of risk |
| | NHSSTAFF11 | NHS Staff Survey - KF15. Fairness and effectiveness of incident reporting procedures | 0.64 | 0.63 | No evidence of risk |
| | NHSSTAFF16 | NHS Staff Survey - KF21. % reporting good communication between senior management and staff | 0.29 | 0.27 | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Staffing | ESRSIC | Composite risk rating of ESR items relating to staff sickness rates | - | - | No evidence of risk |
| | ESRReg | Composite risk rating of ESR items relating to staff registration | - | - | No evidence of risk |
| | ESRTO | Composite risk rating of ESR items relating to staff turnover | - | - | No evidence of risk |
| | ESRSTAB | Composite risk rating of ESR items relating to staff stability | - | - | No evidence of risk |
| | ESRSUP | Composite risk rating of ESR items relating to staff support/ supervision | - | - | No evidence of risk |
| | ESRSTAFF | Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy | - | - | No evidence of risk |
| | FLUVAC01 | Healthcare Worker Flu vaccination uptake | 0.44 | 0.48 | No evidence of risk |
| Qualitative intelligence | WHISTLEBLOW | Whistleblowing alerts | - | - | Elevated risk |
| | GMCconcerns | Serious Education Concerns | - | - | No evidence of risk |
| | Safeguarding | Safeguarding concerns | - | - | No evidence of risk |
| | SYE | Your Experience | - | - | No evidence of risk |
| | NHSchoices | NHS Choices | - | - | No evidence of risk |
| | P_OPINION | Patient Opinion | - | - | No evidence of risk |
| | CQC_COM | CQC complaints | - | - | No evidence of risk |
| | PROV_COM | Provider complaints | - | - | No evidence of risk |

Imperial College Healthcare NHS Trust

Appendix of indicators used in the composite mortality indicators

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Cardiological Conditions and Procedures | HESMORT24CU | In-hospital mortality: Cardiological conditions | No evidence of risk |
| | MORTAMI | Mortality outlier alert: Acute myocardial infarction | No evidence of risk |
| | MORTARRES | Mortality outlier alert: Cardiac arrest and ventricular fibrillation | No evidence of risk |
| | MORTCABGI | Mortality outlier alert: CABG (isolated first time) | No evidence of risk |
| | MORTCABGO | Mortality outlier alert: CABG (other) | No evidence of risk |
| | MORTCASUR | Mortality outlier alert: Adult cardiac surgery | No evidence of risk |
| | MORTCATH | Mortality outlier alert: Coronary atherosclerosis and other heart disease | No evidence of risk |
| | MORTCHF | Mortality outlier alert: Congestive heart failure; nonhypertensive | No evidence of risk |
| | MORTDYSRH | Mortality outlier alert: Cardiac dysrhythmias | No evidence of risk |
| | MORTHVD | Mortality outlier alert: Heart valve disorders | No evidence of risk |
| | MORTPHD | Mortality outlier alert: Pulmonary heart disease | No evidence of risk |
| Cerebrovascular Conditions | HESMORT21CU | In-hospital mortality: Cerebrovascular conditions | No evidence of risk |
| | MORTACD | Mortality outlier alert: Acute cerebrovascular disease | No evidence of risk |
| Dermatological Conditions | HESMORT35CU | In-hospital mortality: Dermatological conditions | No evidence of risk |
| | MORTSKINF | Mortality outlier alert: Skin and subcutaneous tissue infections | No evidence of risk |
| | MORTSKULC | Mortality outlier alert: Chronic ulcer of skin | No evidence of risk |
| Endocrinological Conditions | HESMORT29CU | In-hospital mortality: Endocrinological conditions | No evidence of risk |
| | MORTDIABWC | Mortality outlier alert: Diabetes mellitus with complications | No evidence of risk |
| | MORTDIABWOC | Mortality outlier alert: Diabetes mellitus without complications | No evidence of risk |
| | MORTFLUID | Mortality outlier alert: Fluid and electrolyte disorders | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Gastroenterological and Hepatological Conditions and Procedures | HESMORT27CU | In-hospital mortality: Gastroenterological and hepatological conditions | No evidence of risk |
| | MORTALCLIV | Mortality outlier alert: Liver disease, alcohol-related | No evidence of risk |
| | MORTBILIA | Mortality outlier alert: Biliary tract disease | No evidence of risk |
| | MORTGASHAE | Mortality outlier alert: Gastrointestinal haemorrhage | No evidence of risk |
| | MORTGASN | Mortality outlier alert: Noninfectious gastroenteritis | No evidence of risk |
| | MORTINTOBS | Mortality outlier alert: Intestinal obstruction without hernia | No evidence of risk |
| | MORTOGAS | Mortality outlier alert: Other gastrointestinal disorders | No evidence of risk |
| | MORTOLIV | Mortality outlier alert: Other liver diseases | No evidence of risk |
| | MORTOPJEJ | Mortality outlier alert: Operations on jejunum | No evidence of risk |
| | MORTPERI | Mortality outlier alert: Peritonitis and intestinal abscess | No evidence of risk |
| | MORTTEPBI | Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract | No evidence of risk |
| | MORTTEPLGI | Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract | No evidence of risk |
| | MORTTEPUGI | Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract | No evidence of risk |
| | MORTTOJI | Mortality outlier alert: Therapeutic operations on jejunum and ileum | No evidence of risk |
| Genito-Urinary Conditions | HESMORT31CU | In-hospital mortality: Genito-urinary conditions | No evidence of risk |
| | MORTUTI | Mortality outlier alert: Urinary tract infections | No evidence of risk |
| Haematological Conditions | HESMORT28CU | In-hospital mortality: Haematological conditions | No evidence of risk |
| | MORTDEFI | Mortality outlier alert: Deficiency and other anaemia | No evidence of risk |
| Infectious Diseases | HESMORT26CU | In-hospital mortality: Infectious diseases | No evidence of risk |
| | MORTSEPT | Mortality outlier alert: Septicaemia (except in labour) | No evidence of risk |
| Conditions Associated With Mental Health | HESMORT33CU | In-hospital mortality: Conditions associated with Mental health | Not included |
| | MORTSENI | Mortality outlier alert: Senility and organic mental disorders | No evidence of risk |
| Musculoskeletal Conditions | HESMORT36CU | In-hospital mortality: Musculoskeletal conditions | No evidence of risk |
| | MORTPATH | Mortality outlier alert: Pathological fracture | No evidence of risk |
| | MORTSPON | Mortality outlier alert: Spondylosis, intervertebral disc disorders, other back problems | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Nephrological Conditions | HESMORT30CU | In-hospital mortality: Nephrological conditions | No evidence of risk |
| | MORTRENA | Mortality outlier alert: Acute and unspecified renal failure | No evidence of risk |
| | MORTRENC | Mortality outlier alert: Chronic renal failure | No evidence of risk |
| Neurological Conditions | HESMORT34CU | In-hospital mortality: Neurological conditions | No evidence of risk |
| | MORTEPIL | Mortality outlier alert: Epilepsy, convulsions | No evidence of risk |
| Paediatric and Congenital Disorders and Perinatal Mortality | HESMORT32CU | In-hospital mortality: Paediatric and congenital disorders | No evidence of risk |
| | MATPERIMOR | Maternity outlier alert: Perinatal mortality | No evidence of risk |
| Respiratory Conditions and Procedures | HESMORT25CU | In-hospital mortality: Respiratory conditions | No evidence of risk |
| | MORTASTHM | Mortality outlier alert: Asthma | No evidence of risk |
| | MORTBRONC | Mortality outlier alert: Acute bronchitis | No evidence of risk |
| | MORTCOPD | Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis | No evidence of risk |
| | MORTPLEU | Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse | No evidence of risk |
| | MORTPNEU | Mortality outlier alert: Pneumonia | No evidence of risk |
| Trauma and Orthopaedic Conditions | HESMORT37CU | In-hospital mortality: Trauma and orthopaedic conditions | No evidence of risk |
| | MORTCRAN | Mortality outlier alert: Craniotomy for trauma | No evidence of risk |
| | MORTFNOF | Mortality outlier alert: Fracture of neck of femur (hip) | No evidence of risk |
| | MORTHFREP | Mortality outlier alert: Head of femur replacement | No evidence of risk |
| | MORTHIPREP | Mortality outlier alert: Hip replacement | No evidence of risk |
| | MORTINTINJ | Mortality outlier alert: Intracranial injury | No evidence of risk |
| | MORTOFRA | Mortality outlier alert: Other fractures | No evidence of risk |
| | MORTREDFB | Mortality outlier alert: Reduction of fracture of bone | No evidence of risk |
| | MORTREDFBL | Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) | No evidence of risk |
| | MORTREDFNOF | Mortality outlier alert: Reduction of fracture of neck of femur | No evidence of risk |
| | MORTSHUN | Mortality outlier alert: Shunting for hydrocephalus | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Vascular Conditions and Procedures | HESMORT23CU | In-hospital mortality: Vascular conditions | No evidence of risk |
| | MORTAMPUT | Mortality outlier alert: Amputation of leg | No evidence of risk |
| | MORTANEUR | Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms | No evidence of risk |
| | MORTCLIP | Mortality outlier alert: Clip and coil aneurysms | No evidence of risk |
| | MORTOFB | Mortality outlier alert: Other femoral bypass | No evidence of risk |
| | MORTPVA | Mortality outlier alert: Peripheral and visceral atherosclerosis | No evidence of risk |
| | MORTREPAAA | Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) | No evidence of risk |
| | MORTTOFA | Mortality outlier alert: Transluminal operations on the femoral artery | No evidence of risk |

Intelligent Monitoring

# NHS acute trust banding

22 October 2013

* Risk elevated due to known serious concerns

| Trust Code | Trust Name | Band |
|---|---|---|
| REM | Aintree University Hospital NHS Foundation Trust | Band 1 |
| RBS | Alder Hey Children's NHS Foundation Trust | Band 1 |
| RF4 | Barking, Havering and Redbridge University Hospitals NHS Trust | Band 1 |
| RDD | Basildon and Thurrock University Hospitals NHS Foundation Trust | Band 1 |
| RXQ | Buckinghamshire Healthcare NHS Trust | Band 1 |
| RJF | Burton Hospitals NHS Foundation Trust | Band 1* |
| RJ6 | Croydon Health Services NHS Trust | Band 1 |
| RXR | East Lancashire Hospitals NHS Trust | Band 1 |
| RLT | George Eliot Hospital NHS Trust | Band 1* |
| RD7 | Heatherwood and Wexham Park Hospitals NHS Foundation Trust | Band 1 |
| RQX | Homerton University Hospital NHS Foundation Trust | Band 1 |
| RR8 | Leeds Teaching Hospitals NHS Trust | Band 1 |
| RPA | Medway NHS Foundation Trust | Band 1 |
| RNL | North Cumbria University Hospitals NHS Trust | Band 1 |
| RNS | Northampton General Hospital NHS Trust | Band 1 |
| RJL | Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Band 1* |
| RHW | Royal Berkshire NHS Foundation Trust | Band 1 |
| RK5 | Sherwood Forest Hospitals NHS Foundation Trust | Band 1* |
| RYQ | South London Healthcare NHS Trust | Band 1 |
| RMP | Tameside Hospital NHS Foundation Trust | Band 1 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | Band 1* |
| RDZ | The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust | Band 1 |
| RWD | United Lincolnshire Hospitals NHS Trust | Band 1 |
| RWE | University Hospitals of Leicester NHS Trust | Band 1 |
| R1H | Barts Health NHS Trust | Band 2 |
| RXL | Blackpool Teaching Hospitals NHS Foundation Trust | Band 2 |
| RQM | Chelsea and Westminster Hospital NHS Foundation Trust | Band 2 |
| RDE | Colchester Hospital University NHS Foundation Trust | Band 2 |
| RXC | East Sussex Healthcare NHS Trust | Band 2 |
| RR1 | Heart of England NHS Foundation Trust | Band 2 |
| RWA | Hull and East Yorkshire Hospitals NHS Trust | Band 2 |
| RGQ | Ipswich Hospital NHS Trust | Band 2 |
| RNQ | Kettering General Hospital NHS Foundation Trust | Band 2 |
| RXN | Lancashire Teaching Hospitals NHS Foundation Trust | Band 2 |
| RJ2 | Lewisham and Greenwich NHS Trust | Band 2 |
| RV8 | North West London Hospitals NHS Trust | Band 2 |
| RX1 | Nottingham University Hospitals NHS Trust | Band 2 |
| RAL | Royal Free London NHS Foundation Trust | Band 2 |
| RA2 | Royal Surrey County Hospital NHS Foundation Trust | Band 2 |
| RD1 | Royal United Hospital Bath NHS Trust | Band 2 |
| RXW | Shrewsbury and Telford Hospital NHS Trust | Band 2 |
| RHM | University Hospital Southampton NHS Foundation Trust | Band 2 |
| RFW | West Middlesex University Hospital NHS Trust | Band 2 |
| RA3 | Weston Area Health NHS Trust | Band 2 |
| RVL | Barnet and Chase Farm Hospitals NHS Trust | Band 3 |
| RQ3 | Birmingham Children's Hospital NHS Foundation Trust | Band 3 |
| RMC | Bolton NHS Foundation Trust | Band 3 |
| RAE | Bradford Teaching Hospitals NHS Foundation Trust | Band 3 |
| RXH | Brighton and Sussex University Hospitals NHS Trust | Band 3 |
| RWY | Calderdale and Huddersfield NHS Foundation Trust | Band 3 |
| RW3 | Central Manchester University Hospitals NHS Foundation Trust | Band 3 |
| RTG | Derby Hospitals NHS Foundation Trust | Band 3 |
| RP5 | Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Band 3 |

| Trust Code | Trust Name | Band |
|---|---|---|
| RC3 | Ealing Hospital NHS Trust | Band 3 |
| RWH | East and North Hertfordshire NHS Trust | Band 3 |
| RVV | East Kent Hospitals University NHS Foundation Trust | Band 3 |
| RN3 | Great Western Hospitals NHS Foundation Trust | Band 3 |
| RJ1 | Guy's and St Thomas' NHS Foundation Trust | Band 3 |
| REP | Liverpool Women's NHS Foundation Trust | Band 3 |
| RC9 | Luton and Dunstable University Hospital NHS Foundation Trust | Band 3 |
| RBT | Mid Cheshire Hospitals NHS Foundation Trust | Band 3 |
| RQ8 | Mid Essex Hospital Services NHS Trust | Band 3 |
| RXF | Mid Yorkshire Hospitals NHS Trust | Band 3 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | Band 3 |
| RP6 | Moorfields Eye Hospital NHS Foundation Trust | Band 3 |
| RM1 | Norfolk and Norwich University Hospitals NHS Foundation Trust | Band 3 |
| RTH | Oxford University Hospitals NHS Trust | Band 3 |
| RGM | Papworth Hospital NHS Foundation Trust | Band 3 |
| RT3 | Royal Brompton and Harefield NHS Foundation Trust | Band 3 |
| RBB | Royal National Hospital for Rheumatic Diseases NHS Foundation Trust | Band 3 |
| RJC | South Warwickshire NHS Foundation Trust | Band 3 |
| RBN | St Helens and Knowsley Teaching Hospitals NHS Trust | Band 3 |
| RW6 | The Pennine Acute Hospitals NHS Trust | Band 3 |
| RRK | University Hospitals Birmingham NHS Foundation Trust | Band 3 |
| RWG | West Hertfordshire Hospitals NHS Trust | Band 3 |
| RC1 | Bedford Hospital NHS Trust | Band 4 |
| RLN | City Hospitals Sunderland NHS Foundation Trust | Band 4 |
| RXP | County Durham and Darlington NHS Foundation Trust | Band 4 |
| RTE | Gloucestershire Hospitals NHS Foundation Trust | Band 4 |
| RN5 | Hampshire Hospitals NHS Foundation Trust | Band 4 |
| RQQ | Hinchingbrooke Health Care NHS Trust | Band 4 |
| RYJ | Imperial College Healthcare NHS Trust | Band 4 |
| R1F | Isle of Wight NHS Trust | Band 4 |
| RGP | James Paget University Hospitals NHS Foundation Trust | Band 4 |
| RJD | Mid Staffordshire NHS Foundation Trust | Band 4 |
| RVW | North Tees and Hartlepool NHS Foundation Trust | Band 4 |
| RTF | Northumbria Healthcare NHS Foundation Trust | Band 4 |
| RK9 | Plymouth Hospitals NHS Trust | Band 4 |
| RHU | Portsmouth Hospitals NHS Trust | Band 4 |
| RH8 | Royal Devon and Exeter NHS Foundation Trust | Band 4 |
| RXK | Sandwell and West Birmingham Hospitals NHS Trust | Band 4 |
| RE9 | South Tyneside NHS Foundation Trust | Band 4 |
| RVY | Southport and Ormskirk Hospital NHS Trust | Band 4 |
| RNA | The Dudley Group NHS Foundation Trust | Band 4 |
| RFR | The Rotherham NHS Foundation Trust | Band 4 |
| RKE | The Whittington Hospital NHS Trust | Band 4 |
| RKB | University Hospitals Coventry and Warwickshire NHS Trust | Band 4 |
| RGR | West Suffolk NHS Foundation Trust | Band 4 |
| RRF | Wrightington, Wigan and Leigh NHS Foundation Trust | Band 4 |
| RLQ | Wye Valley NHS Trust | Band 4 |
| RFS | Chesterfield Royal Hospital NHS Foundation Trust | Band 5 |
| RN7 | Dartford and Gravesham NHS Trust | Band 5 |
| RJN | East Cheshire NHS Trust | Band 5 |
| RJZ | King's College Hospital NHS Foundation Trust | Band 5 |
| RWF | Maidstone and Tunbridge Wells NHS Trust | Band 5 |
| RVJ | North Bristol NHS Trust | Band 5 |
| RBZ | Northern Devon Healthcare NHS Trust | Band 5 |

| Trust Code | Trust Name | Band |
|---|---|---|
| RD3 | Poole Hospital NHS Foundation Trust | Band 5 |
| REF | Royal Cornwall Hospitals NHS Trust | Band 5 |
| RAN | Royal National Orthopaedic Hospital NHS Trust | Band 5 |
| RM3 | Salford Royal NHS Foundation Trust | Band 5 |
| RAJ | Southend University Hospital NHS Foundation Trust | Band 5 |
| RBA | Taunton and Somerset NHS Foundation Trust | Band 5 |
| RTD | The Newcastle-upon-Tyne Hospitals NHS Foundation Trust | Band 5 |
| RQW | The Princess Alexandra Hospital NHS Trust | Band 5 |
| RL1 | The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust | Band 5 |
| RL4 | The Royal Wolverhampton NHS Trust | Band 5 |
| RJE | University Hospital of North Staffordshire NHS Trust | Band 5 |
| RM2 | University Hospital of South Manchester NHS Foundation Trust | Band 5 |
| RTX | University Hospitals of Morecambe Bay NHS Foundation Trust | Band 5 |
| RWW | Warrington and Halton Hospitals NHS Foundation Trust | Band 5 |
| RBL | Wirral University Teaching Hospital NHS Foundation Trust | Band 5 |
| RA4 | Yeovil District Hospital NHS Foundation Trust | Band 5 |
| RCB | York Teaching Hospital NHS Foundation Trust | Band 5 |
| RCF | Airedale NHS Foundation Trust | Band 6 |
| RTK | Ashford and St Peter's Hospitals NHS Foundation Trust | Band 6 |
| RFF | Barnsley Hospital NHS Foundation Trust | Band 6 |
| RLU | Birmingham Women's NHS Foundation Trust | Band 6 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | Band 6 |
| RJR | Countess of Chester Hospital NHS Foundation Trust | Band 6 |
| RBD | Dorset County Hospital NHS Foundation Trust | Band 6 |
| RVR | Epsom and St Helier University Hospitals NHS Trust | Band 6 |
| RDU | Frimley Park Hospital NHS Foundation Trust | Band 6 |
| RR7 | Gateshead Health NHS Foundation Trust | Band 6 |
| RP4 | Great Ormond Street Hospital for Children NHS Foundation Trust | Band 6 |
| RCD | Harrogate and District NHS Foundation Trust | Band 6 |
| RAX | Kingston Hospital NHS Foundation Trust | Band 6 |
| RBQ | Liverpool Heart and Chest NHS Foundation Trust | Band 6 |
| RAP | North Middlesex University Hospital NHS Trust | Band 6 |
| RGN | Peterborough and Stamford Hospitals NHS Foundation Trust | Band 6 |
| RPC | Queen Victoria Hospital NHS Foundation Trust | Band 6 |
| RQ6 | Royal Liverpool and Broadgreen University Hospitals NHS Trust | Band 6 |
| RNZ | Salisbury NHS Foundation Trust | Band 6 |
| RCU | Sheffield Children's NHS Foundation Trust | Band 6 |
| RHQ | Sheffield Teaching Hospitals NHS Foundation Trust | Band 6 |
| RA9 | South Devon Healthcare NHS Foundation Trust | Band 6 |
| RTR | South Tees Hospitals NHS Foundation Trust | Band 6 |
| RJ7 | St George's Healthcare NHS Trust | Band 6 |
| RWJ | Stockport NHS Foundation Trust | Band 6 |
| RTP | Surrey and Sussex Healthcare NHS Trust | Band 6 |
| RBV | The Christie NHS Foundation Trust | Band 6 |
| REN | The Clatterbridge Cancer Centre NHS Foundation Trust | Band 6 |
| RAS | The Hillingdon Hospital NHS Foundation Trust | Band 6 |
| RPY | The Royal Marsden NHS Foundation Trust | Band 6 |
| RRJ | The Royal Orthopaedic Hospital NHS Foundation Trust | Band 6 |
| RET | The Walton Centre NHS Foundation Trust | Band 6 |
| RRV | University College London Hospitals NHS Foundation Trust | Band 6 |
| RA7 | University Hospitals Bristol NHS Foundation Trust | Band 6 |
| RBK | Walsall Healthcare NHS Trust | Band 6 |
| RYR | Western Sussex Hospitals NHS Foundation Trust | Band 6 |
| RWP | Worcestershire Acute Hospitals NHS Trust | Band 6 |

Imperial College Healthcare NHS
NHS Trust

# Mortality Report
# (Aug '12 to July '13 data)
# QUALITY COMMITTEE

## Report Date: October 2013

*Ben Jones*
*On behalf of*
Imperial Business Intelligence

dr foster intelligence

innovation respect care achievement pride

# Hospital Standardised Mortality Ratio

- The (H)SMR is a summary mortality indicator. It is based on a subset of 56 diagnosis groups that give rise to approximately 85% of in hospital deaths.
- Measuring hospital performance is complex – HSMRs are one key indicator of overall mortality.
- Logistic regression models are created for each diagnosis group.
- Adjust for casemix, taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, discharge year.
- Each patient has a ‘risk’ of death based on these factors. Risks are aggregated to give an expected number of deaths.
- Model is updated once each year and national benchmark re-baselined.
- Expressed in terms of a ratio:

$$\text{(H)SMR} = \frac{\text{Observed Deaths}}{\text{Expected Deaths}} \times 100$$

# HSMR –Trend by month from Aug 2012 to July 2013


Since new benchmarks were applied in the June 2013 data, Imperial HSMR has continued to improve and now stands at 63. This is the lowest HSMR figure for an individual month in the last year of data. In the past year, HSMR was lower than expected for 11 out of 12 months of the year, with April 2013 the exception.

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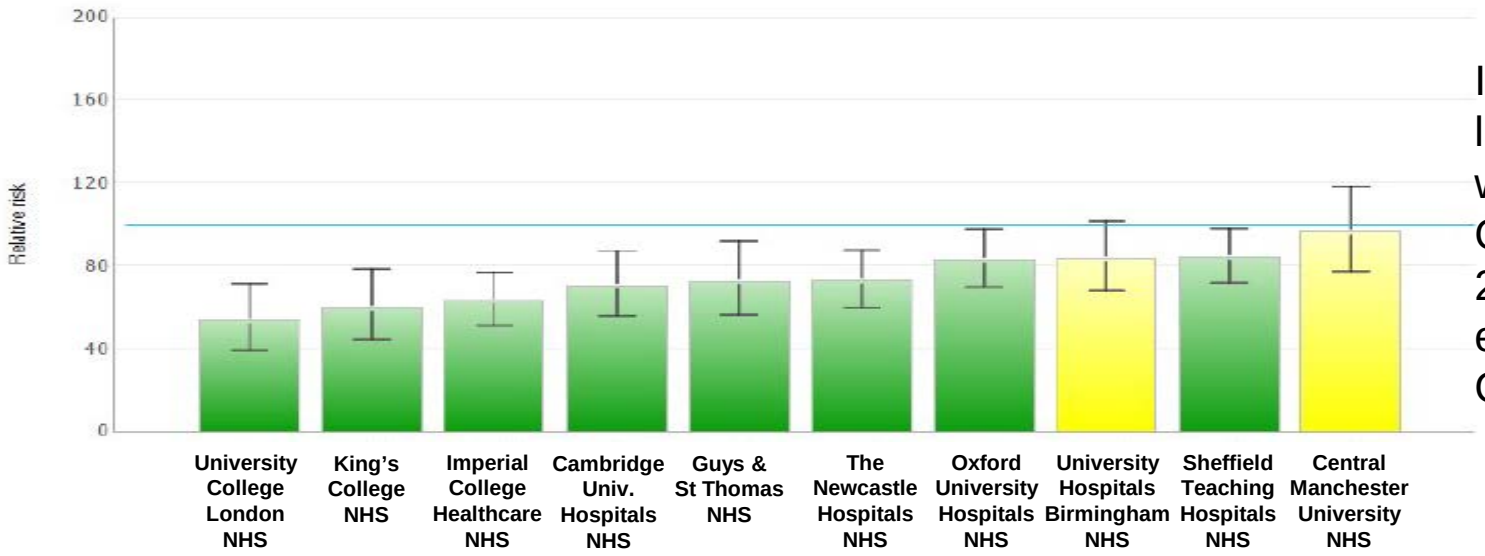
Data Period: Aug 2012 to July 2013

Imperial College Healthcare NHS Trust

# HSMR –for Imperial and rest of Shelford Group- for July 2013




Imperial has 3rd lowest HSMR within the Shelford Group for July 2013. HSMR for entire Shelford Group is 75.

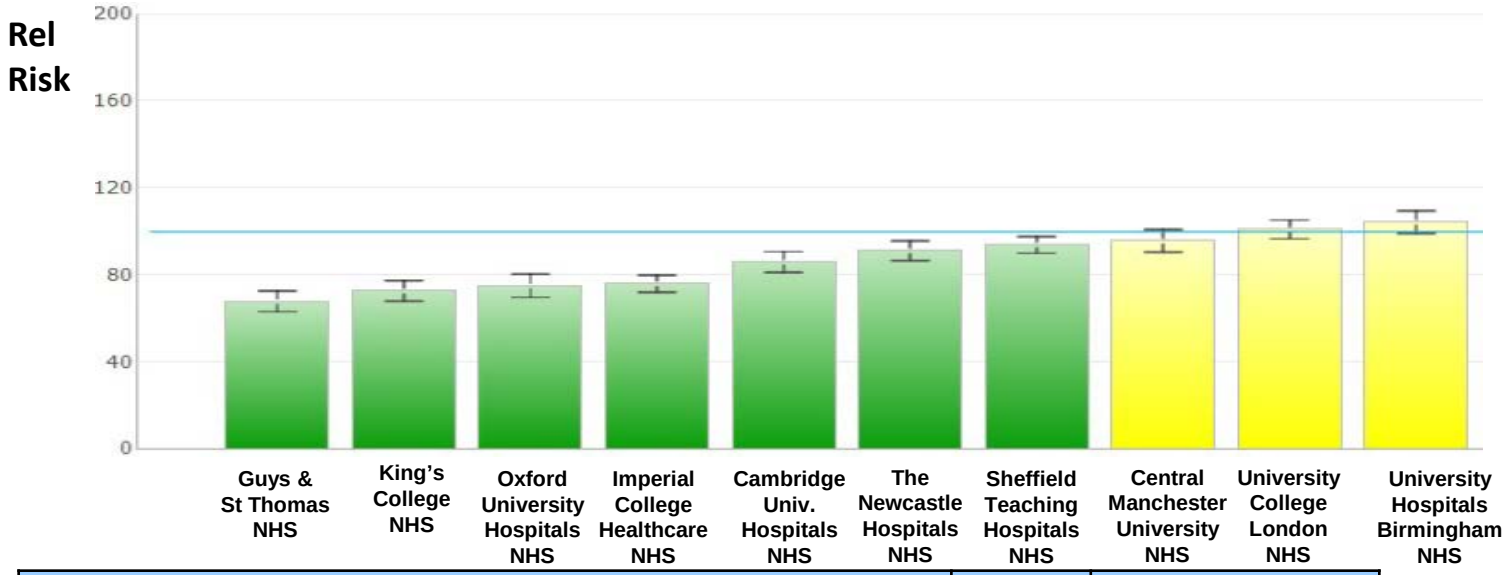
| Peer | Spells | Relative Risk |
|---|---|---|
| ALL | 42024 | 75.17 |
| University College London Hospitals NHS Foundation Trust | 3833 | 53.70 |
| King's College NHS Foundation Trust | 2279 | 59.75 |
| Imperial College Healthcare NHS Trust | 4224 | 63.20 |
| Cambridge University Hospitals NHS Foundation Trust | 3952 | 70.45 |
| Guy's and St Thomas' Hospitals NHS Trust | 2768 | 72.57 |
| Newcastle Upon Tyne Hospitals NHS Foundation Trust | 5409 | 72.85 |
| Oxford University Hospitals NHS Trust | 5635 | 82.92 |
| University Hospitals Birmingham NHS Foundation Trust | 3206 | 83.59 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 7151 | 84.19 |
| Central Manchester University Hospitals NHS Foundation Trust | 3567 | 96.40 |

SMR bandings
- Higher than expected
- As expected
- Lower than expected

Data Period: July 2013

Imperial College Healthcare NHS
NHS Trust

# HSMR –for Imperial and rest of Shelford Group for year to July 2013




**Imperial HSMR value is 4th lowest in the group.**

Imperial HSMR is also much lower than the whole Shelford Group relative risk for data year to July 2013 of 88.11.

| Peer | Spells | Rel Risk |
|---|---|---|
| ALL | 484536 | 88.11 |
| Guy's and St Thomas' NHS Foundation Trust | 32489 | 67.94 |
| King's College Hospital NHS Foundation Trust | 29021 | 72.77 |
| University College London Hospitals NHS Foundation Trust | 42340 | 75.01 |
| Imperial College Healthcare NHS Trust | 48913 | 76.07 |
| Cambridge University Hospitals NHS Foundation Trust | 46071 | 85.98 |
| The Newcastle Upon Tyne Hospitals NHS Foundation Trust | 64073 | 91.19 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 80797 | 93.92 |
| Central Manchester University Hospitals NHS Foundation Trust | 41570 | 95.73 |
| Oxford University Hospitals NHS Trust | 62790 | 100.96 |
| University Hospitals Birmingham NHS Foundation Trust | 36472 | 104.32 |

| SMR bandings | |
|---|---|
| | Higher than expected |
| | As expected |
| | Lower than expected |

Data Period: Aug 2012 to July 2013

# HSMR - ten non-specialist acute providers with the lowest HSMR values in England (All Admissions) in last available year of data

| Peer (National) | RR |
|---|---|
| Guys and St Thomas NHS Foundation Trust | 65.2 |
| Kings College Hospital NHS Foundation Trust | 72.2 |
| University College London Hospitals NHS Foundation Trust | 73.3 |
| The Whittington NHS Trust | 73.7 |
| Royal Free London NHS Foundation Trust | 74 |
| Imperial College Healthcare NHS Trust | 75.9 |
| Ashford and St Peters Hospitals NHS Foundation Trust | 77.5 |
| Chelsea and Westminster Hospital NHS Foundation Trust | 78.2 |
| Salford Royal NHS Foundation Trust | 78.8 |
| Airedale NHS Foundation Trust | 80 |

Data Period: Aug'12 to July'13

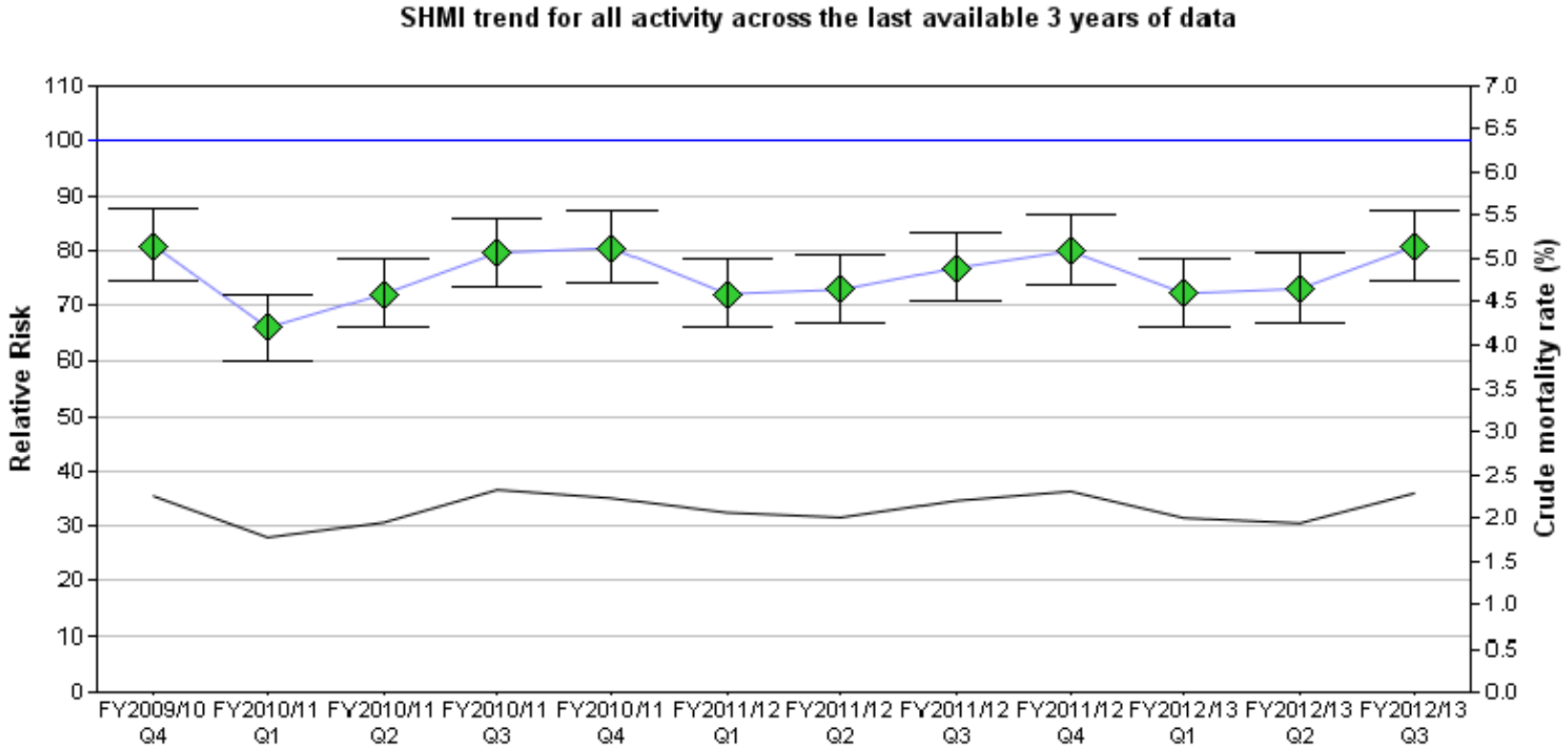
This is the latest HSMR data available. HSMR data is more recent and published more regularly than SHMI data. Imperial is not one of the 5 providers with lowest HSMR.

# Summary Hospital Mortality Indicator

- SHMI is ratio of observed number to expected number of deaths for acute providers. **Covers all deaths in-hospital or within 30 days post discharge from hospital.**
- The expected number of deaths is calculated from a risk adjusted model using a patient case-mix of age, gender, admission method, comorbidity and diagnosis group.
- HSMR adjusts for more factors in risk modeling than SHMI, notably: palliative care, diagnosis sub-group, past history of admissions and month and source of admission.
- Because SHMI adjusts for deaths post discharge, there is a time lag between data submission for this and the HSMR. Whilst SHMI data is only available to December 2012, HSMR is available to April 2013
- SHMI is rebased quarterly using a rolling 12 month period. SHMI allocates the death to the last non-specialist provider within the patient superspell.
- As with HSMR, expressed as a ratio. As both cover different factors and patients, combined analysis allows for robust mortality reporting.

$$\text{SHMI} = \frac{\text{Observed Deaths}}{\text{Expected Deaths}} \times 100$$

# SHMI trend for last 12 available calculations (last 3 years to Dec ’12)




SHMI trend shows that all Imperial quarterly SHMI readings have been lower than expected for the last 3 years. Ranges from lowest of 66 in Apr-June of 2010 to highest of 81 in Oct to Dec 2009. By way of illustration, SHMI tends to follow crude mortality rate trend almost exactly. This is the latest SHMI data made available from the Information Centre,

Data Period: Oct‘09- Dec ‘12

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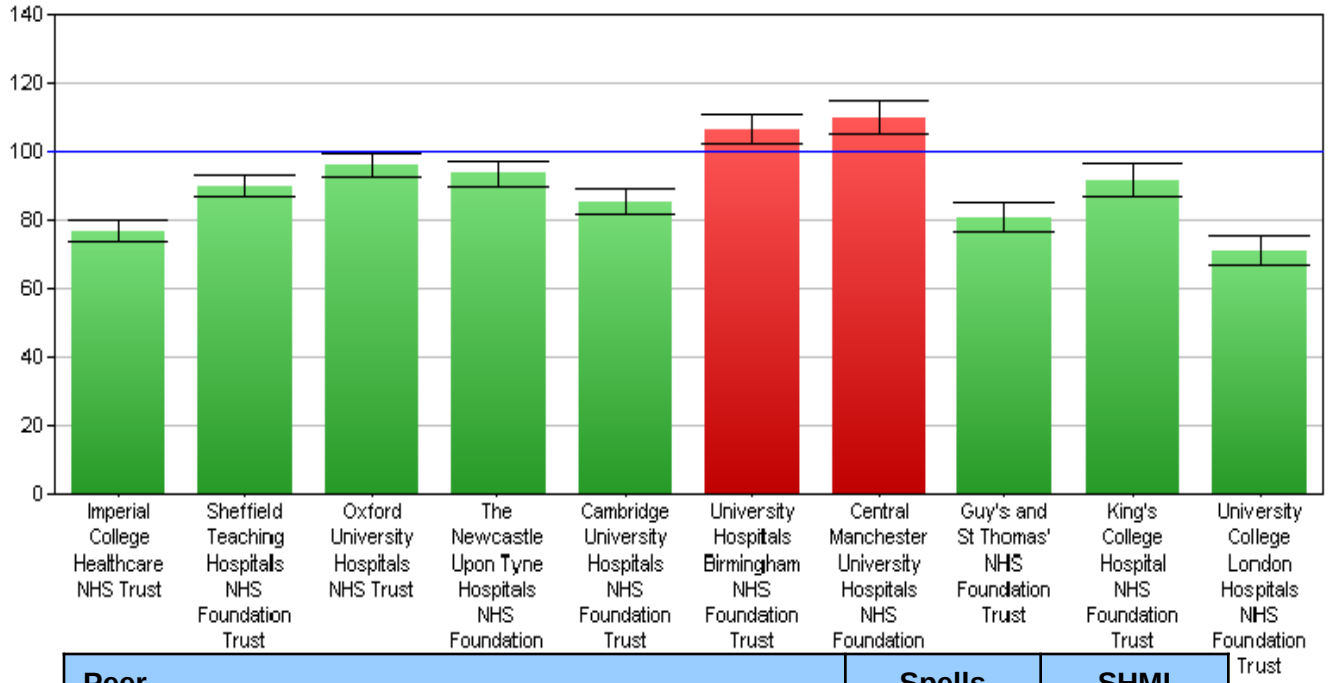
# SHMI –for Imperial and rest of Shelford Group for year to December 2012

Imperial College Healthcare NHS Trust




| Peer | Spells | SHMI |
|---|---|---|
| University College London Hospitals | 65861 | 70.81 |
| Imperial College Healthcare | 105367 | 76.49 |
| Guy's and St Thomas' | 86492 | 80.38 |
| Cambridge University Hospitals | 69695 | 85.05 |
| Sheffield Teaching Hospitals | 104795 | 89.7 |
| King's College Hospitals | 68396 | 91.46 |
| The Newcastle Upon Tyne Hospitals | 106770 | 93.33 |
| Oxford University Hospitals | 103669 | 95.61 |
| University Hospitals Birmingham | 55785 | 106.37 |
| Central Manchester Univ Hospitals | 99448 | 109.57 |

SHMI data is the latest made available by the Health & Social Care Information Centre (HSCIC).

Imperial have the 2nd lowest SHMI in the Shelford Group.

**Data Source: Health & Social Care Information Centre (Dr Foster Intelligence)**

| SMR bandings | |
|---|---|
| | Higher than expected |
| | As expected |
| | Lower than expected |

Data Period: Jan 2012-Dec 2012

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# SHMI - ten non-specialist acute providers with the lowest SHMI values in England (All Admissions)

| Provider | SHMI |
|---|---|
| The Whittington Hospital NHS Trust | 70.31 |
| University College London NHS Foundation Trust | 70.81 |
| **Imperial College Healthcare NHS Trust** | 76.49 |
| Chelsea and Westminster Hospital NHS Foundation Trust | 78.10 |
| Royal Free London NHS Foundation Trust | 78.44 |
| North Middlesex University Hospitals NHS Trust | 79.89 |
| Guy's and St Thomas' NHS Foundation Trust | 80.38 |
| St George's Healthcare NHS Trust | 81.19 |
| North West London Hospitals NHS Trust | 81.50 |
| Bart's Health NHS Trust | 82.42 |

Imperial has the 3rd lowest SHMI ratio of all non-specialist providers in England. Position and ratio (76) unchanged from period Sep '11 to Aug '12.

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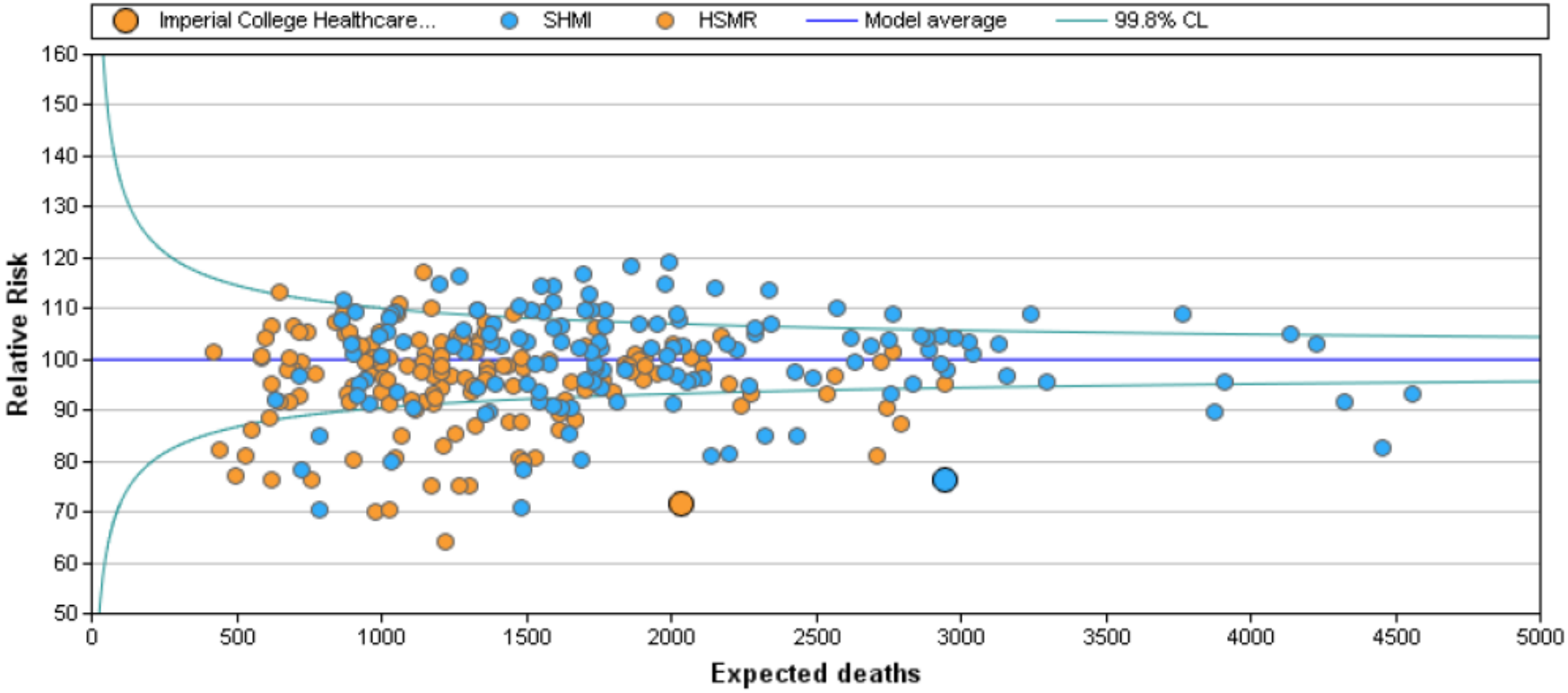
Data Period: Jan'12 - Dec '12

## SHMI and HSMR funnel plot for all non-specialist acute providers in England




Performance funnel plot shows that for both HSMR and SHMI, Imperial have some of the lowest mortality ratios in the country. For consistency, data is drawn from period Jan ’12 to Dec ’12 (where SHMI data is most recently available).

Data Period: Jan ’11- Dec‘12

**Data Source: Dr Foster Intelligence**

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Imperial College Healthcare NHS Trust

# Monthly Infection Prevention and Control Summary
## November 2013
## (October 2013 data)

**Key Indicators**
**October 2013**

| | | | | Divisions | | | | |
|---|---|---|---|---|---|---|---|---|
| | Threshold | Trust | | 1 | 2 | 3 | 4 | PPs |
| MRSA BSI (>48hrs) | 0 | 1 | | 0 | 1 | 0 | 0 | 0 |
| MSSA BSI (>48hrs) | 0 | 2 | | 1 | 1 | 0 | 0 | 0 |
| *E.coli* BSI (>48hrs) | 0 | 5 | | 1 | 1 | 2 | 0 | 1 |
| *C. difficile* (>72 hrs) | 5 | 4 | | 2 | 2 | 0 | 0 | 0 |

**Year to Date 2013/14**

| | YTD 2013/14 | | | | Divisions | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Threshold | | Cases | | | | | | | | | |
| | Year | YTD | Trust | | 1 | | 2 | | 3 | | 4 | | PPs | |
| MRSA BSI (>48hrs) | 0 | 0 | 9 | | 5 | | 4 | | 0 | | 0 | | 0 | |
| MSSA BSI (>48hrs) | N/A | N/A | 27 | | 9 | | 14 | | 4 | | 0 | | 0 | |
| *E.coli* BSI (>48hrs) | N/A | N/A | 40 | | 10 | | 19 | | 10 | | 0 | | 1 | |
| *C. difficile* (>72 hrs) | 65 | 37 | 41 | | 26 | | 14 | | 0 | | 0 | | 1 | |

**Key:**
Division 1 = Medicine
Division 2 = Surgery, Cancer and Cardiovascular
Division 3 = Investigative sciences and clinical support
Division 4 = Women's and Children's
N/A = Not applicable

= Above threshold value
= Below threshold value
= Equal to threshold value

## 1. Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

There is a national expectation of zero MRSA blood stream infections for all Trusts for 2013/14.
In September there were no Trust attributable cases and one non trust attributable case reported. In October a Trust attributable case was reported from a patient who required urgent abdominal surgery. The source of this bacteraemia was thought to be a contaminant.

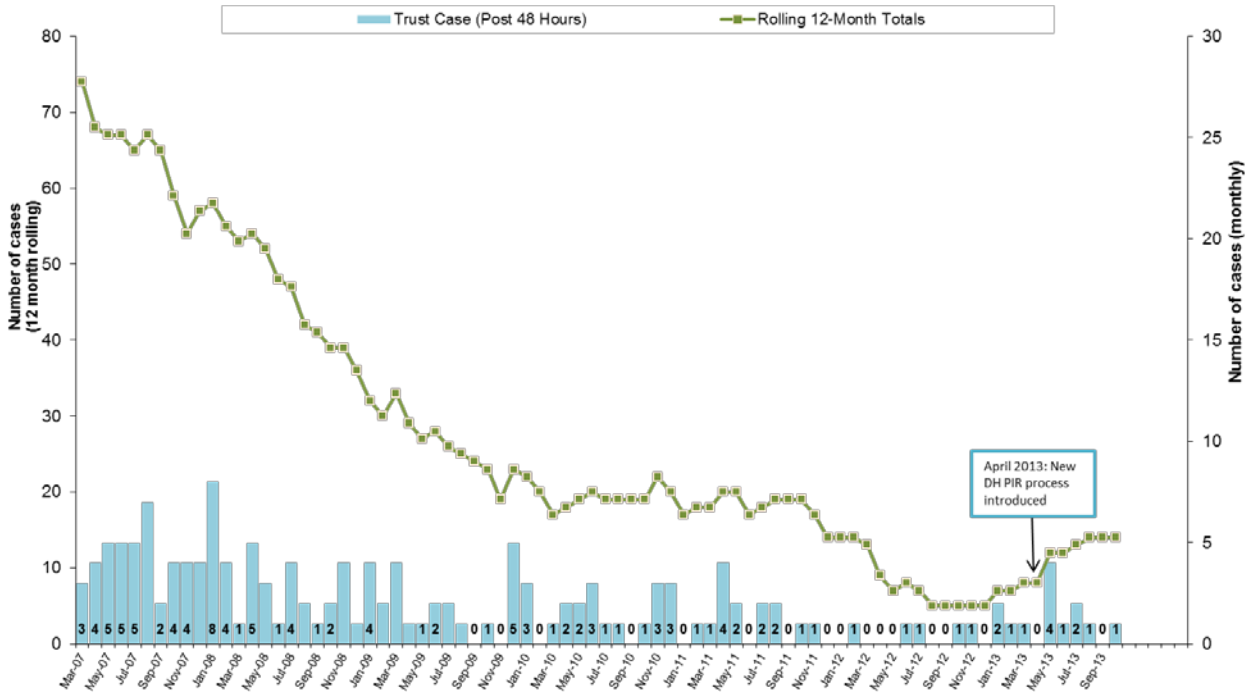
The case in August related to trauma in the community has been finally allocated to the Trust following the arbitration process that was introduced this year, which has brought the total number of cases reported against the Trust to nine for the year to date.

### 1.1 Update on key elements of the MRSA BSI prevention action plan

Actions from the cases detailed above:
There were no actions identified that could have prevented the non-trust attributable case in September.
Actions from the October Trust attributable case have included the removal of a bed in a bay on a surgical ward to improve access to the sink and to facilitate hand hygiene. Other local actions focussed on mandating the documentation of vascular access devices and blood cultures.

**External review of Vascular Access:** In response to the risk of MRSA BSI associated with indwelling vascular devices, the Trust commissioned an international expert to undertake a review of vascular access practice and quality improvement programmes; with a view to providing recommendations on how to further improve our outcomes. Following the 10 days spent in the Trust in August 2013, key recommendations were made that primarily focus on strengthening our existing practices and processes. He endorsed our competency assessment framework, and gave further recommendations for the planning and implementation of the reassessment process. He highlighted the need to increase multi-professional involvement in the planning and delivery of a comprehensive BSI prevention programme. He also provided his expert opinion on surveillance and analysis of the overall burden of MRSA across our health economy. The report and recommendations will be addressed at the TIPC and the Vascular Access group meetings in November 2013.

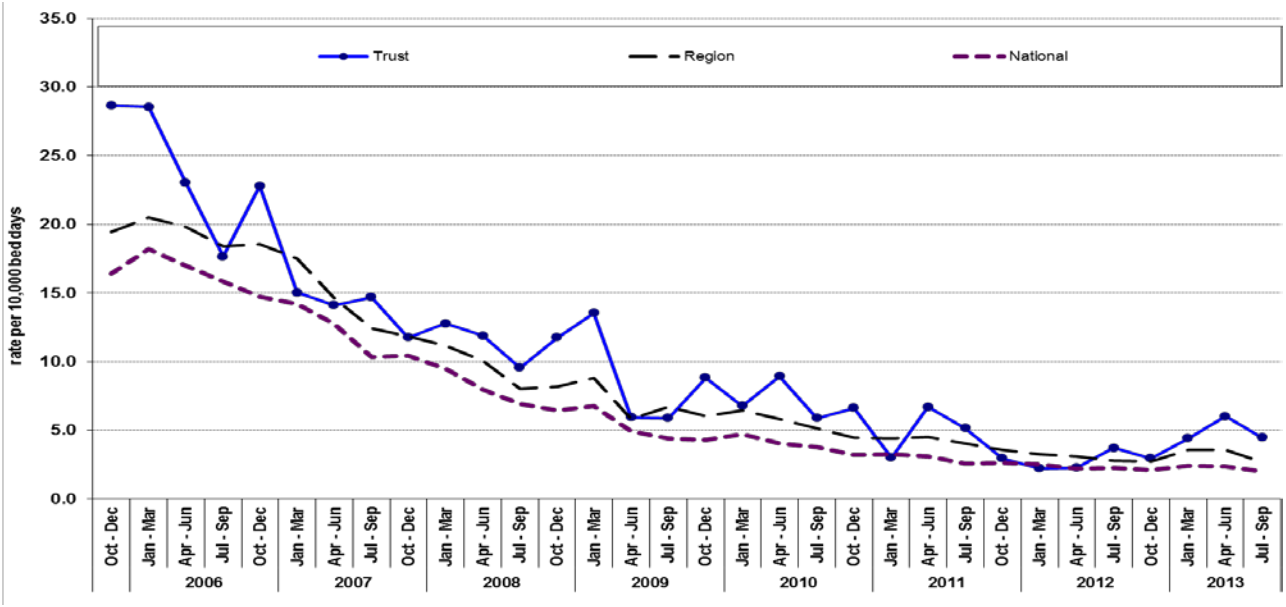
**Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases**



### 1.2 Benchmarking Trust-attributable MRSA BSI rates

Provisional data presented by Public Health England (PHE) in figure 2 shows that the Trust had a quarterly rate of 4.5 per 10,000 bed compared to a regional rate of 2.7 and national rate of 2.0.

**Figure 2: Trend in the Trust-attributable MRSA BSI rate compared to the national & London Region rates (rate/10,000 bed days)**




*Source: PHE Trust reports November 2013*

### 2. *C. difficile* infections

For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of *C. difficile* infection.
In September 11 cases were reported to the PHE, of which five cases were Trust attributable.
In October 14 cases were reported, of which four cases were Trust attributable.
Year to date 41 cases have been reported to the PHE. There is a marked reduction in the quarterly rate.

Of the nine Trust-attributable cases in September and October, all but one occurred in patients aged over 65 with six of these patients being over 75 years of age. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in two of the five cases in September and two of the four cases in October All antibiotics were in line with policy or approved by infection clinical team.

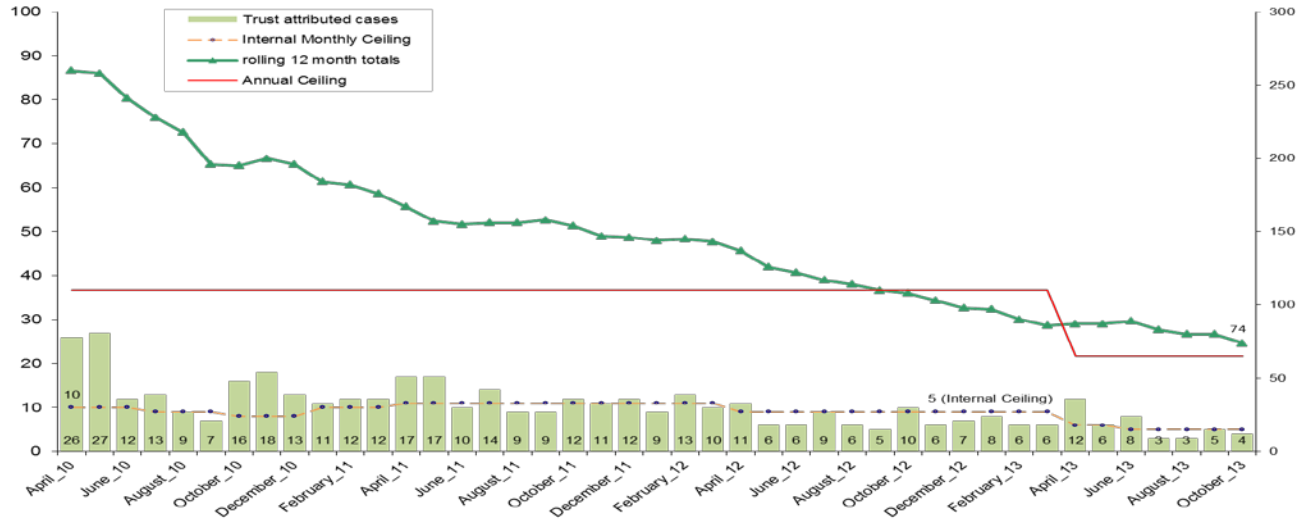
Of the five September cases across three sites; one elderly patient on a medical ward died and the case is undergoing investigation. One patient had appropriate treatment for severe *C. difficile* while undergoing chemotherapy for lymphoma and two vascular patients developed *C. difficile* following infective complications of ischaemic lower limbs requiring antibiotics and infection team input. The fifth patient had appropriate antibiotics for community associated pneumonia on admission but developed diarrhoea and was subsequently treated for *C. difficile*.

Of the four October cases across three sites; one patient had significant antibiotic exposure abroad prior to admission, with episodes of diverticulitis managed with infection team input and antibiotics. One patient on a medical ward had appropriate narrow spectrum antibiotics and infection team input for management of both a community acquired pneumonia and *C.difficile* infection. One patient had antimicrobial therapy in line with policy and the fourth patient had no previous antibiotic exposure.

## 2.1 Update on key elements of the *C. difficile* prevention action plan

A Trust taskforce meets weekly to address healthcare associated infections (HCAI) with specific reference to MRSA blood stream infection and *C. difficile*. A standard operating procedure has been written and disseminated which sets out the requirements for isolating patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea. In addition to the detailed clinical review of each case of *C. difficile*, the time taken to isolate is being monitored. A monthly MDT review of all *C. difficile* cases is undertaken in which risk factors for each case are collated and learning shared with primary care colleagues.
A review of isolation facilities is being undertaken to identify current facilities available for isolation for patients with diarrhoea.

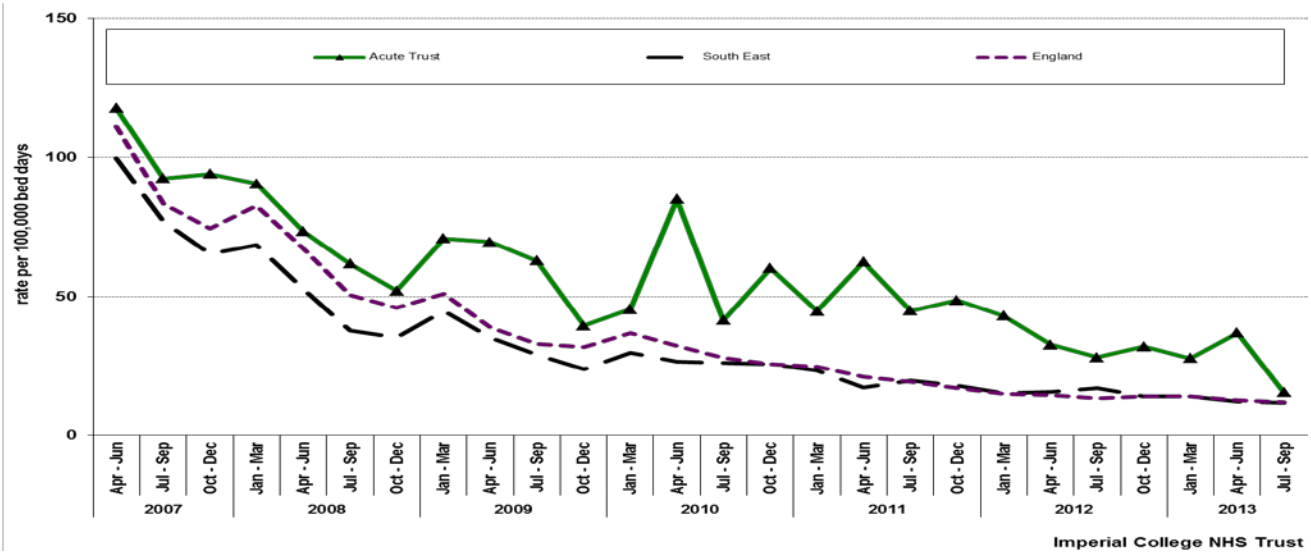
### Figure 3: Trust- attributable *C.difficile* Infections and 12 month rolling totals, April 2010 - October 2013




## 2.2 Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by Public Health England in figure 4 shows a Trust quarterly rate of 15.4 per 100,000 bed days compared to a regional rate of 11.7 and national rate of 11.9.

### Figure 4: Trend in Trust-attributable CDI rate compared to national & regional rate (in 100,000 bed days)

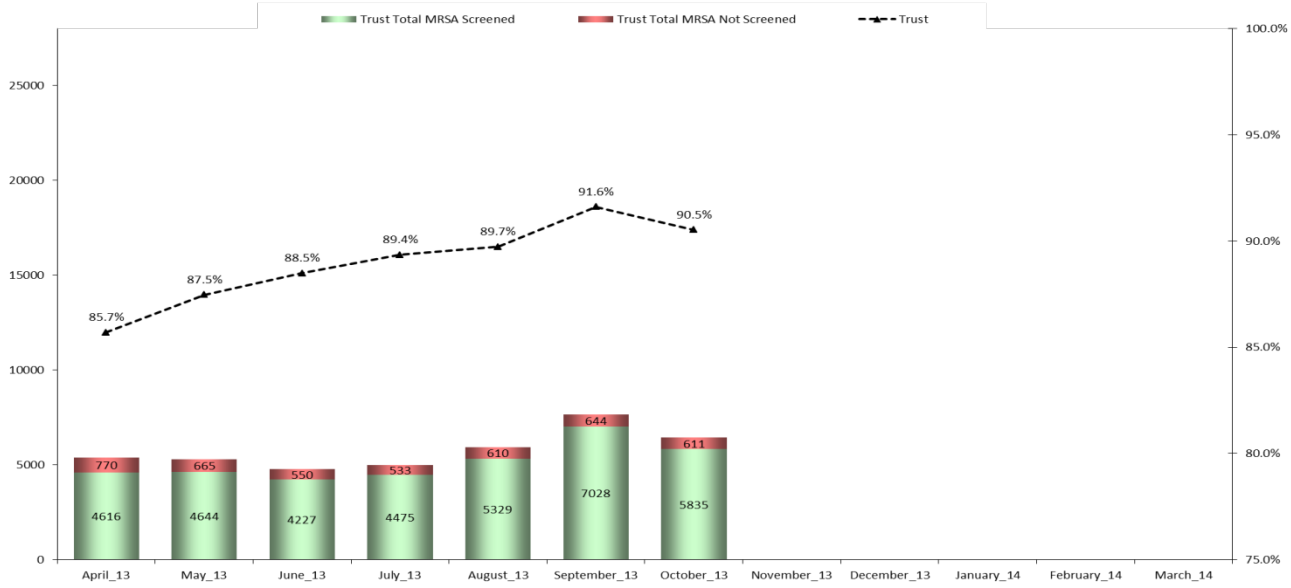


*Source: PHE Trust reports November 2013*

## 3. MRSA Screening

The Trust remains compliant with the Department of Health population MRSA screening requirements. Analysis at an individual patient level identified 6446 patients admitted in October 2013 who required screening, of which 5835 (90.5 percent) were screened. New national guidance on MRSA screening is still awaited.

**Figure 5: MRSA screening compliance rate from April to October 2013**




## 4. Meticillin sensitive *Staphylococcus aureus* bloodstream infections (MSSA BSI)

There is no threshold for this indicator at present. In September 2013 there were two cases of MSSA BSI reported to Public Health England (PHE), of which both were Trust attributable (i.e. post 48 hours of admission), in October two cases were reported of which both were Trust attributable.

In September, one case was related to a central vascular access device and the second case was related to thrombophlebitis associated with a peripheral vascular access device.

In October, one case was related to a skin and soft tissue infection but was not device related and the other was due to pneumonia.

**Figure 6a: Monthly MSSA BSI cases cases**

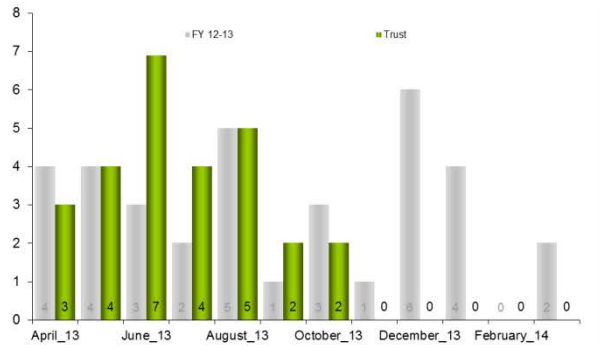
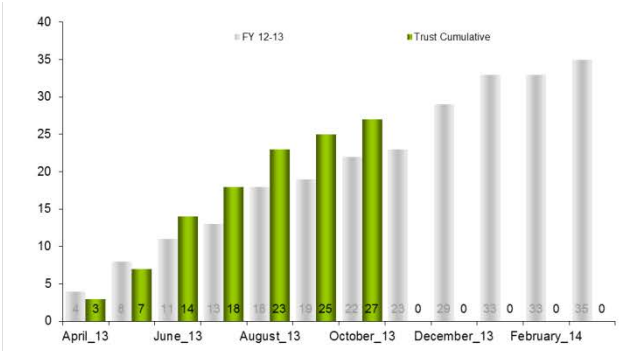



**Figure 6b: Cumulative MSSA BSI**



## 5. *Escherichia coli* bloodstream infections (*E. coli* BSI)

There is no threshold for this indicator at present. The steep rise in *E.coli* BSIs nationally is a cause of significant concern. In September 2013 there were five Trust attributable cases of *E. coli* BSI reported to Public Health England (PHE). In October five Trust-attributable cases were reported to the PHE.

In September one case was related to a urinary source, two to biliary tract obstruction, one to neutropenic sepsis and one to endometritis.

In October, three cases were related to urinary tract sources, of these one was in a pregnant patient. The other two cases related to a post caesarean section wound infection, and to abdominal sepsis following a laparotomy for bowel cancer.

**Figure 7a: Monthly Trust-acquired *E. coli* BSI**

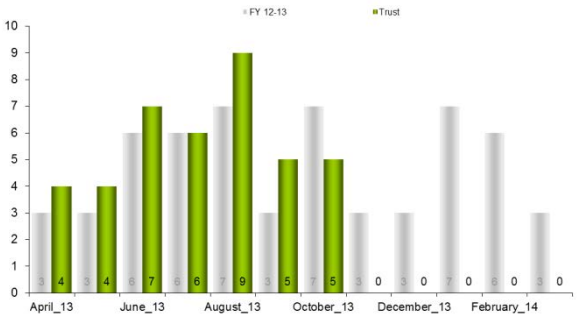



**Figure 7b: Cumulative Trust-acquired *E. coli* BSI**

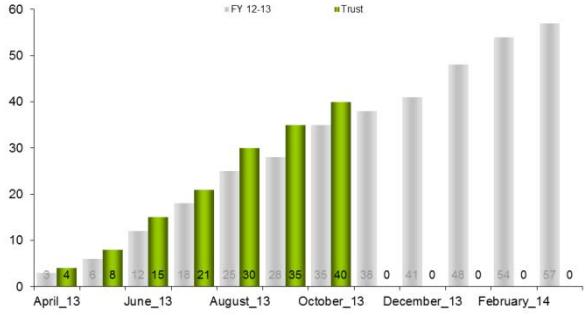
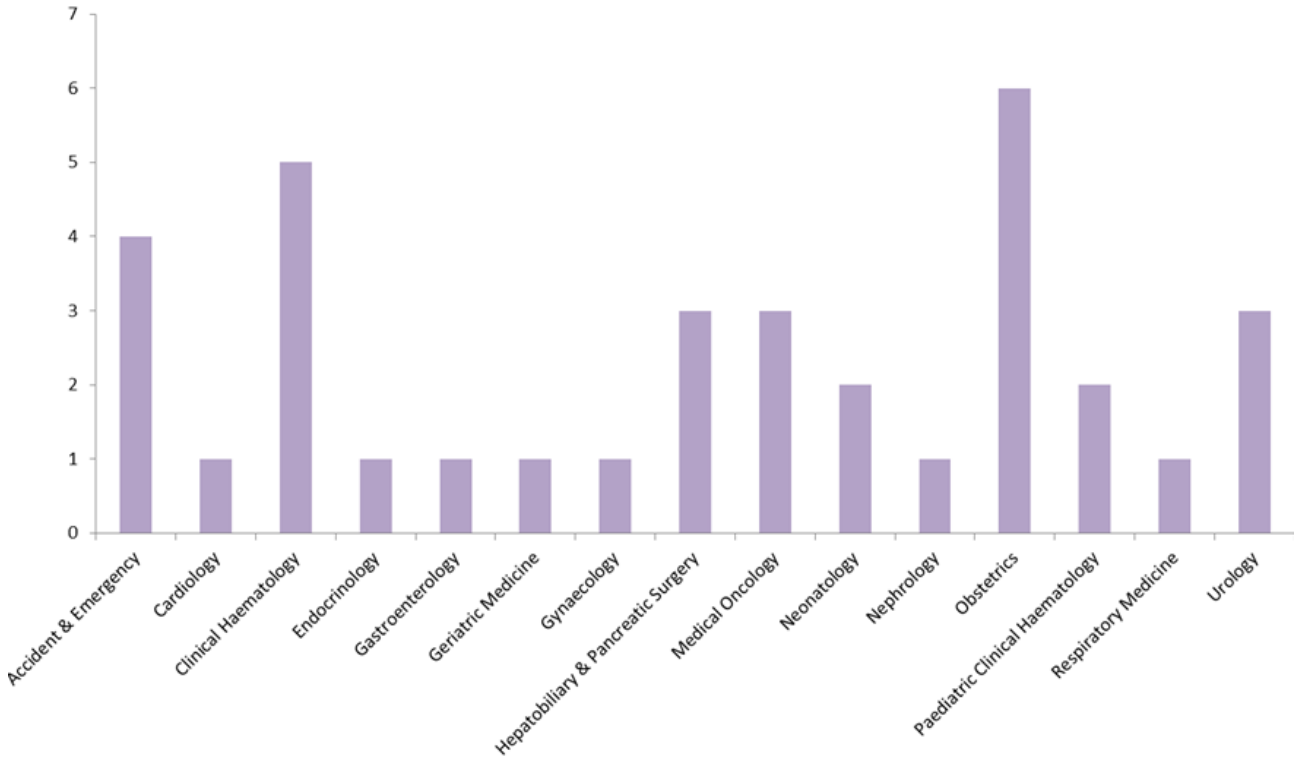



**Figure 8: Distribution of E.*coli* Trust Attributable cases by speciality (April - October 2013)**

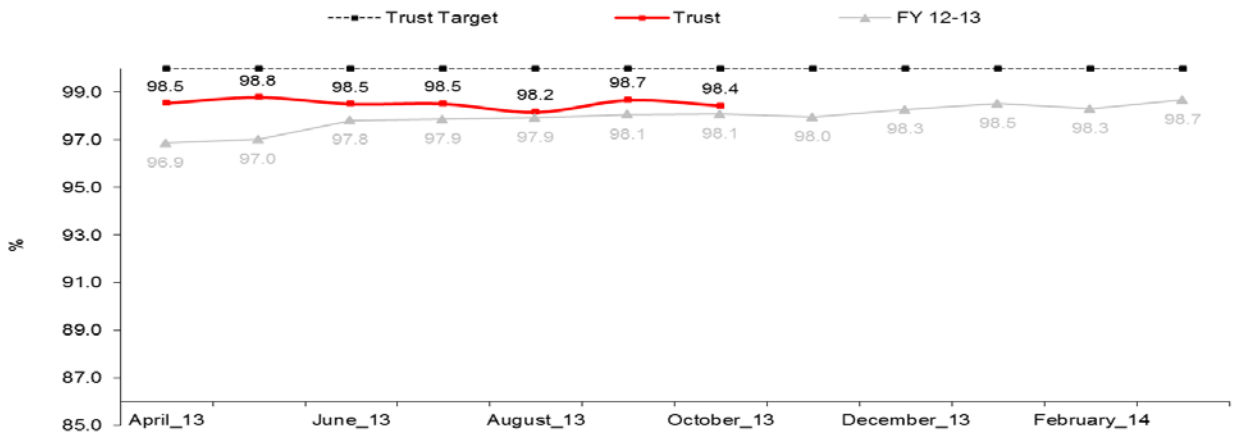


## 6. Hand hygiene compliance

In October 2013, 89.4 percent of clinical areas submitted a total of 5020 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week) Hand hygiene was 98.4 percent, and compliance with bare below elbows was 98.4 percent.

**Hand hygiene compliance audit process:** Hand hygiene is one of the most effective methods to prevent health care associated infections. Audits of hand hygiene compliance measured against the WHO 5 moments of hand hygiene are currently undertaken by each ward monthly and a more detailed and rigorous validation audit is undertaken yearly by the infection prevention and control team.

**Figure 9: Average performance of hand hygiene practice**




## 7. ANTT

The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at Divisional level as part of the infection prevention and control plan. The two yearly reassessment programme for assessors is due in December 2013 and has now commenced. Completion of assessments has steadily been increasing from 75% in March to 89% (5702 clinical staff) at the end of October 2013. Since the competency assessment programme began in December 2011 a total of 6997 staff have been assessed for ANTT competency. Junior doctors are now assessed for ANTT competency on the day of induction in a skills lab setting. These assessments will now be undertaken using medical assessors from the Divisions.

## 8. Antibiotic stewardship

### 8.1 New Trust Adult Antibiotic Policy & Smart-Phone app launched on European Antibiotic Awareness Day (EAAD)

The new adult Treatment of Infection Policy and smart phone antibiotic app will be launched on Monday 18th November to coincide with European Antibiotic Awareness Day (EAAD). EAAD is supported by the Department of Health and its advisory committee on antimicrobial resistance and health care associated infections (ARHAI). Trusts are encouraged to support this initiative and the communications department are involved in promoting EAAD and launching the new policy within the organisation.

The Trust Antibiotic Review Group has made key changes to the adult treatment of infection policy and antibiotic app (developed in collaboration with Imperial College) to enhance patient safety and ensure the prudent prescribing of antibiotics. These key changes are described below:

Changes to the policy include:

- **New indications** – including non-specific LRTI, obstetric & peripartum infection and antibiotic prophylaxis in asplenic patients.
- **Updated sections** on prescribing principles, once daily Amikacin, management of sepsis, bronchiectasis and SBP prophylaxis.
- **New guidance** on antibiotics use in pregnancy and breastfeeding.

The smart phone App also includes:

- The recently released Trust adult surgical prophylaxis policy
- A new IV-oral switch function designed to aid practitioners in switching patients from IV to oral antibiotics. This will add to the work the infection team is undertaking to promote a reduction in line related infections
- The introduction of 'treatment principles' before displaying 'treatment options'
- A revision of the therapeutic drug monitoring section including the addition of the continuous vancomycin policy for critical care (CXH/HH)
- A help function including full references used within the policy

## 8.2 Working with GPs to help the Trust manage *C. difficile* patients

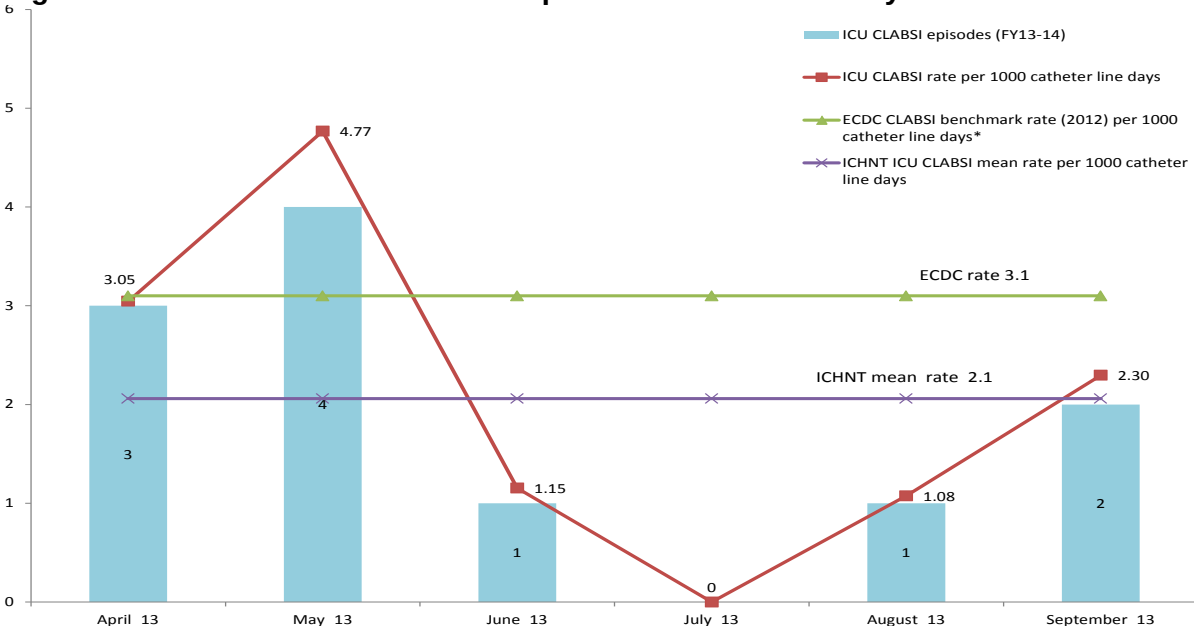
Over recent months, we have been reviewing our cases of Clostridium difficile to identify risk factors and common themes. Some of these risk factors have been the use of proton pump inhibitors and antibiotics, the prescribing of which are not solely confined to the hospital setting. Our consultant pharmacist has highlighted these issues to GP's (via the GP bulletin) to help raise awareness and look to mitigate these.

## 8.3 Antibiotic point prevalence survey

Mini point prevalence surveys have been introduced to ensure the Trust has quarterly reporting of the key antibiotic prescribing indicators. Surveillance was previously biannually. The first mini point prevalence survey results will be available on the 18th November to coincide with this year's European Antibiotic Awareness Day and will be discussed within the Trusts clinical and managerial structures.

## 9. Intensive Care Catheter Line Associated Bloodstream Infections (CLABSI)

**Figure 10: Intensive Care CLABSI rate per 1000 catheter line days FY 2013**




**Source: ECDC Annual Epidemiological Surveillance Report 2012*

The rate takes into account CLABSI episodes in patients staying more than two days in ICU, as per the latest European Centre for Disease Control, Annual Epidemiological Surveillance report (2012).

We aim to achieve a mean rate of 1.4 as achieved in the Michigan Keystone Project, a reduction achieved from a rate of 7.7 at the start of the study (*Bion J, et al. BMJ Qual Saf. 2013; 22: 110-123).*

## 10. Other matters

### 10.1 Carbapenemase producing organisms

Three *Acinetobacte*r isolates were confirmed as NDM-1 carbapenemase producers in October following analysis by Public Health England. On investigation, it was identified that all three patients from whom these isolates came from were on a vascular ward at the same time during June and July 2013. Enhanced screening was undertaken and no further cases were identified.

Two other unrelated carbapenemase producing organisms were identified in October 2013 The first was identified on an admission screen to an intensive care unit and the patient was colonised and required no treatment. The second patient was found to have a different resistant organism on another intensive care unit.

Each case of carbapenemase producing organism prompts a review of individual patient risk factors as detailed in the Department of Health guidance. Risk factors include travel abroad and previous history of healthcare contact both in the UK and abroad.

### 10.2 Pertussis

A staff member working on a paediatric ward was diagnosed with pertussis in October. An investigation was undertaken in conjunction with Public Health England which involved staff and patient's contacts being risk assessed and followed up as appropriate.

### 10.3 Winter preparedness

The Imperial Health at Work team launched the annual flu vaccination programme on the 14th of October 2013 which includes drop in sessions and Occupational Health staff visiting clinical areas to vaccinate staff. Guidelines for the initial management of patients with suspected influenza have now been updated and communicated to the Trust. In addition, the importance of recognising and managing patients with diarrhoea and/or vomiting during the winter months was highlighted at the Trusts Team Brief sessions.

### 10.4 Respiratory viruses

Between the 18th October and 4th November 2013 Public Health Laboratory London reported that there were 17 notifications of patients requiring MERS CoV testing from 10 different hospitals. Of the 12 samples that met the testing criteria all were negative for MERS CoV RNA with alternative diagnosis of influenza and rhinovirus being confirmed instead. This also reflects the Trust experience to date.

In addition, the annually updated influenza algorithm has been amended to included advice on risk assessing and testing for MERS and will be available on the Trust intranet.

### 10.5 Surgical site infection (SSI) prevention and surveillance

A cross divisional working group is being developed to encompass all SSI work programmes under the leadership of a senior surgeon. This is a key safety and quality outcome and will build upon current work being undertaken at speciality level. This will ensure that Trust wide surveillance is coordinated under one umbrella and will facilitate data being reviewed collectively, along with ensuring evidence based practice and shared learning.

In October NICE published Quality Standard 49 Surgical Site Infection, covering the prevention and treatment of surgical site infection (http://publications.nice.org.uk/surgical-site-infection-qs49/introduction) the Trust must ensure that this can be delivered

## 11. Applied Research, Innovation and Education.

### 11.1 The UKCRC Centre of Infection Prevention and Management (CIPM)

- The work of CIPM was cited in the recent DOH 5 year Antimicrobial Resistance Strategy. In particular the report mentioned the Imperial Antibiotic Prescribing App as an example of action taken to improve prescribing practice and cited publications including 'Behavior Change Strategies to Influence Antimicrobial Prescribing in Acute Care: A Systematic Review', Clin Infect Dis 2011 October; 53(7):651-662 Charani E, Edwards R, Sevdalis N, Alexandrou B, Sibley E, Mullett D, Dean Franklin B, Holmes A, and' Investigating the application of data linkage to enhance the use of existing healthcare databases to support hospital epidemiology'. J Hosp Infect. 2011, Garcia Alvarez L, Aylin P, Tian J, King C, Catchpole M, Hassall S, Whittaker-Axon K, Holmes A.
- A paper on research funding into Antimicrobial Resistance (AMR), co-authored by Members of the Centre, highlighted that AMR received less than 4% of Infectious Diseases Funding.
- Professor Shiranee Sriskandan and Dr Rob Edwards were awarded £46,924.89 by the Imperial College NHS Trust BRC to research 'Novel protective antigens in pathogenic group A streptococcus.
- Dr Luke Moore has commenced his PhD 'Investigating the role of matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (MALDITOF) and whole genome sequencing in the critical care setting and the impact on antimicrobial prescribing and bacterial resistance'.
- The Centre, working with Dr Eimear Brannigan and IPC, has updated the e-learning *C. difficile* module. This can be accessed at http://www.imperial.ac.uk/imedia/fom/cipm/player.html
- The multidisciplinary MSc in Infection saw its first cohort of students graduate this year.
- Dr Hugo Donaldson, Consultant Microbiologist won a Teaching Excellence Award for NHS Teachers in 2013 for his teaching on the MSc Infection Management for Pharmacists.

### 11.2 Selected Recent Publications

- Evaluation of a national microbiological surveillance system to inform automated outbreak detection.
  Freeman R, Charlett A, Hopkins S, O'Connell AM, Andrews N, Freed J, Holmes A, Catchpole M.J Infect. 2013 Nov;67(5):378-84.
- Early (2008-10) Hospital Outbreak of Klebsiella pneumoniae Producing OXA-48 Carbapenemase in the United Kingdom. Thomas CP, Moore LSP, Elamin N, Doumith M, Zhang J, Maharjan S, Warner M, Perry C, Turton JF, Johnstone C, Jepson A, Duncan NDC, Holmes AH, Livermore DM, Woodford N. *International Journal of Antimicrobial Agents.* In press.
- Systematic analysis of funding awarded for antimicrobial resistance research to institutions in the UK, 1997-2010. Head MG, Fitchett JR, Cooke MK, Wurie FB, Atun R, Hayward AC, Holmes A, Johnson AP, Woodford N. *Journal of Antimicrobial Chemotherapy.* 2013 September 13.
- Investigating *C. difficile*. Moore LSP, Donaldson H. *British Journal of Hospital Medicine.* In press.
- Antimicrobial stewardship programmes: the need for wider engagement. Charani E, Holmes A. *BMJ Quality & Safety.* Nov 2013.
- Syndromic surveillance of surgical site infections - A case study in coronary artery bypass graft patients.King C, Aylin P, Moore LS, Pavlu J, Holmes A. J Infect. 2013 Aug 31.
- International implementation of WHO's hand hygiene strategy. Castro-Sánchez E, Holmes A. Lancet Infect Dis. 2013 Oct;13(10):824-5.
- The increasing role of pharmacists in antimicrobial stewardship in English hospitals.Wickens HJ, Farrell S, Ashiru-Oredope DA, Jacklin A, Holmes A; Antimicrobial Stewardship Group of the Department of Health Advisory Committee on Antimicrobial Resistance and Health Care Associated Infections (ASG-ARHAI). J Antimicrob Chemother. 2013 Nov;68(11):2675-81.

# Contents

Finance Performance Report for the month ending 31st October 2013



Building world class finance

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# PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

| | In Month | | | Year To Date (Cumulative) | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Forecast £000s | Variance £000s |
| **Income** | | | | | | | | | |
| Clinical | 64,864 | 68,220 | 3,356 | 437,341 | 453,708 | 16,367 | 745,934 | 769,132 | 23,198 |
| Research & Development & Education | 9,562 | 9,522 | (40) | 66,934 | 64,561 | (2,373) | 114,743 | 113,520 | (1,223) |
| Other | 6,651 | 6,685 | 34 | 46,550 | 46,862 | 312 | 79,799 | 76,311 | (3,488) |
| **TOTAL INCOME** | **81,077** | **84,427** | **3,350** | **550,825** | **565,131** | **14,306** | **940,476** | **958,963** | **18,487** |
| **Expenditure** | | | | | | | | | |
| Pay - In post | (38,792) | (39,043) | (251) | (269,759) | (274,451) | (4,692) | (462,891) | (468,816) | (5,925) |
| Pay - Bank | (1,724) | (1,858) | (134) | (12,191) | (12,448) | (257) | (20,798) | (20,723) | 74 |
| Pay - Agency | (1,865) | (2,298) | (433) | (13,428) | (16,216) | (2,788) | (23,743) | (27,375) | (3,632) |
| Drugs & Clinical Supplies | (17,928) | (20,305) | (2,377) | (125,560) | (134,501) | (8,941) | (214,761) | (228,011) | (13,250) |
| General Supplies | (2,962) | (3,091) | (129) | (20,734) | (21,926) | (1,192) | (35,551) | (37,622) | (2,071) |
| Other | (9,396) | (8,925) | 471 | (65,872) | (61,663) | 4,209 | (112,879) | (105,945) | 6,934 |
| **TOTAL EXPENDITURE** | **(72,667)** | **(75,519)** | **(2,852)** | **(507,544)** | **(521,205)** | **(13,661)** | **(870,622)** | **(888,492)** | **(17,870)** |
| | | | | | | | | | |
| **EBITDA** | **8,410** | **8,908** | **498** | **43,281** | **43,927** | **646** | **69,854** | **70,472** | **618** |
| Financing Costs | (4,615) | (4,846) | (231) | (32,293) | (33,432) | (1,139) | (55,371) | (80,989) | (25,618) |
| **SURPLUS / (DEFICIT) including Impairment** | **3,795** | **4,063** | **268** | **10,988** | **10,495** | **(493)** | **14,483** | **(10,517)** | **(25,000)** |
| Impairment of Assets & Donated Asset treatment | 49 | 120 | 71 | 343 | 379 | 36 | 592 | 25,592 | 25,000 |
| **SURPLUS / (DEFICIT)** | **3,844** | **4,183** | **339** | **11,331** | **10,874** | **(457)** | **15,075** | **15,075** | **(0)** |

**Surplus / (Deficit):** The Trust delivered a surplus of £4,183k in month, which is a favourable variance of £339k. The actual achievement of CIP YTD is £24,027k and this is behind plan by £4,033k. The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' (NCD) anticipated income and expenditure for the year. As a result of the improved Divisions' and NCDs' performance the forecast CIP delivery has improved by £4,001k. The forecast financing costs includes an estimate for asset impairment of £25m for the anticipated devaluation of land & buildings.

**Income**: Clinical income is ahead of plan and is mainly associated with continuing over-performance on the CCGs & NHS England SLAs.

**Expenditure: Pay** is down in the month when compared to the previous period due to the transfer of Parkhill Audit to TIAA .

**Non Pay** spend has increased in the month and is mainly attributed to an increase in the issue of PbR excluded drugs and devices which are a straight pass-through cost to CCGs and NHS England. To date over £5m of the overperformance against the plan is direct pass through drugs and devices.

**Financing costs:** This month's expenditure is broadly in line with the monthly average run rate.

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

# PAGE 2 - INCOME

| | In Month | | | Year To Date (Cumulative) | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Forecast £000s | Variance £000s |
| **Income from Clinical Activities** | | | | | | | | | |
| Clinical Commissioning Groups | 34,449 | 35,744 | 1,295 | 232,221 | 241,079 | 8,858 | 396,073 | 408,944 | 12,871 |
| NHS England | 24,612 | 26,910 | 2,298 | 165,950 | 172,410 | 6,460 | 283,046 | 292,327 | 9,281 |
| Other NHS Organisations | 1,519 | 1,308 | (211) | 10,242 | 10,127 | (115) | 17,469 | 16,602 | (867) |
| **Sub-Total NHS Income** | **60,580** | **63,962** | **3,382** | **408,413** | **423,616** | **15,203** | **696,588** | **717,874** | **21,286** |
| Local Authority | 829 | 722 | (107) | 5,587 | 6,228 | 641 | 9,529 | 10,790 | 1,261 |
| Private Patients | 2,845 | 2,903 | 58 | 19,228 | 19,954 | 726 | 32,801 | 33,926 | 1,125 |
| Overseas Patients | 159 | 222 | 63 | 1,066 | 1,252 | 186 | 1,820 | 2,057 | 237 |
| NHS Injury Scheme | 119 | 176 | 57 | 805 | 903 | 98 | 1,373 | 1,470 | 97 |
| Non NHS Other | 332 | 235 | (97) | 2,242 | 1,756 | (486) | 3,823 | 3,016 | (807) |
| **Total - Income from Clinical Activities** | **64,864** | **68,220** | **3,356** | **437,341** | **453,708** | **16,367** | **745,934** | **769,132** | **23,198** |
| **Other Operating Income** | | | | | | | | | |
| Education, Research & Development | 9,562 | 9,522 | (40) | 66,934 | 64,561 | (2,373) | 114,743 | 113,520 | (1,223) |
| Non patient care activities | 2,943 | 2,815 | (128) | 20,596 | 22,151 | 1,555 | 35,306 | 34,226 | (1,080) |
| Income Generation | 506 | 405 | (101) | 3,542 | 2,560 | (982) | 6,070 | 4,491 | (1,579) |
| Other Income | 3,202 | 3,465 | 263 | 22,412 | 22,150 | (262) | 38,423 | 37,594 | (829) |
| **Total - Other Operating Income** | **16,213** | **16,207** | **(6)** | **113,484** | **111,423** | **(2,061)** | **194,542** | **189,831** | **(4,711)** |
| | | | | | | | | | |
| **TOTAL INCOME** | **81,077** | **84,427** | **3,350** | **550,825** | **565,131** | **14,306** | **940,476** | **958,963** | **18,487** |

**Income from Clinical Activities:** The favourable in month variance is associated with the continuing over-performance of CCGs & NHS England SLA contracts. It is expected that the CCGs QIPP programmes will not deliver the anticipated reductions in admitted care and outpatient activity.

| **Statement of Comprehensive Income (SOCI)** | **Risk:** | **G** |
|---|---|---|

# PAGE 3 - EXPENDITURE

| | In Month | | | Year To Date (Cumulative) | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Forecast £000s | Variance £000s |
| **Pay - In Post** | | | | | | | | | |
| Medical Staff | (12,400) | (12,832) | (433) | (85,285) | (88,629) | (3,344) | (150,440) | (151,809) | (1,369) |
| Nursing & Midwifery | (11,945) | (12,203) | (258) | (82,942) | (85,460) | (2,518) | (144,068) | (147,912) | (3,844) |
| Scientific, Therapeutic & Technical staff | (5,542) | (5,548) | (7) | (38,645) | (39,376) | (731) | (66,586) | (68,195) | (1,610) |
| Healthcare assistants and other support staff | (2,054) | (2,325) | (271) | (14,469) | (15,794) | (1,325) | (24,633) | (27,048) | (2,415) |
| Directors and Senior Managers | (2,424) | (2,312) | 112 | (17,354) | (17,361) | (8) | (28,761) | (28,592) | 169 |
| Administration and Estates | (4,427) | (3,821) | 606 | (31,064) | (27,830) | 3,233 | (48,403) | (45,259) | 3,144 |
| **Sub-total - Pay In post** | **(38,792)** | **(39,043)** | **(251)** | **(269,759)** | **(274,451)** | **(4,692)** | **(462,891)** | **(468,816)** | **(5,925)** |
| **Pay - Bank/Agency** | | | | | | | | | |
| Medical Staff | (614) | (727) | (113) | (4,446) | (5,366) | (920) | (8,002) | (9,130) | (1,127) |
| Nursing & Midwifery | (1,251) | (1,414) | (163) | (8,732) | (9,293) | (561) | (14,693) | (15,241) | (548) |
| Scientific, Therapeutic & Technical staff | (400) | (464) | (64) | (2,700) | (3,569) | (868) | (4,565) | (6,919) | (2,355) |
| Healthcare assistants and other support staff | (280) | (314) | (33) | (1,963) | (2,543) | (580) | (3,992) | (4,159) | (167) |
| Directors and Senior Managers | (277) | (50) | 226 | (2,285) | (1,059) | 1,227 | (4,010) | (1,246) | 2,764 |
| Administration and Estates | (767) | (1,188) | (421) | (5,492) | (6,834) | (1,343) | (9,278) | (11,403) | (2,125) |
| **Sub-total - Pay Bank/Agency** | **(3,589)** | **(4,156)** | **(567)** | **(25,619)** | **(28,664)** | **(3,045)** | **(44,540)** | **(48,099)** | **(3,558)** |
| **Non Pay** | | | | | | | | | |
| Drugs | (8,294) | (9,558) | (1,264) | (56,844) | (63,120) | (6,276) | (99,268) | (103,398) | (4,130) |
| Supplies and Services - Clinical | (9,634) | (10,747) | (1,113) | (68,716) | (71,381) | (2,665) | (115,493) | (124,612) | (9,119) |
| Supplies and Services - General | (2,962) | (3,091) | (129) | (20,734) | (21,926) | (1,192) | (35,551) | (37,622) | (2,071) |
| Consultancy Services | (1,289) | (1,588) | (299) | (9,023) | (8,526) | 497 | (15,464) | (12,854) | 2,610 |
| Establishment | (617) | (726) | (109) | (4,343) | (4,537) | (194) | (7,435) | (7,591) | (156) |
| Transport | (824) | (1,037) | (213) | (5,768) | (6,401) | (633) | (9,892) | (11,511) | (1,619) |
| Premises | (3,351) | (2,925) | 426 | (23,457) | (21,749) | 1,708 | (40,219) | (38,547) | 1,672 |
| Other Non Pay | (3,315) | (2,649) | 666 | (23,281) | (20,450) | 2,831 | (39,869) | (35,442) | 4,427 |
| **Sub-total - Non Pay** | **(30,286)** | **(32,320)** | **(2,034)** | **(212,166)** | **(218,090)** | **(5,924)** | **(363,191)** | **(371,577)** | **(8,386)** |
| | | | | | | | | | |
| **TOTAL EXPENDITURE** | **(72,667)** | **(75,519)** | **(2,852)** | **(507,544)** | **(521,205)** | **(13,661)** | **(870,622)** | **(888,492)** | **(17,870)** |
| **Financing Costs** | | | | | | | | | |
| Interest Receivable | 23 | 10 | (13) | 167 | 115 | (52) | 287 | 287 | (0) |
| Receipt of Grants for Capital Acquisitions | 67 | 0 | (67) | 469 | 448 | (21) | 798 | 798 | 0 |
| Interest Payable | (72) | (71) | 1 | (502) | (508) | (6) | (859) | (858) | 1 |
| Other Gains & Losses | 0 | 0 | 0 | 0 | (18) | (18) | 0 | (18) | (18) |
| Depreciation | (2,917) | (3,068) | (151) | (20,413) | (21,455) | (1,042) | (35,001) | (60,893) | (25,892) |
| Public Dividend Capital | (1,716) | (1,716) | (0) | (12,014) | (12,014) | (0) | (20,596) | (20,305) | 291 |
| **TOTAL - FINANCING COSTS** | **(4,615)** | **(4,846)** | **(231)** | **(32,293)** | **(33,432)** | **(1,139)** | **(55,371)** | **(80,989)** | **(25,618)** |

**Pay** spend is down in the month when compared to the previous period due to the transfer of Parkhill Audit to TIAA .
**Non Pay** spend has increased in the month and is mainly attributed to an increase in the issue of PbR excluded drugs and devices which are a straight pass-through cost to CCGs and NHS England.
**Financing costs** are broadly in line with the monthly average run rate.

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

# PAGE 4 - Financial Risk Rating for Clinical & Non Clinical Divisions

| Medicine | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | 🟢 | 🟢 | 🟢 | 🟢 | 🟢 | 🟡 | 🟡 | | | | | |
| | Cost Control | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Forecasting Accuracy | 🔴 | 🔴 | 🔴 | 🔴 | 🔴 | 🟡 | 🟡 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| S&C | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | 🟢 | 🟢 | 🟢 | 🟢 | 🟢 | 🟡 | 🟡 | | | | | |
| | Cost Control | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Forecasting Accuracy | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| DISCS | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | 🟢 | 🟢 | 🟢 | 🟢 | 🟢 | 🟡 | 🟢 | | | | | |
| | Cost Control | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Forecasting Accuracy | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| W&C | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | 🟢 | 🟢 | 🟢 | 🟢 | 🟢 | 🟡 | 🟡 | | | | | |
| | Cost Control | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Forecasting Accuracy | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| corporate | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | | | | | | | | | | | | |
| | Cost Control | 🔴 | 🔴 | 🔴 | 🔴 | 🔴 | 🟡 | 🔴 | | | | | |
| | Forecasting Accuracy | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🔴 | 🔴 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| TRUST | Theme | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial Sustainability * | 🟢 | 🟢 | 🟢 | 🟢 | 🟢 | 🟡 | 🟡 | | | | | |
| | Cost Control | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Forecasting Accuracy | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Financial Governance | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |
| | Working Capital & Equipment | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | 🟡 | | | | | |

| KPI PERFORMANCE COUNT | 🔴 | 🟡 | 🟢 |
|---|---|---|---|
| **Medicine** | 20% | 64% | 16% |
| **S&C** | 16% | 68% | 16% |
| **DISCS** | 16% | 64% | 20% |
| **W&C** | 24% | 60% | 16% |
| **Corporate** | 38% | 57% | 5% |

* Financial sustainability always uses the income figures from the previous month, due to the reporting lag around income of 1 month.

In an attempt to give a more transparent view of FRR performance, the table to the left summarises the proportion of KPIs scored Red, Amber or Green for each Division and Corporate.

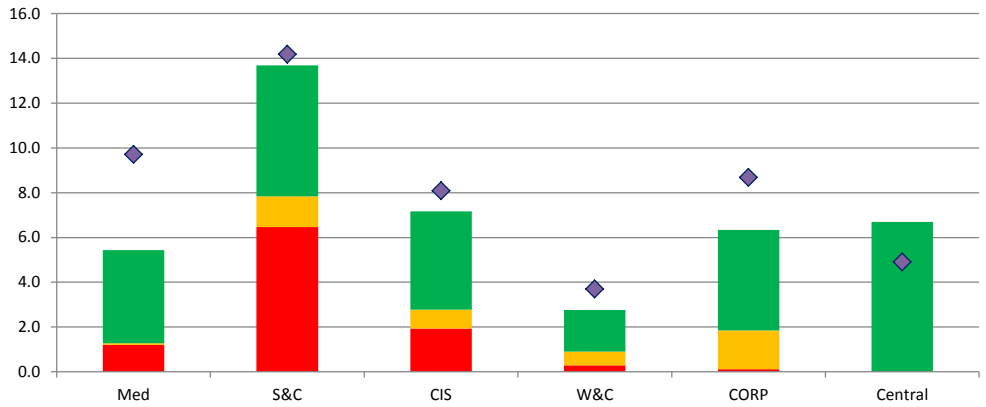
Improvements in timing of income reporting and the rollout of a income reporting tool to Divisions will improve transparency and engagement in maximising income receivable.

Plans to report the FRR, through a Qlikview application, at Directorate level are on track for delivery by December 2013.

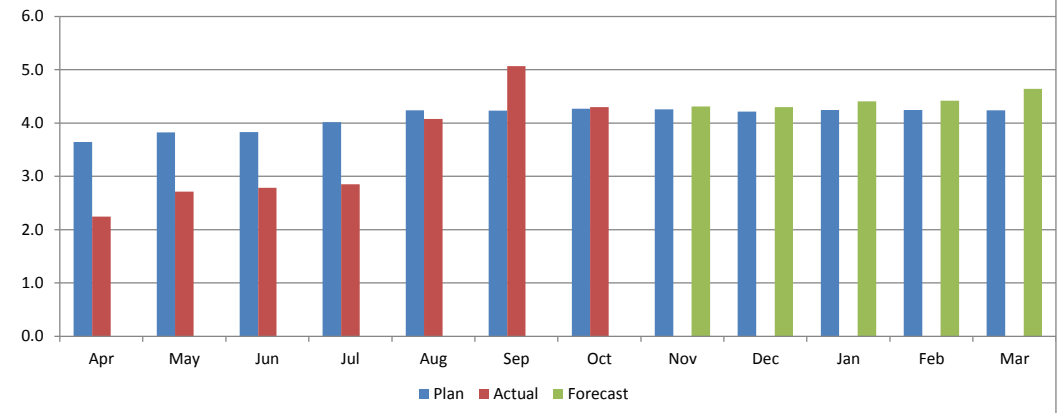
**Statement of Comprehensive Income (SOCI)** **Risk: A**

## PAGE 5 - Cost Improvement Programme

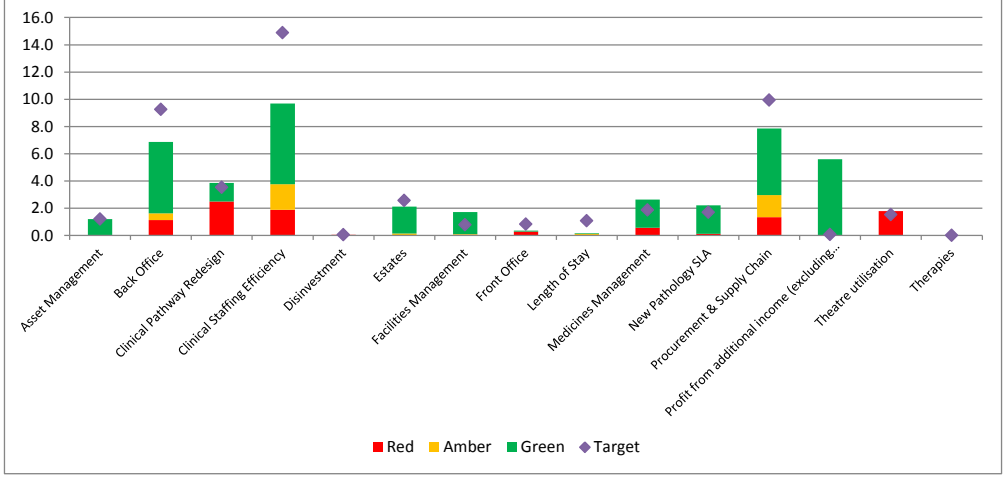
### Divisional CIP Forecast by Delivery Risk Status (£millions)



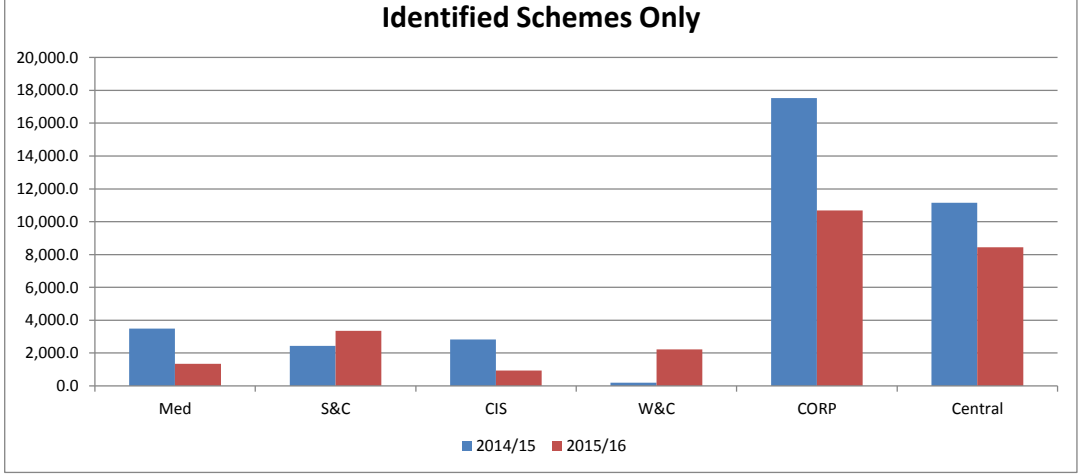

### CIP Monthly Trend (£millions)




### CIP Forecast by Theme (£millions)




### Divisional CIP Plans for 2014/15 & 2015/16 (£millions) Identified Schemes Only




Key Issues:

- £24m savings delivered year to date (deficit of £4m against plan).
- £46.1m of savings forecast for current year (deficit of £3.2m against plan) which is an improvement of £4m when compared to last months' forecast.
- The Trust has committed to the Trust Development Authority delivery of the full £49.25m plan. Current Divisional and Non-Clinical Directorate forecasts are £46.1m, leaving a gap of £3.2m to be mitigated.
- £26.5m of savings identified for 2014/15 by Divisions and Non-Clinical Directorates (3.7% of operating costs), with the remainder relating to central schemes (£11.1m).
- £18.5m of savings identified for 2015/16 by Divisions and Non-Clinical Directorates (2.6% of operating costs), with the remainder relating to central schemes (£8.4m).
- Red Clover have completed a piece of work with the Trust compiling a 3-year Quality & Efficiency Programme using programme suggestions from Chiefs of Service and General Managers.

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

**Variance: Favourable / (Adverse)** **Month 7, October 2013**

# PAGE 6 - STATEMENT OF FINANCIAL POSITION

| | | Opening Balance £000s | Current Month Balance £000s | Previous Month Balance £000s | Monthly Movement £000s | Forecast Balance £000s |
|---|---|---|---|---|---|---|
| **Non Current Assets** | Property, Plant & Equipment | 715,616 | 704,332 | 704,975 | (643) | 686,071 |
| | Intangible Assets | 1,681 | 1,446 | 1,479 | (33) | 1,225 |
| **Current Assets** | Inventories (Stock) | 17,652 | 17,065 | 17,373 | (308) | 15,152 |
| | Trade & Other Receivables (Debtors) | 65,462 | 144,423 | 129,956 | 14,467 | 68,462 |
| | Cash | 55,326 | 24,978 | 17,192 | 7,786 | 50,326 |
| **Current Liabilities** | Trade & Other Payables (Creditors) | (127,930) | (150,110) | (134,493) | (15,617) | (111,011) |
| | Borrowings | (3,059) | (3,075) | (3,075) | 0 | (2,701) |
| | Provisions | (37,353) | (42,658) | (41,070) | (1,588) | (33,299) |
| **Non Current Liabilities** | Borrowings | (23,362) | (21,873) | (21,873) | 0 | (20,709) |
| | Provisions | 0 | 0 | 0 | 0 | 0 |
| | **TOTAL ASSETS EMPLOYED** | **664,033** | **674,528** | **670,464** | **4,064** | **653,516** |

| **Ratio/Indicators** | **Risk Rating** | | |
|---|---|---|---|
| | **Current Month** | **Previous Month** | **Forecast** |
| Debtor Days | 51 | 48 | 27 |
| Trade Payable Days | 60 | 54 | 46 |
| Cash Liquidity Days | 19 | 17 | 18 |

The decrease in property, plant & equipment is due to depreciation for the month exceeding capital expenditure.

The increase in debtors is predominantly due to:

- Increase of £5.4m for NHS England quarter 3 Project Diamond and R&D MFF invoiced in month 7
- £5.6m invoices raised for Oct SLA for CCGs and NHS England still outstanding at end of the month
- Increase in accruals of £5.7m for quarter 2 over-performance, this will be invoiced in November
- Release of ISS prepayment of £2.4m

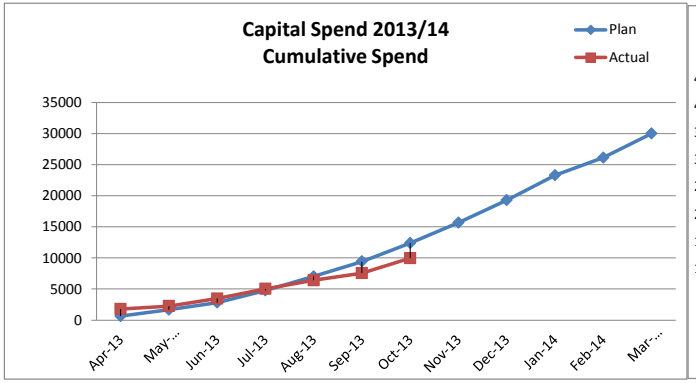
The increase in creditors is predominantly due :

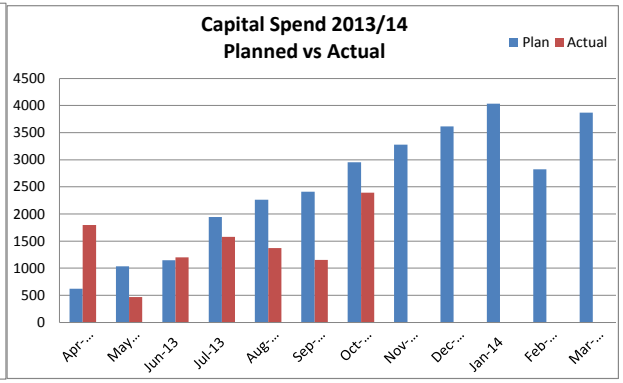
- Increase in deferred income of £10.1m relating to quarter 3 income from Heath Education England
- Increase in deferred income of £3m relating to quarter 3 Project Diamond and R&D MFF
- Other increases in deferred income of £1.2m, being Ravenscourt Park Hospital rental £0.7m and R&D £0.5m
- Increase of £2.6m for Lloyds Pharmacy invoices, paid month in November
- Increase in PDC accruals of £1.7m
- £3m decrease in NHS creditor accruals in respect of invoices paid

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

# PAGE 7 - CAPITAL EXPENDITURE

| By Scheme | In Month | | | Year To Date (Cumulative) | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s |
| Imaging Improvements HH | 53 | 28 | 25 | 314 | 88 | 226 | 2,093 | 350 | 1,743 |
| ICT Investment Programme | 350 | 540 | (190) | 2,500 | 2,807 | (307) | 4,500 | 4,500 | 0 |
| Endoscopy QEQM | 784 | 465 | 319 | 2,528 | 943 | 1,585 | 5,674 | 5,382 | 292 |
| Cardiac Relocation (EP) | 87 | (19) | 106 | 946 | 590 | 356 | 1,708 | 708 | 1,000 |
| Medical Equipment | 500 | 209 | 291 | 1,400 | 1,273 | 127 | 4,000 | 4,048 | (48) |
| Capital Maintenance CXH | 100 | 211 | (111) | 500 | 506 | (6) | 1,000 | 1,000 | 0 |
| Capital Maintenance HH | 100 | 175 | (75) | 500 | 496 | 4 | 1,200 | 1,200 | 0 |
| Capital Maintenance SMH | 100 | 39 | 61 | 500 | 123 | 377 | 1,000 | 1,000 | 0 |
| Access Control Upgrade | 25 | 0 | 25 | 200 | 0 | 200 | 900 | 0 | 900 |
| CCTV Development | 0 | 0 | 0 | 0 | 0 | 0 | 65 | 65 | 0 |
| Imaging Review | 500 | 0 | 500 | 800 | 0 | 800 | 3,000 | 2,000 | 1,000 |
| Theatre Upgrade | 100 | 0 | 100 | 700 | 64 | 636 | 900 | 900 | 0 |
| Pathology Equipment | 30 | 0 | 30 | 140 | 0 | 140 | 140 | 140 | 0 |
| Minor Works | 75 | 0 | 75 | 150 | 0 | 150 | 500 | 500 | 0 |
| Bathroom Upgrade HH Private Patients | 50 | 20 | 30 | 250 | 20 | 230 | 250 | 250 | 0 |
| Bio-Resource Centre | 0 | 86 | (86) | 350 | 128 | 222 | 350 | 850 | (500) |
| Aggregate Site Developments | 100 | 235 | (135) | 600 | 1,391 | (791) | 1,470 | 2,470 | (1,000) |
| Contingency | 0 | 0 | 0 | 0 | 0 | 0 | 1,250 | 2,709 | (1,459) |
| Shaping a Healthier Future Site Development | 0 | 325 | (325) | 0 | 530 | (530) | 0 | 1,300 | (1,300) |
| Radiotherapy Improvements | 0 | 52 | (52) | 0 | 943 | (943) | 0 | 960 | (960) |
| SALIX | 0 | 22 | (22) | 0 | 47 | (47) | 0 | 64 | (64) |
| New Linear Accelerators | 0 | 4 | (4) | 0 | 6 | (6) | 0 | 450 | (450) |
| **Total Capital Expenditure** | **2,954** | **2,392** | **562** | **12,378** | **9,956** | **2,422** | **30,000** | **30,846** | **(846)** |
| Donations | **0** | 0 | **0** | **0** | **(448)** | **448** | **0** | **(798)** | 798 |
| Disposal Proceeds | 0 | 0 | 0 | 0 | (2) | 0 | 0 | (2) | 0 |
| **Total Charge against Capital Resource Limit** | **2,954** | **2,392** | **562** | **12,378** | **9,506** | **2,870** | **30,000** | **30,046** | **(48)** |
| **Capital Resource Limit** | | | | | | | 30,000 | 30,064 | **64** |
| **Underspend / (Over) against CRL** | | | | | | | **0** | **18** | **18** |



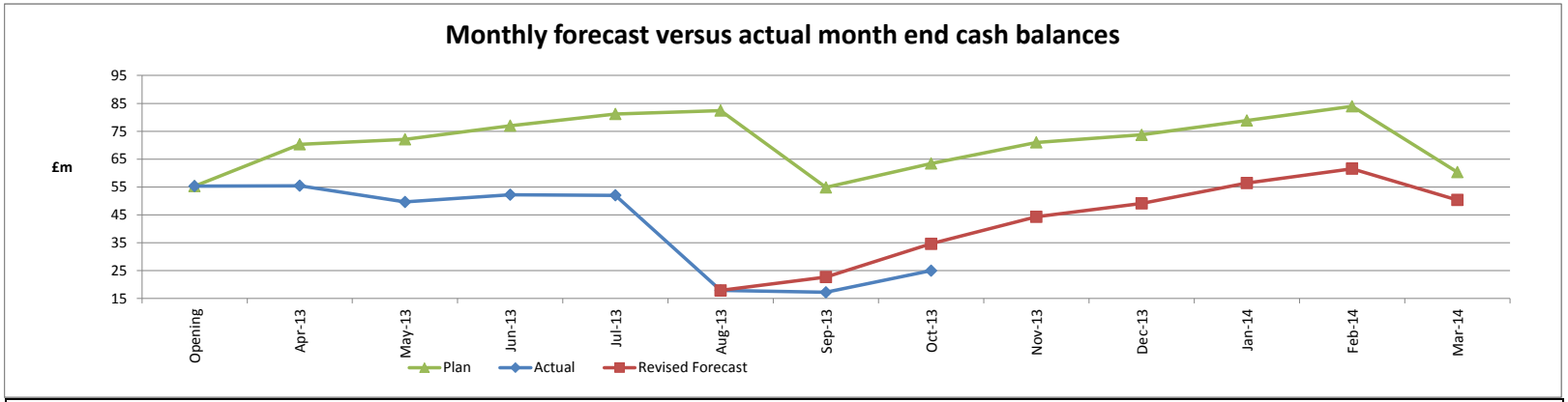




Whilst the total forecast outturn is equal to CRL, this includes a contingency sum of £2.7m, increased from £2.4m last month.

The changes to the forecast are due primarily to:
- Reduction in medical equipment forecast, due to many items that were programmed for replacement being classified as revenue e xpenditure and therefore subject to separate funding bids.
- An increase in Imaging forecast, due to more rapid development of business cases and requirements than anticipated last month , although these are yet to be approved.
- Some further re-phasing of payments for the Endoscopy QEQM project, although there has been no change to the overall completio n date.

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

# PAGE 8 - CASH




| | Opening | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 55,326 | 70,306 | 72,102 | 76,982 | 81,195 | 82,441 | 54,846 | 63,442 | 71,004 | 73,683 | 78,828 | 83,960 | 60,326 |
| **Actual** | 55,326 | 55,410 | 49,606 | 52,213 | 52,005 | 17,842 | 17,192 | 24,978 | | | | | |
| **Revised Forecast** | | | | | | 17,842 | 22,679 | 34,615 | 44,317 | 49,122 | 56,407 | 61,539 | 50,326 |

**Aged Debtor Analysis**

| Category | 0 to 30 Days | 31 to 60 days | 61 to 90 days | 91 days to 6 months | 6 to 12 months | Over 1 Year | Grand Total | Previous Month Total |
|---|---|---|---|---|---|---|---|---|
| NHS | £ 28,238,809 | £ 8,872,645 | £ 13,505,202 | £ 6,255,689 | £ 951,692 | £ 243,662 | **£ 58,067,698** | **£ 44,380,056** |
| Non-NHS | £ 7,792,094 | £ 3,128,852 | £ 265,303 | £ 1,775,094 | £ 2,026,539 | £ 848,247 | **£ 15,836,129** | **£ 11,997,583** |
| Overseas Visitors | £ 177,587 | £ 148,585 | £ 93,104 | £ 340,108 | £ 503,993 | £ 2,287,153 | **£ 3,550,530** | **£ 3,407,340** |
| Private Patients | £ 2,188,357 | £ 1,402,387 | £ 935,650 | £ 1,077,791 | £ 772,964 | -£ 183,628 | **£ 6,193,519** | **£ 6,479,740** |
| **Total** | **£ 38,396,846** | **£ 13,552,468** | **£ 14,799,259** | **£ 9,448,682** | **£ 4,255,187** | **£ 3,195,433** | **£ 83,647,876** | **£ 66,264,719** |
| **% of Total Debt** | **45.9%** | **16.2%** | **17.7%** | **11.3%** | **5.1%** | **3.8%** | **100.0%** | |

**Aged Creditor Analysis**

| Category | 0 to 30 Days | 31 to 60 days | 61 to 90 days | 91 days to 6 months | 6 to 12 months | Over 1 Year | Grand Total | Previous Month Total |
|---|---|---|---|---|---|---|---|---|
| All AP Creditors | £ 5,543,190 | £ 262,240 | £ 310,257 | £ 504,726 | £ 93,043 | £ 457,863 | **£ 7,171,319** | **£ 7,692,141** |
| **Total** | **£ 5,543,190** | **£ 262,240** | **£ 310,257** | **£ 504,726** | **£ 93,043** | **£ 457,863** | **£ 7,171,319** | **£ 7,692,141** |
| **% of Total Creditors** | **77.3%** | **3.7%** | **4.3%** | **7.0%** | **1.3%** | **6.4%** | **100.0%** | |

The cash forecast was revised in August to take into account delays in the receipt of NHS cash due to reorganisation and the subsequent delays in agreeing contracts with commissioners. It also took into account the 8 months advance payment to ISS made in August.

The main elements of the variance from plan of £38.4m are:

- £8.9m raised to NHS England for Q1 and Q2 Project Diamond and R&D MFF funding still outstanding. No indication has been received about when these amounts will be paid.
  A further invoice for Q3 invoice has now been raise.
- £22m over performance for quarters 1 and 2. Quarter 1 was invoiced in August and £11.5m remains outstanding. Quarter 2 will be invoiced in November.
- £3.5m rent receivable overdue for Ravenscourt Park Hospital
- £2.5m NCA invoiced to CCGs, NHS England and NHS Commissioning Board for months 1-5 still outstanding
- £1.1m Q1 NCA invoiced to local authorities not yet received. Q2 not yet invoiced

Payments when taken as a whole are slightly above plan mainly due to the Trust paying an additional £5.5m in advance to ISS for the 8 months to 31st May 2014. The plan only had a six month payment in advance.

At the end of October the balance of cash invested in the National Loan Fund scheme totalled £22m. This amount was invested for 7 days at an average rate of 0.39%. Total accumulated interest receivable at 31st October 2013 was £115k.

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

# Page 9 - FINANCIAL RISK RATINGS (FRR)

**Financial Risk Rating**

| Metric | Weighting | Metric Description | April | May | June | July | August | Sept | Oct |
|---|---|---|---|---|---|---|---|---|---|
| Achievement of Plan | 10% | EBITDA achieved (% of Plan) | 5 | 5 | 5 | 4 | 4 | 5 | 5 |
| Underlying Performance | 25% | EBITDA margin % | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Financial Efficiency | 40% | Net return after financing (%)<br>I&E surplus margin net of dividends (%) | 2 | 2 | 2 | 2 | 3 | 3 | 3 |
| Liquidity | 25% | Liquidity ratio (days) | 4 | 4 | 4 | 4 | 4 | 3 | 3 |
| | | | | | | | | | |
| **Overall Financial Risk Rating** | | | 2 | 3 | 3 | 3 | 3 | 3 | 3 |

**Continuity of Service Risk Rating**

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

The presentation of the Financial Risk Rating (FRR) has changed to a tabular format and includes the new Monitor Continuity of Service (CoS) risk rating for comparison purposes.

All risk metrics are on track for October.

* The liquidity ratio for FRR is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

| **Financial Risk Ratings** | **Risk:** | **G** |
|---|---|---|

# PAGE 10 - SLA Activity & Income by POD (Estimate for October 2013)

| Point of Delivery | Year to Date (Activity) | | | Year to Date (Income) | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Forecast £000s | Variance £000s |
| Admitted Patient Care | | | | | | | | | |
| - Day Cases | 39,153 | 41,595 | 2,442 | 34,058 | 35,002 | 944 | 58,130 | 59,198 | 1,068 |
| - Regular Day Attenders | 8,296 | 8,808 | 512 | 3,848 | 4,001 | 153 | 6,563 | 6,543 | (20) |
| - Elective | 12,351 | 11,748 | (603) | 42,598 | 40,613 | (1,985) | 72,697 | 66,280 | (6,417) |
| - Non Elective | 51,401 | 50,201 | (1,200) | 93,413 | 97,761 | 4,348 | 157,533 | 164,660 | 7,127 |
| Accident & Emergency | 102,124 | 101,737 | (387) | 11,863 | 12,065 | 202 | 22,385 | 23,909 | 1,524 |
| Adult Critical Care | 24,196 | 23,772 | (424) | 29,351 | 28,397 | (954) | 50,093 | 47,844 | (2,249) |
| Outpatients - New | 150,469 | 170,957 | 20,488 | 27,120 | 30,751 | 3,631 | 44,465 | 51,589 | 7,124 |
| Outpatients - Follow-up | 282,384 | 288,246 | 5,862 | 37,779 | 40,795 | 3,016 | 63,485 | 70,256 | 6,771 |
| Ward Attenders | 4,142 | 3,397 | (745) | 672 | 555 | (117) | 1,146 | 931 | (215) |
| PbR Exclusions | 400,605 | 915,385 | 514,780 | 35,069 | 41,190 | 6,121 | 66,858 | 75,129 | 8,271 |
| Direct Access | 1,287,020 | 1,286,158 | (862) | 8,884 | 10,968 | 2,084 | 15,151 | 18,769 | 3,618 |
| CQUIN | | | 0 | 9,690 | 10,368 | 678 | 16,539 | 17,849 | 1,310 |
| Others | 1,386,568 | 1,389,927 | 3,359 | 79,399 | 77,517 | (1,882) | 126,736 | 127,165 | 429 |
| Commissioning Business Rules | (11,999) | (12,612) | (613) | (10,554) | (5,992) | 4,562 | (18,712) | (11,185) | 7,527 |
| SLA Income | 3,736,710 | 4,279,319 | 542,609 | 403,190 | 423,991 | 20,801 | 683,069 | 718,937 | 35,868 |
| Less Non English Organisations | | | 0 | (2,092) | (1,756) | 336 | (3,711) | (3,045) | 666 |
| TDA Over performance | | | | 5,200 | | (5,200) | 13,622 | | (13,622) |
| HTLV | | | | | 922 | 922 | | 1,200 | 1,200 |
| Non Patient Care CCG Income | | | | 1,601 | 817 | (784) | 2,500 | 1,100 | (1,400) |
| Performance Bond | | | | 3,051 | 3,051 | 0 | 5,203 | 5,203 | 0 |
| Adjustment to TDA Plan | | | | (2,537) | (3,409) | (872) | (4,095) | (5,521) | (1,426) |
| **TOTAL** | **3,736,710** | **4,279,319** | **542,609** | **408,413** | **423,616** | **15,203** | **696,588** | **717,874** | **21,286** |

| Income by Sector | Year to Date (Income) | | | Forecast | | |
|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Forecast £000s | Variance £000s |
| North West - London | 189,942 | 201,244 | 11,302 | 318,900 | 341,389 | 22,489 |
| London - Others | 24,540 | 24,385 | (155) | 41,694 | 41,091 | (603) |
| Non London | 11,900 | 11,341 | (559) | 20,277 | 19,988 | (289) |
| NHS England | 162,258 | 171,454 | 9,196 | 276,771 | 289,460 | 12,689 |
| Local Authorities | 6,104 | 6,228 | 124 | 10,900 | 11,025 | 125 |
| Foundation Trust | 2,150 | 2,130 | (20) | 3,667 | 3,623 | (44) |
| Non Contracted Activities | 3,429 | 4,529 | 1,100 | 6,199 | 8,366 | 2,167 |
| Out of Area Treatment | 557 | 557 | 0 | 950 | 950 | 0 |
| Other SLA | 218 | 367 | 149 | | | 0 |
| TDA Over performance | 5,200 | | (5,200) | 13,622 | | (13,622) |
| HTLV | | 922 | 922 | | 1,200 | 1,200 |
| Non Patient Care CCG Income | 1,601 | 817 | (784) | 2,500 | 1,100 | (1,400) |
| Performance Bond | 3,051 | 3,051 | 0 | 5,203 | 5,203 | 0 |
| Adjustment to TDA Plan | (2,537) | (3,409) | (872) | (4,095) | (5,521) | (1,426) |
| **TOTAL** | **408,413** | **423,616** | **15,203** | **696,588** | **717,874** | **21,286** |

The report is an analysis of NHS SLA Income from clinical activities.
The Year to Date Month 7 position is favourable against plan by £15.2m. The main reasons are : -

- Increase in Day case activity with the key over performing service line being Clinical Haematology a favourable variance of £1.2m.
- Elective activity is below plan by £2.0m. The key under performing service lines are Trauma & Orthopaedics (£0.9m), Vascular Surgery (£0.6m) , Head & Neck Reconstruction (£0.4m) and Cardiology (£0.3m).
- Non Elective work is above plan by £4.3m with the key over performing service line being Accident and Emergency, showing an over performance of £2.1m. Other over performing areas include General Medicine £0.5m, Paediatrics £0.5m, and Major Trauma £0.5m.
- Outpatient first appointments are above plan £3.6m of which Imaging Diagnostics and Cardiology represents £2.9m.
- Outpatient follow up appointments have also increased against plan. The main variances are Cardiology £0.4m and AMD One Sto p £0.5m.
- The variance relating to PbR Exclusions is mainly due to Chemotherapy Drugs which are £4.1m above plan.
- Direct Access is above plan by £2.0m, showing an increase on both Pathology £0.4m and Imaging tests by £1.6m.

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

Imperial College Healthcare NHS
NHS Trust

NHS

# TRUST DEVELOPMENT AUTHORITY

## OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.

**Monthly Data: August 2013 Submitted 30/09/2013.**

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

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence

**COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:**

| Condition | Compliance Yes/ No | Comment | Executive lead |
|---|---|---|---|
| 1.**Condition G4** Fit and proper persons as Governors and Directors. | Yes | None | Jayne Mee, Director of People and Organisational Development. |
| **2. Condition G7** Registration with the Care Quality Commission. | Yes | None | Janice Sigsworth Director of Nursing. |
| **3. Condition G8** Patient eligibility and selection criteria. | Yes | None | Steve McManus, Chief Operating Officer. |
| **4. Condition P1** Recording of information | Yes | None | Marcus Thorman, Director of Finance. |
| **5. Condition P2** Provision of information. | Yes | None | Marcus Thorman, Director of Finance. |

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| | | | |
|---|---|---|---|
| **6. Condition P3** Assurance report on submissions to Monitor. | Yes | None | Marcus Thorman, Director of Finance. |
| **Condition** | **Compliance Yes/ No** | **Comment** | **Executive lead** |
| **7. Condition P4** Compliance with the National Tariff. | Yes | None | Marcus Thorman, Director of Finance. |
| **8. Condition P5** Constructive engagement concerning local tariff modifications. | Yes | None | Marcus Thorman, Director of Finance. |
| **9. Condition C1** The right of patients to make choices. | Yes | None | Steve McManus, Chief Operating Officer. |
| **10. Condition C2** Competition oversight. | Yes | None | Marcus Thorman, Director of Finance. |
| **11. Condition IC1** Provision of integrated care. | Yes | None | Claire Braithwaite, Divisional Director of Operations. |

Imperial College Healthcare NHS
NHS Trust

NHS

# TRUST DEVELOPMENT AUTHORITY

## OVERSIGHT: Monthly self-certification requirements - Board Statements Monthly Data: August 2013, Submitted 30/09/2013.

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

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

| For CLINICAL QUALITY, that: | Compliance Yes/ No | Comment | Executive lead |
|---|---|---|---|
| 1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. | Yes | None | Nick Cheshire, Medical Director. |
| 2. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements. | Yes | None | Janice Sigsworth, Director of Nursing. |
| 3. The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation | Yes | None | Nick Cheshire, Medical director. |

| | | | |
|---|---|---|---|
| requirements. | | | |
| **For Finance, that:** | **Compliance Yes/ No** | **Comment** | |
| 4. The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time. | Yes | The Trust remains a going concern as defined by the most up to date accounting standards. | Marcus Thorman, Director of Finance. |
| **For GOVERNANCE, that:** | **Compliance Yes/ No** | **Comment** | |
| 5. The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times. | Yes | As part of the on-going FT application the Trust is to review its compliance with the NHS Constitution. This work to be integrated into the review of the outcome of the Francis recommendations, with the action plan monitored by the Quality Committee/Audit, Risk and Governance Committee. | Janice Sigsworth Director of Nursing. |
| 6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner. | Yes | The Trust has a Risk Management Strategy and a Corporate Risk Register. The CRR identifies the key risks to the organisation. The CRR accompanied the Annual Governance Statement. | Cheryl Plumridge, Director of Governance and Assurance. |
| 7. The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance. | Yes | The Annual Governance Statement identifies significant issues for the coming year. A revised Risk Management Strategy has been approved at the July Trust Board meeting. | Janice Sigsworth Director of Nursing. |
| 8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted | Yes | All audit committee recommendations to the Board are implemented satisfactorily. Risk Management Strategy has been approved at the July Trust Board meeting. ICHT's final 2013/14 Operating Plan was approved in May 2013 | Cheryl Plumridge, Director of Governance and Assurance. |

| | | | |
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| by the board are implemented satisfactorily. | | | |
| 9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk) | Yes | The Annual Governance Statement identifies significant issues for the coming year. | Cheryl Plumridge, Director of Governance and Assurance. |
| 10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward. | Yes | Although the Trust is compliant with the majority of the reportable indicators, we have breached the zero tolerance for MRSA and also not achieved all cancer waiting time indicators for July.<br><br>A thorough investigation has been completed as to how four patients were found to have MRSA blood stream infection. These patients were receiving a range of treatments for complex conditions requiring intravenous lines making them more vulnerable to infections. Some of these patients had required prolonged inpatient care requiring a variety of invasive procedures over several weeks.<br>All Trust procedures and practice have been reviewed in order to maintain the highest possible standards of patient care and safety.<br>The Trust has taken action to enforce patient safety practice and infection prevention and control on all wards and clinical areas, including adhering to checklists for best practice when inserting intravenous lines and daily checks with ensuring they are removed as soon as they are no | Steve McManus, Chief Operating Officer. |

| | | | |
|---|---|---|---|
| | | longer required.<br>The Trust has three further MRSA blood stream infection cases that have been reallocated to the Trust that are currently being actively contested and one further case that is in arbitration. Therefore the Trust only recognises a year to date position of four cases.<br><br>**Cancer waiting times**<br>In August 2013 the cancer waiting time standards for July were published showing the Trust improved on performance by meeting 7 out of the 8 National Standards as well as the one local standard. The Trust failed to meet the 62 day first standard, hitting 79.7% (an improvement on last month) against the 85% target. This meant that 22 patients had their treatment delayed, ten patients above the tolerance level of 12. Of the 22 patients delayed, four of them were patients referred from local trusts outside the recommended Inter-Trust Referral time line (all were referred at > than 42 days, 2 of which were > 62 days). The majority of breaches were due to delay in access and reporting of diagnostics, the tumour site with the largest volume of breaches was within the Urology services as the Trust continues to clear the backlog.<br><br>The focus and scrutiny on cancer performance continues to remain a high priority. The cancer management team have recently developed a new Cancer Improvement Plan to address specific issues | |

| | | | |
|---|---|---|---|
| | | which are causing delay along the patient pathway; the focus is mainly on improving communication and timeliness of referrals from local referring Trusts. A second network meeting took place in September and local Trusts have agreed to work together to ensure referrals are sent in a more timely fashion. The Trust is piloting a new Inter-Trust Referral form in Lung with increased clinical details which will mean patients can be fast tracked more quickly to the appropriate service. The re-engineering of cancer pathways focusing on access to diagnostic services is still on going, with two new pathways commencing work in September, Head and Neck and the Upper GI. Somerset, which is a new system that tracks the patient through their treatment pathway and includes an electronic record of the interaction with the multi-disciplinary team, is now rolled out into all multi-disciplinary meetings. This means the Trust is in a better position to track for the first time access into outpatients, diagnostics, the Multi-disciplinary Team and final treatment to highlight any delay along the patient pathway.<br><br>Weekly meetings will continue to be held with the Chief Operating Officer and the cancer management team to bring breaches down to the absolute minimum. The Trust has committed to achieving all 8 cancer standards by October 2013. | |
| 11. The Trust has achieved | Yes | The Trust is compliant and | Kevin Jarrold, |

| | | | |
|---|---|---|---|
| a minimum of Level 2 performance against the requirements of the Information Governance Toolkit. | | will re-submit the toolkit return on 31 March 2014. | Chief Information Officer. |
| 12. The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies. | Yes | The Trust has a declaration of interest policy and maintains a register of interests in accordance with accepted NHS practice with an item on each Board agenda dealing with interests.<br>There is no longer a NED vacancy as a NED Designate has been appointed.<br>The Trust is currently undertaking a review of the Board and Committee structure. A review of the committee structure has been carried out, and the recommended new committee structure was approved at the July Trust Board.<br>A Board Development programme is being undertaken during the autumn as part of the FT application process. | Cheryl Plumridge, Director of Governance and Assurance. |
| 13. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. | Yes | A Board development programme is being undertaken during the autumn as part of the FT application process, which will further enhance the Trust Board's skills. | Jayne Mee, Director of People and Organisational Development. |
| 14. The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan. | | A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.<br>A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year. | Jayne Mee, Director of People and Organisational Development. |

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TDA Oversight: Monthly return of August 2013 submitted 30/09/2013_KS
S:\AHSC - Foundation Trust Application\SOM\13.14 Returns\M5 August 13.14

Imperial College Healthcare NHS Trust

NHS

# TRUST DEVELOPMENT AUTHORITY

## OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.

**Monthly Data: September 2013 Submitted 30/10/2013.**

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7. Condition P4 – Compliance with the National Tariff.
8. Condition P5 – Constructive engagement concerning local tariff modifications.
9. Condition C1 – The right of patients to make choices.
10. Condition C2 – Competition oversight.
11. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence

**COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:**

| Condition | Compliance Yes/ No | Comment | Executive lead |
|---|---|---|---|
| 1.**Condition G4** Fit and proper persons as Governors and Directors. | Yes | None | Jayne Mee, Director of People and Organisational Development. |
| **2. Condition G7** Registration with the Care Quality Commission. | Yes | None | Janice Sigsworth Director of Nursing. |
| **3. Condition G8** Patient eligibility and selection criteria. | Yes | None | Steve McManus, Chief Operating Officer. |
| **4. Condition P1** Recording of information | Yes | None | Marcus Thorman, Director of Finance. |
| **5. Condition P2** Provision of information. | Yes | None | Marcus Thorman, Director of Finance. |
| **6. Condition P3** Assurance report on | Yes | None | Marcus Thorman, Director of |

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| submissions to Monitor. | | | Finance. |
| **Condition** | **Compliance Yes/ No** | **Comment** | **Executive lead** |
| **7. Condition P4** Compliance with the National Tariff. | Yes | None | Marcus Thorman, Director of Finance. |
| **8. Condition P5** Constructive engagement concerning local tariff modifications. | Yes | None | Marcus Thorman, Director of Finance. |
| **9. Condition C1** The right of patients to make choices. | Yes | None | Steve McManus, Chief Operating Officer. |
| **10. Condition C2** Competition oversight. | Yes | None | Marcus Thorman, Director of Finance. |
| **11. Condition IC1** Provision of integrated care. | Yes | None | Claire Braithwaite, Divisional Director of Operations. |

Imperial College Healthcare NHS
NHS Trust

NHS

# TRUST DEVELOPMENT AUTHORITY

## OVERSIGHT: Monthly self-certification requirements - Board Statements Monthly Data: September 2013, Submitted 30/10/2013.

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

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

| For CLINICAL QUALITY, that: | Compliance Yes/ No | Comment | Executive lead |
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| 1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. | Yes | None | Nick Cheshire, Medical Director. |
| 2. The Board is | Yes | None | Janice |

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| satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements. | | | Sigsworth, Director of Nursing. |
| 3. The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements. | Yes | None | Nick Cheshire, Medical director. |
| **For Finance, that:** | **Compliance Yes/ No** | **Comment** | |
| 4. The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time. | Yes | The Trust remains a going concern as defined by the most up to date accounting standards. | Marcus Thorman, Director of Finance. |
| **For GOVERNANCE, that:** | **Compliance Yes/ No** | **Comment** | |
| 5. The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times. | Yes | As part of the on-going FT application the Trust is to review its compliance with the NHS Constitution. This work to be integrated into the review of the outcome of the Francis recommendations, with the action plan monitored by the Quality Committee/Audit, Risk and Governance Committee. | Janice Sigsworth Director of Nursing. |
| 6. All current key risks to compliance with the NTDA's Accountability Framework have been identified | Yes | The Trust has a Risk Management Strategy and a Corporate Risk Register. The CRR identifies the key risks to the organisation. The CRR accompanied the Annual Governance Statement. | Cheryl Plumridge, Director of Governance and Assurance. |

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| (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner. | | | |
| 7. The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance. | Yes | The Annual Governance Statement identifies significant issues for the coming year. A revised Risk Management Strategy has been approved at the July Trust Board meeting. | Janice Sigsworth Director of Nursing. |
| 8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily. | Yes | All audit committee recommendations to the Board are implemented satisfactorily.<br>Risk Management Strategy has been approved at the July Trust Board meeting.<br>ICHT's final 2013/14 Operating Plan was approved in May 2013 | Cheryl Plumridge, Director of Governance and Assurance. |
| 9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance | Yes | The Annual Governance Statement identifies significant issues for the coming year. | Cheryl Plumridge, Director of Governance and Assurance. |

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| framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk) | | | |
| 10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward. | Yes | In September one non-Trust attributed case of MRSA blood stream infection was reported, there were no cases allocated to the Trust, meaning that the total number of 'cases' reported against the Trust remains at eight for the year to date. However, the Trust only recognises 4 cases year to date as there are three that are being contested and one is in arbitration.<br><br><u>MRSA</u><br><br>The MRSA policy has now been updated to reflect actions from investigations, key changes are:<br>• In addition to screening all patients on admission, patients with a proven history of MRSA carriage or infection are to be screened on admission and then screened every week throughout their hospital stay; all patients who are in hospital for longer than two weeks are to be screened every week for the duration of their admission;<br>• Patients who are having a vascular access device inserted electively should be screened and the result available prior to their procedure where possible.<br><br><u>C.difficile</u><br><br>For C.difficile there were five Trust attributed cases reported in September 2013, against a threshold of five for the month, and therefore we remain above our year to date threshold at 37 cases, against a maximum of 65.<br><br>Each case of C.difficile has a detailed case review undertaken to help understand the organism's prevalence and contributory factors for acquisition. Patients are also reviewed on C.difficile clinical rounds occurring on all sites. The infection team (including microbiology, infectious diseases, infection pharmacy, IPC) review risk factors for all C.difficile cases including hospitalisations, contact with other patients with symptomatic C.difficile, antibiotic and PPI administration and demographics to further our understanding of the local epidemiology. These initiatives support education and shape the management of C.difficile going forward. | Steve McManus, Chief Operating Officer. |

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| | | A C.difficile e-learning module developed by IPC and Imperial College has been refreshed and made available to all Trust staff at the following link: http://www.imperial.ac.uk/imedia/fom/cipm/player.html<br><br><u>Cancer</u><br><br>In September 2013 the cancer waiting time standards for August were published showing the Trust maintained the same performance as July by meeting 7 out of the 8 National Standards as well as the one local standard. The Trust failed to meet the 62 day first standard, hitting 65.5% against the 85% target. This meant that 24 patients had their treatment delayed. Of the 24 patients delayed, three of them were patients referred from local trusts outside the recommended Inter-Trust Referral time line (all were referred at > than 42 days, one of which was > 62 days). The majority of breaches were due to delay in access and reporting of diagnostics, the tumour site with the largest volume of breaches (9.5) was within the Urology services as the Trust continues to clear the backlog. Across the 17 Trusts within the LCA, ICHT is one of seven Trusts who are failing the 62 day standards.<br><br>The focus and scrutiny on cancer performance continues to remain a high priority. The re-engineering of cancer pathways focusing on access to diagnostic services continues, with two new pathways that commenced work in September, Head and Neck and the Upper GI. The two urology pathways for prostate and haematuria were launched week commencing 21st October 2013, this will ensure all new referrals are booked into a rapid access clinic and receive all diagnostics on the day of their first outpatient appointment or within 3 days of being seen by the clinician. This will speed up the urology pathway providing target times for diagnostic assessment to be achieved and reported.<br><br>For a number of tumour sites e.g. LGI, Urology, Lung and Breast we have already implemented direct access to diagnostics. We have full engagement of the Imaging team to rapidly replicate this to all other tumour sites so delays in diagnostics will be reduced to a minimum. The focus will be on were possible to either book 'direct to test' from referral as is the case with LGI and Urology or at the time the clinician requests the diagnostic test so the patient leaves their first outpatient clinic attendance with their agreed diagnostic and follow up appointment. A generic minimum standard pathway has been drawn up and is being signed off by the LCA which will be adopted throughout all tumour sites. A new cancer waiting times management tool is being developed to give the Trust a facility to prospectively manage | |

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| | | patients and identify patients earlier in their pathway that needs to be escalated as well as give the Trust the ability for the first time to predict future cancer performance.<br><br>Weekly meetings will continue to be held with the Chief Operating Officer and the cancer management team to review and drive improvements in the cancer performance. | |
| 11. The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit. | Yes | The Trust is compliant and will re-submit the toolkit return on 31 March 2014. | Kevin Jarrold, Chief Information Officer. |
| 12. The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies. | Yes | The Trust has a declaration of interest policy and maintains a register of interests in accordance with accepted NHS practice with an item on each Board agenda dealing with interests.<br>There is no longer a NED vacancy as a NED Designate has been appointed.<br>The Trust is currently undertaking a review of the Board and Committee structure. A review of the committee structure has been carried out, and the recommended new committee structure was approved at the July Trust Board.<br>A Board Development programme is being undertaken during the autumn as part of the FT application process. | Cheryl Plumridge, Director of Governance and Assurance. |
| 13. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. | Yes | A Board development programme is being undertaken during the autumn as part of the FT application process, which will further enhance the Trust Board's skills. | Jayne Mee, Director of People and Organisational Development. |
| 14. The Board is | | A high calibre senior management team is in place | Jayne Mee, |

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| satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan. | | with the capacity, capability and experience to deliver the annual operating plan.<br>A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year. | Director of People and Organisational Development. |